Health Joint Legislative Hearing on SFY2022-2023 Executive Budget Proposal
February 8, 2022

Good afternoon, I'm Nadia Chait, Director of Policy & Advocacy at The Coalition for Behavioral Health. The Coalition represents over 100 community-based mental health and substance use providers, who provide the full array of outpatient and residential behavioral health services to over 500,000 New Yorkers annually.

New Yorkers are in desperate need of mental health and substance use services. The COVID pandemic led to unprecedented rates of anxiety, depression, and substance use. In the first year of the pandemic, overdose deaths increased 37%. Suicide is one of the leading causes of death for adolescents in NY, yet half of all children with a mental health condition don't receive treatment. More than 1 in 5 adult New Yorkers are unable to access the mental health treatment they need.

We are pleased that the Executive's budget proposal, in sharp contrast to executive budgets of recent years, makes significant investments in behavioral health services and takes substantial steps to improve Medicaid managed care. Behavioral health services were carved into Medicaid managed care in 2015, and since that time, providers have experienced inordinate, time-consuming and expensive challenges, including payment delays, inappropriate denials, duplicative audits, and more.

Medicaid managed care has shortchanged New Yorkers, as providers are forced to spend more money on administration and less money on providing care. New York is facing an incredible shortage of behavioral health professionals, in part due to the low salaries in this field. Providers cannot raise salaries when payments from managed care organizations (MCOs) are months or years delayed. Instead of dedicating resources to services, providers are forced to fight MCOs whose audit protocols do not comply with state agency regulations. New Yorkers are footing the bill for these absurd administrative requirements when every dollar available should be going to programs and services.

Competitive Procurement of Medicaid Managed Care

We are strongly in support of the Executive Budget proposal to competitively procure Medicaid managed care, which has the potential to resolve many of these issues.

Critically, the State would **limit the number of managed care plans** in any geographic region to no more than 5. This is a critical step. Currently, providers have been forced to deal with up to ten different plans, each with different requirements. This created an immense administrative burden for providers, requiring the hiring of additional billing staff to chase payments from multiple MCOs. Each plan has different procedures for audits, utilization review, and prior authorization. Each plan has a different appeal process. Each plan requires different materials for providers who are negotiating contracts. None of these duplicative requirements do anything to improve the quality of care provided, they simple increase administrative spending at the cost of services spending.

Additionally, clients have often churned between different plans, without always realizing how changing plans changes access to providers. MCOs have not properly educated clients on the impact of these changes. Instead, providers are left to manage these transitions, helping clients find new providers even when the client was happy with the services they were receiving. Limiting the plans will reduce the administrative burden on providers and reduce churning between plans. At the same time, by ensuring

each region has at least 2 plans, Medicaid beneficiaries will still be able to change plans when it is beneficial.

Value-based payment is also difficult with the number of plans currently in the market. Many of our providers, including some of the largest behavioral health providers in the state, do not have enough individuals enrolled in one managed care plan to engage in a value-based contract. By reducing the number of plans, providers will have a larger population in each plan, which will eliminate one significant barrier to value-based payment.

Through a competitive bid, the State proposes to **add criteria to evaluate the accessibility and geographic distribution of network providers**. Currently, many MCO networks are too small, limiting access to care. Our providers sometimes reach out to MCOs and are told that their network is 'full,' when providers are hearing from individuals enrolled in these plans that they cannot access care. As the Department of Heath develops the RFP, these criteria must be described clearly and must be specific, to ensure robust access to care. In particular, MCOs must build networks that provide the full array of mental health and substance use care, and should be evaluated on their ability to offer access to these critical services.

The proposal includes critical language to **evaluate bidders based on their past performance.** Currently, plans face few, if any, consequences for poor performance. In 2018, six different MCOs were found by DOH to have failed to pay providers appropriately for services delivered on thousands of claims. MCOs were found to owe providers millions of dollars. While DOH did force the MCOs to repay the providers, there were no consequences. Providers were not paid for over a year, in some cases for as long as two years. They did not receive interest or any late payment fees from the MCOs. DOH did not assess any penalties on the MCOs, and all of these companies continue to receive contracts for Medicaid managed care.

These cases represent just a handful of the many instances where MCOs have failed to meet basic performance standards. Providers routinely have to chase after payments from MCOs. When APG rates are increased, MCOs will take months to pay the increased rate, though they are required to begin paying the new rate on the day it goes into effect. Plans frequently deny claims at inappropriately high rates, requiring providers to spend staff time and resources on appeals. With a competitive procurement process that will evaluate plans based on past performance, the incentives for plans will change. Plans will need to step up their performance, or face being shut out of New York's managed care program entirely. For these reasons, we strongly support the proposal to competitively procure Medicaid managed care.

However, this proposal will only be successful in its goals if the **State, particularly DOH, OMH & OASAS, dramatically increase their oversight of the MCOs**. Plans have consistently been able to get away with failing to meet basic contract standards because the State has failed to oversee the plans. In one egregious example, the State recently recovered $111 million from MCOs that underspent on behavioral health services. That is $111 million that should have gone to help the many New Yorkers who need mental health and substance use care, but instead sat in the bank accounts of MCOs. While the State eventually recovered these funds, it took several years and significant advocacy from those outside of government. Additionally, the State has not been transparent about which plans these funds came from, and how widespread this issue was and remains.

Competitive procurement will help this issue by reducing the number of plans and adding additional criteria. The State must take a more active oversight role, however, to ensure that these gains are not squandered. The State must ensure compliance as stringently with MCOs as it does with the organizations providing services every day.

Healthcare Worker Bonuses

We are pleased to see funding for up to $3,000 in bonuses for healthcare and mental hygiene workers. Our staff are deeply underpaid because of inadequate government funding, and this bonus is a welcome incentive. Healthcare and mental hygiene workers have been on the front line of the pandemic for two years, and deserve recognition of their incredible work. However, a bonus does not solve the low salaries and insufficient benefits that plague our sector. It is a one-time bandaid that does not change the structural issues. We urge the State to look beyond bonuses and other one-time funding to permanent rate increases and contract funding that will allow our staff to receive the compensation they deserve.

Expansion of Behavioral Health Benefits into Child Health Plus

We strongly support the proposal to expand Medicaid behavioral health benefits into Child Health Plus. It has never made sense for children and families to not have access to these critical services. As children work through the trauma of the pandemic, we are seeing significant behavioral health needs. The Surgeon General has declared a youth mental health crisis, and the American Academy of Pediatrics, American Academy of Child & Adolescent Psychiatry, and the Children's Hospital Association declared a national emergency in youth mental health. Right now, our providers are forced to turn away children because they have Child Health Plus. Children whose family transitions from Medicaid to Child Health Plus are forced to lose access to critical services. This is terrible for children, families, and communities. The expansion of behavioral health benefits into Child Health Plus will help the mental wellbeing of our children.

Include Health Home Care Management in the COLA

The Executive Budget provides a critical investment in the form of a 5.4% COLA for human service providers. However, the Health Home Care Management program, which is under DOH, is excluded from the COLA. Health homes work to engage individuals with serious and complex physical health, mental health, and substance use disorders in their local community to improve health outcomes. Care managers are out in communities every day, connecting individuals to physical and behavioral health care, housing, and other critical supports. The Health Home Plus program, which provides a more intensive service for certain populations, is included in the COLA, but the rest of the Health Home program is not. This is an unfortunate oversight that will only harm workers who have been on the frontlines before and during the pandemic. The COLA language should be amended to include the Health Home Care Management program, for $28.3 million.

Thank you for the opportunity to testify today. If you have questions, please contact me at nchait@coalitionny.org.