



NYS CCBH Recommendations on Implementing the C.K. Settlement



OVERVIEW AND FRAMEWORK FOR RECOMMENDATIONS

The *C.K. v McDonald* settlement requires New York to deliver timely, statewide access to Intensive Care Coordination (ICC), Intensive Home-Based Behavioral Health Services (IHBBHS), and Mobile Crisis Services (MCS), with sufficient providers, clinically grounded eligibility, sound rates, public data, and corrective action. In our current system, access to these programs is constrained less by a lack of service models than by insufficient provider capacity, fragmented eligibility rules, and reimbursement that does not support the actual cost of delivering this care.

Each CCBH recommendation below is meant to advance one or more of five priorities: increasing access to ICC, IHBBHS, and MCS; increasing youth and family voice and choice in service delivery; simplifying and standardizing eligibility and infrastructure — not service delivery; increasing provider flexibility in service delivery; and increasing reimbursement rates to reflect the full scope of service delivery and staffing costs.

Every obligation in the settlement ultimately depends on provider capacity to meet community need. Increasing access to the right services at the right time necessitates the State collaborating closely with families and the community-based organizations that provide services throughout the state to develop a practical and sustainable implementation plan.

In addition to specific recommendations for settlement objectives, CCBH also offers an overall recommendation about process. We urge the State to begin with analysis of the data on family service needs and provider capacity throughout the state before moving into service and system structure development. That data should be used for developing access and network standards, in collaboration with families and providers. Then, the data on service need and capacity, and the standards for meeting them, can inform the work on service development, rate methodologies, transition planning, and quality and accountability tracking.

Broader System Context: These recommendations focus on the specific services and processes named in the settlement, and that focus will likely consume much attention in the years ahead. But we urge the State and all stakeholders to keep the rest of the child-serving system in mind at every step. Implementing changes only to meet the terms of the settlement risks further destabilization of the wider children's behavioral health system that youth and families continue to rely on. Successful implementation requires a system-wide perspective to prevent unintended consequences. By aligning the settlement's rollout with the broader children's behavioral health continuum, we then can effectively integrate care and strengthen the entire service network.

1. MAKE SERVICE DELIVERY FAMILY-CENTERED — WITH PROVIDER FLEXIBILITY TO ADJUST CARE AS NEEDS CHANGE

***Priorities advanced:** Increasing youth and family voice and choice in service delivery; increasing provider flexibility in service delivery.*

***Settlement anchor:** Individualized service delivery and intensity (§§ 14, 25(a)); detailed service standards and CFTSS/HCBS redesign (§§ 20–34); family and stakeholder involvement (§§ 33, 52, 56–57).*

Families should be able to choose their goals, providers, and delivery approaches, and treating providers should be able to adjust services in response to changing family needs without unnecessary delay.

- One care plan per family, held by a community-based care manager who coordinates the team.
- Integrate inclusive care team meetings into the service model so every relevant care team member has the availability to participate, fostering collaboration and better patient outcomes.
- Give families and youth meaningful choices about their services, providers, and goals.
- Count all family engagement, including phone calls, emails, text messages, and meetings, as part of the standard service array. Allow services to be delivered in any community setting deemed appropriate by the provider and family, including via telehealth.
- Create family-centered services tailored to the unique needs of the child and family, ensuring all names and descriptions of services are clear, accessible and easy for all to understand.
- Give families plain-language information about eligibility, provider choice, denials, reductions, appeals, and future options.
- Remove barriers to increasing and decreasing services based on family need; allow intensity to step up or down promptly when the treatment team identifies a change, without unnecessary discharge and re-admission to a waitlist.
- Ensure continuity of care during transitions between levels of care, including discharge from hospitals and residential settings, by requiring timely coordination, a clear transition plan, and continued involvement of the existing care team whenever clinically appropriate.
- Design competency-based rather than strictly degree-based staff qualifications, recognizing both credentialed and non-credentialed roles, to expand the workforce and match family needs.
- Treat respite — including short-term and overnight options — and youth/family peer support as integral, not optional.
- Develop a clear transition plan to support families and providers as new services are rolled out. This strategy will ensure continuity in care and minimize disruption for families during this time of transition.

2. STREAMLINE PROCESSES AND INFRASTRUCTURE; DO NOT STANDARDIZE SERVICE DELIVERY

***Priorities advanced:** Simplifying and streamlining eligibility and infrastructure, not standardizing service delivery; increasing access to ICC, IHBBHS, and MCS.*

***Settlement anchor:** Clinically grounded eligibility and consistent statewide access procedures (§§ 35–40); direct referral pathways and points of access (§36(c)); Barriers to Access (§§ 76–80); MCO and State policy changes necessary to implement the plan (§87).*

Eligibility, referral pathways, provider credentialing, and paperwork should follow the same statewide process for each family and service. What needs to be individualized and flexible is the service delivery itself.

- Establish a “no wrong door” referral approach. Simplify and streamline the assessment and referral process, allowing for multiple easily navigable referral pathways, reduced administrative hurdles, and elimination of duplicative requirements on families who need more than one service.
- Ensure providers and family access to charts, treatment plans, and other information across programs aligned with requirements for information sharing and confidentiality.
- Remove “fail first” requirements and nonclinical eligibility exclusions tied to prior hospitalization or high-acuity history; recognize repeated ED presentations without admission.
- Eliminate MCO-driven access barriers for families by carving behavioral health services out of managed care. If MCOs are to remain involved in these services, at the very least:
 - Eliminate MCOs’ ability to re-adjudicate treatment and service delivery decisions
 - Eliminate MCOs’ ability to demand documentation beyond state requirements
 - Meaningfully hold MCOs accountable for impeding access to care
- Use one statewide approach to credentialing, provider applications, documentation, authorization formats, denials and appeals, and remittance communication.
- Treat C-SPOA as an important access and coordination route, not the only door — preserve direct referrals from families, providers, hospitals, schools, and other community stakeholders.
- Remove prohibitions on concurrent services where clinically appropriate and non-duplicative.
- Standardize consent through a state-approved release of information and electronic processes, and use consented, interoperable alerts for hospital admission and discharge.

3. STRUCTURE RATES TO SUSTAIN THE FULL SCOPE OF PROVIDER COSTS TO DELIVER QUALITY SERVICES

***Priorities advanced:** Increasing reimbursement rates to reflect the full scope of service delivery and staffing costs.*

***Settlement anchor:** Rate transparency, sound basis, and sufficiency to enlist enough providers statewide (¶¶ 41–43, 90).*

Rates need to support the full scope of provider costs, including the administrative and professional development structure that is necessary to ensure the quality, compliance and availability of each billable encounter.

- Structure rates to sustain the full scope of provider costs to deliver quality services, considering the following, but not limited to:
 - **Personnel**
 - Competitive wages and fringe benefits
 - Supervision, including supervisor-to-staff ratios
 - Evening and non-traditional hours
 - Workforce-pipeline costs: provisional billing for interns and trainees, competency-based non-licensed roles under clinical supervision, career ladders, loan repayment, and retention incentives
 - Appropriate staffing and training costs needed to best serve specialized populations (e.g. youth with complex, co-occurring needs such as I/DD, SUD)
 - Regional wage and cost differences
 - Two-worker safety staffing
 - Team meetings and interdisciplinary coordination
 - Collateral contacts, service planning, and transition work
 - **Other than Personnel Services**
 - Travel time and transportation costs
 - Realistic billable productivity assumptions (including turnover, recruitment/retention, onboarding, training, protected leaves of absence, documentation, no-shows/cancellations, etc.)
 - Cost of training and ongoing fidelity to evidence-based models
 - For mobile crisis specifically: dispatch, readiness and coverage (not just completed encounters), vehicles/technology, and paired/team staffing
 - Administrative overhead
 - Intake and outreach
 - EHR/IT, billing, and credentialing
 - Quality assurance, compliance, outcomes oversight and reporting

- Publish the assumptions and methodologies behind reimbursement rates; obtain current data from and consult with service providers in developing and revising rates.
- Rebase rates every 3-5 years and apply an inflation/trend mechanism between full reviews, including an annual Targeted Inflationary Increase tied to the July CPI-U.
- When using transitional and/or start-up funding, which is typically higher than ongoing rates, thoroughly evaluate all operational data and costs, in order to ensure the new rate accurately reflects actual service costs and program needs.
- Execute and pay State contracts and start-up awards quickly enough so that providers are not required to finance program rollouts from reserves.
- Explore bundled, braided, or case-rate models to build in and fund more flexibility and individualized care for each child and family.
- Calibrate state funding so a county's tax base does not determine the availability or quality of children's mental health services and create inequities across the state.

4. ANALYZE COST AND OUTCOME DATA, SHARE FINDINGS, AND ESTABLISH EQUITABLE RATES AND INFORMED POLICIES

Priorities advanced: Supports all five priorities by making progress on each of them measurable and enforceable.

Settlement anchor: Public data and dashboards (¶¶ 45–46); QIP performance indicators and data systems (¶¶ 62–72); provider, recipient, and referred-but-not-received review (¶¶ 74–80); reporting and rate review (¶¶ 88–90); corrective action (¶¶ 91–92); underserved populations (¶57).

To make the other three recommendations work, there must be a clear way to measure their success through an equity-centered framework. A method to track progress, rectify historical disparities, and ensure accountability, will promote lasting success that aligns with our collective, best intentions.

- Co-design consistent, statewide indicators on access, utilization, equity, and outcomes with the provider community; integrate them with existing reporting to avoid duplication, and pair them with data infrastructure support.
- Include youth and families as meaningful partners in implementation and, review of access and outcome data, ensuring that their experience informs decisions about whether services are accessible, appropriate, and responsive to their needs.
- Track the full path from child/family need to actual service delivery.
- Monitor active provider capacity in all services.
- If MCOs remain involved in behavioral health services, monitor MCO impacts on access to and delivery of care, including:
 - Denials and service reductions, denial/reduction reasons, appeals, and additional documentation requests
 - Network adequacy and directory accuracy, measured regionally and not solely statewide
 - Underpayments and other billing failures
 - Credentialing delays
 - Apply timely, meaningful financial penalties for repeated or material MCO noncompliance.
- Use claims and encounter data together with referred-but-not-served reviews, provider reviews, and family/youth experience, rather than relying on claims alone to show whether the right service was delivered at the needed intensity.
- Require regional corrective action where statewide averages hide local shortages on a timely basis.

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