CAMPAIGN FOR HEALTHY MINDS HEALTHY KIDS
Ensuring New York Children's Right to Behavioral Health Care

MRT II Recommendations and Proposals

1. Fulfill the State's commitment to fully fund and implement the Children's Medicaid Redesign Plan: start by placing a moratorium on cuts to any services or programs redesigned by the children's behavioral health MRT subcommittee and restore cuts that have already occurred.

Our state cannot improve the health and wellbeing of its children, nor can it truly contain Medicaid costs, if it continues to not only fail to invest, but to repeatedly cut funding for children's behavioral health care.

The stated promise of the children's Medicaid redesign begun nine years ago was to increase access to services through Medicaid and provide more service coverage under Medicaid Managed Care. In order to achieve this promise, the State estimated the cost of implementation would be $63.7 million, yet ultimately funded only $15 million for the transition. New York must provide the remaining $48.7 million the State committed to support the Medicaid transition.

The work of the children's Medicaid redesign committee is still underway; New York cannot afford to cut any of these services and programs before they have been fully implemented. Already, the State has moved forward with cuts to new Children and Family Treatment and Support Services (CFTSS), even though these services have reached less than 5% of the 200,000 children who were intended to receive care. The State also included Health Homes Serving Children in its 1% across-the-board cuts to Medicaid. These cuts should be restored, and all children's services planned through Medicaid redesign – including CFTSS, Home and Community Based Services, Children's Health Homes, and Article 29-I Medical Services for Foster Children – must be fully funded and given the opportunity to reach the children who need them.

If New York does not commit the resources it promised to expand access, we are in fact at risk of serving *fewer* children than were served prior to Medicaid transition. The MRT II must defer to the expertise of the Children's MRT Subcommittee and allow it to fulfill the State's promise.

2. Support the principles of Medicaid Matters New York, which represents Medicaid consumer advocates throughout the state. These principles include the following:

- The Medicaid global cap is outdated and does not account for the program we have now. The global cap must be reconsidered.
- New Yorkers need a Medicaid budget that realistically pays for the services that keep people well, living independently in their homes, and free from economic ruin.
- There are resources to pay for Medicaid and other vital services. Our state leaders must support raising revenue, rather than accepting austerity.
- Shifting Medicaid costs back to counties, including New York City, exacerbates inequities and has the potential to harm consumers. It moves Medicaid financing in the wrong direction and should be rejected.

- The State spends billions of dollars on contracts that provide eligibility and enrollment services by a large corporate entity. Those contracts must be reexamined, and we need new oversight controls on large corporations that work on the State's behalf.
- New York needs a transparent process that includes meaningful engagement of consumers and advocates and reasonable negotiations between the Executive and Legislature. Above all, we must all remember why Medicaid matters the most: to provide for the millions of New Yorkers who rely on it every day.

3. Reject cost shifts to counties.

Proposals that shift costs to local governments will dramatically impede counties, including New York City, from addressing local health and human service needs, and will result in poorer outcomes for the most vulnerable New Yorkers. Counties have little control over eligibility determinations or scope of services. By cost shifting to counties, the State would put at risk some of the most critical services and programs children and families rely upon. The State must not balance the Medicaid budget on the backs of children and families through inequitable cost shifts.

4. Hold insurance providers accountable for poor performance: reduce the number of Managed Care Organizations (MCOs), and eliminate Behavioral Health Organizations (BHOs).

Time and again, New York's Managed Care Organizations have demonstrated their inability to fulfill their obligations to meet the health needs of the patients entrusted to their care. Yet despite the poor performance of many MCOs, the State continues to prop them up. The result has been a system that throws barrier after barrier in front of families seeking care, and ultimately costs the State money as a result of administrative complexity and chronic unmet health conditions.

New York can begin to course correct by enforcing penalties on MCOs for poor performance and low-quality care. Moreover, the State should eliminate bad actors and reduce the number of Medicaid plans. By consolidating the remaining plans and only supporting high-performing providers, New York can save on duplicative administration costs and remove barriers to enrollment. As part of this consolidation, MCOs should be required to standardize their operations, including by using universal forms and Electronic Health Records. This will enable providers to spend more time on care rather than cumbersome technology and administration.

Finally, the State should entirely eliminate Behavioral Health Organizations and instead require MCOs to provide behavioral health services in-house. BHOs have consistently under-performed, which has led to a costly, inefficient system that has deprived children and families of essential services. Funds currently being poorly spent through BHOs would be better spent providing clinical care. With the elimination of BHOs, MCOs should also be required to offer family support services in addition to clinical support.

Collectively, these steps will help the state create a less expensive system that reduces administrative burdens, improves navigation, increases availability of services, and begins to create a more coherent care management system.

5. Enable Health Homes Serving Children (HHSC) to continue implementation independent from the proceedings of the MRT II.

HHSC serve children with serious emotional disturbance diagnosis; medically fragile children; children with multiple chronic conditions, including mental health illnesses; intellectually/developmentally disabled children; children who have experienced complex trauma or adverse childhood experiences; and children with HIV/AIDS. In the short three years HHSC have been operational, they have had to operationalize multiple transitions and reforms without the start-up funding afforded adult health homes, which drew enhanced federal match during start-up. Major transitions included:

- converting the targeted case management program to Health Home care management
- converting from fee-for-service billing to Managed Care billing
- experiencing two different outreach rate changes and restructuring designed for the adult system
- converting 6 long-standing waiver programs with their own rules, regulations, staff, and documentation and converting them to Health Homes
- transitioning over 5,500 children from waiver care management into Health Home care management with a new array of HCBS services and/or cross-walking the child to Child and Family Treatment and Support Services.

HHSC have not had a stable year of operations since inception, and have been impacted by repeated policy changes that have had little consideration of the unique needs of the child population in Health Homes. Future reforms of the child-serving system, closure of residential facilities, changes to the juvenile justice system, and the upcoming transition of the foster care system to Family First Preservation Act will increase the need for HHSC care coordination.

Children's Health Home should be excluded from any major changes proposed through the MRT II process that are derived from the adult system. The Children's Health and Behavioral Health MRT Subcommittee, with subject matter experts on children's health and behavioral health services, is the only place where decisions about Health Homes Serving Children should be made.

6. Reconsider the Medicaid Global Cap.

The Global Medicaid Cap puts artificial limits on the ability of the State to meet the changing needs of a growing and diverse population and must be reconsidered. The mechanism for the Medicaid Global Cap is nearly a decade old, and it remains an impediment to meeting the health needs of New Yorkers today and in the future. Early and consistent investments in children's health and mental health ensure that children grow up to be healthy, thriving adults, and create the best path towards creating long-term cost-savings across health care and human service systems. We need a Medicaid budget that realistically covers what our program needs to provide for the people who rely on it.

While we are concerned about the broad array of services impeded by the global cap, we want to draw particular attention to the impact the Global Medicaid Cap would have on the implementation of Children's Medicaid Redesign. Interrupting the Children's MRT Subcommittee's work will add Medicaid costs, add emergency department involvement, stop the linkages between children in need and access to unavailable and hard-to-find care, interrupt the transition of previously exempt child populations to Medicaid Managed Care, and continue the ongoing pain and suffering of families that cannot get help for their children or lose their children to the alarming trend of rising suicide rates.