The New York State Council for Community Behavioral Healthcare ("The Council") represents the interests of 110 mental health and substance use disorder prevention, treatment, and recovery organizations located across the state. Our member agencies provide a broad range of programs and services in a variety of settings including community-based freestanding agencies, counties, and general hospitals. NYS Council members are aligned in our efforts to ensure a robust continuum of care is available to any New Yorker seeking services through the public mental hygiene system. Our advocacy efforts are designed to enhance the availability of high-quality care that is person-centered, culturally competent, and available on demand to meet the unique needs of the individuals we serve.

The New York State Department of Health's Office (DOH) of Health Insurance Programs (OHIP) has laid out an ambitious agenda in its *1115 Strategic Health Equity Reform Payment Arrangements: Making Targeted, Evidence-Based Investments to Address the Health Disparities Exacerbated by the COVID-19 Pandemic 1115 Research and Demonstration Waiver (#11-W-00114/2).* We found much to celebrate in your proposal, including the development of Health Equity Regional Organizations (HEROs) to provide needed planning, Social Determinant of Health Networks (SDHNs) to enable community based organizations meeting social care needs (SCN) to integrate with healthcare delivery systems, investments in advanced Value-Based Payment (VBP) models, enhanced access for criminal justice-involved populations, investments in supportive housing, reimbursement for Critical Time Interventions, and ongoing support for telehealth (including audio only). As such, the New York State Council, and our 110-community behavioral health (BH) provider members stand ready to support OHIP in your transformation initiatives.

It is long past time that we as a state address the systemic failures, access gaps, and inadequate responses to health-related social needs that have driven the inequitable health outcomes that this waiver proposes to address. If we are going to address historical health inequities, we must acknowledge the historical funding inequities from which community BH providers have suffered, inequities driven by the stigma and discrimination directed at the people they serve. The New Yorkers served by both OMH[1] and OASAS[2] are disproportionately Black and Latino when compared to the demographics of New York State.[3] ***Investments in community BH <u>are</u> health equity investments.***

As such, if New York State's proposed 1115 waiver is going to deliver on its promise, BH providers need to be supported in the waiver design and implementation through governance authority, access to data, negotiating leverage, and financial resources. It is in the spirit of helping this waiver succeed that we offer the below suggestions for enhancements to it.

While, as we indicated above, there is much to like about this waiver proposal, we would be remiss if we failed to acknowledge the extent to which it is built on a shaky foundation. The existing 1115 waiver that NYS is proposing to amend has moved NY's Medicaid system steadily in the direction of greater roles and more power for managed care organizations (MCO), including a relatively recent carve-in to managed care of BH services. This carve-in has failed New York's Medicaid population. Since 2019, over 150 citations have been issued by the Department of Health against various MCOs responsible for managing Medicaid BH benefits for mental health and Substance Use Disorder (SUD) service recipients. Over 95 citations have been issued by DOH related to violations of mental health parity, with the remainder related to various timely payment and other contractual issues. In addition, and as the result of our advocacy, the newly enacted state budget includes an appropriation to OMH and OASAS of $111M (state share, grossing to $222M) recouped overpayments made to MCOs that failed to meet critical performance targets and Medical Loss Ratios (MLR) that are included in their contracts to ensure MCOs are spending most funds on care for Medicaid

[1] https://omh.ny.gov/omhweb/tableau/pcs.html
[2] OASAS Data as of October 2020.
https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/opioid_dashboard/op_dashboard&p=tbl&ind_id=op39
[3] https://www.census.gov/quickfacts/NY

beneficiaries. In addition, the Office of Mental Health recently completed a review of Medical Necessity criteria utilized by MCOs and found that all but one MCO used criteria that were not compliant with contractual requirements. If DOH is not going to impose accountability on MCOs through a procurement process (which would be the best way to do so), DOH must use every other opportunity to do so. This waiver presents just such an opportunity. **MCOs with a significant track record of citations and other enforcement actions, and those who failed to voluntarily return overpayments made to them by the state - funds that belonged to OASAS and OMH - should not be eligible to access the Value-Based Payment Incentive Payment Pools or Global Payment Model incentives** proposed in the 1115 waiver. We simply cannot reward their poor performance and bad behavior.

In addition to that overarching feedback, we have specific issues we would like to highlight.

Goal 1

We strongly support the utilization of Medicaid funds to address SCN, and the development of minimum rates for these essential services. We also endorse the use of the North Carolina Healthy Opportunities Pilot's model, which offers a broad array of housing, interpersonal violence, food, transportation, enhanced care management, and medical respite supports. **We propose adding rates to cover indicated, selective, and universal Substance Use Disorder (SUD) prevention services**, which are highly effective[4] and cost effective,[5] but generate a return on investment over a very long term and are as such insufficiently compensated through value-based payment arrangements.

Goal 1.1

In addition, we believe the HERO procurement must incent the development of HEROs whose governance leadership meaningfully reflects the demographics of the Medicaid recipients in the region for which it proposes to plan. The diversity of programmatic membership in the HERO governance is laudable, and we are grateful to see Behavioral Health Independent Practice Associations (IPA) required in the governance structure. We believe, however, that it is essential to

[4] http://addiction.surgeongeneral.gov/vision-future/time-for-a-change

[5] https://nida.nih.gov/about-nida/noras-blog/2022/04/investing-in-prevention-makes-good-financial-sense

ensure that organizational diversity is not the only diversity represented in the HERO governance. We therefore propose that **the HERO procurement process should incent the development of HERO governance structures that have racial, ethnic, sexual orientation and gender identity, and age diversity as well.** In addition, the HERO procurement process should **prioritize applicants who include Medicaid members, especially those with lived experience of the behavioral healthcare delivery system, in governance positions**.

Furthermore, those HERO applicants whose MCO governance members represent Managed Care Organizations with a significant track record of citations and other enforcement actions, and those who failed to voluntarily return overpayments made to them by the state, should be penalized. The state knows which plans are non-compliant[6] and the extent of their noncompliance; they should use that information to differentiate when making HERO awards. In addition, MCO network adequacy and the extent of their participation in VBP arrangements for HARP recipients (a product in which VBP penetration is extremely low) should be taken into consideration when making HERO awards, as those have both been priorities for the state for some time. **HERO funding should not reward plans that have failed in their most basic obligations to Medicaid recipients.**

And if other members of the HERO governance have problematic track records, their applications should be penalized as well. Providers who failed to fulfill their obligations under DSRIP, who have been found to have committed fraud, who have not been thoughtful and reliable stewards of funds entrusted to them, or who have lost licensure for quality reasons should not be rewarded with HERO governance roles. **The HERO procurement process should consider the past performance of all the governing organizations.**

We strongly support the idea that "HEROs will serve as the central hub of a data infrastructure that operates with continuous feedback and measure adjustment with additional dimensions of data collection and analysis emerging as necessary to address additional areas of need." HEROs will, however, only be able to fulfill this role effectively if they have access to the necessary data. We therefore propose that DOH mandate through the model contract that MCOs share

[6] https://omh.ny.gov/omhweb/bho/docs/nys-mhpaea-report.pdf

complete and comprehensive data with HEROs. **OHIP should require that plans share detailed and timely data with HEROs to support their planning efforts.**

Likewise, the Regional Health Information Organizations (RHIOs), which were also developed at taxpayer expense, have data that HEROs need to function effectively. **RHIOs should be required to share their entire historical claims database to enable HEROs to utilize longitudinal data acquired over more than a decade for their planning purposes**. And to the extent DOH can influence its sister state agencies, data about health-related non-healthcare data sources (i.e., housing, criminal justice, foster care) should be shared with the HEROs as well.

Additionally, it should not be left to chance whether a HERO decides that certain populations of New Yorkers, in particular children (especially children with Serious Emotional Disturbances) and people with Serious Mental Illness (SMI), are sufficiently important to rise to the surface in the planning process. If HEROs are to be entrusted with planning for their region, the state should ensure that their planning meets the needs of these vulnerable groups. **HEROs should be required to produce annual plans for people with Serious Mental Illness and children served by the Medicaid system.** And given the challenges both children and people with SMI have accessing care, HEROs should include assessments of the adequacy of MCO networks in their regions in those plans.

And while the New York State Council supports the development of HEROs, and the investment to build them, we are concerned that the sustainability plan for HEROs is poorly conceived. Neither the grant funding nor the member contributions envisioned by the application are sustainable funding models in the long term. And while we acknowledge the value provided by Common Ground Health, they remain primarily grant funded. The market for planning has not developed, so methods for maintaining the HEROs which are developed remains a problem. **The state should identify a business model for HEROs that is sustainable before investing $325 million in developing them**.

Goal 1.2

The Council applauds the state's identification of the need for platforms enabling Community Based Organizations (CBOs) to interface with the healthcare delivery system, and the development of Social Determinant of Health Networks (SDHN) to serve as those platforms. In far too many communities around the country, the

desperately needed integration of CBOs with healthcare providers has been hamstrung by the inability for the two sectors to communicate, share data, understand each other's priorities, and develop financially viable pathways for collaboration. SDHNs can be essential in overcoming those challenges. Because community BH providers have provided both medical and social services for decades, they have unique capabilities for bridging that gap. In addition, the state has recently invested in building platforms in the BH sector (BHCCs and the IPAs into which they developed) that serve a function very similar to that which the SDHNs will play. As such, **when the state procures SDHNs, bidders should be incented to partner with the BH IPAs in their community** to leverage the infrastructure, connections, and capabilities they have developed.

In addition, **SUD prevention providers should be included in the SDHNs** in acknowledgement of the extent to which prevention services fit in the definitions of Educational Organizations, Community Organizing Groups, and Youth Serving Agencies. As educational organizations, prevention providers facilitate curriculum programs inside schools across the state. They are also constantly promoting all aspects of physical and mental health. Prevention Agencies also act as Youth Serving Agencies as providers of program services inside community organizations. In this example, they act as or work with Community Organizing Groups, arming them with the tools they need to impact their towns, villages, neighborhoods, and schools. Furthermore, SUD prevention agencies are networked not only with each other but with a wide array of organizations including health, education, law enforcement, youth, faith-based, and more, which will help to link the SDHNs more effectively with the delivery system if they are included.

We also support the procurement of a technology platform to provide a closed-loop SCN referral system. As with many large procurements of this kind, the state has an opportunity to develop local businesses and providers or to allow state resources to be captured by out of state equity interests. New York State should take the opportunity to support our local economy. **The procurement of the statewide SCN referral system should advantage local and not-for-profit providers**, and not national private equity backed corporations.

Goal 1.3

The Council emphatically supports the development of Value-Based Payment (VBP) contracts utilizing differential attribution methodologies (e.g., Article 31, 32, 36, or integrated clinic). Rather than incenting plans to do so through access to VBP Incentive Payment Pools (VBP-IPP), the state should **mandate through the model contract that plans attribute their members based on the preponderance of their service utilization.** Plans attribute their members to their primary care providers (PCP) because it is logistically simpler for them; they have that field in their legacy databases. Unfortunately, that practice misses the reality that 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 most of their visits 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 whom they spend the most time. Community BH providers need to be the lead agencies for people with serious BH conditions. We are grateful to OHIP for opening the door to attribution based on a primary BH provider, but we urge OHIP to go further. OHIP should demand that plans attribute their members in a way that is consistent with OHIP's priorities, which are to improve outcomes and control costs.

Similarly, we support the requirement that Advanced VBP Contract Requirements include "an appropriately constructed network of providers based on the needs of the target populations." We strongly agree that Medicaid recipients need access to an adequate network of providers and would emphasize that ***ALL*** Medicaid recipients need access to community BH care that is high-quality, convenient, and culturally sensitive. Even if the target population for a VBP arrangement is the general Medicaid population, some of those members will require outpatient community BH care, and they should be able to access it without enrolling in a Health and Recovery Plan (HARP). And we agree with you that one of the lessons learned from DSRIP is that BH providers in governance roles are critical to "developing VBP arrangements that promote whole person care." As such, **every**

Advanced VBP Contract should include a BH IPA in a governance role, or the network is not "appropriately constructed."

We also strongly support the inclusion of data sharing requirements in Advanced VBP contracts. Too often providers engaged in VBP contracts lack access to the data that would enable them to positively impact the lives of the people they are serving. 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. **MCOs engaging in Advanced VBP contracts should be required (in a manner compliant with HIPAA) to share complete and comprehensive data with the provider network about the outcomes, utilization, and costs of the population whose care they are being asked to manage**. This is the only way to ensure that providers operate with the best available information about their clients and VBP contracts are negotiated on a level playing field.

Additionally, it is simply not possible to meet the needs of New York's Medicaid recipients, especially Black and Latino Medicaid recipients, without investing in community Behavioral Health care. Prepaid or global payment models that prioritize health equity will require meaningful BH capacity. 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 with meaningful VBP opportunities. MCOs should be held accountable for ensuring that their members have that access. As such, **DOH should establish minimum MLR spending levels for community BH providers in Advanced VBP contracts.**

And if the state intends for this waiver to improve the quality, accessibility, and integration of services to populations for whom English is not their first language, distinct efforts will need to be made to improve the availability of services in languages other than English. For decades providers have endeavored to offer services to their clients in the languages in which they are most comfortable, but they have done so without adequate state compensation for doing so. Medicaid's support for translation services or incremental compensation for clinicians who

are multi-lingual has been consistently insufficient. If DOH truly hopes to address the health outcome disparities that New Yorkers with limited English proficiency experience, **this waiver must improve the reimbursement available for service provision in languages other than English and the support for translation services.**

Lastly, there is no specific funding earmarked for children or children's services in this waiver proposal. This is remarkable given that Medicaid covers 50% of births each year, 60% of children ages 0 – 3 years, and 40% of children ages 0 – 18 years. As such, this proposal fails to address the overwhelming crisis New York is facing in youth mental health. Children are addressed only as a subpopulation that warrants special consideration. VBP arrangements are envisioned for kids or subpopulations of kids like those in the child welfare system or those with Serious Emotional Disturbances. This lack of funding targeted at children is a mistake given the poor track record of value-based arrangements for meeting children's needs. **Discrete investments of at least $1.5 billion should be made in services for children, especially children with Serious Emotional Disturbances.**

Goal 1.4

We agree that "NYS will need to expand the number of community health workers (CHW), care navigators and peer support workers, particularly drawing from low-income and underserved communities to ensure the workforce reflects the community they serve." This is essential not only to address long-standing health inequities, but also to mitigate a workforce shortage that has reached a crisis point. **OMH-Certified Peers and OASAS-Certified Peer Recovery Advocates should receive the same investments in recruitment, training, and career ladder development as CHWs**.

Goal 1.5

The Council strongly supports the extension of Medicaid eligibility to incarcerated individuals who will, or may be, released within 30 days. We agree with the state's contention that doing so will facilitate smoother re-entry and greater engagement with service provision. While we understand the impetus to limit eligibility to the health home population,[7] we cannot help but stress how it leaves

[7] "Those Medicaid enrolled members who have two or more qualifying chronic diseases (such as Hepatitis C and diabetes), or one single qualifying condition of either HIV, a serious mental illness, or an opioid use disorder, and who are scheduled to be discharged from a jail or prison within 30 days"

out large numbers of people who would benefit from this eligibility. Likewise, while we agree wholeheartedly that during this pre-release eligibility period individuals should have access to "depot, long acting and other addiction and mental health medications for treatment of schizophrenia and opioid addiction," we must emphasize that they should also have access to therapy. Just as the pharmaceutical interventions can help to facilitate successful linkages that maintain stability, the pre-release development of a therapeutic relationship with a licensed BH professional can be an exceptionally powerful transitional support. **Medicaid coverage should be extended to <u>all</u> financially eligible incarcerated individuals, and it should cover <u>all</u> services provided by outpatient BH clinics.**

Furthermore, the problem this pre-release funding seeks to address is paralleled in people who have been in psychiatric hospitals for extended inpatient stays. People discharged from psychiatric hospitals have the same challenges accessing care and maintaining the clinical gains they have made as people coming out of correctional settings. Just as we are extending pre-release Medicaid eligibility to incarcerated populations, **we should also extend pre-release Medicaid eligibility to people being discharged from long-term psychiatric hospitalizations.**

Goal 2

The Council is gratified to see the state's acknowledgement of the value of permanent supportive housing to lives of dignity, meaning, productivity, and health for Medicaid recipients, and the inclusion of housing supports in the waiver application. We must acknowledge, however, that there are no funds included in this waiver application for permanent supportive housing. **The state must identify sources of funding to develop sufficient permanent supportive housing, especially housing for people with Serious Mental Illnesses.**

We also support the development of new and expanded models of medical respite care for post-hospitalization discharges. This will fill a gap in the service delivery system that has caused people to get stuck in unnecessarily restrictive (and expensive) settings. This problem is particularly acute with respect to BH hospitalizations, especially among complex cross-system children. Therefore, **models of medical BH respite care should be developed and funded.**

Goal 3

The Council acknowledges the need for funding that enables financially distressed safety net and critical access hospitals and nursing homes to move toward VBP. Tertiary and quaternary care need to be accessible to Medicaid recipients in every area of the state, and safety net hospitals need to be able to participate in VBP. **We urge the state to ensure that funds received by safety net and critical access hospitals support the psychiatric beds that are least well supported by the market**.

We are also pleased to see investments in workforce, but we are concerned that the BH workforce will not receive the funding or attention it needs from the Workforce Investment Organizations (WIO). Even before the COVID pandemic, HRSA was projecting a nationwide BH practitioner shortage of between 27,000 and 250,000 FTE by 2025.[8] The pandemic has exacerbated this already bad situation. Demand is skyrocketing at the same time qualified providers are choosing to leave the industry because of low wages and fear of infection.[9] New York has 177 Mental Health Professional Shortage Areas.[10] 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. **OHIP should earmark at least one third (33%) of the workforce funding for community BH providers' workforce.**

The New York State Council for Community Behavioral Healthcare is grateful for the opportunity to share our recommendations with OHIP regarding your 1115 waiver application. We and our members stand 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.

For more information about the NYS Council, please contact Lauri Cole, MSW, Executive Director at (518) 461-8200 or lauri@nyscouncil.org

[8] https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/behavioral-health2013-2025.pdf

[9] Murphy, A.A., Karyczak, S., Dolce, J.N. et al. Challenges Experienced by Behavioral Health Organizations in New York Resulting from COVID-19: A Qualitative Analysis. Community Ment Health J 57, 111–120 (2021). https://doi.org/10.1007/s10597-020-00731-3

[10] https://data.hrsa.gov/topics/health-workforce/shortage-areas