FAQS: THE HUMAN SERVICES COLA

WHAT IS THE HUMAN SERVICES COLA?

A: First authorized in the 2006-07 Enacted State Budget, a permanent cost of living adjustment (COLA) was put into statute after a broad-based nonprofit community asked to establish a stable, predictable level of spending on services required by the State Constitution as stated in Article 17 – "The aid, care and support of the needy are public concerns and shall be provided by the state and by such of its subdivisions ...". The NonProfit Community acts on behalf of the State on public concerns and requires stable funding – that is why the statutory Human Services COLA was enacted.

HOW IS THE STATUTORY COLA DETERMINED?

A: In an effort to identify a realistic estimate of the level of spending for taxpayers, the Human Services COLA was tied in statute to the actual US consumer price index for all urban consumers (CPI-U) as published annually by the US Department of Labor. There are many CPI measures used to calculate spending growth. With regard to the Medicaid Global Cap the state has chosen to allow growth at no greater than the ten–year average rate for the long–term medical component of the CPI.

WHAT IS THE 2019-20 HUMAN SERVICES COLA? THE MEDICAID GLOBAL CAP COLA?

A: The CPI-U would have yielded a 2.9% COLA for affected human services community agencies this year if it were not deferred. The 10-year average for the long-term medical component of the CPI will yield a 3% increase in the Medicaid Global Cap spending this year (from $18.9 billion to $19.4 billion) and the Executive Budget sets the extension of the Medicaid Global Cap through SFY 2020-21 with a growth factor of 3.2%

WHAT IS THE HISTORY OF FUNDING THE STATORY HUMAN SERVICES COLA?

A: Since being added to law in April 2006, the Human Services COLA has been funded twice. In all other Final Budgets, the law has been deferred for OMH, OPWDD, OASAS, SOFA, OTDA and OCFS, resulting in over $700 million in support of programs and services for the aid, care and support of the needy and the individual who work to provide that aid, not being available.

WHAT DOES A VISUAL DEPICTION OF DEFERRING THE STATUTORY HUMAN SERVICES COLA LOOK LIKE?

Background on Workforce Investment: ~$707.05M in deferred COLAs since 2008

FY	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Statutory COLA	5.60%	-2.10%	1.20%	3.60%	1.40%	2%	2%	0.20%	0.8%	1.50%	2.9%
Actual COLA	0%	0%	0%	0%	0%	0%	2% (limited)	0.2%	0%	0%	TBD
$ Savings (million)	$171.00	--	$44.25	$150.40	$71.20	$106.30	--	--	$4	$19.90	$140.00

New York HPA Health Plan Association

Testimony of the New York Health Plan Association

to the

Senate Finance Committee
and the Assembly Ways & Means Committee

on the subject of
2019-2020 Executive Budget Proposals
on Mental Health Care

February 7, 2019

Introduction

The New York Health Plan Association (HPA), comprised of 28 health plans that provide comprehensive health care services to more than eight million fully-insured New Yorkers, appreciates the opportunity to present its members' views on the Governor's budget proposals.

Our member health plans have long partnered with the state in achieving its health care goals. These partnerships include collaborating on efforts to develop affordable coverage options for individuals, families and small businesses, providing access to care that exceeds national quality benchmarks for both commercial and government program enrollees, and improving access to quality care in its government programs. HPA members include plans that offer a full range of health insurance and managed care products (HMO, PPO, POS, etc.), public health plans (PHPs) and managed long term care (MLTC) plans. The New Yorkers who rely on these plans are enrolled through employers, as individuals, or through government sponsored programs — Medicaid Managed Care, Child Health Plus — and through New York's exchange, the NY State of Health (NYSOH).

We appreciate the opportunity to offer our view on the proposed 2019-2020 Executive Budget in relation to its application for spending on mental health and hygiene priorities.

Transition to Medicaid Managed Care

Approximately three years after the transition of behavioral health and substance use disorder services into Medicaid managed care, health plans believe that a great deal of progress has been made in providing members with substance use disorders and behavioral health needs with higher quality and better coordinated and integrated care than when the system was in fee-for-service Medicaid. Health plans also believe that there is still more education and relationship building that needs to continue — with providers and with the state. Health plans

see their role as ***partners*** working in collaboration with providers to assure that members receive all the care they need in the most appropriate setting.

Many providers are still struggling to submit appropriate claims to plans. For the past few years, bills have been introduced by the Legislature to require universal coding for Medicaid behavioral health services — when in reality, at the plans recommendation, there has been universal coding from the beginning of the transition in 2015. Plans continue to work diligently with providers to address their difficulties and ensure their financial stability, while at the same time helping providers better understand data about outcomes regarding the members they serve and how best to benefit from the move to value based payment.

COMBATTING THE OPIOID AND SUBSTANCE USE DISORDER CRISIS

We have seen the numbers and they are frightening. In 2017, 3,921 New Yorkers died from a drug-related overdose, according to data from the Centers for Disease Control and Prevention. From 2016 to 2017, the annual increase in drug-related deaths in New York rose 7.8 percent. For every drug overdose that results in death, there are many more nonfatal overdoses. Unfortunately, this epidemic continues to grow, touching New Yorkers across all demographics and communities.

Over the past several years, New York has taken a number of steps to address the opioid and substance use disorder (SUD) epidemic, including legislation to increase access to treatment and broaden coverage of treatment options, and oversight of parity compliance.

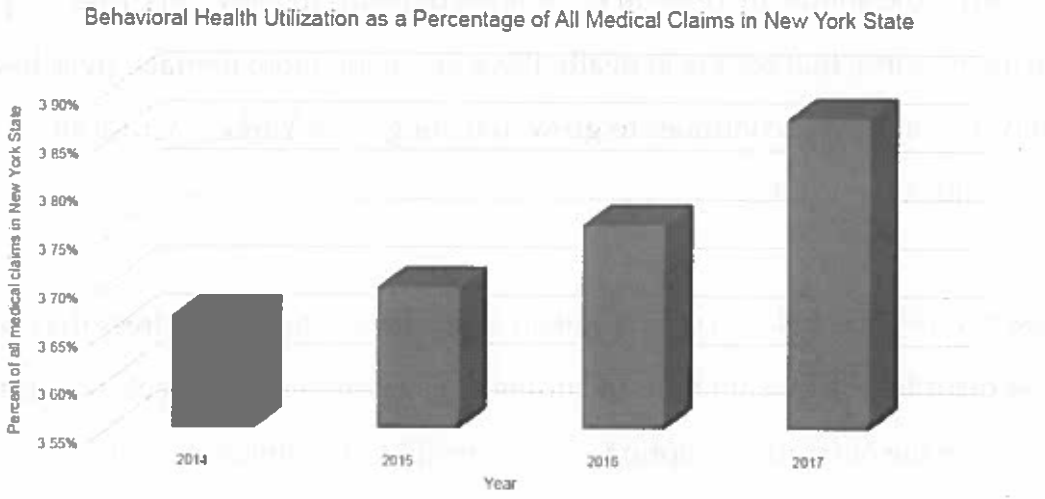
Expanding Mandated Inpatient SUD Treatment from 14 to 21 Days

The Governor's budget would expand the mandate requiring coverage of inpatient treatment for substance use disorders from 14 to 21 days, with no prior or concurrent authorization.

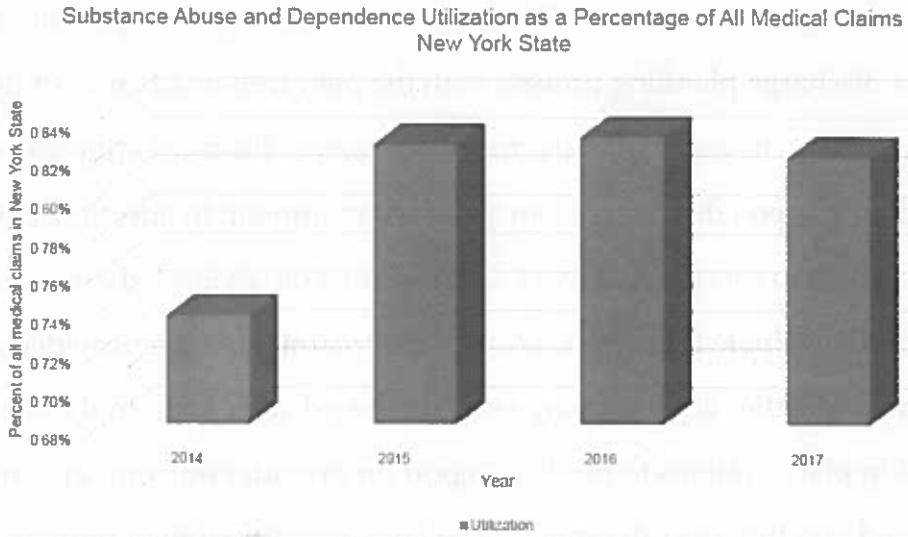
Health plans recognize the impact opioid addiction is having on individuals, their families and our state, providing coverage for a broad range of services — including inpatient and outpatient treatments — to ensure that all New Yorkers struggling with substance abuse are able to get the care they need in the right setting. Over the last four years, there has been an increase in utilization of behavioral health and substance abuse services. Based on data provided by FAIR Health, an independent nonprofit that collects data for and manages the nation's largest database of privately billed health insurance claims, the use of behavioral health, substance abuse, and opioid abuse services increased from 2014-2017 as follows:

- Over the last 4 years, utilization of behavioral health services increased 6 percent.
- Over the last 4 years, utilization of substance abuse and dependence services increased 11 percent.
- Over the last 4 years, utilization of opioid abuse and dependence services have increased 46 percent.[i]

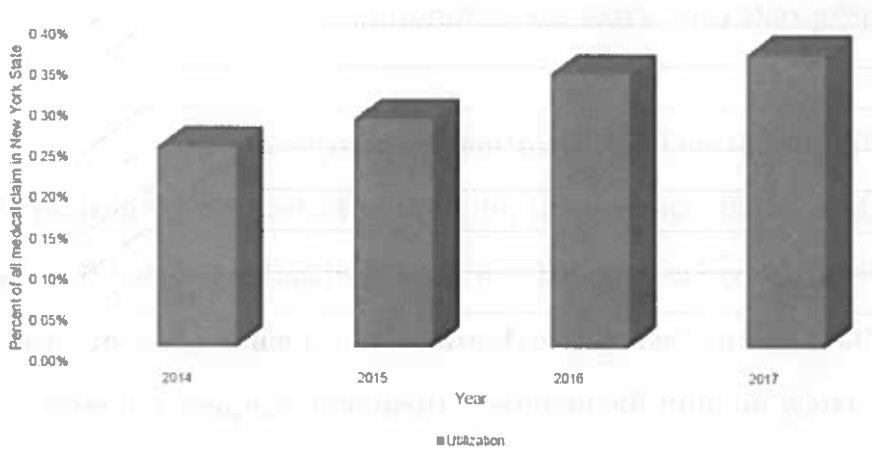
Behavioral Health Trends in New York State



Substance Abuse and Dependence Trends in New York State



Opioid Abuse and Dependence Trends in New York State



While clearly well-intentioned, plans believe that expanding the number of mandated treatment days will do little to address the epidemic. Plans are reviewing data since the 14-day mandate was implemented in 2016, but there is some information that may indicate providers are discharging patients on the 13th day and that re-admissions are increasing.

Rather than expanding the mandated number of days for treatment, the state should focus on adopting standards for coordinated care management across the delivery system. The state should require providers to communicate with the plan throughout the inpatient stay and begin to engage in a discharge planning process with the plan well in advance of the member's discharge from the facility – to assure that the member receives the most appropriate next level of treatment immediately upon discharge from inpatient treatment. In addition, despite all the steps New York has taken to set rules for what services must be covered, there remains a lack of outcome measures to evaluate the effectiveness of the treatment being provided and whether providers and facilities are following evidence-based standards. In the coming year, the state should put in place systems to publicly report on provider outcomes to ensure quality of care being provided and that the full range of evidence-based treatment options are available to individuals throughout the continuum of their care. The same principles should apply to inpatient psychiatric hospitalizations for children under the age of 18. Plans must be involved from the beginning of the hospitalization to ensure that children and their families receive the most appropriate care across the continuum.

Eliminating Prior Authorization for Medication Assisted Treatment

The Governor's budget would also prohibit prior authorization for medication assisted treatment. Health plans recognize the need to initiate medication assisted treatment quickly, but have concerns that without the ability to know when a member has initiated treatment, the plan cannot appropriately monitor the member's treatment progress and ensure that they are properly engaged with a qualified provider or providers as part of the comprehensive care management required.

Further, allowing OMH to review and approve plan medical necessity criteria is unnecessary as the Department of Health and the Department of Financial Services already have significant regulatory oversight of health plan activities.

Expanding Behavioral Health Parity

The Governor's budget would codify the federal parity statute. While this, in itself, is not troublesome, the fact that parity compliance oversight will be funded through a new $1.7 million in assessments on health plans is unnecessary, particularly on top of the more than $5 billion in taxes already imposed on health insurers. New assessments increase the cost of coverage for employers and individuals without doing anything to improve care.

Conclusion

HPA and its member plans are proud of the role they continue to play in helping New York improve access to affordable health coverage and quality of care for its residents. Plans remain committed to working with you and your colleagues on initiatives and strategies that help ensure New York individuals, families and business continue to have access to high-quality, affordable health insurance.

We thank you for the opportunity to share our views today.

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[1] Data and charts © 2019 FAIR Health, Inc. Used by Permission. Copying and further use prohibited. FAIR Health is not responsible for any of the opinions expressed herein.