NYS Council for Community Behavioral Healthcare

FREQUENTLY ASKED QUESTIONS ON NEW YORK'S BEHAVIORAL HEALTHCARE SERVICES CARVE OUT PROPOSAL

Why did NYS move Medicaid benefits for New Yorkers that need mental health and/or substance use disorder services into Medicaid managed care (MMC)? When did it happen? Why is carving such services out of MMC critical and how will it impact efforts for integrated care?

In 2015, the Medicaid Redesign Team's proposal to carve-in certain mental health and substance use disorder services to the state's Medicaid managed care program was implemented. The stated goals of this major policy change were to expand access to integrated care, increase clinical innovation, enhance, and expand access to care, and drive better outcomes for Medicaid beneficiaries with mental health and/or substance use disorder challenges. None of these goals have been realized, despite the high costs associated with paying insurers to administer the benefit.

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

We are solely proposing to carve out **a group of services, not beneficiaries,** from the state's Medicaid managed care program. The carve out will enhance Medicaid members' ability to access behavioral health services from **all** Medicaid providers in the public mental hygiene system. At the present time, Medicaid beneficiaries have **limited access to providers** and are **restricted to in-network providers** of a single Medicaid Managed Care plan. Under the carve out proposal, all eligible Medicaid members will remain in their current MMC plan for physical health services. Any programs or services that are not eligible for fee-for-service reimbursement will not be carved out.

Opportunities to increase Integrated Care will not be hindered by a carve out. New York State and MCOs will still receive data from the eMedNY system in a timely manner, potentially paving the way for alternative payment arrangements and opportunities to improve holistic care. In fact, the carve in of behavioral health services have not resulted in any of the outcomes that the Medicaid Redesign Team envisioned, including increased availability of integrated care, clinically integrated networks, better outcomes for New Yorkers or increased access to services.

To assess the association of the transition to integrated managed care (IMC) in Washington Medicaid with health services use, quality, health-related outcomes, and measures associated with social determinants of health, a team of distinguished researchers studied 1,454,185 individuals ages 13 to 64 years. Study results found that integrated care at the financial level (utilizing integrated payments reimbursed through Medicaid managed care) **did not** lead to any change in the rates of mental health visits among Medicaid beneficiaries with mild, moderate, or severe mental illness. Among enrollees with severe mental illness, employment decreased by 0.9 % when enrollees received integrated care, and arrests increased by 0.5 %.

This result is consistent with a 2020 qualitative review commissioned by the National Council for Behavioral Health that found that carve ins were not uniformly associated with integration at the delivery system level. In many states, financial integration lacked accompanying efforts to address systemic barriers, like inadequate investment in health information technology, lack of financial reserves in BHAs, and insufficient administrative infrastructures to handle increased demands from multiple managed care plans. (citation at bottom of this page)

Returning to a fee-for-service, reimbursement would be consistent, streamlined and simplified. Rates of inappropriate claims denials (currently hovering at 60%) would drop precipitously, providers could re-purpose the hundreds of thousands of dollars they currently spend transacting business with large corporations to address workforce shortages, increase access to services where there are waiting lists, and care recipients would have a wider choice of providers.

Why is there a problem with utilizing for-profit Medicaid managed care plans to manage benefits for New Yorkers with mental health and substance use disorder challenges?

Governor Hochul and the members of the NYS Legislature recently put significant resources into mental health and substance use disorder systems of care. Yet, the crisis in access to care continues unabated. We have serious workforce shortages (20-30% job vacancy rate depending on program type) and waiting lists for services including Medication Assisted Treatment, children's community-based services, and outpatient care. The underlying culprit is the state's use of largely for-profit insurance plans who were brought in through managed care nine years ago to administer behavioral health benefits in Medicaid. Despite the laws, regulations, and contract provisions pertaining to MCO timely payment, MCOs delay payment to providers and have failed to spend required minimum amounts of the monthly premium on care and treatment.

Over **220 citations** have been issued by DOH, OMH and OASAS against various MCOs that participate 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, and a recent 'secret shopper' initiative through the Attorney General's Office revealed that while insurance plans advertise robust networks of providers for their beneficiaries to choose from, a high percentage of the network providers listed in provider directories either do not exist, do not take insurance or are not accepting new clients.

The state is plagued by high administrative costs associated with attempting to oversee MCOs that have not delivered system improvements or benefits but instead have extracted scarce resources from the OASAS and OMH systems of care. Promises of improved clinical integration, increased penetration of integrated care, or value-based arrangements have not materialized. The state has observed and documented restrictions in behavioral health services, high behavioral health claims rate denials and significant MCO underspending on behavioral health services. It is time to end this experiment and increase opportunities to reduce state expenses and reinvest in our systems of care.

Where does the money go?
MCOs receive billions in premiums each year to pay for and manage benefits for Medicaid beneficiaries with mental health and substance use disorders. In 2022, the state paid Medicaid plans close to $4B *for mental health and substance use disorder services.* It is important to note that **insurers are permitted to keep 11%** of the funds they are to manage the benefits for administrative costs and profit. And yet, there is no value associated with this for-profit model and necessary care and treatment are not being appropriately covered.

Three years ago, the NYS Council discovered that the state failed to enforce a requirement that required it to recoup funds paid to MCOs that had failed to meet required behavioral health expenditure targets. These targets ensure that MCOs expend the majority of funds paid to them by the state on actual services provided to Medicaid beneficiaries. The NYS Council filed 25 FOIL requests across six regulatory agencies, and prepared to take legal action. NYS Council leaders met with state leaders who heard our concerns and shortly thereafter. To date, $500M has been collected from MCOs that continue to fail to meet Behavioral Health Expenditure Targets and in so doing, deprive Medicaid beneficiaries of services.

Under the fee-for-service Medicaid system, 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) eight different plans. In a recent provider survey, 52% of survey respondents note that they are in worse financial shape than before the 2015 carve in.

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 health plans can no longer delay payment and/or hold on to resources that are meant to pay for services for Medicaid beneficiaries. The decision to carve in these services was made by a previous administration. Governor can make a different decision for all of the reasons stated above. Considering the variety of other special populations that remain carved out and the concerns laid out in both the Boston Consulting Group report as well as a recent analysis performed by Guidepoint Consulting (on behalf of OPWDD) that resulted in a recommendation to keep I/DD services out of managed care, ***we see no reason why New Yorkers with significant behavioral health conditions should remain at risk as result of their services being carve in.***

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