NYS Council for Community Behavioral Healthcare

TESTIMONY ON THE FY 2023-2024 EXECUTIVE BUDGET PROPOSAL

SUBMITTED TO THE
JOINT LEGISLATIVE BUDGET COMMITTEE ON
FEBRUARY 28, 2023

TOPIC: HEALTH/MEDICAID

Good morning. My name is Lauri Cole. I am the Executive Director of the NYS Council for Community Behavioral Healthcare. The NYS Council represents 126 community-based organizations that provide a broad range of mental health and substance use/addiction prevention, treatment, recovery, and harm reduction programs and services, along with an increasing amount of primary care for New Yorkers with these conditions. NYS Council members are the general hospitals, departments of mental hygiene, and freestanding not for profit agencies in your districts that provide critical safety net services to some of New York's most vulnerable adults, children, youth, and families who play an essential role in ensuring access to high quality low-cost care.

Over the past several years, the rest of the world has come to understand what we have always known – **that mental health and substance use disorder care is health care.** Many of our members serve as the primary care provider for New Yorkers with these conditions precisely because we provide services without stigma or bias, and through an equity lens.

I am here today to speak with you about the access to care crisis that has restricted the availability of these essential services, and to discuss executive budget proposals that would either exacerbate or reduce these barriers.

Behavioral Health Care is Healthcare

Before commenting on specific executive budget proposals, we want to inform the Committee that there are serious and longstanding **waiting lists for mental health and/or substance use/ addictions services in local communities across the state**. The inability for New Yorkers to access care on demand has a direct and long-lasting impact on the health and wellbeing of our communities. Mental health and substance use disorder issues are health issues, and as such, they deserve equal time and attention at this hearing. Unfortunately, there are no witnesses on the list today that will speak directly to the many issues that our clients face as they continue to encounter barriers that prevent them from getting the care they need and deserve.

Increased need for behavioral health services, along with a long history of disinvestment in our sector, has left us flat footed, severely under resourced, and unable to recruit or retain the staff we need to meet requests for assistance. The result is a community of New Yorkers that do not have access to primary prevention services that are proven to positively impact decisions by young people around the use of substances.

Treatment services are currently at a premium across the state. Waiting lists for care delay interventions and leave disease processes unchecked. At the present time, our neighbors and family members who need care are sitting on interminable waiting lists. They are stuck in emergency rooms and homeless shelters, while rates of overdose and suicide increase, particularly in communities of color. These issues must be met with investments in prevention and other services to include robust treatment and recovery options that will save lives and return scarce resources to the state budget.

COVID-19 reinforced the knowledge we have had for decades that health inequities are pervasive across the health and behavioral health systems of care. The only way to address these inequities is for New York State to ensure all core services are available to all communities, and that our workforce reflects the individuals we care for. **At the present time, we cannot make a promise to provide culturally competent care due to massive staff vacancies and woefully inadequate salaries. We are unable to pay decent salaries to our primarily female workforce that is, in some areas of the state, about 80% Black and Hispanic single females with children**. We must be able to pay these dedicated staff what they need to survive and thrive but rates for reimbursement are largely stagnant and have been for some time. Our clients deserve culturally competent care that is both person-centered and values the preferences of the individuals we serve and the needs of the staff performing this difficult work.

While the Governor's executive budget proposal includes a $1B investment in mental health, there is barely any new investments in the substance use disorder/addictions programs and services that are clawing their way through a lethal Opioid Epidemic that is destroying communities and families across New York. **Opioid Settlement Funds must not be used as a placeholder or substitute for substantial new investments in prevention, treatment, recovery, and harm reduction services that are severely under-resourced and desperate for adequate staffing.**

Of the Governor's proposed $1B in mental health investments, $890 million is devoted to capital and housing, while just over $200 million is devoted to prevention, treatment, and recovery services. This investment, while historic and unprecedented, is not balanced. Under the Governor's proposal, our workforce that has been depleted and demoralized for over a decade, would receive a 2.5% COLA which is not nearly enough to address longstanding disinvestment in our systems of care.

To be clear, mental health and substance use disorder agencies are NOT included in the Governor's 5% Medicaid rate hike proposal for hospitals, nursing homes, and assisted living programs. Now more than ever there is a tremendous need for significant investment of funds for our workforce – investment that is at least comparable to other health providers.

The Human Services sector, and mental health and substance use disorder agencies specifically, have requested an ***8.5% COLA adjustment tied to the CPI, along with $500M in rate and contract increases to address longstanding disinvestment in our programs and services that are being crushed by ever-escalating costs associated with operating these***

programs and services. The time is now to make significant ongoing investments in both systems of care.

Carve Us Out of Medicaid Managed Care

In 2015, the state's Medicaid Redesign Team (MRT) implemented a proposal to carve in behavioral health services for New Yorkers with significant mental health and/or substance use disorder conditions, into Medicaid managed care. This has had a dramatic negative impact on providers ability to provide access to care.

Within six months of the implementation of our carve-in, providers knew they were in serious trouble as they quickly learned that MCOs do not feel compelled to follow state laws and contract requirements regarding timely and full payment, and the state does not adequately surveil, monitor, and enforce these requirements. We began meeting with leaders at the Department of Health (DoH) and the Office of Health Insurance Programs (OHIP) shortly after the carve-in began. We showed them example after example of instances in which MCOs were evading their responsibilities to pay rates set by the state on time and in full. We also showed them contracts from insurers that included prohibited clauses that were being sent to providers despite rules against such clauses. Over the last 3 years, over 200 citations have been issued by state agencies and DoH against various MCOs on two major issues: inappropriate claims denials, and failure to comply with federal and state parity laws. The citations have not resulted in meaningful behavior changes by MCOs – in fact, their bad behavior has become more flagrant. As a result, scarce provider resources are often utilized to hire armies of staff who spend their days chasing insurance companies who owe them thousands if not tens of thousands of dollars. MCOs have learned that there are few consequences associated with the games they play to delay payment. This results in a reduction in care as providers do not have adequate resources to recruit or retain the workforce necessary to meet demand. Payments to providers are often delayed many months and sometimes years while the state allows them to sit on resources that do not belong to the insurer.

For the last six years, we have begged DoH, and specifically OHIP, to do its job and adequately surveil, monitor, and enforce state laws that are largely ignored by payers. They have failed to respond adequately. We are desperate and need your assistance. I am here to request that you take immediate action to lead us out of this mess by insisting behavioral health services be **carved out of Medicaid managed care.** There is no added value for care recipients, and providers are inundated by administrative burdens associated with having to transact business with (in some cases) as many as ten different MCOs. The state has largely abdicated its responsibility for oversight of services to some of New York's most vulnerable individuals and this must change at once.

SUPPORT WITH REQUEST:

Network Adequacy Proposal: (HMH, Article VII, Part II, Subpart F)

While we wait to be carved out of Medicaid managed care, we request that you add language to the Governor's Network Adequacy proposal in the Health/Mental Hygiene Article VII bill under Part II, Subpart F, that would require the state to robustly enforce all applicable laws and contract provisions associated with the availability of behavioral health services in Medicaid managed care.

This proposed language was submitted to the Chairs by our association several weeks ago:

- **The state must perform a quarterly analysis of Provider Network Data Set (PNDS) data without fail. DoH must analyze the data which should be aggregated by MCO and also by service type.**
- **If the plan fails to meet Network Adequacy (NA) standards per the Model Contract, this should automatically trigger regulatory action by the state, without exception. Regulatory action must begin with fines of no less than $10,000 per instance of non-compliance.**
- **If the plan fails to meet NA standards 3 times in one year, the state must prohibit the MCO/plan from enrolling new insureds for a period of no less than 6 months.**
- **Results of the NA analysis as well as the methodology used to calculate NA, and the immediate action taken by the state must be published on DoH website and be easily accessible to the public. Insurers should be listed by name rather than anonymously.**

In addition to the above request, the NYS Council has also submitted budget language that would amend this proposal to ensure that both in network and out of network services across the behavioral health continuum of care, are paid at the Medicaid APG government rate. This is necessary due to the ongoing disparity that exists in the reimbursement rates between the Medicaid APG government rate that is set by the state, and rates commercial insurers are permitted to pay for the same exact services provided by the same level of staff. Commercial rates are, on average, just 50% of the Medicaid rate. The state permits this situation to persist. As such, we refer to it as state sanctioned discrimination in that it is the state that has set up a serious barrier for New Yorkers with commercial insurance as they seek services and find that many providers are unable to provide care due to extremely low commercial reimbursement rates.

SUPPORT WITH REQUEST: Statewide Healthcare Facilities Transformation Program – V (HMH Article VII – Part P) Creates a new $1 billion Statewide V program with at least $500 million award to health care providers for various projects, and up to $500 million for critical health care information technologies and telehealth capacity. **REQUEST: Eligibility for these funds should be expanded beyond Article 31 and Article 32 Clinics, to include any MH or SUD Program or Service that provides Health and/or Wellness Services**

SUPPORT WITH REQUEST: **Interstate Licensure Compact**: (HMH Article VII Part W, Sections 30 & 31) The NYS Council supports this proposal with a request that the **Legislature expand the titles that it applies to, to include LCSWs, LMHCs, CASAC and LMFT.** This will result in a larger pool of qualified practitioners who can work in our programs thereby decreasing waiting lists and ensuring access to care that is timely and at the correct level of care.

SUPPORT WITH REQUEST: Private Right of Action for Parity Violations, (HMH, Part II, Subpart D)
Did you know that at the present time, NYS and specifically, OMH, OASAS and DoH have issued over 200 citations to insurers for their failure to comply with mental health and substance use disorder parity requirements, and the accompanying self-compliance requirements NYS implemented several years ago? The Governor's proposal would allow individuals with commercial insurance to sue insurers for violations of telehealth parity, and to potentially recover the greater of actual damages or $1,000. **REQUEST: This proposal DOES NOT**

apply to Medicare, Medicaid, CHIP, Essential Plan, or other federal or state "insurance affordability program" coverage. We think this provision should include all payers.

SUPPORT: Access to Care Expansions (Article VII, Health/Mental Hygiene proposals) Commercial insurance would be required to cover:

1. OMH Residential (medically monitored, not community residences)
2. Crisis Residential
3. OCD/Eating Disorders residential services
4. Residential Treatment Facilities (RTFs)
5. *Mobile Crisis Intervention
6. Care Coordination
7. Critical Time Interventions
8. ACT

SUPPORT: ***Mobile Crisis services** must be covered just like ambulance services - no Prior Authorization, no limits as to which Mobile Crisis provider can be called.

SUPPORT: **School-based MH clinics** will be paid at no less than Medicaid rate or (if provider prefers) a negotiated rate, by commercial insurers. If the school-based clinic is out of network, the family will be held harmless for in-network cost sharing, and there will be no balance billing permitted.

SUPPORT WITH REQUEST: Telehealth Rate Parity in Commercial Insurance, (HMH, Article VII, Part II, Subpart C)

Thankfully, the Governor's Executive Budget seeks to expand on last year's requirement for Medicaid plans to reimburse Article 31 and 32 services delivered by telehealth at the in-person rates by requiring commercial insurers to do the same. At a time when there are significant waiting lists for care in outpatient and other programs across the state, all New Yorkers must have access to services on demand, and telehealth is one way to ensure timely access to care.

It should be noted that across the state, the ongoing rate disparity that exists in the behavioral health system between the 'government rate' paid by Medicaid and far (far) lower reimbursement rates paid by commercial insurers for the exact same services, **has caused an access to care crisis for New Yorkers with commercial insurance**. New York must immediately address this disparity that we often refer to as state sanctioned discrimination against New Yorkers with private health insurance. DFS should be required to set commercial rates on par with APG government rates paid to behavioral health providers. Until then, we applaud this proposal as a step toward the goal of equal access to telehealth – a valuable tool in the arsenal of weapons we have at our disposal to respond quickly to New Yorkers in need of assistance. **REQUEST: This proposal would apply an equivalent payment parity provision in Articles 32 and 43 of the Insurance Law and Article 44 of the Public Health Law, such that all regulated plans would need to pay for these services at the in-person rate, although not necessarily the government-established Medicaid rate [HMH, Part II, Subpart C]. We urge lawmakers to review our requests to the Chairs to ensure that the language in this proposal specifically requires payment of Medicaid APG government rates as the floor for these payments.**

SUPPORT WITH REQUEST: Indigent Care Pool for CCBHC Demonstration Agencies, and Implementation of Joint Licensure for these agencies

The NYS Council vigorously supports executive budget proposals having to do with reimbursement and licensing of CCBHC Demo agencies, and expansion of reimbursement to ensure access to care for all New Yorkers seeking services through these Clinics.

At the present time there are 13 CCBHC Demonstration agencies participating in this federal initiative. All are required to serve any New Yorker, regardless of his/her ability to pay. However, the CCBHC federal reimbursement model does not factor in the cost of services provided to those with no insurance. As such, the NYS Council advocated for, and the Governor's budget includes a proposal requiring DoH to seek federal approval for an **Indigent Care Pool,** to meet at least some of the needs of CCBHC agencies that serve significant numbers of New Yorkers with no insurance. **This proposal should also include additional funds for purposes of ensuring CCBHCs can service New Yorkers who do not have the means to pay multiple co-pays and high deductibles.** This would provide some ongoing reimbursement assistance to CCBHC Demo agencies much like the current Uncompensated Care Pool assistance available to other agencies that qualify for participation in the Uncompensated Care Pool. We

As economic conditions continue to stress households across the state and the country, more New Yorkers are unable to afford the high costs of health insurance, and even more are unable to meet high deductibles and copay requirements. The Indigent Care Pool begins to address some of the costs CCBHCs incur as they continue to serve uninsured New Yorkers**. It does not however address care provided to individuals who are underinsured such as those with high deductible plans or copay requirements that make use of their insurance unaffordable.** An Indigent Care Pool makes good economic sense, and it will result in less need for more acute (and expensive) levels of care for individuals who might otherwise delay care for themselves or their loved ones due to the absence of health insurance.

We also support the executive budget proposal that would implement a **joint licensure process for CCBHC Demo agencies.** This proposal will significantly reduce administrative burdens allowing more time for the agency to focus on the provision of high-quality care. Currently, CCBHCs are required to receive separate Article 31 and Article 32 clinic licenses. Existing CCBHCs in the federal demonstration would be certified under this new licensure "where the clinic demonstrates compliance with the certification standards." We support this proposal and urge both houses of the NYS Legislature to include it in its' one house budget proposals.

SUPPORT: Repeal of Article 28 Restrictions on Social Workers and Coverage of LMHCs/LMFTs (Article VII, HMH, Part Q, Section 2)

Effective January 1, 2024, the Budget would remove the restriction that allows Article 28 clinics only to bill for social worker services if they are providing individual psychotherapy to children under 21 or pregnant or postpartum women. Going forward, social workers would be able to provide any allowable services in such settings. Additionally, such clinics would be able to employ licensed mental health counselors (LMHCs) or licensed marriage and family therapists (LMFTs) to their full scope of practice as well.

SUPPORT: **Increases Medical Loss Ratios (MLR) for Plans** (DoH Agency Appropriations Report) The Budget proposes administratively to increase the minimum medical loss ratio

(MLR) requirement for all plans to 89%. Currently, only Health and Recovery Plans (HARPs) are subject to an 89% MLR requirement, while other plans are subject to an 86% MLR. DOH projects that this would result in $67 million in savings in FY 2025.

SUPPORT: Proposal to Expand CCBHC Federal Demonstration Program in New York State, (Article VII, HMH, Part HH)

The Governor's budget proposal includes an expansion of a model of mental health and substance use disorder care that is fast becoming the new standard of care across the country. Sine 2017, New York State has been participating in a federal demonstration program, the Certified Community Behavioral Health Clinic (CCBHC) initiative. The model has been embraced by CMS, HHS and SAMHSA, and is spreading like wildfire across the country. Since NYS entered the federal demonstration program, New Yorkers with behavioral health conditions with access to these services have benefited from requirements that hold demo agencies to a high standard of care. Importantly, the model seeks to reimburse these providers at cost – something similar to the FQHC Prospective Payment System reimbursement model.

The NYS CCBHC Demo has produced great outcomes including expanded access to care, closer formal collaborations between community providers that reduce siloed care, and an overall increase in the availability of culturally competent services. The model addresses the complex co-occurring needs of New Yorkers with mental health and substance use disorder conditions, and co-morbid physical health challenges – and all while saving New York significant resources. Demo agencies must meet 115 criteria that ensure high quality on demand care. Specifically, demo agencies must offer open access to care for any New Yorker seeking services regardless of the ability to pay, as well as Medication Assisted Treatment, crisis services, and much more.

According to the Office of Mental Health, in Demo Years 1 & 2, the CCBHC federal demonstration program in New York achieved the following results:

- Behavioral health inpatient services showed a 27% decrease in average cost per month over the prior year period
- Behavioral health ER services showed a 26% decrease in average cost per month over the prior year period
- Health inpatient services showed a 20% decrease in average cost per month over the prior period
- Health ER services showed a 30% decrease in average cost per month over the prior year period.

In our opinion, there are few more direct routes to ensure New York is fulfilling its' commitment to provide low cost, high-quality care to New Yorkers with complex behavioral health conditions than through **vast expansion** of the CCBHC Initiative. In November, we submitted language to the Governor's Office that (if it had been included in the executive budget exactly as submitted) would have opened the demonstration program up to any eligible provider. The Governor's proposal would add 26 new Demo agencies. This is a great start. As such, we urge you to prioritize and vigorously support this proposal.

SUPPORT: Commercial Insurance Coverage for Maintenance and Detox Treatment, (HMH Article VII, Part II, subpart E)

This proposal would assure state-regulated commercial insurance coverage for detox or maintenance treatment of SUDs including all buprenorphine products, methadone, long-acting injectable naltrexone, or medications for opioid overdose reversal, without prior authorization for initial or renewal of such treatments. While it is unfortunate that we have to go to this length to ensure commercial insurance covers life-saving detox and maintenance treatment of SUDs, we vigorously support this proposal for its' focus on access to care for commercial insurance beneficiaries.

SUPPORT: Preauthorization and Concurrent Review Proposals (HMH, Part II, Subpart E)

Pre-authorization: This proposal would prohibit insurers from performing preauthorization or concurrent reviews for the first 30 days of mental health treatment for adults in an in-network inpatient hospital or crisis residence licensed or operated by OMH, except where the insured meets designated clinical criteria or is receiving care in a facility designated by OMH in consultation with DFS and DOH. Given the likelihood that this proposal will close another loophole that insurers often take advantage of in order to deny or delay care, the NYS Council applauds this proposal

Concurrent Review: This proposal requires utilization review determinations for mental health conditions to be made using evidence-based, age-appropriate clinical review criteria approved by OMH in consultation with DFS and DOH. The NYS Council welcomes this proposal that seeks to standardize concurrent review decision-making by requiring utilization of a gold standard tool.

SUPPORT: Fentanyl Analogs (HMH Article VII Part BB)
Adds Fentanyl analogs to the list of controlled substances and adds new crimes for "imitation of a controlled substance" which creates a new misdemeanor and felony for knowingly possessing an imitation controlled substance.

OPPOSE: Elimination of the 340B Program Subsidy
The federal 340B Program was created to allow safety-net hospitals and clinics to purchase outpatient prescription drugs at significant discounts, so they could stretch their resources to serve more financially vulnerable patients. Elimination of the 340B program subsidy for these essential providers will have the effect of significantly reduces the availability of care for some of New York's most vulnerable citizens. As such, we call on the NYS Legislature to reverse a 2020 decision from the prior administration that could prevent these safety net health care providers from taking advantage of a federal cost-savings program that clearly impacts access to and continuity of care for New Yorkers in need of healthcare services, to include mental health and substance use disorder services.

OPPOSE: Prescriber Prevails (HMH, Article VII, Part D)
The Budget proposes to end the "prescriber prevails" provision. Prescriber prevails is a crucial patient protection that allows patients and their health care providers to have the final say over medication decisions. Without it, Medicaid patients could be left without protection in a time when accessing the right health care is more important than ever. Unfortunately, the Governor's current budget recommends repealing this protection.

The NYS Council vigorously opposes the Prescriber Prevails proposal. As experts in the fields of mental health and substance use disorders/addictions care, we know that the elimination of prescriber prevails language would be detrimental to New Yorkers who have often spent years working with prescribers to find the correct medications / combination of medications that will successfully address symptoms associated with serious mental illnesses. Biological differences require the ability for prescribers to work with clients to identify the appropriate combination of medications for the individual without interference by the state. Ultimately, elimination of prescriber prevails language will cost the state scarce resources as clients are forced to try alternative medications that will interrupt their recovery and sustained periods of community tenure.

Thank you for this opportunity to discuss executive budget proposals in the areas of Health and Medicaid. For more information, please contact Lauri Cole at 518 461-8200.