New York State
Quarterly Update to the
MRT Children's Behavioral Health Subcommittee
October 21, 2013
Albany, NY

Agenda

- Welcome and Review of the Day's Agenda (Donna Bradbury)
- Progress Report (Laura Velez)
- Transition Age Youth (Angela Keller)
- Upcoming Focus – next 6 months (Angela Keller)
- Refining the Vision for the Transition to Medicaid Managed Care (Steve Hanson)
- Health Home and Managed Care Intersection (Greg Allen/Lana Earle)
- Managed Care Design Discussion (Linda Kelly)
- Discussion (Donna Bradbury/Gail Nayowith)

Progress since last Quarterly Meeting

- Quarterly meeting schedule with Children's BH Subcommittee confirmed
- Children's Medicaid Managed Care work plan revised to reflect the new January 2016 implementation date
- Mercer has begun to provide technical assistance to NYS on the children's Program and Policy Design, affording opportunity for NYS to learn from other States' models
- A children's managed care transition listserv has been launched to communicate on a regular basis with stakeholders – there are over 500 registrants currently
- Informal survey conducted of OMH inpatient providers' to collect challenges and strategies with current managed care procedures, for initial input on contract standards
- Agency staff have begun work on recommendations and requirements to modify the Health Home model to meet the needs of children
- Will begin engagement with the Plans on December 12, as part of DOH's Managed Care Plan monthly meetings

Homework from June

- Feedback on three questions compiled:
  - What are five critical standards for the managed care plans to be able to manage children's behavioral health services?
  - What are some specific indices to evaluate the quality and readiness of the provider networks to be proposed by the managed care plans?
  - What requirements should be proposed to the existing Health Home model before transition of children with behavioral health needs?
- Steps taken from feedback:
  - Suggestions for the Health Home model modifications have been shared with DOH and the interagency workgroup
  - A standards grid has been developed and will launch the work of the performance management workgroup
  - The evaluative feedback will inform our readiness review criteria development

Transition Age Youth

- NYS has submitted the OMH HCBS Waiver renewal application to CMS for approval. Three new services are proposed to be added to the HCBS Waiver: Pre-Vocational Services, Supported Employment and Youth Peer Advocate Services. These services are similar in scope to OCFS' services within the B2H Waiver and the 1915i-like services being added through the 1115 amendment for adult services.

- NYS plans to amend the OMH HCBS Waiver to extend the eligibility age of entry for accessing the Waiver from 18 to 21. This will assist in the year of transition between adult and children's systems' movement to managed care (2015-2016).

Transition Age Youth

- One of the risk factors to be considered for HARP eligibility is a young adult having a significant history of involvement with children's services system.
- For children who are between the ages of 18 and 21 who are not eligible for children's waiver services, the MCOs will be expected to utilize the authority under EPSDT to ensure that the child receives the full range of medically necessary services available under Medicaid.
- For TAY with a history utilizing children's programs and/or HCBS waivers (both OMH and Office of Children and Family Services), the MCO must begin a transition plan for any enrollee under age 21 that ensures continuity of care up until age 23 or until the youth is stabilized in the adult system (whichever is later). For MCOs that do not have HARP lines of business, this includes ensuring that the child is screened for entry into a HARP and is transitioned to an MCO with a HARP if that is the individual's choice and s/he is eligible.

Managed Care Transition

Launch! – January 1, 2016

The next 6 months:

- Complete children's analytic plan to identify populations accessing children's behavioral health services
- Establish eligibility criteria for levels of behavioral health services
- Develop benefit package and service delivery model

Refining the Vision

Proposed 2016 Children's Medicaid Managed Care Model

For all children 0-20 years old

Mainstream Medicaid Managed Care Organization: Benefit Package*

- All Health & Pharmacy Expanded Benefits
- Behavioral Health State Plan Services
- *Potential* Children's 1915i – like Services
- Children's 1915c HCBS Waivers (OMH and OCFS B2H)

Required to contract

Required to have MOUs and/or working relationships

Care Management for All

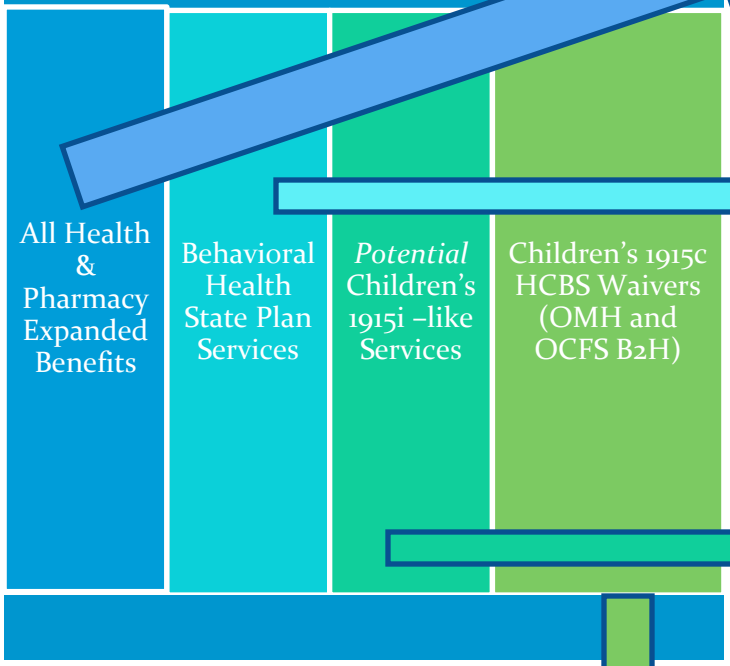
Care Management will be provided by a range of models that are consistent with a child's needs (e.g., Managed Care Plans, Patient Centered Medical Homes and Health Homes (HH). Health Homes will serve children with the highest level of need.)

Service Provider Network

- Pediatric Health Care Providers
- Pediatric Specialty Health Care Providers
- Children's Behavioral Health Providers
- Foster Care Providers
- Community Based Providers (e.g., family support/peer services)
- School Districts & CSEs
- Local Government (LDSS, LGU, SPOA, Probation)
- Community Services & Support s (non-Medicaid)
- Juvenile Justice/ Criminal Justice System
- Regional Planning Consortiums

***MCOs may opt to contract with other entities (e.g., BHOs) to manage behavioral health benefits**

Mainstream Medicaid Managed Care Organization: 2016 Benefit Package



- ✓Clinic
- ✓Inpatient/Outpatient Psychiatric/Hospital Services
- ✓Pediatric Care (medical, developmental, BH)
- ✓Pharmacy
- ✓Home Health
- ✓Dental & Orthodontics
- ✓Foster care per diem

OMH: day treatment, rehabilitation services within community residences, residential treatment facilities, and intensive/ supportive/ blended case management

OASAS: RRSY, opioid replacement treatment, outpatient chemical dependence rehabilitation, outpatient clinic, methadone maintenance, rehab supports for community residences

OCFS: foster care per diem paid to voluntary agencies to manage the health and behavioral health needs of children in foster care.

Supportive services to be defined for children who fall between the cracks and/or do not need 1915c level of care

OMH HCBS :individualized care coordination, family support, crisis response, skill building, and respite care
OCFS B2H Health Care Integration: Family/Caregiver Supports and Services; Skill Building; Day Habilitation; Special Needs Community Advocacy and Support; Prevocational Services; Supported Employment; Planned Respite; Crisis Avoidance, Management and Training; Immediate Crisis Response Services; Intensive In-home Supports and Services; Crisis Respite; Adaptive and Assistive Equipment; and Accessibility Modifications.

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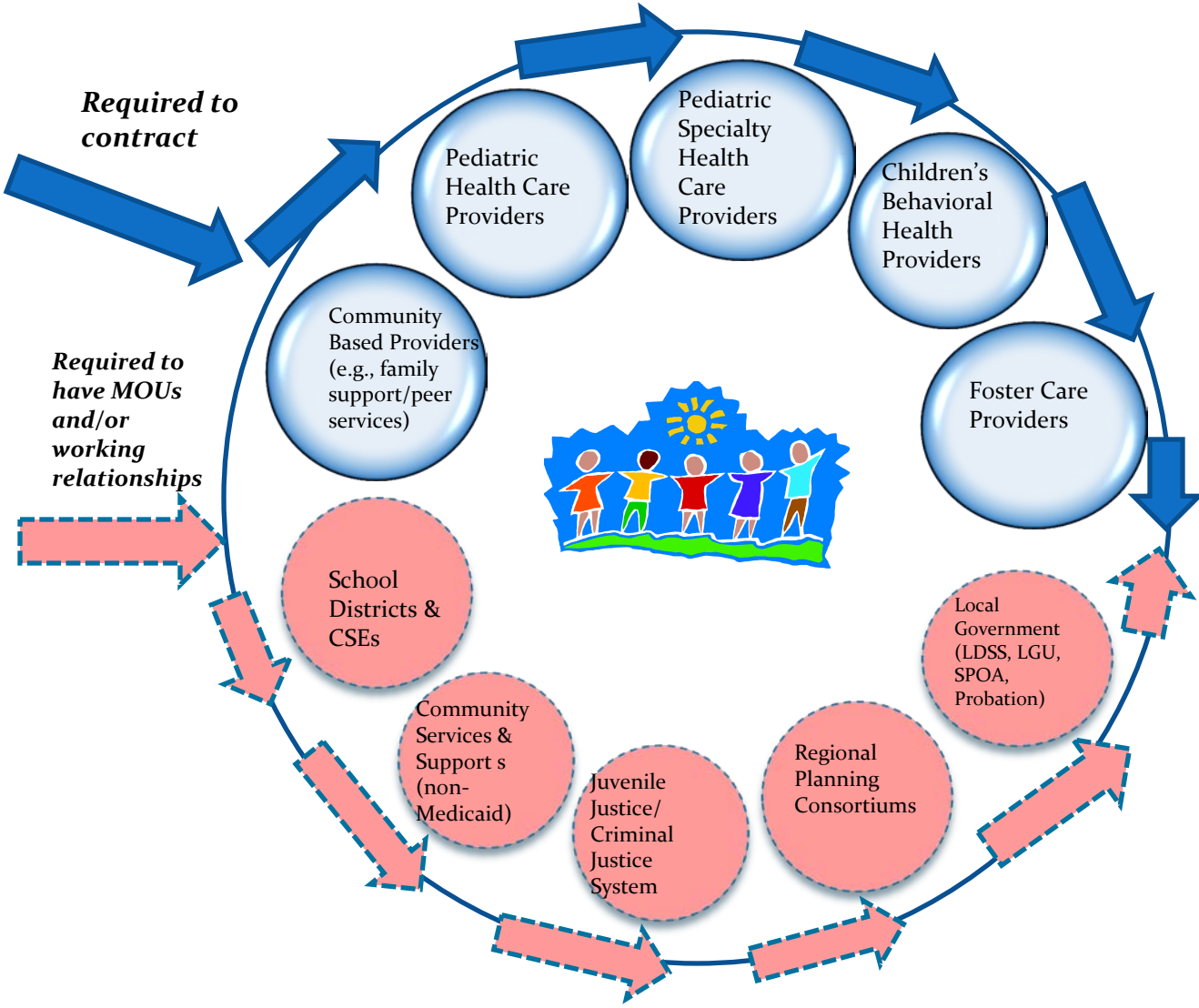
Network Requirements under Discussion



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Care Management for All

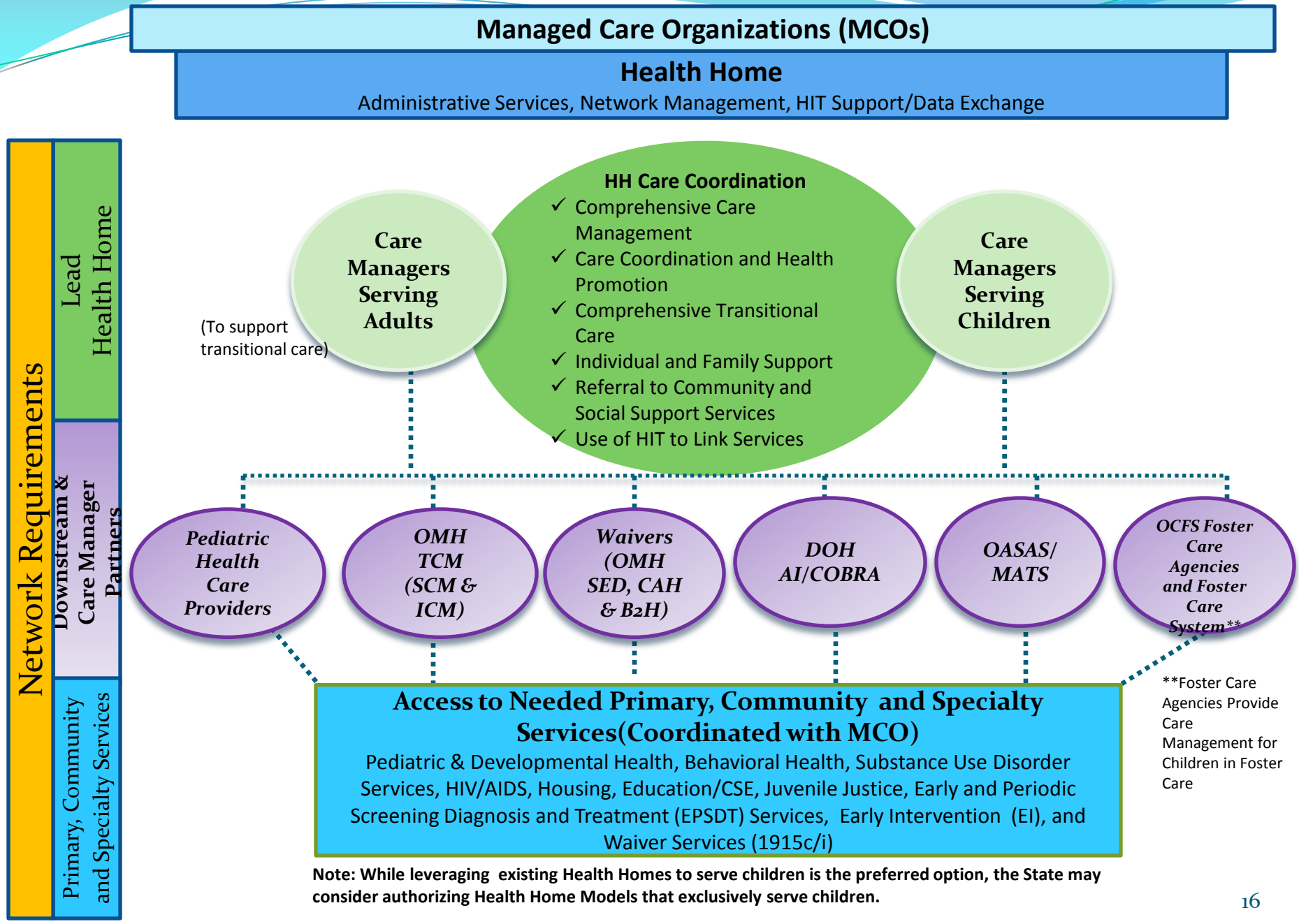
Care Management will be provided in a variety of intensities, for example:

- within primary care for medical, developmental and behavioral health coordination;
- by Plans for children needing lower levels of care and to manage the overall benefit package access; and,
- by Health Homes for those children meeting the eligibility criteria

Principles for Serving Children in Managed Care and Health Homes

- ✓ Ensure managed care and care coordination networks provide comprehensive, integrated physical and behavioral health care that recognizes the unique needs of children and their families;
- ✓ Provide care coordination and planning that is family-and-youth driven, supports a system of care that builds upon the strengths of the child and family;
- ✓ Ensure managed care staff and systems care coordinators are trained in working with families and children with unique, complex health needs;
- ✓ Ensure continuity of care and comprehensive transitional care from service to service (education, foster care, juvenile justice, child to adult);
- ✓ Incorporate a child/family specific assent/consent process that recognizes the legal right of a child to seek specific care without parental consent;
- ✓ Track clinical and functional outcomes using standardized pediatric tools that are validated for the screening and assessing of children;
- ✓ Adopt child-specific and nationally recognized measures to monitor quality and outcomes; and
- ✓ Ensure smooth transition from current care management models to Health Home, including transition plan for care management payments.

New York State Health Home Model for Children



Note: While leveraging existing Health Homes to serve children is the preferred option, the State may consider authorizing Health Home Models that exclusively serve children.

Principles for Establishing Health Home Network Requirements for Children

- In order to take advantage of infrastructure that has already been developed, existing Health Homes will be given an opportunity to apply to serve children.
- Applications from new entities would be considered based on capacity or need for access to specialty services.
- Applications will be reviewed by a multidisciplinary team: DOH (including OHIP, AIDS Institute and OHITT), OCFS, OMH, OASAS and NYC DOH MH for:
  - Capability to meet child specific Health Home qualifications and standards and to abide by the principles for serving children and families;
  - Ability to meet needs of complex populations (e.g., children with chronic conditions, those with SED/SUD, children in the Foster Care and Juvenile Justice systems);
  - Ability to partner with school districts and the education system; and
  - Requirement to use Foster care agencies for care management when a child enters foster care.

Next Steps for Developing Recommendations for Health Home Model for Children

Health Home State Agency Team will work to make recommendations to further define the Health Home Model for Children, including:

- ✓ Eligibility criteria for children
  - Current Health Home criteria of two chronic conditions, HIV or SMI/SED
- ✓ Defining adequate Health Home Networks and ensuring access
- ✓ Transitional and payment provisions for "Legacy" care management models for children
- ✓ Conducting assessments and meeting Federal requirements for conflict free case management
- ✓ Incorporation of procedures for assent and consent for children in the Health Home model

Anticipated Schedule for Enrolling Children in Health Homes	
Review Health Home Children's Model with Stakeholders - MRT Children's Work Group, HH-MCO Work Group	October 2013
Collaborate with Stakeholders to Refine Health Home Model and Develop Health Home Application for Children	November 2103 - March 2014
Applications for Health Homes Serving Children Made Available	April 2014
Due Date for Submission of Applications for Health Homes Serving Children	August 2014
Health Home State Agency Team Review and Approval of Applications	October 2014
Develop and Distribute Health Home Assignment Lists for Children	November – December 2014
Begin Enrolling Children in Health Homes	January 2015
Behavioral Health Services for Children in Managed Care	January 2016

Transitions to Serve Children: Managed Care and Health Homes

Children transition into Health Homes

January 2015

PARALLEL PLANNING

Children's Medicaid Services transition into managed care

January 2016

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Benefit Package & Waivers (under discussion)

- NYS will file an 1115 amendment to request approval of the children's model.
- NYS is considering applying for authority under the 1115 amendment for 1915i-like services that would complement the array of State Plan and Waiver services
- Eligibility for each service level is under discussion
- Needed services articulated by stakeholders and principles under consideration for adding to State Plan, 1915c and 1915i

Potential Plan Network Requirements for Managing Children's Behavioral Health Services (under discussion)

- Contract with all OMH and OASAS licensed/certified providers and OCFS foster care providers
- Contract with State-operated OMH/OASAS providers as "Essential Community Providers"
- Allow members to have a choice of at least 2 providers of each BH specialty service (with rural exception)
- Continue to pay government rates to contracted providers for ambulatory services and foster care per diem rates currently in place, for 24 months after contract execution
- Establish written agreements to establish working relationships with LDSS with regard to children in foster care and other court mandated care
- Comply with all mandatory network requirements for 24 months from contact execution
- Develop a working relationship with school districts specifically regarding decision making processes of placing children
- Develop working relationships with local government (LGU, LDSS, SPOA, Probation) in the Plan's area

Discussion

Next Quarterly Meeting
January 27, 2014
1:00 – 3:00 PM
New York City