NH Community Behavioral Health ASSOCIATION

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NH Medicaid Care Management Services Model Contract
#RFP-2019-OMS-02-MANAG
July 24, 2018

The NH Community Behavioral Health Association's (CBHA) members have reviewed the RFP and supporting materials and offer these comments and questions for your consideration:

1. How will the requirement to have the MCOs staff clinical providers with admitting privileges at each acute care hospital reduce duplication of services and not impact the existing workforce shortage? Page 45, Section 3.15.2, second paragraph of the Model Contract, would require MCOs to hire clinicians who are credentialed at hospitals with the expectation that they be available to go in within 12 hours of a member being admitted to an emergency department (ED) and within 24 hours of being placed on the waitlist. This creates the possibility that the MCO will be second guessing community mental health center (CMHC) staff; and that the MCOs will hire staff away from CMHCs at higher salaries. It is also possible that hospitals who currently pay CMHCs to be present in their ED may cut back on those contracts. CBHA believes that being credentialed and having admitting privileges at local hospitals may not be easily attained. We would recommend that MCOs work with CBHA members to contract for, finance and delegate this responsibility to existing staff of CMHCs and support the effort by offering other related communication services that assist in timely notification and geographic coverage.

2. How will the IDNs and the MCOs collaborate? CBHA is concerned that MCOs may interpret the need to contract directly with IDNs for services currently rendered or contained in the Alternative Payment Model that exists with CMHCs.

3. What is the provider impact of the co-pay elimination in the expansion population? Will rates increase to reflect the lack of co-pays?

4. Is there an opportunity for delegated provider credentialing or a centralized provider credentialing mechanism to reduce the duplicative credentialing of three payers?

5. What transition of care mechanisms are expected to be established?

6. How much of the care coordination will be delegated to providers? How will MCO care coordination efforts coordinate to reduce duplication? Currently CMHCs are required by Administrative Rules (He-M 401 and He-M 426) and by contract with DHHS (Exhibit A 9.1) to provide case management services. How would this differ from what is being asked of MCOs? At the DHHS public informational meetings, the Power Point slides indicate that IDNs could be certified for care management or there could be other local care management entities (CME). How does the State envision this working for the current BMHS eligible population served by the CMHCs?

7. Will the MCOs be required to have the same administrative practices in addition to the single formulary? In the initial stages of MCO implementation, DHHS participated in creating a common "companion guide" that provided some consistency in the administration of CMHC agreements. Today, MCOs have strayed from that original agreed upon companion guide, thus each MCO creates some unique administrative features that are cumbersome for our member CMHCs. CBHA recommends that DHHS require MCOs to develop some common "companion guide"; unique features of the MCOs can be done through incentive programs and other arrangements outside the core payment model.

8. What administrative requirements by the State will be eliminated when the MCOs are awarded their contracts?

9. What are the terms of the MCO withhold backend settlement process? Will this be transparent?

In addition to these general comments, we offer these specific Model Contract comments by page:

Page 17 Definition of Transitional Health Care indicates post discharge visit for physical, mental health, SUD admission within 2 days. Conflicts with current practice of within 7 days and also with language re: 7 days later in this document.

Page 39 Second bullet would require background screenings on a monthly basis. Currently they are quarterly. This creates an increased administrative burden with no discussion as to why it would be critical to increase the frequency to this level.

Page 58 Section 4.1.9 Non-Emergency Medical Transportation requires that members use a Family and Friends mileage reimbursement program if they, a family member or a friend have a car unless they meet specific criteria. MCOs are expected

to have 50% of NEMT go through this program. This change seems like DHHS would be adding barriers to accessing care for a vulnerable population.

Page 59 Section 4.2 Pharmacy Management. Moving to one PDL is a very positive improvement. CBHA urges the use of a single PDL and would further encourage DHHS and the MCOs to consider using the prior authorization process ONLY for scripts written that do not fall within the PDL. This is common managed care practice as MCOs rarely if ever decline authorization for a medically necessary script: they are more eager to see scripts steered toward an agreed upon PDL. Maintaining a prior authorization process therefore is administratively burdensome and contains no clinical quality or economic value in overall patient management.

Page 65-67 Section 4.3.1.1 MCO Role in Work and Community Engagement – 4.3.1.1.4 Status Tracking and Outreach. Need to clarify/ensure that providers do not have financial risk if someone is deemed to have not met this requirement when services were provided in good faith to the recipient.

Page 106 Third bullet states Transitional Health care shall be available for clinical assessment and care planning within seven (7) calendar days. This conflicts with the definition of Transitional Healthcare noted above from page 17. Seven days is what HEDIS requires.

Page 107 Section 4.7.5.2 Access Standards for Behavioral Health again refers to Transitional Healthcare in 2 days. Sections seem to be providing conflicting information.

Page 107-108 American Society of Addiction Medicine Level of Care. Response to inquiry within 2 days. Services begin within 2 days after initial screening. We question this as a reasonable expectation.

Page 143 4.11.1.10 Written Consent. What action has the State taken to revise the statute that limits ability to bill for SUD services for adolescents (RSA 318-B:12-a)?

Page 144 4.11.2 Emergency Services. Is this section meant to imply that there should be mobile crisis units in each region of the state? How would this be possible if the state is not funding the non-billable or inadequately reimbursed services? Is the state planning to put out RFPs for additional MCUs throughout the state? It would be important to ensure that any models of crisis response meet the needs of the served communities and are fiscally sustainable. For example, in a region with only a fraction of the annual admissions compared to the three that currently have MCUs, the cost per person served would be exponentially higher and may not be a model that most effectively and cost efficiently meets the needs of the region. If this means something else it needs clarification.

Page 150 4.11.5.5 Assertive Community Treatment Teams. MCOs shall pay an enhanced rate, but how will this happen for duals whose claims electronically cross

over from Medicare which does not transfer the modifier which indicates ACT services have been provided? This is an issue that would need to be resolved to ensure proper payment to providers.

Page 151 4.11.5.11 Peer Recovery Support Services. There is currently no approved CPT code for mental health peer support. Will a code be added and in effect by the implementation date of any MCO contracts established through this RFP process?

Page 152 4.11.5.17 Reducing Psychiatric Boarding. Having MCOs add clinical staff (who will probably be hired away from the community mental health centers at higher rates of pay) to second guess our staff's emergency assessments and IEAs is a bad idea and likely will not have the desired impact of reducing psychiatric boarding.

Page 154 4.11.5.18.2 Discharge Planning. Paragraph three allows seven days for discharge note to get to aftercare provider. Aftercare provider is required to see individual in 24 hours if ACT and within 7 days (or 2 depending on where you look) for non-ACT. It seems it would be helpful for aftercare provider to have that information prior to the first post discharge visit.

Page 155 4.11.3.18.3 This needs further clarification that if a member's benefits are terminated due to non-compliance that the provider will not be exposed to recoupment or nonpayment of services provided in good faith prior to notification of termination of benefits.

Page 170 4.13.1 Network Requirements third paragraph states that "All Participating Providers shall be licensed and or certified in accordance with the laws of NH…" should have clarification for providers credentialed at the facility level such as CMHCs. Individual staff at CMHCs are not required to be licensed when working at the Bachelor or Masters level of service provision. Community Mental Health Centers are approved through the process outlined in He-M 403, and reviewed for approval every five years, but do not have a licensure or certification status available beyond that process.

Page 186-187 4.15 Provider Payments General Provisions. The contract should clearly state that MCOs are required to have the capacity to process all claims, including Medicare crossovers and other secondaries, electronically. The lack of this ability has added significant costs to providers who must manually process secondaries.

Page 190-191 Managed Care Information System. As noted above, requirement of electronic processing of Medicare crossovers and other secondaries should be included in terms. Does the language in 6.11.2.4 cover this?