Request for Information Response
for Qualifications for Behavioral Health Benefit Administration

We appreciate the opportunity to reply to the Request for Information (RFI) for Qualifications for Behavioral Health Benefit Administration.

The Mental Health Association in New York State is comprised of 29 affiliates in 52 counties throughout New York. Many of our members provide community-based mental health services but we are also very involved in education, training, and advocacy on behalf of the greater good of the mental health community. Our mission is to ensure available and accessible mental health services for all New Yorkers. Much of our advocacy is focused on community based recovery services. Throughout our comments, there are many references to recovery oriented services. We also strongly believe that there has to be great variability in terms of options for recovery. Recovery is not a linear path – it involves choices, options, and opportunities. Our goal in responding to the RFI is to support and encourage a vision of recovery through many of the services that our members and other community organizations provide on a daily basis. We look forward in this new environment to continue to provide the best quality community and value-driven services that have been a hallmark of our members statewide. We also will continue to advocate strongly for a collaborative system of care that recognizes that the most important voices are those of the individuals with psychiatric disabilities and their loved ones.

We at the Mental Health Association in New York State, Inc. (MHANYS) firmly believe that this document and the follow up RFP are among the most significant documents that will impact New York’s Mental Health System for many years to come.

Safety Net
Before commenting on specific areas, there are several overarching pieces that must be addressed. First and foremost, there must be a clear delineation of the role of the State in oversight of the Plans. Throughout the document there are references to state involvement but there is no clear policy statement that details the various roles of government. The State must develop a protocol that insures an immediate response to individuals who drop out or have their services dramatically diminished because of the transition to managed care. We cannot emphasize enough how important it is that there be a safety net in place for individuals with psychiatric disabilities. Separate from funding for capitation, the State
must assure that there is funding available for community services that insure a safety net for individuals who fall through the cracks.

Both a safety net of care through a robust and enhanced existing community services structure that relies on local assistance dollars and a new community reinvestment pool and a strong oversight role for government must be fixtures in this new environment.

No one wants to see this transition fail, but the reality is that there must be a strong and responsive foundation in place to assist any individuals who either drop out of services or have their services dramatically reduced in a managed care setting. The best way to do this is:

A) Continue a secure local assistance funding stream for not for profit organizations that provide the safety net services enhanced through an updated reinvestment and

B) Retain a strong collaborative and oversight role for State Government

**Metrics**

There must be a clear delineation of all the metrics that would be covered under the HARP plans. The idea of providing differential rates for plans that exceed expectations is a good policy, but there must be clear quality of life outcome measures in place to insure that recovery goals are the foundation of metrics. Increased differential rates for plans and providers should include employment and educational opportunities, family engagement, suicide prevention training, mental health first aid, peer services, trauma services, and engagement programs for youth in transition. In addition, there should be a differential rate increase for plans that use existing providers (discussed in the Existing Provider Section) HEDIS measures and Quality Time Intervention metrics are also an essential part of the HARP and non-harp outcomes. That said we must be assured that the many recovery outcomes are in the final RFI that is submitted. Without quality metrics in place, the entire transition to capitation would be dramatically impacted.

**Existing Provider Network**

Throughout the RFI, there are various references to existing providers. The twenty-nine Mental Health Association members throughout New York State have provided quality services in their communities for many years as have many of our colleagues in the community. The ability of the MHAs and others to provide services has gone through years of strict certification and licensure through the New York State Office of Mental Health. The credibility and quality of their work should be embraced in a managed care setting. The best way to incent plans to work with existing provider is to create a metric that would provide bonus payments to plans that work with the existing provider network over the long term. As we said in the beginning we must have a strong and value driven plan in
place to insure continuity so that individuals do not lose services. Incentives for existing MHAs and other providers will insure continuity and stronger outcomes with their knowledge of the recovery process and what is necessary to help people live productively in the community.

**Reinvestment**

We are appreciative in the document that there is recognition of the reinvesting of savings into the community. Moving forward in the future, there must be a specific plan in place that allows for 100% of managed care savings to be allocated back into community behavioral health services. With the creation of the RCE teams through Centers of Excellence and the proposal put forth by the Conference of Local Mental Hygiene Directors around regional teams in managed care, there are real opportunities to achieve stakeholder input from peers, families, providers, and local government for a full reinvestment of savings achieved through managed care. Reinvestment funding should be dedicated to housing, crisis management, peer services, family support, parents with psychiatric disabilities, youth in transition service, and other priority areas identified by the regional teams through working with not-for-profit community agencies.

**Medication Access**

We continue to urge the State to provide full access to an array of medication choices for anti-depressants and atypical anti-psychotics (including injectables). In addition, the State must provide strong adherence to ‘prescriber prevails’ language which must be part of the essential safeguards in place for individuals with behavioral health issues transitioning to managed care. Also, the State should provide a full interpretation of the impact of the non-quantitative part of the final parity regulations and the impact to the Medicaid population.

**Learning Collaboratives and Mental Health Literacy**

Of great interest to our members is the 1915 I services which are what many of our members do on a daily basis. Their skills and expertise will be an important part of the successful implementation of managed care. There is a varying level of knowledge within the plans of the mental health recovery movement. Learning collaboratives between the mental health community and the plans are essential. Beyond initial meetings, there must also be continued collaborations and on-going training on the essential components of recovery including training on peer services, family engagement, suicide prevention, Wellness Recovery Action Plans, Trauma Informed Care, Advanced Directive Training, and youth in transition engagement.

Also, we strongly believe that there has to be an essential mental health literacy tool in place so that health plan providers have additional tools to support someone towards
recovery. Mental Health First Aid (MHFA), which has been heralded at the Federal, State and local level, should be a mandatory training component for all entities involved in the behavioral health transition to managed care.

**Outside Oversight and Complaint Line**

There should be a 24-hour toll free manned line in place so that peers, families, and other stakeholders who have concerns related to both the transition to managed care and customer complaints can contact someone with knowledge and expertise. There should be a collaboration with the State for a not for profit organization who is running the call center to help triage complaints and insure that corrective plans of action are in place for entities that are not meeting expectations around metrics and plan design. Information gleaned from the calls can be used for quality assurances purposes and planning for both the State and the Plans.

**Specific Document Recommended Changes**

Within the existing document, we have also raised some questions and concerns (recommended changes are in bold).

On Page 1, in reference to Vision 1.1, Number 5 Vision Evidenced Based – **we strongly suggest that this is an opportunity to talk about how to integrate training into evidence based practices.**

1.5 – Program Design (Page 5) – Under integration of State Operated Psychiatric Services, **there should be specifics in place to detail what is meant by ‘a consumer-oriented model where Plans will be responsible for managing admissions and discharges from State hospitals’**

3.1 – Organizational Capacity (page 24) F, i. – 365 day a year toll free line to provide information and referral on BH benefits and services. **We believe that this should be a person staffed line, much like the recommendation for crisis referral in F ii.**

3.2 – Experience Requirements, C IV (page 28) – in reference to a BH advisory subcommittee, **we recommend a Statewide advisory group as well and the HARP advisory regional subcommittees should have a spelled out annual amount of meetings annually.**

3.3 – Contract Personnel, B iii D – (Page 29) Provider, recruitment, education, in service training and orientation. **We recommend that this piece be expanded to include**
incentives like career ladders, tuition reimbursement, distance learning, and expanded training opportunities

3.3 – Contract Personnel, D ii (page 30) – under BH network development, we recommend that there be a rate enhancement for plans that work with existing MHA’s and other providers who have a track record of both clinical and recovery services in their community.

3.3 – Contract Personnel, F (page 34), number 1 – Please specify what is meant by New York State. Also, after organization charts and job descriptions are approved, will they be available on a public web site?

3.3 – Contract Personnel, J (page 36) D – Provider recruitment, education, in-service training, and orientation. This should also include a reference to using this to identify training needs within the plan’s network

3.3 – K iii (page 37) – Description of HARP utilization care managers, This list of experience should include supported education, family engagement, suicide prevention, trauma informed care and WRAP.

3.4 – Member Services B iii (page 38) – Should also include reference to The Justice Center

3.4 – Member Services C, ii (page 38) – The member handbook should also be available through a public website

3.5 – Network Service Requirements D I (page 39) – Add individuals transitioning out of the criminal justice system and justice involved youth.

3.5 – Network Service Requirements G (pages 41 and 42) – This grid should include family support and engagement

3.8 – Network Training, D (page 47) – Additional HARP Training Requirements) Trauma informed care and services should be included in this list

3.9 – Utilization Management, E v b (page 49) – Promotion of recovery principles. Inclusion of trauma informed care and services
3.9 – Utilization Management – P, ii (page 51) – **Is it possible to get a more detailed description of prior authorization and determinations of medical necessity?**

3.10 – Clinical Management – E (page 52) – **It is important for all plans to highlight prescriber prevails information in member handbooks and in any relevant resource material shared by plans with their members and families.**

3.10 – Clinical Management – K1 (page 53) – “The enrollment of all HARP members in Health Homes will be facilitated by the HARP within 15 days” **What is the consequence of not meeting that requirement?**

3.10 – Clinical Management – K5 e (page 54) – **We strongly recommend the inclusion of WRAP, family engagement, suicide prevention and trauma informed care as part of the health education curriculum**

3.10 – Clinical Management – K5 j (page 54) – **Cognitive Behavioral Therapy for SUD, we believe it should also be added for Mental Health as well.**

3.12 – Quality Management – B I (page 57) – 1915 (i) like services utilization. **We strongly believe that the I services are integral to successful recovery. As part of quality assurance responsibility, there should be a grid that provides a breakdown of the specifics of each individual I service that was utilized in the previous quarter.**

3.13 – Reporting – (page 57) – **We recommend an additional section in reporting that would include interviews with consumers and families as part of the process.**

3.13 – Reporting F iii (page 58) – The HARP will conduct at least two additional NYS mandated quality studies. **We recommend that these studies are done in conjunction with community providers and other stakeholders.**

3.15 – (page 60) Information Systems and Website Capabilities – **We strongly recommend the addition on the web site of the appeals process for consumers if their care is denied. We also recommend that the website include a list of all advisory board members.**

3.16 – Financial Management – C-iv (page 60) – If the plan underspends relative to the required medical loss ratio, the difference will be rebated to NYS. **We recommend that it be spelled out that this money will be rebated to New York State specifically for behavioral health services.**
3.17 – Performance Incentives A – (page 62) – For MCOs, the present structure for quality incentives will be maintained but with a greater emphasis on behavioral health performance metrics. **We recommend that all these metrics are spelled out in detail and that incentives are in place for plans that exceed the proposed metrics.**

3.18 – Implantation Planning (page 62) – **We recommend that the State in conjunction with non-profit community providers develop a directory of all community services available in the State and that is distributed to all the plans. That way plans will know of the full availability of services in their region.**

4.0 – Request for Qualifications – Member Services C, 1 (page 71) – Describe how the required toll free (required 8 a.m. to 6 p.m., 7 days a week) call line will be organized. **We recommend that call line hours should be expanded to insure that families and others can call after normal work hours**

4.0 – Request for Qualifications – Member Services – C, 3 (page 72) – Describe the responders’ plan to train the member service staff on the requirements under this RFQ and insure they understand the NYS system. **How is the New York State system defined and how do you insure that these expectations are met?**

4.0 – Request for Qualifications – Member Services C, 4 (page 72) – **We recommend the involvement of the Justice Center in this process.**

4.0 – RFP – Network Management, E 15 (page 75) – **We recommend that there also be examples asked of family involvement in helping the recovery process.**

4.0 – RFP – G, 1-d (page 78) – **We recommend the addition of families to the engagement process**

4.0 – RFP – H 1 c (page 80) – **We recommend that community based providers are part of the continuity of care for Transition Age Youth**

4.0 – RFP – J 3 (page 82) – Propose a plan for implementing BH content on the responder’s website to be utilized by members and family members, providers, stakeholders, and State agencies that provide a provider directory, education and advocacy information as described in the RFQ. **We also recommend that an online appeals process for consumers is included on the responder’s website**

4.0 – Support Services – Family Support and Training (Page 102).
Family support services and trainings should include a basic design that allows for families to become active participants in treatment teams and strives toward their own achieving of wellness and balance. Through the work MHANYS has done with parents with psychiatric disabilities and family members of veterans with behavioral health issues, we have learned several valuable lessons. The combination of family engagement through the use of wellness recovery action plans, trauma training, Advanced Directive training, suicide prevention training and peer support training have proven to be very effective in responding to needs of families. We urge the state during the RFP process to work with the MHANYS Peer Parent Advisory Board to help identify the services that work best to help in engaging parents as they navigate the system of care.

We also feel strongly that dedicating only thirty hours in a calendar year to family support and training does not provide enough hours to fully engage in a robust family support and engagement model. These hours must be greatly expanded.

4.0 – Support Services – Education Support Services (page 106). The rate of unemployment for individuals with psychiatric disabilities is at 85% and has been for many years. One of the ways to dramatically improve employment is to upgrade and support additional educational services. In addition one of the best ways to improve outcomes for youth in transition that drop out of schools at alarming rates is also an expansion of educational services. Supported educational expansion should include leveraging additional Medicaid dollars through utilization of EPSDT for screenings and assessments, trauma training, enhancement of capacity for peer mentors and tutors and development of transition coordinators in the health plan to help engage individuals with behavioral health issues in educational settings whether through college, community college, vocational schools, on-line courses or distance learning opportunities.