

DoH/OHIP 1115 Waiver Concept Paper: Comments and Recommendations

The New York State Department of Health’s Office of Health Insurance Programs (OHIP) has laid out an ambitious agenda in its *1115 Waiver Demonstration: Conceptual Framework A Federal-State Partnership to Address Health Disparities Exacerbated by the COVID-19 Pandemic* “to change the way the Medicaid program integrates and pays for social care and health care in NYS.” We found much to celebrate in your proposal, including the development of SDHNs, investments in advanced VBP models, enhanced access for criminal justice-involved populations (especially the Medicaid eligibility 30 days prior to release), investments in HCBS and supportive housing, reimbursement for Critical Time Interventions, and ongoing support for telehealth (including audio only). As such, the New York State Council and our 105-community behavioral health (BH) provider members stand ready to support OHIP in your transformation initiatives. We propose modest amendments to your plan to ensure that New York State maximizes the value of this opportunity for our poorest and most vulnerable citizens.

NYS’s BH provider community is diverse and complex. Over 400 providers serve nearly 1 million people annually[[1]](#endnote-2) in 921[[2]](#endnote-3) OASAS-licensed programs and 5058[[3]](#endnote-4) OMH-licensed programs providing services ranging from very clinical (Comprehensive Psychiatric Emergency Programs, Inpatient Addiction Treatment Services, Article 31 and 32 outpatient clinics) to home and community-based services (family support, peer support, child and family treatment and support services) to SDH-type services (employment, residential).

**Behavioral Health providers are integral to the success of OHIP’s healthcare transformation agenda.** People’s health outcomes are impacted by how they behave far more than by the healthcare they receive,[[4]](#endnote-5) and working with clients to change their behavior is what community BH providers do.

BH disorders are the costliest conditions in the United States[[5]](#endnote-6) and the largest cause of disease burden,[[6]](#endnote-7) not because we spend so much treating them (less than 8% of US Medicaid spending went to BH in 2020),[[7]](#endnote-8) but because treatment of common medical conditions is made much more expensive by the presence of a BH condition.[[8]](#endnote-9) While nearly one in five Americans has a BH condition, few get the treatment they need,[[9]](#endnote-10) a situation that has been badly exacerbated by the COVID-19 pandemic, which has led to skyrocketing rates of BH conditions (now two in five Americans)[[10]](#endnote-11) while badly damaging the BH provider community’s stability.[[11]](#endnote-12) Just as New York must invest in its public health and medical infrastructure in preparation for the next pandemic, we must invest in community BH to prepare for the ‘pandemic of despair’ that is only beginning to crest, and for the disasters, both manmade and natural, to come. We have already seen overdose deaths increase in 2020 by 32.3% statewide and 36.9% in New York City.[[12]](#endnote-13)

People with mental illness[[13]](#endnote-14),[[14]](#endnote-15),[[15]](#endnote-16),[[16]](#endnote-17) and substance use disorders (SUD)[[17]](#endnote-18),[[18]](#endnote-19),[[19]](#endnote-20) are the costliest healthcare recipients, and their high costs are persistent.[[20]](#endnote-21) As a result, while only 20% of Medicaid recipients have behavioral health conditions, they account for 80% of all Medicaid spending,[[21]](#endnote-22) with per capita costs nearly four times those of their peers without behavioral health disorders[[22]](#endnote-23) even if we don’t account for their disproportionate involvement in non-health public spending (i.e., human services, housing, and criminal justice).[[23]](#endnote-24) In New York State, only 21% of Medicaid members have a BH claim, but they account for 60% of spending, 45% of emergency department visits, 53% of hospital spending, and 82% of hospital readmissions.[[24]](#endnote-25)

**It will be impossible for New York State to improve patient outcomes and bend the healthcare cost curve without enlisting the BH provider community in the effort and providing them with the resources they need to integrate effectively with the healthcare and social services delivery systems.**[[25]](#endnote-26)

Likewise, community BH providers will be critical for OHIP to achieve its goal of addressing the inequities that plague “persons living in poverty, Black and Latino/Latinx and other underserved communities of color, older adult populations, criminal justice-involved populations, high-risk mothers and children, persons with intellectual and developmental disabilities (I/DD), persons living with severe mental illnesses, persons with substance use disorders, and persons experiencing homelessness. The population served by both OMH[[26]](#endnote-27) and OASAS[[27]](#endnote-28) are disproportionately Black and Latinx when compared to the demographics of New York State.[[28]](#endnote-29)

Unfortunately, New York State’s DSRIP program failed to make the necessary investments in the community BH sector to ensure that it could function as a full partner in transformation efforts. *Of the more than $8.4 billion dollars invested in healthcare transformation activities by New York State between 2015 and 2020 (DSRIP, VBP QIP, and BHCC),* ***less than ¾ of a percent ($62.5 million) were invested in community BH agencies****.[[29]](#endnote-30) Our organizations have been left out of the infrastructure reforms other areas of healthcare have been able to make with the assistance of state and federal investments.* If New York State’s upcoming 1115 waiver is going to deliver on its promise, more resources will have to be invested in community BH providers, who are essential not only for New Yorkers with severe mental illness and substance use disorders, but to all New Yorkers because there is no health without mental health.[[30]](#endnote-31) Furthermore, because BH providers have decades of experience providing both healthcare and social services, they can help to span the chasm between the health and social services sectors, knitting together the service delivery systems and providing wraparound care for New Yorkers dependent on the safety net.

Therefore, NYSCCBH requests five things:

1. **Section 3.2: Earmark a significant portion of the workforce dollars for community BH providers.** Even before the COVID pandemic, HRSA was projecting a nationwide BH practitioner shortage of between 27,000 and 250,000 FTE by 2025.[[31]](#endnote-32) New York has 177 Mental Health Professional Shortage Areas.[[32]](#endnote-33) The pandemic has exacerbated this already bad situation. Demand for our services is skyrocketing at the same time qualified providers are choosing to leave the industry because of low wages and fear of infection.[[33]](#endnote-34) The New York State Council wholeheartedly supports OHIP’s intention to invest in the healthcare delivery workforce; we must take care of the people who take care of the people. Community BH providers, especially those working in New York’s historically underserved communities need these workforce investments at least as badly as other parts of the delivery system. Incoming federal funds including federal eFMAP will help, but these funds constitute a one-time infusion of assistance that will not address the serious ongoing workforce shortages up and down our organizations. This leaves behavioral health providers vulnerable to current and future public health crises. Significant funds should be set aside to address our desperate workforce development needs.
2. **Section 1.1: Require that HEROs have diversified governance and that community BH providers have meaningful governance roles.** During DSRIP we learned that if governance is controlled by a single provider type (e.g., hospitals) that the work is distorted to reflect the needs and interests of that provider type. If OHIP wants HEROs to produce plans that reflect the needs and capabilities of different types of providers, then governance rules should require that no provider type control even a preponderance of the governance control. OHIP should require that HEROs have governance shared between different types of providers (community BH, primary care, social determinant of health networks, hospitals) in relatively equal portions, in addition to the QEs, SDHNS, MCOs and other stakeholders. It is not enough to ensure that providers have a seat at the table; we must ensure that diverse provider types are represented. In this way, OHIP can ensure that HEROs don’t view the needs of the region through the lens of the lead provider type.
3. **Exhibit 3: Establish minimum MLR spending levels for community BH providers in Value-Based Payment Incentive Program VBP arrangements.** Money spent on behavioral health saves money in other areas of healthcare spending.It is simply not possible to meet the needs of New York’s Medicaid recipients, without investing in community Behavioral Health care. Value-based payment models that prioritize health equity will require meaningful BH capacity. MCOs should be held accountable for ensuring that their members have that access. New Yorkers need easy access to a comprehensive network of behavioral health providers that includes crisis support, Certified Community Behavioral Health Clinics (CCBHC), housing, and psychosocial supports. That will only happen if the historical underfunding of the BH delivery system is addressed.
4. **Section 1.3: Mandate through the model contract that plans attribute their members based on the preponderance of their service utilization**. For many people, particularly people with serious mental illness and chronic substance use disorders (many, although not all of whom, are served through Health and Recovery Plans), the primary provider of their care is not their PCP. Many people served by the community BH sector get the vast majority of their care from their BH provider. Attributing them to their PCP (with whom they may or may not have a relationship) is both inappropriate and ineffective. The Medicaid system will be much better able to control their costs if the responsibility for doing so rests with the provider with which they spend the most time. Community BH providers need to be the lead agencies for people with serious BH conditions. We are pleased that in the Concept Paper, OHIP opens the door to attribution based on a BH provider, but we urge OHIP to do more. OHIP should require that plans attribute their members in a way that is consistent with OHIP’s priorities, which are to improve outcomes and control costs.
5. **Section 1.1a: Mandate through the model contract that MCOs share data with providers who serve their members and HEROs.** The data Medicaid plans hold are not proprietary. They do not belong to the MCOs. The data belong to the taxpayers of New York, who have paid to have it collected. That plans refuse to share those data with providers inhibits care quality and care management and is anti-competitive. OHIP should require that plans share data with their provider network (in a manner compliant with HIPAA) about their clients, outcomes, utilization, and costs, to ensure that providers operate with the best available information about their clients and VBP contracts are negotiated on a level playing field. In addition, OHIP should require plans to share detailed and timely data with HEROs to support their planning efforts.

The New York State Council for Community Behavioral Healthcare is grateful for the opportunity to share our recommendations with OHIP regarding your 1115 waiver submission to CMS. We and our members are ready to help OHIP improve outcomes, drive an equity agenda, control costs, and improve the experience consumers have of New York State’s Medicaid system as we recover from the COVID-19 pandemic.

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10. https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/ [↑](#endnote-ref-11)
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12. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm#dashboard [↑](#endnote-ref-13)
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