NYS Council for Community Behavioral Healthcare

NEW YORK'S BEHAVIORAL HEALTHCARE SYSTEM IS SEVERELY COMPROMISED

Fundamental Change is Needed NOW

NYS Must Carve Outpatient Behavioral Health Services Out of Medicaid Managed Care

Why did NYS move Medicaid benefits for New Yorkers that need mental health and/or substance use disorder services into Medicaid managed care beginning in 2015?

The stated goals of the carve-in of our services were to expand access to integrated care, increase clinical innovation, enhance, and expand access to care, and drive better outcomes for clients. None of this has been realized despite the high costs associated with paying insurers to administer this benefit. Under Medicaid Fee for Services (FFS) nothing would stop the state from creating value-based arrangements with payers that promote integrated care and foster wholistic care, but the outpatient BH system as a whole should not be forced to continue with this failed experiment of managed care for some of our New York's most vulnerable residents.

What's the problem with utilizing for-profit Medicaid managed care plans to manage benefits for New Yorkers with mental health and substance use disorder/addiction challenges?

Governor Hochul and the members of the NYS Legislature recently put significant resources into mental health care however the access to care crisis continues unabated. We have serious workforce shortages (21% annually), and waiting lists for services including (but not limited to) Medication Assisted Treatment, children's community-based services, and outpatient care. The underlying culprit is NYS' use of largely for-profit insurance plans who were brought in through managed care nearly 8 years ago to administer behavioral health benefits in Medicaid.

The business model of these plans is NOT to reimburse providers for services already provided on time or in full. One survey of approximately 60 providers found that plans owed more than $10 million after 90 days of waiting for reimbursement. And some plans are still not paying the 2022 COLA secured in the state budget.

Plans in MMC are violating NY laws - over **200 citations** have been issued by DOH/OMH/OASAS against various MCOs in the carve-in of behavioral health services. In 2022, Milliman concluded that the majority of MMC companies that are managing these benefits fail to comply with federal and state parity laws and regulations and/or New York's requirements around self-monitoring of compliance with parity rules.

The state is plagued by high administrative costs associated with attempting to oversee MCOs that have not delivered system improvements but instead have extracted scarce resources from the OASAS and OMH systems of care as insurers deny or delay payment and meet their profit and administrative targets. Promises of improved clinical integration, increased penetration of integrated care, or value-based arrangements, and no increased access to care or improved client outcomes. The state has observed and documented restrictions in BH services, high behavioral health claims rate denials and significant MCO underspending on BH services. It's time to end this experiment and increase opportunities to decrease state expenses and reinvest in our systems of care.

How will a carve out of mental health and substance use disorder outpatient services impact Medicaid beneficiaries that need these services?

The carve out will **enhance** a Medicaid members ability to access BH services from all Medicaid providers in the public mental hygiene system. At the present time, Medicaid beneficiaries have limited access that is restricted to in network providers of a single Medicaid Managed Care plan. All Medicaid members will remain in their current MMC plan for physical health services. No Program or Service that cannot be reimbursed via Fee for Service should be carved out.

Returning to FFS for reimbursement similar to how NY provided behavioral healthcare services under Medicaid a decade ago would be far superior to MMC. Outpatient BH benefits would be consistent, streamlined and simplified and providers could re-purpose the hundreds of thousands of dollars they currently spend transacting business with large corporations to address workforce shortages and increase access to services where there are waiting lists.

Where does all the money go?

Medicaid managed care (MMC) plans are paid billions in premiums each year to manage Medicaid benefits for beneficiaries. In 2022, the state paid Medicaid plans *$2.5B in premiums* for mental health outpatient services to Medicaid beneficiaries. It is important to note that Insurers *can keep 11% (administration and profit)* of the premiums they are paid.

Two years ago, the NYS Council identified that MCOs had failed to meet contractually required behavioral health expenditure targets that ensure they spend the majority of funds on actual services for beneficiaries. The NYS Council acted, filing 25 FOILS across 6 state regulatory agencies, and prepared for litigation against the state for its failure to enforce the contract provision that had deprived the OASAS and OMH systems of care of hundreds of millions of dollars. Fortunately, the Hochul Administration began to recoup from the MCOs and $222M was returned to OASAS and OMH for a two-year period of overpayments to plans with additional funding being recouped going forward; however, this enforcement did not change insurer tactics that begin with delaying and denying reimbursement to providers delivering these services. Carving out mental health and substance use disorder outpatient services from Medicaid managed care will return scarce resources to our systems of care and ensure plans can no longer delay payment and/or hold on to resources that are meant for services to New Yorkers with mental health and substance use disorder conditions.

Under FFS, claims are paid on time and providers do not see the same level of inappropriate payment denials. Under Medicaid Managed Care, providers must use scarce resources and dedicated staff to manage contracting, billing and chasing payment from (on average) 8 different plans, in some cases more. In a recent provider survey, **52%** of survey respondents note that they are in worse financial shape than before the carve in of BH into MMC; this is unsustainable.

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