BEHAVIORAL HEALTH RESEARCH CENTER OF THE SOUTHWEST

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Mr. Chair and members of the subcommittee, my name is Dr. Cathleen Willging, a senior scientist and mental health services researcher at the Behavioral Health Research Center of the Southwest in Albuquerque, New Mexico. This morning, I will present the most pressing concerns that my colleague, Dr. Rafael Semansky, and I have compiled about the State of New Mexico's proposed Centennial Care Waiver. The comments are based on our 13-years of experience researching implementation of various managed care initiatives in New Mexico that have targeted individuals eligible for Medicaid and those who use publicly-funded behavioral healthcare. We will begin with our general critique of the waiver application submitted to the Centers for Medicare and Medicaid Services, or CMS, in April 2012. We will then conclude with a brief discussion of recommendations related to Native Americans.

Our overall review of the waiver application indicates that the State is:

- Regressing to a complicated service delivery model requiring multiple Managed Care Organizations (MCOs) and a behavioral health "carve in." Published research on Medicaid reform by the University of New Mexico and the Bazelon Center for Mental Health Law found that this model failed to promote access and utilization of cost-effective behavioral health services when it was first introduced to New Mexico in 1997;

- Neglecting oversight and monitoring mechanisms that are essential to ensuring transparency and stakeholder involvement in the evaluation of the Centennial Care Waiver; and

- Creating costly and inefficient bureaucratic burden for behavioral health providers, who will be forced to engage the administrative practices of multiple MCOs, versus a single entity Behavioral Health Organization (BHO), to procure service authorizations, submit claims, and obtain payment.

Our specific comments and questions are as follows:

1. The carve-in approach is based on an old model with known problems. In 1997, New Mexico began its foray into Medicaid managed care with multiple MCOs and a carve-in requirement for behavioral healthcare. The MCOs had little experience either administering or providing mental healthcare to adults and children with high levels of service need. Sixty behavioral health programs closed, and it became common for private practice providers to turn away Medicaid clients. A Legislative Finance Committee audit determined that the MCOs had reduced moneys allocated for behavioral healthcare. Only 55% of these funds were expended on actual services. In addition, due to the small number of clinicians outside Albuquerque and Santa Fe, most MCOs were unable to operate a statewide network of behavioral health providers that met the CMS standards for access. The administrative burden for providers that contracted with the multiple MCOs was substantial. The current single entity approach—one BHO to administer mental health and substance use services funded by Medicaid, the Substance Abuse and Mental Health Services Administration, and other public financing—is an improvement over having providers contract with multiple MCOs.

    - How will the Centennial Care Waiver, which is premised on a structure that is nearly identical to the original 1997 Medicaid managed care model, ensure that these pervasively

documented problems do not happen again? Indeed, most MCOs continue to have little to no experience with adults with serious mental illness and children with serious emotional disturbance.

- Thus, to what extent will the MCOs participating in the Centennial Care Waiver have the expertise to manage a behavioral health carve in?

- What state oversight and monitoring mechanisms will be put in place to prevent the MCOs from financially short changing behavioral health expenditures?

- Will behavioral health providers receive appropriate compensation for the increased administrative burden of contracting with multiple MCOs, each with its own utilization review, billing, and credentialing systems?

- Finally, how will the Medical Assistance Division assure that the carve-in networks of each participating MCO meets the Federal access standards set by CMS?

2. In 2005, the State's introduction of a single entity BHO to manage delivery of behavioral health services was innovative. What were the intrinsic problems with this approach that led the State to eliminate it in the Centennial Care Waiver? Indeed, provider agencies had worked out the initial problems in billing and service codes with ValueOptions New Mexico, the first single entity BHO contractor, and did not want more change by switching to the second contractor, OptumHealth New Mexico, prematurely. Despite ongoing problems with OptumHealth since the company assumed the single entity role in 2009, providers and clients alike in New Mexico remain open to a behavioral health carve-out model with adequate state oversight, monitoring, and protections.

3. The State should appoint an external monitor to assess the readiness review process and the implementation period. We have substantial evidence of weaknesses in previous readiness reviews and contract compliance/implementation monitoring. Both MCOs participating in Medicaid managed care and the State are understandably invested in seeing this process as ready and working. Consequently, both parties may be naturally resistant to recognizing or openly acknowledging problems. With both ValueOptions and OptumHealth, for example, the State had to bring in external monitors to verify providers' widespread reports of payment problems. External monitoring in place in advance would be effective then to prevent otherwise avoidable implementation barriers.

4. If the State moves forward with the Centennial Care Waiver, it should again require a "hold-harmless" period for the behavioral health system, as it did in the transition to a single entity approach in 2005. This requirement would prevent precipitous changes to codes, processes, rates, etc., during the transition and early implementation period. During the 2005 transition, the hold-harmless period helped mitigate serious and damaging changes to the behavioral health system.

5. From 1999 to 2005, CMS required the State to periodically post "Early Warning System" data publicly. This system was instituted to monitor the "health" of behavioral health services under Medicaid managed care. The posted data included quarterly reports on service authorizations,

utilization, denials, performance measures, and critical incidents. These objective data, collected across multiple MCOs, provided one critically important way in which communities and external groups could monitor care under Medicaid. At present, such data are reported to the Behavioral Health Purchasing Collaborative and are not made publicly available in user-friendly formats. Frequent and repeated requests for data transparency from providers, advocacy organizations and legislative committees have been unsuccessful or responded to in an untimely fashion.

- As part of the transition to Centennial Care, will the State renew dissemination of data and information about the functioning and overall health of the behavioral health system?

6. Although both vital and low cost, the new behavioral health services that Centennial Care will add to the Medicaid package (recovery services, family support and respite for youth) are unlikely to meet the mental health needs of adults and children with serious illnesses. What is necessary is greater billing and service flexibility to provide comprehensive community-based care to those most in need. It seems likely that the proposed additional services will fall afoul of the same limitations and restrictions that hampered the success of the comprehensive community support services (CCSS) initiative. Rather than make these services broadly available and easily accessible, the State intends to limit them to behavioral health homes, which dramatically impedes client access.

7. Plans to integrate physical health and behavioral health via health home models are great in principle, but because they are so poorly articulated in the waiver application, it is unclear whether they will do much to resolve problems of system fragmentation. Because existing health home models were originally developed and tested in urban areas, they are not readily transferrable to rural areas. The peer review literature tells us that transforming an existing practice into a behavioral health home is a lengthy and complex process, especially when qualified personnel and financial resources are in short supply. Additional support will be needed in rural areas to promote behavioral health homes in reality versus in name only. Such support typically entails technical assistance and ongoing training, incentives for inter-agency collaboration, and enhanced capitation, in addition to coordinated electronic medical records systems that facilitate communication between physical health and behavioral health providers. While the waiver application calls for nurse care managers who will attend to care management and care coordination in these behavioral health homes, a recent study on workforce estimates conducted by our research team suggests that there are very few psychiatric nurses in New Mexico who are able to perform these specific functions.

    - How will the State address complex implementation details, ensure adequate support, and tackle workforce disparities that will impact behavioral health homes in rural areas?

8. Since the implementation of the first behavioral health system redesign in 1999 (due to a CMS intervention), an expressed goal of the State has been to eliminate administrative levels to direct more Medicaid funding to services. Although the carve-out approach decreased some administrative burden for providers, by reducing the number of participating MCOs to a single BHO, providers still experienced dramatic increases in administrative burdens in many other areas. Though the Centennial Care Waiver includes the reduction of administration as a principle, it replaces the single BHO with three to four MCOs, and makes regionally-based core service agencies responsible for care management, service authorization and utilization review at the local

level. As a result, it is likely that the carve-in approach with multiple MCOs will result in further increased administration for providers, much like in the 1997 Medicaid managed care program. To add to this point, there is little evidence to suggest that the current core service agencies actually have the capacity to perform the functions expected of them.

Next, we harken to the State's previous experience with managed care reform involving Native Americans to highlight potential problem areas and offer recommendations regarding Centennial Care.

1. When the State instituted mandatory managed care for Medicaid recipients in 1997, members of federally recognized tribes, legally entitled to Medicaid services through the Indian Health Service or tribal facilities operating under Public Law 93–638, could opt out of the managed care system. However, since the State did not publicize this choice widely in reservation communities, many Native Americans were auto-assigned to an unfamiliar MCO program. Oftentimes the services in the MCO provider network were located in communities far from their homes, and were not culturally responsive let alone accessible. Thus, Native Americans with Medicaid continued to turn to Indian Health Service and tribal facilities for their physical and behavioral healthcare, even though the MCOs received prepaid Medicaid capitation payments for these patients.

    - Under the Centennial Care, how will the State ensure that Native Americans are aware of their rights and choices within the Medicaid system? How will it evaluate its outreach efforts to ensure they are culturally responsive and effective?

    - If the State institutes mandatory managed care for Native Americans, what will happen to the money that the MCOs receive for those who get care in Indian Health Service or tribal facilities? Although the facilities are to be paid the OMB (Office of Management and Budget) rate via federal pass through funds, the MCOs will still get a subsidy for care they do not deliver to Native Americans assigned to their plans. We contend that this subsidy should be set aside to improve physical and behavioral healthcare for our State's woefully underserved Native American population and should not comprise a windfall for the MCOs.

2. In our 5-year study of New Mexico's recent "behavioral health transformation," we conducted 320 in-depth qualitative interviews with 169 Navajo American participants, including 12 community leaders, 42 behavioral health providers, 67 individuals with "lived experiences" of serious mental illness, and 48 of their family and friends. Several key findings pertinent to the Centennial Care emerged from this study.

    - Foremost, solid collaboration between Native American Nations, the State and its managed care contractors should be the hallmark of any initiative to implement quality behavioral healthcare for Native Americans. Under the behavioral health transformation, the State made minimal effort to consult with Tribes and Pueblos prior to the inception of new programs and services. Such consultation needs to take place in an ongoing and meaningful manner if State-mandated reforms are to benefit Native American communities. It currently appears that the State has made minimal attempt to truly engage Tribes and Pueblos in genuine collaboration related to Centennial Care.

    - During the behavioral health transformation, we found that State officials and managed care employees often lacked basic knowledge of tribal governments, healthcare structures, and

overall administrative systems. Ignorance of sovereignty issues and the federally guaranteed healthcare rights of Native Americans abounded. The problem of insufficient knowledge created challenges for the State and BHO in their attempts to secure tribal support for reform initiatives. Contracting processes posed particular challenges. Under Centennial Care, we believe it is an imperative to rectify this situation by providing ongoing education and training in these areas to State and MCO employees responsible for consulting with the Native American Nations, engaging in contract negotiations, or otherwise implementing managed care approaches that will affect indigenous New Mexicans.

- During the transformation, some Native American providers had a hard time adjusting to the demands of a managed care system, partly due to the Western-centric nature of imposed clinical and administrative practices. Under the Centennial Care Waiver, we believe there is a need to thoroughly and continuously evaluate proposed care coordination, comprehensive assessment, and utilization review practices to ensure they are linguistically appropriate and culturally sensitive, and are resulting in high quality services for Native Americans.

- Technical assistance and other resources, including workforce investments, must also be made available to providers specializing in services for Native American populations if they are to operate successfully under a statewide managed care reform. Here, the State could establish incentives for Native American providers to pursue education and licensure, as well as create alternative licensure and credentialing requirements for some Native American providers, whose qualifications may not be recognized by the MCOs.

Finally, whether we are talking about the behavioral health system in general or the potential impacts on Native Americans in particular, there are no serious plans for genuine, transparent, “real time” evaluation that includes stakeholder input in the waiver application. We believe the state legislature and the CMS must become more proactive in ensuring that a solid evaluation plan is in place at the start of this latest reform. Both the State and the MCOs must be forthcoming with data, especially individual-level claims data, to undertake rigorous evaluation. An evaluation occurring independent of the State and MCOs should be considered. The legislature could potentially fund such an initiative.

Thank you for the opportunity to a share with you our concerns regarding the Centennial Care Waiver. Please do not hesitate to let Dr. Semansky or me know if you require clarification or additional information.

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