NYS Council for Community Behavioral Healthcare

NYS Council Admin Relief/Reconciliation Mitigation

Area of Concern	Recommendation	Regulation/Guidance or Note from Lauri
Facilitating Admissions/ Increase Access to Care	Waive requirements for SOMH providers 'in good standing' from having to apply for formal approval before they can increase # of annual visits to the clinic. **Increases availability of on demand care while still holding providers to 'in good standing' status with the Office.** (Q: Is there a definition of 'in good standing'?)	14 NYCRR Part 551 -Proposed PAR -Current PAR DOH certificate of need program
	Clinics 'in good standing' and in areas with waiting lists for care should have new standalone and satellite clinic applications fast tracked. **This will increase access to care while keeping the process to get there in place.** Expedite the satellite program creation process, which currently takes over nine months. The existing timeline is incompatible with the academic calendar and hinders responsiveness to community needs. Process is overly burdensome, often requiring resubmission of information already provided to OMH through other channels. Especially challenging in high-need areas w/ limited mental health infrastructure. **Increase access to on demand / timely care.**	14 NYCRR Part 551 -Proposed PAR -Current PAR
	Approve requests for a provider to offer appointments after hours to support needed telehealth outside of clinic's open (staffed) hours. **Increases access to care while still maintaining licensing and other standards of care through the certification process.**	
	Allow IOP approvals before the 1 year waiting period. **Increases access to care while still holding provider accountable to program standards and processes established by the Office.**	
	Initially, use of EZ PAR addendums for school-based mental health programs made the process more efficient, however providers are now being asked to do crosswalks, safety plans, and a host of additional	14 NYCRR Part 551 -Proposed PAR -Current PAR

	work such that the efficiency gains made in the beginning are being wiped out. **Efficiency is imperative given workforce shortages and other demands on providers.** Providers perceive that there is now a person at OMH who reviews the completeness of items sent by provider when filing an EZ PAR application. But if anything is missing from the provider (to include attestations from every single site), providers don't know it is outstanding for some time before they are contacted by the Office, seeking more info. This prolongs the process and slows access to care. Can the Office build in greater transparency so, provider can see what has/has not been accepted by the Office? Also, it should be noted that NYC has added additional requirements on top of state demands here. **Providers want the state to 'get' that schools seek immediate approvals in order for the school to 'holding the space', once it has agreed to host a SBMH clinic satellite.**	
	OMH Clinics are the only US and NYS treatment settings that deviate from the AMA and CMS standard for intake billing code 90791 by requiring a 45-minute minimum which does not support a wide range of clinical presentations and individual needs; however high-quality admissions decisions can be made in less than 45 minutes. **NYS must align intake code 90791 with AMA-CMS requirements adopted by DoH, OASAS and OMH during COVID-19 Public Health Emergency to increase on demand access to care.**	OMH MHOTRS Guidance page 24
Would require state funding OR would save scarce resources	Carve out outpatient services from the state's Medicaid managed care program and return reimbursement to FFS. **State would save a minimum of $400M/year by doing so.** Insurers are permitted to keep 11% of what they are paid by the state to 'manage' care for 'operating expenses' and profit while they simultaneously and often illegally withhold hundreds of millions of dollars collectively.	

	No value add, claims denial rates high, only increases barriers to care, requires 3-6 additional staff in back offices to process and fight with plans, and results in workforce shortages due to providers not having access to the money that is not being paid on time and in full by the insurers. No meaningful enforcement by DoH or DFS. <mark>We know this requires more than just OMH approval however, NYS Medicaid Director stated DoH would not be opposed but OMH Commissioner needs to request a carve out and has not done so.</mark>	
	During COVID, OMH allowed flexibility in use of State Aid. There were two main components to this flexibility: • OMH allowed funding to be used across programs/program codes, allowing for a surplus in one area to be applied to a deficit in another. If OMH had a procedure in place where this could be done without huge amounts of requirements or a drawn-out approval process, it would be extremely helpful to agencies who know where the money can be best spent. • During COVID the state essentially combined the years of 2020 and 2021 for CFR reporting purposes. Rather than simply combining years, we suggest OMH find ways to deal with funds that weren't spent for one year rather than simply reconciling, which means taking back the funds later. Perhaps a small percentage could be held as a reserve for agencies to create a cushion against future deficits or allow for a percentage to be carried forward for the following year, or to be used for capital expenditures or other one-time investments in certain mental health programs. To this issue (from a provider): *In the past, we requested to move funds permanently from one stream to another within our state funding. It took OMH about 8 months to approve it when we made that request, and they gave us the approval during the week of Christmas, which put us in an end of year pinch.* ***If they could approve such requests (that have the full support of the LGU) more quickly, it would help us operate with more certainty.***	
	Targeted funding to help agencies and clinics train staff to manage the oncoming churn associated with	

	Medicaid Work Requirements, and to assist care recipients to get their coverage back if they lose it/fall off, or if it is up for renewal. In addition, patient education initiatives to ensure individuals understand the impending changes and how to maintain coverage. **Increases access and continuity of care for New Yorkers in need of services.**	
	Expand CPT allowances: • Reduce the minimum time thresholds for common CPT psychotherapy codes (90832, 90834, 90837) to allow for reimbursement for shorter, but clinically appropriate sessions. The risk is ultimately on the provider. • Incorporate case conferencing, crisis intervention services, and care coordination as billable under psychotherapy CPTs when they are clinically necessary, and ensure these codes can be billed for both Medicaid and non-Medicaid encounters through state-administered fee schedule. **Ultimately, these allowances would recapture critical revenue for uncompensated clinical activities, maintain staff capacity for high-risk and coordination-heavy cases, and allow for uninsured or underinsured clients to receive services. Would also allow for greater internal consistency in billing practices across all payers, and would avoid requiring dual workflows for provider and billing teams.**	
	Expand list of billable activities in non-CCBHC clinics to include same-day multi-service encounters such as care coordination, peer support, benefits navigation, health monitoring and health assessments.	
Staffing	Previously obtained background check and fingerprinting information should be utilized when an employee of one program wants to work in another program in the same agency. **Q**: Is there a way to create reciprocity in sharing results of these checks between OMH and OASAS? **Saves money and time on the provider end. Creates efficiencies that can be the difference between efficiently onboarding and covering staff vacancies.**	OMH Pre-Employment Check Guidance OASAS Background Check Guidance
	Encourage, but do not mandate, collateral participation. Staff often spend considerable time attempting to engage estranged or overextended	

	caregivers, which detracts from direct care delivery. **Reducing this requirement would improve staff efficiency and morale.**	
	Permit mid-level providers to assess restraint and seclusion in emergency situations when a prior order is in place, enhancing responsiveness and care continuity.	
	Utilize OMH personnel to assist in transporting patients from the ED to admit beds when EMS is unable to do so timely. **This would allow for better optimization of bed usage, reduce overcrowded EDs and improve patient care.**	
Surveys/Reporting Requirements/Tools/ Documentation	Capacity Survey: We see the value however we are concerned with the approach that requires entering data for each individual site into the MHPD system, and we strongly recommend submission on a quarterly rather than monthly basis and a delay to the start date for this exercise. Also, providers would benefit from this information being accepted as a batch submission in a single upload. **This adjustment would maintain the integrity of the data while reducing excessive administrative burden and speeding the process.**	14 NYCRR 553.2 OMH Bureau of Inspection and Certification
	Streamline reporting requirements by reducing or eliminating the need for multiple reports, including NYESS, Position Vacancy Reports, Capacity Reports, PSYCHES OUD, and CAIRS. Consolidating these efforts would significantly reduce administrative burden and associated costs.	14 NYCRR 553.2 OMH Bureau of Inspection and Certification (Hospital-based recommendation)
	Eliminate duplicative reporting by integrating all required data submissions into a single platform. **This would not only reduce administrative overhead but also help mitigate staff turnover due to redundant tasks.**	
	Improve alignment and integration of screening tools (e.g., tobacco use), risk assessments, safety planning, and treatment planning. **This would reduce the administrative burden of tracking multiple deadlines, increase time available for clinical care, and decrease staff frustration** and turnover.	
Program/System Design	Expand the use of virtual hearings for Mental Hygiene legal matters to **improve accessibility and efficiency.**	

	Authorize the use of mobile applications for safety planning among individuals with smartphones.	
	Allow documentation within progress notes to indicate that a safety plan was reviewed, rather than requiring a separate dated plan, to **streamline documentation processes.**	