Draft Comments from NYS Council for Community Behavioral Healthcare

1. 1.1 Vision: We commend the State on recognizing the link between Adverse Childhood Experiences (ACEs) and chronic health and behavioral health conditions later in life. However, despite a mention of the ACE Study, information about how Plans should apply the findings of this important research is not included in the draft requirements. We encourage the State to consider requiring MCOs to implement the ACE Screening tool with all children served (something that can be facilitated through partnerships with network providers where appropriate) and use ACE Screening results to inform Care Plans to ensure that toxic stress is identified and addressed among all enrollees.

2. 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 initiatives in an effort to streamline and provide clarity to the industry on the charge(s) that will be given to the various agencies under the planned transition.

3. Section 1.3 Anticipated Timelines: In the draft requirements, the State recognizes the possibility of federal delays as a result 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.

4. Section 1.3 Health Home Care Management for Children: Given the slow roll out/implementation of the adult HCBS assessment process, we encourage consideration of additional processes, procedures, and requirements to which qualifying MCOs will be held, to minimize barriers and expedite the assessment process for children.

5. Section 1.3 Health Home Care Management for Children: We encourage the State to seek out opportunities for Health Homes 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. Children with behavioral health needs have existing linkages in the community with an array of providers and this will require significantly more coordination than for the adult population.

6. 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.

7. Section 1.3 Transition of State Plan and Demonstration Services into Medicaid Managed Care: Medical Necessity Criteria developed by MCOs should be transparent to providers and, where possible, consistent across plans to avoid confusion, administrative complexity, and to allow greatest access to necessary services.

8. 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 MCO applicants who have prior direct experience managing behavioral health services for children's populations in New York or similar markets.

9. 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. 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.

10. Section 1.3 Transition of Populations into Medicaid Managed Care & Transition of Children in the Care of a VFCA into Managed Care: We applaud and fully support the State's commitment to moving children being served by VFCAs into Medicaid Managed Care, and recognize the inherent challenges that necessitate a later carve in date (as compared to enrollment of other eligible child/youth populations). However, given the fact that many children in foster care frequently cycle in and out of the child welfare system, we encourage the State to put in place continuity of care standards to which MCOs must adhere prior to January 1, 2019. In other words, prior to the enrollment of children served by VFCAs, it is likely that a subset of these children will become eligible and then ineligible for Medicaid Managed Care simply by nature of their changing involvement with the VFCA/child welfare system. Therefore, it is important that the State require MCOs 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. In addition, the State and selected MCOs must also plan to provide support to VFCAs that do not have prior experience working with MCOs that goes above and beyond the VFCA MC Readiness Funding, which has already been allocated and spent. As seen in the transition of adult behavioral health services to Medicaid managed care, many providers were unfamiliar with managed care contracting, billing, and payment processing. Many organizations lacked staff or infrastructure to bill appropriately for payment. It is vital that the State and selected MCOs provide training and assistance to ensure continuity of care and avoid any financial disruptions that would impede these organization's ability to provide care.

11. 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 performance (including

quality, patient satisfaction, prompt payment, complaint rates) prior to being approved to participate in the children's behavioral health transition.

12. 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 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 adequacy 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.

13. 3.1.G Organizational Capacity: Given the cross-system involvement of most children/youth who will be enrolled in Medicaid Managed Care in New York, the required participants of each MCO's Children's 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 expertise in working with those involved in the juvenile justice system, as these entities will be essential advisors within the new Managed Care service delivery system for children and youth.

14. 3.2.J.ii Managerial Staff Position Requirements: We encourage the State to consider requiring qualified MCOs 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.
    a. In addition, given the difficulties MCOs serving adults and health homes have had in coordinating to date, consider requiring MCOs to have a Health Homes Liaison on the team who can work with Health Homes Serving Children in the MCO'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.

15. 3.3 Member Services: In many instances, especially in rural communities, plans may encounter shortages in available practitioners certified to treat children with behavioral health conditions. The State should provide guidance in this document on how it expects/plans to address these shortages, the MCO's role in supporting and enhancing existing provider capacity, and the rules that will govern patient access and provider reimbursement in the event there are no available in-network provider in a particular geography.

16. 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, consider explicitly requiring Plans to contract with all CCBHCs in their geographic area(s).

17. 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 MCOs.

18. 3.6.D Network Monitoring: We applaud and support the requirement that MCOs 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.

19. 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.

20. 3.11 Quality Management: The State should consider requiring MCOs to monitor and report on 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.

21. 3.15.C Financial Management: We are very supportive of the State allowing plans and providers to explore alternative payment arrangements for the children's behavioral health transition; however, in light of the significant degree of Medicaid reform activities occurring as part of the Delivery System Reform Incentive Payment Program (DSRIP) and Performing Provider Systems (PPS), we ask the State include additional detail on how this transition may be affected by DSRIP, including the Value-Based Payment Roadmap (VBP). While many projects associated with DSRIP are focused on adult populations, it is likely that these initiatives may cross over and impact the children's population. Further, it will be helpful to the industry as a whole to have a more global understanding of how this transition fits into DSRIP and the larger Medicaid reform environment.

22. 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 MCO'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 MCOs 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, MCOs should be expected to interface with the local school systems/educational authorities in a deeper way. We encourage the State to consider including a requirement that MCOs 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.

23. Overall Comment: 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 MCOs to incorporate this into their assessments as a method of engaging parents/guardians and effectively targeting family education/engagement interventions.

24. Overall Comment: Within the draft requirements, there is no requirement or recommendation that MCOs collaborate with other MCOs working in the same geographic area to align their requirements, standards, and policies, leaving the onus on community agencies to adhere to each MCO's standards separately. Requiring MCOs 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 to 3.10 Cross System Collaboration.