NYS Council for Community Behavioral Healthcare

April 5, 2017

To Whom It May Concern:

The NYS Council for Community Behavioral Healthcare (NYS Council) welcomes the opportunity to submit feedback to New York State on the draft Children's System Transition Requirements and Qualification Standards for Mainstream Medicaid Managed Care Organizations (MMCOs). The NYS Council is a statewide non-profit membership association representing the interests of nearly 100 behavioral health (mental health and substance use) prevention, treatment and recovery organizations across New York. Our members include free standing community-based agencies, general hospitals, and counties that operate direct services for children, adolescents and adults. On behalf of our members, we are submitting comments and feedback that reflect the experience and interests of behavioral healthcare organizations across the state. We look forward to collaboratively working with the State and selected MMCOs to support the continued improvement of the Medicaid delivery system to better meet the needs of the state's vulnerable children, youth, and families.

Oversight, Surveillance and Monitoring: *There continues to be several concerns over sufficient oversight, surveillance and monitoring of Medicaid Managed Care plans managing New York's Medicaid behavioral health community. Providers serving New York's adult behavioral health population have encountered difficulty with MMCOs in meeting all the requirements set forth by DOH, OMH, and OASAS in the implementation of BHOs and HARPs across New York State. The NYS Council urges greater agency oversight and surveillance over MMCO in the planned transition of children with behavioral health conditions into Medicaid Managed Care. Providers in the behavioral health sphere sometimes do not have the sophistication or infrastructure to actively manage their relationship with MMCOs and have relied on governmental oversight to support access to critical services for New York's BH population. The state agency role in these transitions should focus on supporting this access and ensuring that the management of services does not result in disrupting this access or compromising the financial security of providers of care.*

- Section 1.2 Overview of Current Child Serving Systems: Management and health care delivery for complex and special needs children is managed by a variety of state agencies, including oversight from DOH, OMH, OASAS, and OCFS. We ask that the State identify ways for these organizations to better integrate and coordinate their oversight role to both (1) streamline and provide clarity to the industry on the charge(s) that will be given to the various agencies under the planned transition and (2) increase its oversight, surveillance, and monitoring of BHOs and HARP entities serving both the adult and child behavioral health population.
- Section 1.3 Transition of State Plan and Demonstration Services into Medicaid Managed Care: As part of its criteria when screening plan applicants for the children's transition, we recommend the State only consider MMCO applicants who have prior direct experience

managing behavioral health services for children's populations in New York or similar markets.

- 3.1.B Organizational Capacity: If a plan applicant is currently a BHO or HARP in the Medicaid program, the State should require it demonstrate prior positive performance along a number of measures including quality, patient satisfaction, prompt payment, complaint rates, prior to being approved to participate in the children's behavioral health transition.
- 3.1 E Organizational Capacity: We applaud the State's requirement that plans train staff in specific rules and policies of New York State; however, plans should also be required to demonstrate to the State that it has provided sufficient training to ensure staff are providing appropriate direction to patients and providers. There have been complaints/concerns expressed over the depth of the training that has been provided to these personnel as part of the transition of the adult population to Medicaid managed care, resulting in confusion across the delivery system related to requirements and processes.
- 3.10 Cross System Collaboration: Within the draft requirements, there is no requirement or recommendation that MMCOs collaborate with other MMCOs working in the same geographic area to align their requirements, standards, and policies, leaving the onus on community agencies to adhere to each MMCO's standards separately. Requiring MMCOs to work together where possible to align their standards around areas like credentialing, prior authorization requirements, HCBS Provider Manual Policies, etc., is essential for the sustainability of community based providers, and we recommend adding such a requirement.
- 3.11 Quality Management: Plan oversight was and still remains a major challenge of the adult transition that New York is struggling with today. Therefore, the State must require MMCOs participating in the children's transition to track, monitor, and publicly report on outcomes related to member access, continuity of care, service penetration, service intensity, as well as enrollee outcomes related to social determinants of health that are relevant to children and youth, including high school graduation/dropout rates, number of runaway/homeless youth, teenage pregnancy rates, etc.

Network Adequacy and Access to Care: *The adult transition to Medicaid Managed Care was incredibly challenged by issues related to network adequacy, and we anticipate—given existing wait lists and dearth of child serving Medicaid providers (i.e., child psychiatrists) across many areas of the state—that improvements related to network adequacy/access are paramount to the success of the children's transition. Therefore, it is critical that the State require MMCOs to proactively support access to care through activities including but not limited to community in-reach and proactive client engagement, provider capacity building efforts, reduced administrative requirements, and sufficient rates that cover the cost of service provision.*

- Section 1.3 Transition of Populations into Medicaid Managed Care: A major challenge of the transition of adult behavioral health services to Medicaid managed care, which we expect to continue as part of the children's transition, was that many providers were unfamiliar with managed care contracting, billing, and payment processing, and many community based organizations lacked staff or infrastructure to bill appropriately for payment. Therefore, the State must require the selected MMCOs to provide support to agencies that do not have prior experience working within Medicaid Managed Care, including effective training, assistance, and reduced administrative burdens to avoid financial disruptions that would impede the ability for these organizations to provide care.

- Section 1.3 Transition of State Plan and Demonstration Services into Medicaid Managed Care: During the adult transition, many community providers were challenged by MMCOs working in the same geographic area with different requirements related to Medical Necessity, Contracting, Certification, and other administrative requirements. This misalignment of requirements placed undue burden on providers, causing some to pull out of MMCO networks and/or Medicaid altogether. Therefore, for the success of the children's system transition, the State must require MMCOs be more transparent to providers and, where possible, consistent across plans to avoid confusion, administrative complexity, and to allow greatest access to necessary services.
- Section 1.3 Health Home Care Management for Children: During the adult delivery system transition, there were significant barriers inherent in the HCBS assessment process that impeded access to care. While the State has begun addressing some of these issues through the revised assessment process for adults (i.e., the discontinuation of the CMHA requirement), we strongly believe that MMCOs must have a role in minimizing these types of barriers that will impede access to HCBS/SPA services for children and youth. Therefore, we encourage the State to consider additional processes, procedures, and requirements to which qualifying MMCOs will be held to expedite the HCBS/SPA assessment process for children in order to ensure that they are connected to these critical services as expeditiously as possible. We also encourage the State to explore expanding the types of entities that would be permitted to determine eligibility for HCBS to encourage the widest reach of these services. Under the HARP program, many eligible individuals are yet to be reached by HCBS services due to the centralized nature of determining eligibility for these services.
- 3.3 Member Services: In many instances, especially in rural communities, plans may encounter severe shortages in available practitioners certified to treat children with behavioral health conditions. The State must require MMCOs to proactively address these shortages, including supporting and enhancing existing provider capacity, as well as implement enforceable rules that will govern patient access and provider reimbursement in the event there are no available in-network provider in a particular geography.
- 3.4 Service Delivery Network Requirements/Access to Care: Right now, there are little to no expectations that MMCOs actively in-reach into the communities they serve to both find and engage members in care as well as support providers to expand access to an array of services. Rather, MMCOs involved in the adult transition appear to be content managing care within the status quo, which has resulted in adults being served in settings that are not aligned to their needs and/or not being served at all. Therefore, the standards for the children's transition must contain MMCO requirements and state oversight processes related to the MMCO's role as active participants in the system of care, supporting and facilitating members and providers to enhance access to care in the communities that they serve.
- 3.4 Service Delivery Network Requirements/Access to Care Table 5: MMCOs must be required to have a network inclusive of a sufficient number of early childhood services providers, as children receiving early intervention services are a critical population that require access to providers with specialized expertise.
- 3.5 Network Contracting Requirements: Certified Community Behavioral Health Clinics (CCBHCs) are not mentioned as essential network providers in the draft requirements. As these entities are responsible for providing behavioral health and other support services to Medicaid

children and youth in their service areas, the State should explicitly require Plans to contract with all CCBHCs in their geographic area(s).

- 3.6.D Network Monitoring: We applaud and support the requirement that MMCOs accept OMH and OASAS licenses as part of the credentialing process for providers. We encourage the State to explore other ways to streamline and standardize the credentialing process in an effort to support network adequacy and avoid disruptions in patient access.
- 3.8 Utilization Management: The State should consider adding an explicit reference to parity requirements and plans obligation to meet these requirements in their treatment of the children's behavioral health population. We also encourage the State to include a requirement that all utilization management criteria should be evidence based and transparent to the provider industry.

Template Contracts, Payment Flexibility and Prompt Payment Requirements: *In the adult behavioral health transition to managed care there has been ongoing concern expressed by the provider industry over the (1) contracting process with Medicaid MMCOs, (2) the flexibility permitted by DOH in supporting government-level payments for the initial 24 months of implementation and (3) plans ability to pay providers promptly for necessary services. As stated in more detail below, it has come to our knowledge that plan entities that are contracting in the community are sharing template or draft contracts that have been approved by DOH containing payment terms that many not support or may contradict the requirement that plans pay government-level rates as required. Many providers are unable to push back on plan entities and are not afforded the opportunity to negotiate in good faith over the adequacy of payment rates proposed by managed care entities. For the transition to be successful, it is imperative that cash flow not be disrupted to behavioral health entities serving vulnerable populations throughout the State. Many behavioral health entities do not yet have the sophistication or infrastructure to manage these new relationships with managed care entities and it is the State's responsibility to ensure the transition does not interrupt access or put providers in a financially vulnerable position.*

- Section 1.3 Transition of Children's HCBS to Managed Care: We strongly support the State's decision to make coverage and payments non-risk for 24 months, consistent with past Medicaid Managed Care transitions. However, it is our understanding that more than a few plans may have used "payment flexibility" options available under the adult behavioral health carve-in to pay non-governmental rates as required. We are supportive of entities having flexibility to contract in the way that best serves the parties; however, in some instances plans have inserted these non-governmental payment rate provisions into agreements thus failing to give providers the opportunity to negotiate in good faith over whether such rates are adequate to support their operations. We encourage the use of this provision to promote the adoption of value-based payment, where appropriate, but we urge DOH and other agencies to ensure template contracts observe the requirement to support government rates as required by law. We also encourage the State to explore expanding the types of entities that would be permitted to determine eligibility for HCBS to encourage the widest reach of these services. Under the HARP program, many eligible individuals are yet to be reached by HCBS services due to the centralized nature of determining eligibility for these services.
- 3.15.C Financial Management: While we support the shift to value-based payment arrangements and the flexibility for parties to mutually agree to alternative payment terms that are in the best interest of both the provider and plan, we are extremely concerned that several

plans have incorporated payment terms into their model or template contracts that do not reflect the state's position that providers be paid the equivalent of governmental rates. We request DOH and the other oversight agencies, better monitor what payment terms are included in draft contracts and ensure that any alternative payment terms that are proposed by plans are the result of mutual, good faith negotiation between plans and providers and are signed off on by the appropriate state agencies prior to the contract being enforced.

Continuity of Care: *The NYS Council strongly believes that ensuring continuity of care as children transition across service settings and delivery systems is essential to successfully supporting children, youth, and families. Children are unique in the number of systems they are impacted by, and their system involvement continuously changes as they grow and mature. It is critical that the State acknowledge and address these issues, especially as it relates to continuity of care for children. MMCOs are well positioned to support continuity of care for each child they serve, but the State must hold them to concrete standards and requirements, which must include families/caregivers, school systems and providers of developmentally diverse services as active participants in each child's care.*

- Section 1.3 Transition of Populations into Medicaid Managed Care & Transition of Children in the Care of a VFCA into Managed Care: It is critical to acknowledge that children in foster care frequently cycle in and out of the child welfare system as part of the children's delivery system transition. Therefore, the State must require MMCOs to adhere to specific continuity of care standards for these children prior to January 1, 2019. We anticipate that prior to the enrollment of children served by VFCAs in Managed Care, it is likely that a subset of children will become eligible and then ineligible for Medicaid Managed Care simply by nature of their changing involvement with the child welfare system. Therefore, it is critical that the State require MMCOs to be planful and proactive about working with VFCAs (and other community based agencies like health homes, as well as birth/foster parents) to support these children and youth as they move between the managed care and fee for service systems.
- 3.2.J.ii Managerial Staff Position Requirements: Given the difficulties MMCOs and health homes have had in coordinating within the adult system to date, consider requiring MMCOs to have a Health Homes Liaison on the team who can work with Health Homes Serving Children in the MMCO's target region to facilitate the development of coordinated processes (i.e., those related to care management and transitions in care) on behalf of health home enrolled children and youth.
- Overall Comment: Although we agree with the requirement that Plans must contract with all licensed school-based mental health clinics within the Plan's service area (3.5.ii), throughout the rest of this document, mention of MMCO's coordination and collaboration with local school systems is relatively sparse. Schools are a primary setting where children, youth, and families access services and supports, and therefore should be considered essential partners in Medicaid service delivery. The requirement that MMCOs meet with the RPCs in 3.10.B on a quarterly basis is not sufficient to ensure robust coordination, and we noted that within section 2.0 Definitions, RPCs are not explicitly defined to include school systems (we recommend that the state including school systems in the definition of RPC). However, beyond the RPCs, MMCOs should be expected to interface with the local school systems/educational authorities in a deeper way (i.e., involving the school system in a child's care planning and treatment implementation). We also encourage the State to consider including a requirement that MMCOs staff an Educational Systems Liaison whose primary role is to support the connection

between school systems (as non-network providers in a formal sense) and the Medicaid service delivery system in the region that they serve.

The Unique Nature of Children's Services: *The NYS Council recognizes the complexity and unique nature of the children's services system, which includes factors related to ongoing child development that drives changing needs/capacities, the correlative needs of the family system that impact the needs of the child/youth, and involvement with a large number of systems and entities. Therefore, we strongly believe that the State must not conceptualize the children's delivery system transition as a mirror of the adult system and must include more meaningful MMCO requirements and oversight processes that relate to the needs specific to children and youth.*

- Section 1.3 Health Home Care Management for Children: Children with behavioral health needs have existing linkages in the community with an array of providers, requiring significantly more coordination than for the adult population. Therefore, MMCOs (in partnership with existing Health Homes) must be required to seek out opportunities to better work with existing providers to ensure there is no duplication in care management services and/or conflicting instructions and guidance given to patients and their families.
- 3.1.G Organizational Capacity: The required participants of each MMCO's Children's Advisory Committee is not nearly robust enough given the cross-system involvement of most children/youth who will be enrolled in Medicaid Managed Care. The Advisory Committee should be expanded to include all Health Homes Serving Children in the geographic area, representatives from the local educational authority/ies, as well as local providers with experience working with those involved in the juvenile justice system and early childhood service providers, as these entities will be essential advisors within the new Managed Care service delivery system for children and youth.
- 3.2.J.ii Managerial Staff Position Requirements: The State must acknowledge the unique needs of specific target populations within the group of eligible children and youth and require MMCOs to proactively meet these needs. For example, the state should consider requiring qualified MMCOs to designate additional Liaisons with specific roles related to other special populations within the target population, including Transition Age Youth (TAY) and those who are Juvenile Justice System involved.
- 3.4 Service Delivery Network Requirements/Access to Care: Working to support and treat families, when clinically indicated, within the context of children's services is essential to the success of children's services. Therefore, MMCOs must be required to engage family members as part of care, including but not limited to family therapy, and should be required to adhere to explicit access standards related to family services that go beyond a general standard of "Caregiver/Family Supports and Services." Other states (i.e., Washington) have had success implementing the Caregiver Activation Measure (CAM), the caregiver version of the Patient Activation Measure (PAM), as an assessment of the knowledge, skills, and confidence essential to providing care for a person with chronic conditions. Consider requiring MMCOs to incorporate this into their assessments as a method of engaging parents/guardians and effectively targeting family education/engagement interventions.

Other Comments:

- Section 1.3 Anticipated Timelines: In the draft requirements, the State recognizes the possibility of federal delays because of recent leadership changes at HHS and CMS. Can the State better determine, with specificity, the willingness and/or any anticipated delays to better prepare plans, providers, and patients on how the State's planned timing for the transition may change? This will have significant impact on timing of dialogue related to establishing contractual relationships between plans and providers and communication with patients and their families to avoid unintended disruptions in care.
- Section 1.3 Transition of State Plan and Demonstration Services into Medicaid Managed Care: We support the State's decision to provide an expanded menu of covered services for children. We encourage the State to explore, where applicable, whether expansion of these services to additional populations (i.e., SMI, IDD) would benefit adult populations as well.
- 3.5.E Network Contracting Requirements re: OASAS Residential Programs: A more robust description/definition of what constitutes an "allied clinical service provider" is needed to ensure this requirement is standardized across MMCOs.

Respectfully,

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