**New Yorkers with substance use and mental health disorders have experienced disparities in access to behavioral health (BH) clinic treatment services and in health status because New York’s Medicaid program has failed to provide access to BH services with rates that support the cost of providing high quality care. Black, Indigenous, People of Color and other underserved communities have been disproportionately impacted by the growing inequities in our healthcare system. New York State faces a moment of crisis in communities that have insufficient accessible BH services, in the wake of a pandemic and during epidemic levels of suicide, addiction, and overdose. Community BH providers are hanging by a financial thread and increases in demand are being met by decreases in clinic capacity. The financial pressure on community BH providers has only grown since the State transitioned BH Medicaid services to Mainstream Managed Care (MMC) plans and Health and Recovery Plans (HARPs). The current state of crisis brought MH and SUD community-based providers together to seek a solution that would address inadequate and inequitable Medicaid funding.**

**Funding Proposal ($290.1M):**

We have developed a funding proposal that will address the tenuous fiscal viability of service providers caused by inadequate Medicaid rates that have failed to keep pace with inflation. Our funding proposal will also address structural injustices impacting people of color and other underserved communities by strengthening and better coordinating supports that address Social Drivers of Health (SDOH) for Medicaid beneficiaries in order to ensure access to safe housing, nutritious food, educational and vocational opportunities.

1. **Behavioral Health Quality Improvement Program (BH-QIP) Targeting Disparities & Equity ($39.3M)**: Licensed Article 31 and Article 32 outpatient clinics will be evaluated to determine a performance driven add-on payment. Providers would be rewarded based on attainment of thresholds for quality and equity metrics. Equity metrics would address long term structural issues like access to care, retention, outcomes for BIPOC populations, and other equity-driven challenges.
2. **SDOH Coordination Fee ($210.5M):** The SDOH coordination fee would reimburse BH providers for critical coordination supports that connect individuals to vital social services to address their whole person needs and promote stability and recovery in the community. This fee would fund currently non-billable provider time spent on contacting and coordinating resources, including housing, food, school and social programs, vocational and education services, and coordinating stakeholders and caregivers. National and state evidence show that this coordination support improves recovery and wellness for individuals and generates a return on investment for the overall system.
3. **Trended Ambulatory Patient Group (APG) Rate ($40.3M):** Outpatient BH providers are experiencing hardship because of reimbursement rates that do not cover the cost of service amid escalating demand. When NYS fails to adjust rates to enable BH service providers keep pace with inflation and concurrently fails to include BH equitably in infrastructure programs, it puts enormous strain on a BH service delivery system struggling to maintain safe, compliant physical space; recruit and retain high-quality, appropriately specialized clinical and non-clinical staff; and sustain mission-based services across the state. All rates paid to BH providers (including APGs, BH-QIP, and SDOH coordination fees) should trend with inflation annually.

***Upper Payment Limit considerations***

In recognition of federal Upper Payment Limit (UPL) rules that constrain New York State’s ability to increase rates for community outpatient BH services, we propose that both the BH-QIP and SDOH Coordination fee be structured as managed care directed payments. This removes those payments from UPL calculations. Further, we propose that the APG rates trend at the same rate as federal Medicare rates, thus ensuring that they do not pierce the UPL.

**BH Providers are financially distressed[[1]](#footnote-1)**

* The average provider had less than three weeks of cash on hand (18.4 days)
  + A quarter of providers had less than one week of cash on hand (5.8 days)
  + Only 20% had over two months of cash on hand
* 30% of providers are likely to have difficulty paying their current obligations for the coming year
* 40% of providers had a total margin of zero or less
  + More than a quarter of providers had a negative margin in 2019

**Growing Need for Adequate BH Services in Wake of COVID-19**

According to “**Mental Health Impact of the Coronavirus Pandemic in New York State**,” published by the New York State Health Foundation:

* The proportion of New Yorkers reporting poor mental health has remained high throughout the pandemic, reaching 37% of adult New Yorkers and 49% of young adult New Yorkers (ages 18–34 years) who had the highest rates
* Overdose rates have continued to set new records almost every year for close to two decades
* New Yorkers of color generally reported the highest rates of poor mental health throughout the survey period. In October 2020, 42% of Hispanic and 39% of Black New Yorkers reported symptoms of anxiety and/or depression in the prior week.

**Capacity Continues to Shrink as Medicaid Beneficiaries Seeking BH Services Grows**

According to utilization and capacity data published by the Office of Mental Health (OMH), Statewide mental health capacity has continued to shrink while the number of beneficiaries seeking community BH services have grown steadily. ***Outpatient behavioral health capacity shrank or remained flat in all regions from 2013-2019 despite substantial growth in the number of service recipients.*** Article 31 and 32 outpatient clinics continue to close due to financial concerns leaving fewer providers responding to the growing need. Our proposal will help to sustain and strengthen capacity when it is most needed.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **2013** | | **2019** | | | |
| **Region** | **Capacity[[2]](#footnote-2)** | **Recipients** | **Capacity** | **% Change** | **Recipients** | **% Change** |
| Western Region | 3,477 | 105,896 | 3,245 | -6.6% | 144,845 | +36.7% |
| Central Region | 1,320 | 62,263 | 1,319 | -0.1% | 86,820 | +39.4% |
| Hudson River Region | 3,956 | 62,363 | 3,870 | +2.0% | 69,962 | +12.2% |
| New York City | 8,482 | 238,205 | 8,807 | +3.8% | 301,954 | +26.7% |
| Long Island | 2,687 | 29,157 | 2,691 | +0.1% | 37,388 | +28.2% |

1. Based on an analysis of 143 NY BH providers’ 2019 forms 990. [↑](#footnote-ref-1)
2. Per 100,000 [↑](#footnote-ref-2)