

TO: Amir Bassiri, NYS Medicaid Director, NYSDOH

FROM: Lauri Cole, Executive Director, NYS Council for Community Behavioral Healthcare

DATE: November 29, 2022

**RE: Recommendations to Reform the Behavioral Health Medicaid Managed Care Model to Strengthen Protections for Care Recipients and Providers**

Following our meeting earlier this month, on November 9, 2022, our government relations consultant Marcy Savage sent you an outline that identifies various systemic problems that providers experience as they struggle to transact business with MCOs (also embedded below at the end of this memo). Also, during our recent discussion, we heard your request for recommendations as to how the state could strengthen protections for providers and consumers through reform of the Behavioral Health MMC model.  We did some initial research and learned the following:

***Other States***

* At the present time, 37 states have enacted some form of Medicaid managed care for special need and other populations in their states.   Of these, only 3 do not employ a competitive procurement to identify vendors that will manage benefits for these individuals, New York being one of the three.
* In Arizona, the state publicly posts financial penalties and citations by name of the plan.  In fact, there is an entire section of a state hosted website devoted to transparent information related to the carve in of Medicaid services to include operational reports, audited financial statements, citations and enforcements, etc.  Here's a link:

[https://www.azahcccs.gov/Resources/OversightOfHealthPlans/OpReviews.html](https://nam11.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.azahcccs.gov%2FResources%2FOversightOfHealthPlans%2FOpReviews.html&data=05%7C01%7Cdnovy%40cbcare.org%7C4d80b860819c46d5b02108daccda9bff%7C566ec174c03c45ec89c2acb165a8ce4c%7C1%7C0%7C638047536534481852%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=f8FaZrUBvbPnPodqRvCZYVlvEe%2FtwzdL7ZoySGtt6GA%3D&reserved=0)

* In Massachusetts, the state employs a recurring competitive procurement model, and the *state does not permit health plans to outsource administration of their BH benefit.  Oregon has a similar provision that limits hand off of responsibility to BHOs.*
* Texas utilizes plan incentives/disincentives to ensure MCOs meet**service penetration** expectations.  Service penetration is a measure of the extent to which an MCO **reaches IN** to populations and communities it services, to ensure it is reaching and providing entree to individuals / populations who are not receiving care but who (based on epidemiological data) likely need assistance.
* *In Pennsylvania, the state carves out behavioral health services and utilizes a Regional Behavioral Health Organization (RBHO) in every county to manage the benefit.  The RBHO is governed by providers.  The state pays the BHO a lump sum capitation payment.  The BHO manages all the BH services beginning with paying claims, collecting required data, conducting UR, and issuing reports to the state on outcomes and quality measures.   Excess capitation funds are reinvested with the BHO.  The contracts are structured to be able to accept alternative payment arrangements.  In this example, the BH IPAs could possibly serve as the BHO entity.*

***Other Recommendations***

Other protections that should be considered if the state continues to carve BH services into Medicaid managed care:

* Payment Protections for Inpatient Services - At the present time, certain services operated by BH agencies (residential, detox, etc.) do not have payment protections such as an APG government rate.  Providers are forced to negotiate rates based on market conditions.
* Retroactive Payment - Currently, the state does not require (and enforce the requirement) that MCOs pay providers retroactive to the date of the implementation of a new rate.  The state is required to give plans 90 days to load new rates that are posted on the appropriate state website and if plans do not do so, they are required by law to pay back to the implementation date however more often than not, providers do not receive retro payments that reflect the new rate as of the implementation date.
* Build capacity to adequately surveil, monitor, and enforce the laws, contract requirements, regulations and guidance governing the carve in of behavioral health services. To do so, the Department must budget for additional FTEs to ensure expeditious enforcement of all Model Contract provisions.
* Plans should be required to accept medical records electronically.
* Require plans to meet metrics for service penetration and service intensity - two metrics that are considered to part of a set of metrics public insurance experts view as the 'holy grail' and bottom-line metrics plans must address.  Other 'protective metrics' that tell the story as to whether clients receiving these services are receiving what they need include:  network adequacy, continuity of care, consumer satisfaction, and rate viability.  All are part of the budget language that was enacted in 2013 but (to our knowledge) have never been made part of the Model Contract requirements for plans.
* A workgroup composed of public health insurance experts should be convened to provide the state with objective recommendations regarding how to modernize its’ Network Adequacy standards. This will provide the state with cover in the event that insurers push back on recommendations.
* Plans should be required to have minimum staffing levels for provider relations personnel.  There should be call center standards, average speed of answer, time on hold, dropped calls % (these all exist for member call centers).  Plans should be required to report on all of these measures regularly and should be penalized if they do not maintain the required standards.  There should be timeframes within which plans are required to resolve provider complaints.  This should also be measured and monitored.  Plans should have to report on the number of provider complaints and appeals rec'd the same way they report on member complaints.
* Plans should be required to utilize the same forms to collect information and data from providers. At the present time, a provider that transacts business with 10 MCOs is required to meet the unique paperwork requirements of each insurer, and the forms are different from insurer to insurer. Use of standardized forms should be a minimum requirement for participation in the BH carve in.

***November 9th Outline of Behavioral Health Concerns related to MCOs***

Issues with OHIP MC Plan Complaint Process

-OHIP changing/adding requirements to file a complaint when providers submit complaints

-OHIP staff have discouraged complaints calling it a 'last resort'

-Process is very onerous for providers with a long list of requirements and information needed to file a complaint

-BCS staff lack education re:  BH laws, regs, guidance.

-Often BCS staff are just sending the plan response to the provider without understanding whether it actually addresses the complaint or not.  OHIP/BCS should not simply see itself as a liaison between plan and provider, OHIP needs to use its regulatory authority to ensure plan compliance and assist providers in this regard.

- Complaints are treated as a “one off” and there is no consideration that the issue could be affecting all providers, not just the one that complained.  Plans should be required to address issues that are identified across programs and for all providers, not just for the complainant.

Issues with OHIP Failing to Adequately Oversee MMC in BH

*General*

-Multiple years of non-enforcement of BHET requirements

-NYSDOH allows indefinite periods of time for MCOs to "fix" technology and other "glitches" with delays impacting providers and consumers

-Citations fail to yield meaningful and timely fines

*Network Adequacy*

-Plans continue to ask for roster information (lists of their employees) in the name of 'credentialing' at the practitioner level when it is the PROVIDER (Agency) that the plan is responsible to credential.  Plans are supposed to utilize the Agency’s operating certificate to credential.  Asking for employee roster information enables plans to potentially list employees twice, falsely claiming network adequacy.

-Plan’s ask for rosters under the guise of “program integrity” to check that employees are not on any exclusion lists, but agency’s contractually agree to ensure that all of their employees are licensed appropriately and have not been excluded from any state or federal program.  Agency’s check exclusion lists monthly and are required to retain proof of the checks.

-NYSDOH failure to surveil and monitor Network Adequacy (PNDS) reports leads to double dipping by plans.

*Inadequate Staffing in MMC Plans*

-Inadequate staffing at MCOs results in little to no customer service although plans are being paid to provide 'technical assistance' to providers as part of PMPM fee

*Lack of Compliance with Administrative Simplification*

-State continues to allow plans to require paper EOBs when CMS Administrative Simplification requires plan to transact electronically if provider wants to do so

-State has failed to require MCOs to use universal documents that would ease provider burden and streamline decision-making for example, universal credentialing form

*Insufficient Oversight of Denial Reports*

-State oversight of denial reports is insufficient to monitor if plans are paying claims timely and in full.  Plans routinely deny claims using denial reason codes that do not reflect the actual reason the claim is denied.  For example, a plan will deny a claim saying that the provider did not obtain an authorization, however, the actual reason for the denial is that plan has a systemic problem that views the provider as being out of network.  On a claims report to the state, this appears to be a provider problem – they didn’t get authorization – but it is a plan problem.  This is not a hypothetical; this is actually happening now with at least one plan.

*Default Enrollment Issues*

- State is allowing plans to default enroll individuals under the Integrated Benefits for Duals program, however there is no readiness review to ensure that they are able to pay claims correctly.  For example, the ongoing issues with Fidelis that has resulted in several complaints.

*Lack of Timely Payment*

- The NYS Council administered a survey to its members re:  MMC plan timely payment, and full payment of APGs - the results are very troubling.  The amounts of money owed to providers while insurers sit on these dollars are significant - $50,000, $100,000, $125,000, $150,000 etc.  In these instances, the most frequent response to the question re: how long they have been waiting for payment from the plan, is over 9 months.

Thank you for your consideration of our recommendations for reforming the behavioral health Medicaid Managed Care program, along with the concerns and issues our member agencies are facing across the State with MCOs. We are looking forward to continued discussions with you and your team in this regard.