



WRITTEN TESTIMONY

Prepared for the members of the

JOINT LEGISLATIVE BUDGET COMMITTEE

Hearing Topic: FY 2022 Executive Budget Proposals: Health/Medicaid

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NYS Council for Community Behavioral Healthcare

The New York State Council for Community Behavioral Healthcare is a statewide membership association representing the interests of over 100 community-based mental health and substance use disorder/addiction prevention, treatment and recovery providers in local communities across New York, and the tens of thousands of New Yorkers who rely on their assistance each day. Our members include nonprofit organizations, counties that operate direct services, and general hospitals that offer a variety of inpatient and outpatient programs and services across New York.

As the members of this esteemed Committee are well aware, long before the COVID-19 pandemic, New York's public mental health and substance use disorder/addictions prevention, treatment and recovery systems of care were fighting two public health crises as they faced skyrocketing rates of opioid overdoses and deaths, and increasing rates of suicide in certain populations. Add to this the fact that we cannot recruit or retain the staff we so desperately need in order to ensure continued access to care due to New York's failure to provide the resources we

need to remain even remotely competitive with other businesses where the work is far less difficult, and the fact that reimbursement rates do not approximate the actual cost of care, and you have a recipe for the disaster we are facing at the present time. Forty percent of our workforce leaves their jobs annually, and an increasing number of our staff are receiving Medicaid benefits while working more than one job, and some are living in homeless shelters. In short, we are in dire straits and in desperate need of additional resources. And all predictions are that, in the very near future, there will be a very significant increase in the demand for these life-saving services. Please keep this in mind as you read the following information:

NYS transitioned individuals served by the public behavioral health sector under the Medicaid fee-for-service (FFS) program to a managed care environment beginning in the summer of 2015. Because of public concern that the transition to managed care (and implementation of stricter utilization controls) might reduce funding for behavioral health services, the transition was accompanied by legislation enacted to prevent resources that had been historically devoted to providing behavioral health services to individuals with mental illness and/or substance use disorders from being deployed for other purposes.

That legislation, Chapter 60 of the Laws of 2014 added a new subdivision 5 to section 365-M of the Social Services Law (hereinafter referred to as "Subdivision 5"), requiring that any savings in behavioral health expenditures be reinvested into community behavioral health services, including residential services.¹ Accordingly, Subdivision 5 directs DOH and the budget director

¹ Subdivision 5 of section 365-M of the Social Services Law provides: "Pursuant to appropriations, the department of health shall reinvest funds allocated for behavioral health services, which are general fund savings directly related to savings realized through the transition of populations covered by this section from the applicable Medicaid fee-

to develop the methodologies used to calculate the savings in consultation with OMH and OASAS.²

To date, DOH does not appear to have disclosed information related to its methodology to calculate savings, the results of applying such methodologies, and the details regarding implementation of such reinvestment in public reports, as required by Subdivision 5. “The commissioner shall include detailed descriptions of the methodology used to calculate savings for reinvestment, the results of applying such methodologies, the details regarding implementation of such reinvestment pursuant to this section, and any regulations promulgated under this subdivision, in the annual report required under section forty-five-c of part A of chapter fifty-six of the laws of two thousand thirteen.” (Section 365-M(5) of the Social Services Law).

Consequently, the NYS Council has been left with no alternative than to file a Freedom of Information Law (FOIL) request through its counsel to obtain information that should have been

for-service system to a managed care model, including savings resulting from the reduction of inpatient and outpatient behavioral health services provided under the Medicaid programs licensed or certified pursuant to article thirty-one or thirty-two of the mental hygiene law, or programs that are licensed pursuant to both article thirty-one of the mental hygiene law and article twenty-eight of the public health law, or certified under both article thirty-two of the mental hygiene law and article twenty-eight of the public health law, for the purpose of increasing investment in community based behavioral health services, including residential services certified by the office of alcoholism and substance abuse services.”

² “The methodologies used to calculate the savings shall be developed by the commissioner of health and the director of the budget in consultation with the commissioners of the office of mental health and the office of alcoholism and substance abuse services.” *Id.*

publicly available. (DOH FOIL # 20-11-157). Although that request was filed on November 9, 2020, DOH has not issued any substantive response to our counsel as of today's date.

In recognition of the requirements under Subdivision 5, DOH indicated during the transition of behavioral health services into Medicaid managed care that it planned to establish behavioral health expenditure targets for mainstream (non-HARP) managed care organizations. (DOH, "Transition of Behavioral Health Benefit into Medicaid Managed Care and Health and Recovery Program Implementation, Oct. 2015, available at: <https://aclnys.org/wp-content/uploads/2015/07/Behavioral-Health-Policy-Guidance-10-1-15-FINAL.pdf>, at Slide 49.).

In that document, DOH acknowledged that the Governor's Medicaid Redesign Team (MRT) recommendations and subsequently enacted legislation requires that "any savings in behavioral health services not be profit to the MCOs, but be reinvested into other behavioral health and related services to address unmet needs of the behavioral health population." (*Id.*).

To the best of our knowledge, DOH has neglected to disclose any information to the public related to behavioral health expenditure targets, as they had previously indicated. "MMCs and HIV-SNPs will be held to a BH expenditure target. The requirements for identification of cost reductions in MCO behavioral health expenditures are under development. This section will be updated when these requirements are finalized." (DOH, "Transition of Behavioral Health

Benefit into Medicaid Managed Care and Health and Recovery Program Implementation, Oct. 2015, available at: <https://aclnys.org/wp-content/uploads/2015/07/Behavioral-Health-Policy-Guidance-10-1-15-FINAL.pdf>, at Slide 49.). As of today's date, we are not aware of any updates to that document.

Furthermore, under its current contracts with mainstream managed care organizations, DOH has reserved the right to recover the difference between actual behavioral health expenditures and the expenditure targets in the event that a MCO's behavioral health expenditures fell below 96% of the target. "The State reserves the right to recover the difference between 96% of the total annual Behavioral Health Expenditure Target, based on the premium targets for each aid category and actual plan membership in each aid category in a calendar year, and actual total Behavioral Health expenditures in the calendar year, if less than 96% of the Minimum Expense Target." (Medicaid Managed Care/ Family Health Plus/ HIV Special Needs Plan/ Health And Recovery Plan, Model Contract, Mar. 1, 2019, available at: https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf, at Section 3.22(b)(i).)

To the best of our knowledge, DOH has not issued any information to the public on whether mainstream MCOs have satisfied the behavioral health expenditure targets, and if not, whether DOH has recovered amounts from mainstream MCOs when behavioral health expenditures fell below 96% of the target. Consequently, the NY Council has been left with no alternative than to file a Freedom of Information Law (FOIL) request through its counsel to obtain information that should have been publicly available. (DOH FOIL #20-11-298). Although that request was filed

on November 17, 2020, DOH has not issued any substantive response to our counsel as of today's date.

Despite the purpose and intent of Subdivision 5, DOH has occasionally referred to the behavioral health expenditure targets as a "Behavioral Health MLR". During the transition of behavioral health services into Medicaid managed care, DOH stated: "Mainstream Plans will have a BH Medical Loss Requirement." (See "DOH, Implementing Medicaid Behavioral Health Reform in New York, MRT Behavioral Health Managed Care Update, Mar. 27, 2015, *available at*: https://www.health.ny.gov/health_care/medicaid/redesign/docs/2015-3-27_final_mrt_update.pdf, at Slide 23.) Although DOH's introduction of a second term for behavioral health expenditure targets is confusing, our understanding is that both terms refer to expenditure targets for behavioral health services.

In contrast to mainstream managed care organizations, DOH did not establish behavioral health expenditure targets for HARP plans. Instead, during the transition of behavioral health services into Medicaid managed care, DOH stated that "HARP will have an integrated MLR (NYC HARP MLR of approximately 89%)". ("DOH, Implementing Medicaid Behavioral Health Reform in New York, MRT Behavioral Health Managed Care Update, Mar. 27, 2015, *available at*: https://www.health.ny.gov/health_care/medicaid/redesign/docs/2015-3-27_final_mrt_update.pdf, at Slide 23.)

DOH's substitution of an MLR for HARP plans in place of establishing behavioral health expenditure targets is highly questionable. Pursuant to federal regulations (42 C.F.R. §

438.8(e)), MLR calculations are based on claims incurred for any medical expense, not solely claims incurred for behavioral health services. It is conceivable that a HARP plan could meet its MLR requirement (based on total medical expenses) but still have expenses for behavioral health services that fall short of the behavioral health expenditure target established by DOH for mainstream plans. DOH has not offered any public explanation for how using an MLR for HARP plans would satisfy the requirements of Subdivision 5.

Nevertheless, DOH has pledged that any MLR recoveries from HARP plans will be reinvested in services for individuals with behavioral health disorders. “Any MLR under expenditure by any HARP will be recovered by NYS to be reinvested in services for individuals with behavioral health disorders.” (DOH, “Transition of Behavioral Health Benefit into Medicaid Managed Care and Health and Recovery Program Implementation, Oct. 2015, *available at*: <https://aclnys.org/wp-content/uploads/2015/07/Behavioral-Health-Policy-Guidance-10-1-15-FINAL.pdf>, at Slide 48.). The Committee should hold DOH to this pledge and ensure that any recoupments from HARP plans are reinvested into the behavioral health system.

To the best of our knowledge, DOH has not issued any information to the public on whether HARP plans have satisfied the MLR requirements, and if not, whether DOH has recovered amounts from HARP plans whose MLRs fell below MLR requirements. Consequently, the NY Council has been left with no alternative than to file a Freedom of Information Law (FOIL) request through its counsel to obtain information that should have been publicly available. (DOH FOIL # 20-11-038). Although that request was filed on November 2, 2020, DOH has not issued any substantive response to our counsel as of today’s date.

This Committee should demand full transparency from DOH in regard to any savings in behavioral health expenditures resulting from the transition to managed care. To this end, the Committee should demand a full accounting of the amounts recovered from mainstream managed care plans for failing to meet any behavioral health expenditure targets and from HARP plans for failing to meet MLR requirements. No less important, this Committee should seek an assurance from DOH that both savings and recoveries from managed care plans will be reinvested into the behavioral health system as required by Subdivision 5 and pledged by DOH.

Thank you for considering our request.

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