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# Children's Medicaid System Transformation – Overview / Refresher Course

**Slide 21 was updated on 9/20/17 to correct an error in the note**

# Medicaid Redesign Team (MRT) Goals of Children's Medicaid System Transformation

- ✓ Keep children on their developmental trajectory
- ✓ Maintain child at home with support and services
- ✓ Maintain the child in the community in least restrictive settings
- ✓ Identify needs early and intervene
- ✓ Focus on recovery and building resilience
- ✓ Prevent escalation and longer term need for higher end services
- ✓ Maintain accountability for improved outcomes and delivery of quality care



# ***Primary, Most Important Goal of Transition***

## ***Ensure that the Transition is Seamless for Children and their Families***

- ✓ Continuity of Care of Providers and Services
- ✓ Well informed children, families, providers
- ✓ Access to the State for information and assistance
  - ❖ How can we help?
- ✓ Partnership with providers, plans and stakeholders to make transition seamless



## How does the Design of the Transformation Achieve the Goals?

- ✓ Increase access to appropriate interventions by enhancing service array available in the continuum of care – remove silos and provide right services at the right time
- ✓ Expand services and eligibility for those services - More “tools” in the tool box to develop care plan
- ✓ Offer children Medicaid services within a Managed Care delivery system
  - Integrate the delivery of physical and behavioral health services
  - Integrate approaches to care planning and service provision
- ✓ Fundamentally shift focus to improving and achieving high quality outcomes by shifting from systems that reward value instead of volume –State’s continual move towards value based payments by year 2020



## Key Components of Children's Medicaid System Transformation

- ✓ Transition of six 1915(c) waivers to 1115 Waiver authority
  - Office of Mental Health (OMH) Serious Emotional Disturbance (SED) Waiver;
  - Department of Health (DOH) Care at Home (CAH) I/II waiver
  - Office for People with Developmental Disabilities (OPWDD) Care at Home Waiver
  - Office of Children and Families (OCFS) Bridges to Health (B2H) SED, Developmental Disability (DD) and Medically Fragile Waivers
- ✓ Alignment of 1915(c) HCBS under one array of Home and Community Based Services (HCBS) authorized under 1115 Waiver
- ✓ Remove the Managed Care exemption for children now in six 1915(c) waivers
- ✓ Transition to Health Home Care Management
  - ✓ Current 1915(c) Waiver Providers Transition to Health Home
  - ✓ Care Management provided under 1915(c) Transition to Health Home Care Management



# Key Components of Children's Medicaid System Transformation

- ✓ Transition of certain carved out Behavioral Health services into Managed Care benefit package
- ✓ Six New State Plan Services for Children
- ✓ Lifting the exemption of children in foster care with Voluntary Foster Care Agency (VFCA) to Managed Care (January 1, 2019)
- ✓ Expansion of Children's aligned HCBS eligibility to-Level of Need Population (January 1, 2019)
- ✓ All services available to eligible members through both the fee-for-service and Managed Care delivery systems, based on the individual's enrollment



# Before and After Children's Transformation

## Before Transformation

- Current State Plan services
- Care Coordination is limited to six 1915c Waiver Programs and OMH TCM Program, programs include slot limitations
- Limited array of Home and Community Based Services (HCBS) available only to 1915c Waiver - children services depend on and vary by waiver
- Children's delivery of services is siloed
- Behavioral health and physical health services are not integrated
- Care planning is not integrated
- Transitional care across children's system is lacking

## After Transformation

- ✓ **Health Home care management for children with two or more chronic conditions, serious emotional disturbance (SED), complex trauma, HIV (Children Health Home launched in December 2016)**
- ✓ Current State Plan services PLUS
  - ✓ **Six new state plan services**
- ✓ **Expanded array of 12 HCBS based on expanded target, risk, and functional criteria with Health Home care management**
- ✓ **Integrate and transition behavioral health benefits to managed care plan**
- ✓ **Transition foster VFCA population to managed care**
- ✓ **Foster transitional care and continuity of care across children serving systems (education, child welfare, juvenile justice)**
- ✓ **Shift focus to quality, monitoring, and tracking and reward quality outcomes (value based payments)**



## Schedule of Key Implementation Dates

New York State Proposed 1115 Waiver Amendment (Effective Date of Waiver Amendment January 1, 2018)	Effective Date
<b>Children's 1115 Waiver</b>	
<b>Health Home Readiness System</b> Activities and Developing Health Home Relationships (Business Associate Agreements with Health Homes, Connectivity to Health Home Systems) for all 1915(c) Waiver Providers transitioning to Health Home	Now thru to 11/17
<b>Other Readiness Activities - Trainings, Webinars</b>	Now thru 2019
<b>Six 1915(c) Children Waiver Authority Transitions to 1115 Waiver Authority</b> OMH HCBS Waiver, Bridges to Health (DD, MF, SED) Care at Home I/II and OPWDD Care at Home)	1/1/18
<b>Interim Transition Process</b> - Preparatory activities for aligned service delivery and transition of care coordination for children/families from 1915(c) Children's Waivers to Health Home for (OMH HCBS Waiver, 3 Bridges to Health (DD, MF, SED), Care at Home I/II and OPWDD Care at Home)	1/1/18 to 7/1/18
Children's <b>Behavioral Health Benefits Transition to Managed Care</b> and Exemption from Enrollment in Managed Care will be Removed for Children in the Six 1915(c) Waivers <b>Six New State Plan Services for Children</b>	7/1/18
Complete alignment of Children's HCBS 1915(c) under 1115 (Level of Care)	7/1/18 to 12/31/18
<b>Foster Care Population to Managed Care, Expansion of HCBS and Family of One to Level of Need Population</b>	1/1/19





# Components of Transformation Require Various State and Federal Approvals

- ***Children's 1115 Waiver Amendment – Submitted to CMS on May 9, 2017***  
[http://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/1115\\_waiver\\_amend.htm](http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/1115_waiver_amend.htm)
- ***Medicaid MCO Children's System Transition Plan***
- ***2 State Plan Amendments for Six New State Plan Services***
- ***Rates***
- ***Title 18 and Agency Regulations***
- ***Independent Entity***
- ***Qualification of MMCPs***
- ***Designation of providers for new SPA and HCBS***
- ***MMCP Model Contract and Policy Paper***



# State Plan (SPA) Services



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## Six New State Plan Services

- Other Licensed Practitioner
- Crisis Intervention
- Community Psychiatric Supports and Treatment (CPST)
- Psychosocial Rehabilitation Services
- Family Peer Support Services
- Youth Peer Advocacy and Training

- ✓ Proposed in two State Plan Amendments submitted to CMS in December 2016
- ✓ Available to all children that meet medical necessity criteria
- ✓ Effective date of July 1, 2018 Draft SPA manual and service descriptions available at:  
[http://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/proposed\\_spa.htm](http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/proposed_spa.htm)

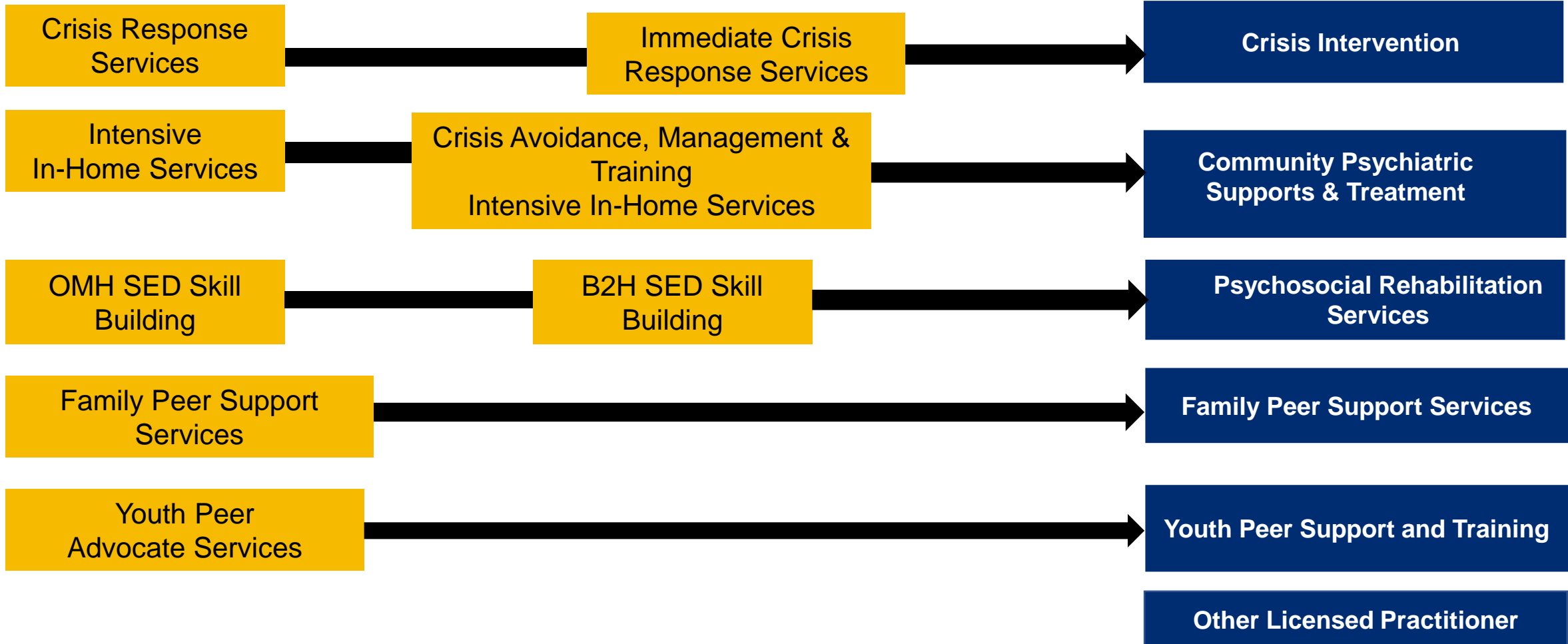


# State Plan Amendment: Existing services moving into SPA

Existing OMH Serious Emotional Disturbance (SED) Waiver Services

Existing OCFS Bridges to Health (B2H) Waiver Services

New SPA Services  
July 1, 2018



# Overview of New State Plan Services

## ✓ Other Licensed Practitioners:

Non-physician licensed behavioral health practitioner (NP-LBHP) who is licensed in the State to prescribe, diagnose, and/or treat individuals with the physical, mental illness, substance use disorder, or functional limitations at issue, operating within the scope of practice defined in State law and in any setting permissible under State practice law (i.e. services can be delivered in the community outside the four walls of the agency). Activities would include:

- Recommending treatment that also considers trauma-informed, cultural variables and nuances.
- Developing recovery or treatment plan
- Activities within the scope of all applicable state laws and their professional license including counseling, individual, or family therapy.

NP-LBHPs include individuals licensed and able to practice independently as a

- Licensed Psychologist
- Licensed Clinical Social Worker
- Licensed Marriage and Family Therapist or
- Licensed Mental Health Counselor

An NP-LBHP also includes a Licensed Master social Worker under the supervision or direction of a Licensed Clinical Social Worker, a Licensed Psychologist or a Psychiatrist



# Overview of New State Plan Services

## ✓ Crisis Intervention:

Crisis Intervention (CI) services are provided to all children/youth who are identified as experiencing a seriously acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved (e.g. collateral, provider, community member) to effectively resolve it.

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# Overview of New State Plan Services

## ✓ **Community Psychiatric Support & Treatment (CPST):**

CPST services are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the child's treatment plan. CPST is designed to provide community-based services to children and families who may have difficulty engaging in formal office settings, but can benefit from community based on-site rehabilitative services.

## ✓ **Psychosocial Rehabilitation:**

Psychosocial Rehabilitation Services (PRS) are designed to work with children and their families to implement interventions outlined on a treatment plan to compensate for or eliminate functional deficits and interpersonal and/or environmental barriers associated with a child/youth's behavioral health needs.



# Overview of New State Plan Services

## ✓ **Family Peer Support Services:**

Family Peer Support Services (FPSS) are an array of formal and informal activities-and supports provided to families caring for/raising a child who is experiencing social, emotional, medical developmental, substance use and/or behavioral challenges in their home, school, placement, and/or community. FPSS provide a structured, strength-based relationship between a Family Peer Advocate (FPA) and the parent/family member/caregiver for the benefit of the child/youth.

## ✓ **Youth Peer Support and Training:**

Youth support and training (YPST) services are youth formal and informal services and supports provided to youth and families raising an adolescent who are experiencing social, emotional, medical, developmental, substance use and/or behavioral challenges in their home, school, placement, and/or community centered services. These services provide the training and support necessary to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process.





# Aligned Children's Home and Community Based Services (HCBS)



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## Alignment of HCBS Services

- Respite (Planned and Crisis)
- Caregiver/Family Supports and Services
- Prevocational Services
- Supported Employment
- Community Self-Advocacy Training and Support
- Habilitation
- Adaptive and Assistive Equipment
- Accessibility Modifications
- Palliative Care
- Health Home Care Management
- Customized Goods and Services
- Non-Medical Transportation

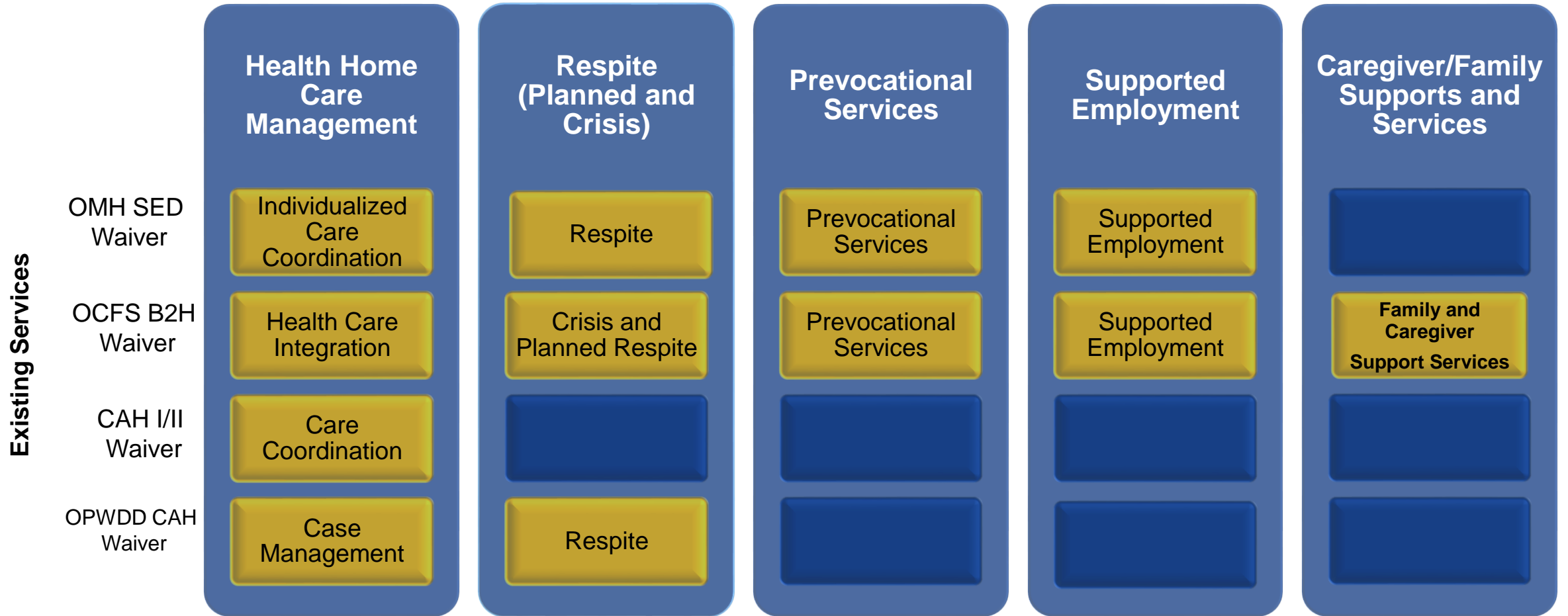
### ***Determining HCBS eligibility***

- ✓ Level of Care – Population, Risk and Functional criteria that indicate a child is eligible for or at risk of institutional placement
- ✓ Level of Need – new concept to prevent escalation to LOC and LOC step down in services - Population, Risk and Functional criteria for a child that does not meet institutional/hospital/ placement criteria but does have extended impairment in functioning (applicable to SED and Abuse, Neglect, Maltreatment and Complex Trauma Population)
- ✓ Draft HCBS manual and service descriptions available at:

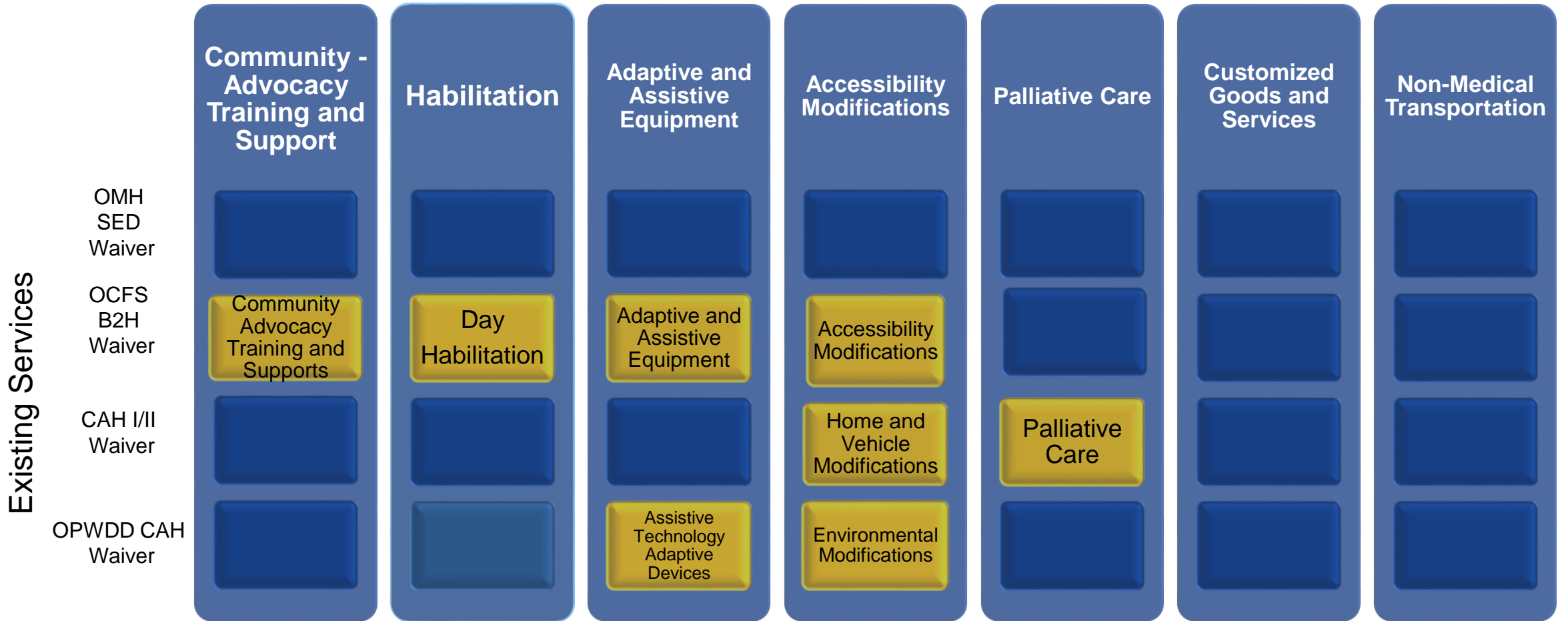
[http://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/hcbs.htm](http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/hcbs.htm)



# Children’s Home and Community Based Services: Existing Services Moving into newly Aligned HCBS Benefit Array



# Children’s Home and Community Based Services: Existing Services Moving into newly Aligned HCBS Benefit Array



# Overview of Aligned HCBS Under the 1115 Waiver

- ✓ **Health Home Care Management** for children receiving HCBS
  - ✓ Note: For children who opt out of Health Homes the State Independent Entity for FFS enrolled children will conduct the HCBS eligibility determination, HCBS plan of care development and on-going monitoring of the POC. For children enrolled in plan the MCO will monitor the POC (as developed by the State IE).
  
- ✓ **Habilitation** These services focus on helping children with developmental, medical and behavioral disabilities who are eligible for HCBS to be successful in the home, community and school by acquiring both social and environmental skills associated with his/her current developmental stage. This service assumes that the child has never had the skills being acquired. Habilitation services assist children who have never acquired a particular skill with the self-help, socialization and adaptive skills necessary for successful functioning in the home and community when other types of skill-building services are not appropriate. This service may be delivered in an individual or group setting. Habilitation is provided to the child and the child's family/caregiver to support the development and maintenance of skills sets.



# Overview of Aligned HCBS Under the 1115 Waiver

- ✓ **Caregiver/family supports and services** enhance the child's ability, regardless of disability Services (developmental, physical and/or behavioral), to function as part of a caregiver/family unit and enhance the caregiver/family's ability to care for the child in the home and/or community. Note: this service differs from the State Plan service of Family Peer Support Services, which is delivered by a credentialed/certified Family Peer Specialist with lived experience.
- ✓ **Respite** focuses on short-term assistance and/or relief for children with disabilities (developmental, physical and/or behavioral), and family/caregivers which can be provided in a planned mode or delivered in a crisis environment. To the extent that skilled nursing is provided as a form of respite, this service has to be ordered by a physician. This service may be provided in a one-to-one, individual session or group session. The need for Crisis Respite may be identified as a result of a Medicaid State Plan crisis intervention or may come from referrals from the emergency room, the community, LDSS/LGU/SPOA, school, self-referrals, or as part of a step-down plan from an inpatient setting. Crisis Respite should be included on the POC to the extent that it is an element of the crisis plan, or risk mitigation strategy.



# Overview of Aligned HCBS Under the 1115 Waiver

- ✓ **Prevocational Services** are individually designed to prepare a youth age 14 or older to engage in paid work, volunteer work or career exploration. Prevocational services are structured around teaching concepts such as compliance, attendance, task completion, problem solving, and safety based on a specific curriculum related to youth with disabilities (developmental, physical and/or behavioral). In addition, prevocational services assist, facilitating appropriate work habits, acceptable job behaviors, and learning job production requirements. Prevocational services are not job-specific, but rather are geared toward facilitating success in any work environment for children whose disabilities do not permit them access to other prevocational services. The service will be reflected in participant's service plan directed to teaching skills rather than explicit employment objectives.



# Overview of Aligned HCBS Under the 1115 Waiver

- ✓ **Supported Employment** services are individually designed to prepare individuals with disabilities (developmental, physical and/or behavioral) age 14 or older to engage in paid work. Supported employment services provide assistance to participants with disabilities as they perform in a work setting. Supported Employment provides ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.





# Overview of Aligned HCBS Under the 1115 Waiver

- ✓ **Community Advocacy Training and Support** improves the child's ability to gain from the community experience and enables the child's environment to respond appropriately to the child's disability and/or health care issues. The use of this service may appropriately be provided to prevent problems in community settings as well as when the child is experiencing difficulty. The POC objectives must clearly state how the service can prevent as well as ameliorate existing problems and to what degree. This service cannot be used to develop an Individualized Education Program (IEP), the plan for students with disabilities who meet the federal and state requirements for special education, or to provide special education services to the child. This service may be provided in an individual session or in a group setting.

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# Overview of Aligned HCBS Under the 1115 Waiver

- ✓ **Palliative Care** is specialized medical care focused on providing relief from the symptoms and stress of a chronic condition or life threatening illness. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a specially-trained team of doctors, nurses, social workers and other specialists who work together with a patient's doctors to provide an extra layer of support. It is appropriate at any stage of a chronic condition or life threatening illness and can be provided along with curative treatment. Children must meet LOC functional criteria and suffer from the symptoms and stress of chronic medical conditions OR illnesses that put individuals at risk for death before age 21. This service includes, bereavement services, Pain and symptom management, Expressive Therapy and massage therapy.

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# Overview of Aligned HCBS Under the 1115 Waiver

- ✓ **Adaptive & Assistive Equipment** provides technological aids and devices that can be added to the home, vehicle, or other eligible residence of the enrolled child to enable him/her to accomplish daily living tasks that are necessary to support the health, welfare, and safety of the child. The adaptive and assistive equipment available through the HCBS cannot duplicate equipment otherwise available through the Medicaid State Plan or other federal/state funding streams. The equipment enables the child to increase, maintain and/or improve his or her ability to function in the home and community based setting with independence and safety.
- ✓ **Accessibility Modifications** provides internal and external physical adaptations to the home or other eligible residences of the enrolled child that are necessary to support the health, welfare and safety of the child. These modifications are additive to services available through Medicaid State Plan or federal/state funding streams, and enable the child to function with greater independence related to the child's disability and/or health care issues and prevent medical institutionalization. All equipment and technology used for entertainment is prohibited.



# Overview of Aligned HCBS Under the 1115 Waiver

- ✓ **Non-Medical Transportation** services are offered, in addition to any medical transportation furnished under the 42 CFR 440.17(a) in the State Plan. Non-medical Transportation services are available for individuals to access authorized HCBS and destinations that are related to a goal included on the child's POC. Examples where this service may be requested include transportation to: HCBS that a child was determined eligible to receive, a job interview, college fair, a community integration activity, a habilitation activity such as learning how to use the grocery store or public transportation, etc. This service will be provided to meet the child's needs as determined by an assessment performed in accordance with Department requirements and as outlined in the child's POC.



# Overview of Aligned HCBS Under the 1115 Waiver

- ✓ **Customized Goods and Services** are services, equipment, or supplies not otherwise provided through this demonstration or through the Medicaid State Plan, that are available under a pilot program and address an identified need in the service plan. The item or service must, decrease the need for other Medicaid services, promote inclusion in the community and increase the child/youth's safety in the home or community environment. To be an eligible service, the participant must lack funds to purchase the item or service OR the service is not available through another source. These services should be used as the funding source of last resort – only for those costs that cannot be covered by any other source and that are vital to the implementation of the POC. Funding shall not exceed \$2,000 annually per participant.



# ***HCBS Eligibility Determination Criteria***



# HCBS Eligibility Determination Criteria

- Effective **July 1, 2018**, the State will implement new HCBS Level of Care (LOC) Eligibility Determination criteria.
- The LOC HCBS Eligibility Determination criteria will replace criteria and tools used under the 1915(c) waivers (Note: the 1915(c) tools will continue to be utilized during Interim Transition Process between January 1, 2018 and June 30, 2018 under the 1115 waiver).
- Effective January 1, 2019, the State will implement new HCBS Level of Need (LON) Eligibility Determination criteria
- *Transitioning children from an existing waiver will be grandfathered in HCBS for 1 year from the completed signed and finalized CANS-NY completed by the waiver provider who has become the HH CM*

The HCBS Eligibility Determination criteria for both LOC and LON HCBS includes three components applied in the following order:

- 1) Target Population,
- 2) Risk Factors, and
- 3) Functional Criteria



# Target Population Criteria for LOC HCBS Eligibility

## Effective July 1, 2018 – LOC HCBS Eligibility Criteria – Under Age 21 – Target Population Criteria

Serious Emotional Disturbance (SED)

Medically Fragile Children (MFC)

Developmental Disability (DD) and Medically Fragile

Developmental Disability (DD) and in Foster Care





# Target Population Criteria for LON HCBS Eligibility

## Effective January 1, 2019 – LON HCBS Eligibility Criteria – Under Age 21 – Target Population Criteria

Serious Emotional Disturbance (SED)

Abuse, Neglect, Maltreatment or Complex Trauma as defined by Health Home



# HCBS Risk Factor and Functional Eligibility Criteria

See August 24, 2017 Draft Transition Plan Webinar for Detailed information on the risk and functional criteria for each of the LOC and LON populations

[https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/docs/2017-08-24\\_child\\_transition\\_plan\\_final.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2017-08-24_child_transition_plan_final.pdf)



# Health Home Care Management



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# Health Home Care Management for Children

- Health Home Program expanded to serve children - launched in December 2016
- There are 16 Health Homes designated to serve children (individuals under 21)
- Health Homes listed by Name and County approved to serve and contact information provided on website  
[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/docs/hh\\_children\\_designations.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_children_designations.pdf)
- Children that meet current Health Home eligibility criteria can be enrolled in Children's Health Home today/prior to the Children's Transformation (if they are not enrolled in 1915(c) waiver or other excluded setting)
- Health Home criteria is now being expanded to include I/DD chronic conditions (under separate HH SPA - requires CMS approval for 2018)



# Health Home Chronic Condition Eligibility Criteria

- The individual **must** be enrolled in Medicaid
- Medicaid members eligible to be enroll in a Health Home **must** have:
  - Two or more chronic conditions (e.g., Substance Use Disorder, Asthma, Diabetes\*) **OR**
  - One single qualifying chronic condition:
    - ✓ HIV/AIDS or
    - ✓ Serious Mental Illness (SMI) (Adults) or
    - ✓ Serious Emotional Disturbance (SED) or Complex Trauma (Children)
- Chronic Condition Criteria is NOT population specific (e.g., being in foster care, under 21, in juvenile justice etc. does not alone/automatically make a child eligible for Health Home)
- In addition, the Medicaid member **must** be appropriate for the intensive level of care management services provided by Health Home, i.e., satisfy appropriateness criteria



# Health Home Appropriateness Criteria

- ***Individuals must meet the Chronic Condition Criteria AND be Appropriate for Health Home Care Management***
- *Appropriateness Criteria:* Individuals meeting the Health Home eligibility criteria must be appropriate for the intensive level of care management provided by Health Homes. Assessing whether an individual is appropriate for Health Homes includes determining if the person is:
  - ✓ At risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)
  - ✓ Has inadequate social/family/housing support, or serious disruptions in family relationships;
  - ✓ Has inadequate connectivity with healthcare system;
  - ✓ Does not adhere to treatments or has difficulty managing medications;
  - ✓ Has recently been released from incarceration, placement, detention, or psychiatric hospitalization;
  - ✓ Has deficits in activities of daily living, learning or cognition issues, or
  - ✓ Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home.



# Health Home Care Management and Plans of Care for HCBS

- To ensure HCBS coordination of care, children eligible for HCBS will receive care management services and a care plan for their HCBS services
- ***Children who are eligible for HCBS are eligible for Health Home***
- ***Children who are Health Home eligible are NOT automatically eligible for HCBS***
- Health Home care managers develop a single Health Home comprehensive plan of care that includes all services a child needs (health, behavioral health, community and social supports, specialty services etc.)
- The Health Home comprehensive plan of care will be updated or developed to ***include*** HCBS services for children that are eligible for HCBS and enrolled in Health Home – Health Homes will ensure the Health Home plans of care meets HCBS care plan requirements
- There is not a separate HCBS care plan for members enrolled in Health Home
- Enrolling children who are eligible for HCBS in Health Home ensures children receive a comprehensive plan of care that includes ALL the services a child needs



# Transitioning 1915(c) Waiver providers to Health Home Care Management

- Work is in progress to ensure current 1915(c) Waiver providers that will transition to HH care managers have access to systems (MAPP HHTS, UAS-NY, etc) and have a relationship with Health Homes – completion by November 2017
- New HH care managers will be trained regarding all Health Home systems, standards and policies and procedures – completion by March 2018
- To preserve the expertise of existing waiver providers transitioning to Health Home care management, ***children enrolled in 1915(c) waivers at the time of transition (up until March 31, 2018) will transition to Health Home care management with their current care manager (by choice and with consent)*** between April 1, 2018 and June 30, 2018
- HCBS eligible children during the transition without a current care manager will be linked to an existing Health Home care manager through a referral process
- This linkage between care managers and children and families will preserve care manager relationships with the child and their family, endorse continuity of care and help ensure a seamless transition





# Health Home and HCBS Transition

- Children in a 1915(c) Waivers that transition between April – June 30, 2018 will continue their HCBS services with a completion of a Health Home CANS-NY and initial HCBS plan of care
  - The completed signed and finalized CANS-NY will continue HCBS services for 1915(c) Waiver children for a year without other eligibility requirements
- Children already receiving Health Home care management services, not in a 1915(c) Waiver, can be determined HCBS eligible beginning July 1, 2018 by HH care managers:
  - Work with HH children, youth and families to review their current plan of care and needs
  - With consent and or the request for additional services
  - Determination of HCBS eligibility through completion of HCBS eligibility process



# Transition of Benefits and Populations to Medicaid Managed Care



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# Benefits Transitioning to Managed Care

- ✓ Home & Community Based Services (HCBS) under 1915(c) Waivers of OMH, OCFS and DOH
- ✓ New State Plan Services (SPA)
- ✓ OMH SED Designated clinics
- ✓ OASAS Community Based Outpatient Services

## Existing Services in Managed Care Today

- Physical health & dental care
- Mental health and substance abuse outpatient clinics
- Inpatient health and behavioral health care



# Medicaid Exemptions and Exclusions

Exempt from Managed Care means that the individual has the option to enroll in a Medicaid Managed Care plan, but is not required to.

Excluded from Managed Care means that the individual cannot enroll in a Medicaid Managed Care plan and must receive their Medicaid benefits through the fee-for-service delivery system.

Generally, exemptions and exclusions exist for the following instances:

- The person has comprehensive third party health insurance or Medicare (excluded)
- The person is required to spend down a portion of their income on medical expenses on a monthly basis to maintain Medicaid eligibility (excluded)
- The person is Native American (exempt)
- The person has requested a one-time six month exemption from Managed Care enrollment
- The person is living in a setting that is exempt or excluded (for example: certain residential and inpatient settings, children who are blind or disabled living separate from their parents for 30 days or more, and infants living with incarcerated mothers)
- The person is receiving special services through a waiver program



***Provider Designation Process:  
Aligned Children's HCBS and  
New State Plan Services***



## Designation of Children's SPA and HCBS Providers

- To provide newly aligned children's HCBS and or the six new State Plan services, providers must be designated by the State
- The designated provider will be required to contract with Managed Care Plans to provide such services to children enrolled in Managed Care Plans
- Application is available online:  
[https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/provider\\_design.htm](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm)

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## Designation of Children's SPA and HCBS Providers

- For initial start up and to provide the time necessary (*about nine months*) for contracting, credentialing and claims testing – NYS recommended that current providers submit their applications will continue to be accepted on ongoing basis
- Target date for formal designations for current system providers who submitted a complete application prior to July 31, 2017 is (this date dependent on SPA approval)
- The State will be working with plans to track the status of network contracting of designated providers

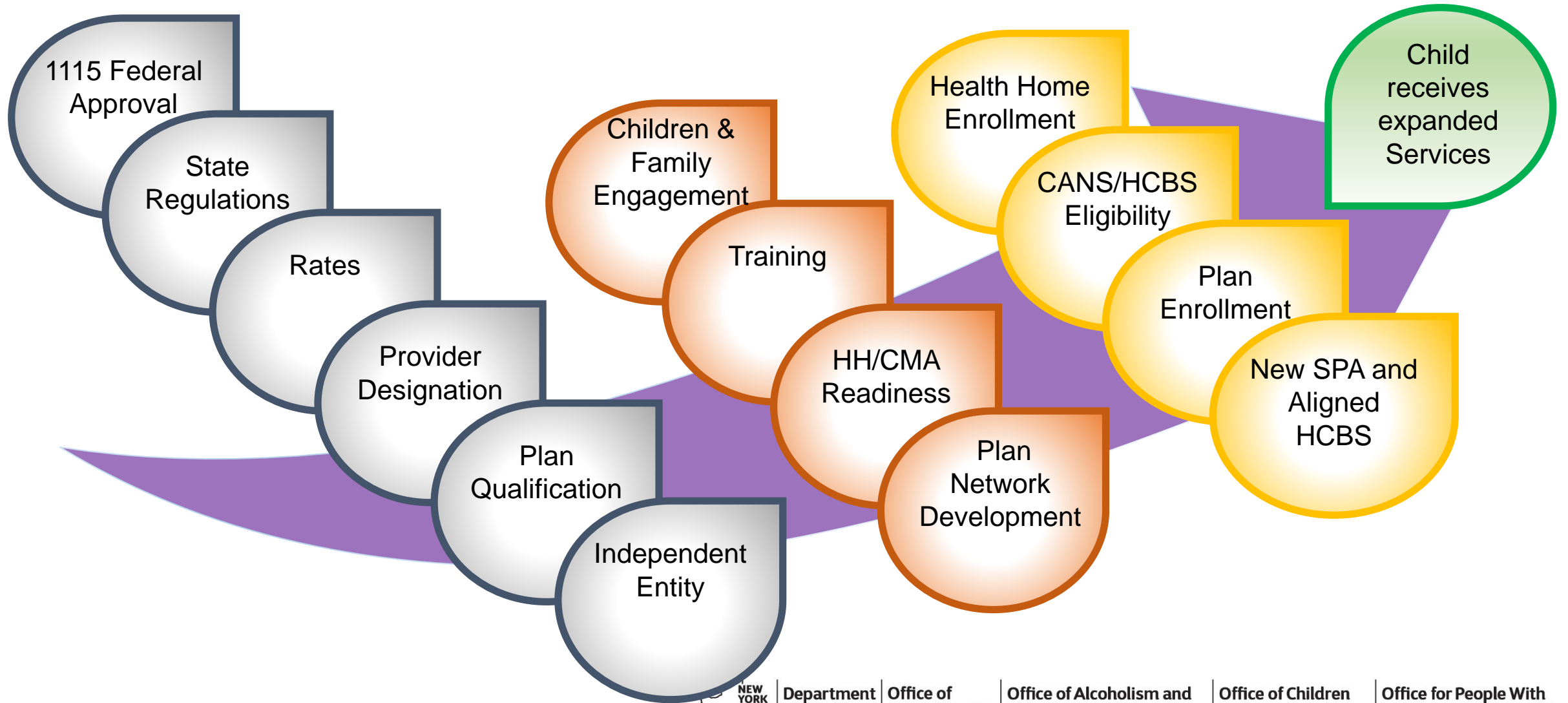


# *Transitioning to the Children's Transformation*





# Children's Medicaid System Transformation



# Communicating with Children and Families

- Families that are in a 1915(c) waiver will be notified by letter about the administrative change in the services they are receiving (i.e., the 1915(c) Transition to the 1115 Waiver ) in late fall 2017
- Letter will be in plain language
- Letter will reinforce that all of the services the child is receiving will continue unchanged
- Letter is required to be released at least 30 days prior to the transition - the State will inform providers, ahead of time, when the letter will be sent
- Letter will suggest family discuss changes and their questions with their current case manager and will also provide State contact
- The State will work with waiver providers and stakeholders to ensure they are prepared prior to when the letter is sent to communicate with families, provide information and address questions
  - State will provide guidance and assistance to providers – how can we help?



# August 24<sup>th</sup> Webinar Held on Draft Transition Plan

- The Transition Plan provides a road map for all activities under the Children's system transformation, including:
  - The timing and process for transitioning from 1915(c) care management to Health Home care management
  - The timing and process for transitioning from 1915(c) HCBS to the fully aligned 1115 HCBS
- Draft Transition Plan released for public comment on August 15, 2017

Webinar on Draft Transition Plan held on August 24, 2018 - posted to website

[https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/docs/2017-08-24\\_child\\_transition\\_plan\\_final.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2017-08-24_child_transition_plan_final.pdf)

- Stakeholder comments were due on September 8, 2017
- State is working to review comments and finalize Transition Plan – another Webinar will be scheduled
- With finalized transition plan the State will begin to provide detailed information on operationalizing the Transition Plan, including workflow for HCBS
- Next two slides provide high level timeline of key activities described in the Draft Transition Plan



## ***Interim Transition Process from January 1, 2018 to June 30, 2018 – Key Dates for DRAFT Transition Plan***

### **January 1, 2018 – June 30, 2018**

- Authority for 1915(c) Waiver Transitions to the 1115 Waiver
- 1915(c)-like processes, structures and services remain in place
- No change to HCBS Service Array (Interim HCBS available)
- No change in LOC Eligibility Criteria or Medicaid eligibility
- All HCBS delivered FFS
- All HCBS billing under new 1115 rate codes using crosswalk from 1915(c) to 1115

### **March 2018**

- Medicaid Managed Care Plan (MMCP) Enrollment notices sent to children and families
- 60 day period to choose a MMCP

### **April 2018**

- 1915(c) Care managers meet with families, begin transition to Health Home
- Obtain Health Home consents, enroll child in Health Home and conduct CANS-NY assessment in the UAS
- Cross walk existing 1915(c) to new SPA/HCBS in Health Home POC
- Health Home POC authorizes Fee-for-Service (FFS) HCBS referrals

### **May 2018**

- Statewide Independent Entity: 1915(c) Transitioning Children that opt out of Health Home will be referred to Independent Entity for development of HCBS plan of care
- MMCP member services begin for children that received notice in March

### **June 2018**

- MMCP accepts POCs from Health Home or Independent Entity to begin service planning
- Transition of 1915(c) Transitioning Children to Health Home complete
- Interim Transition Process is Complete

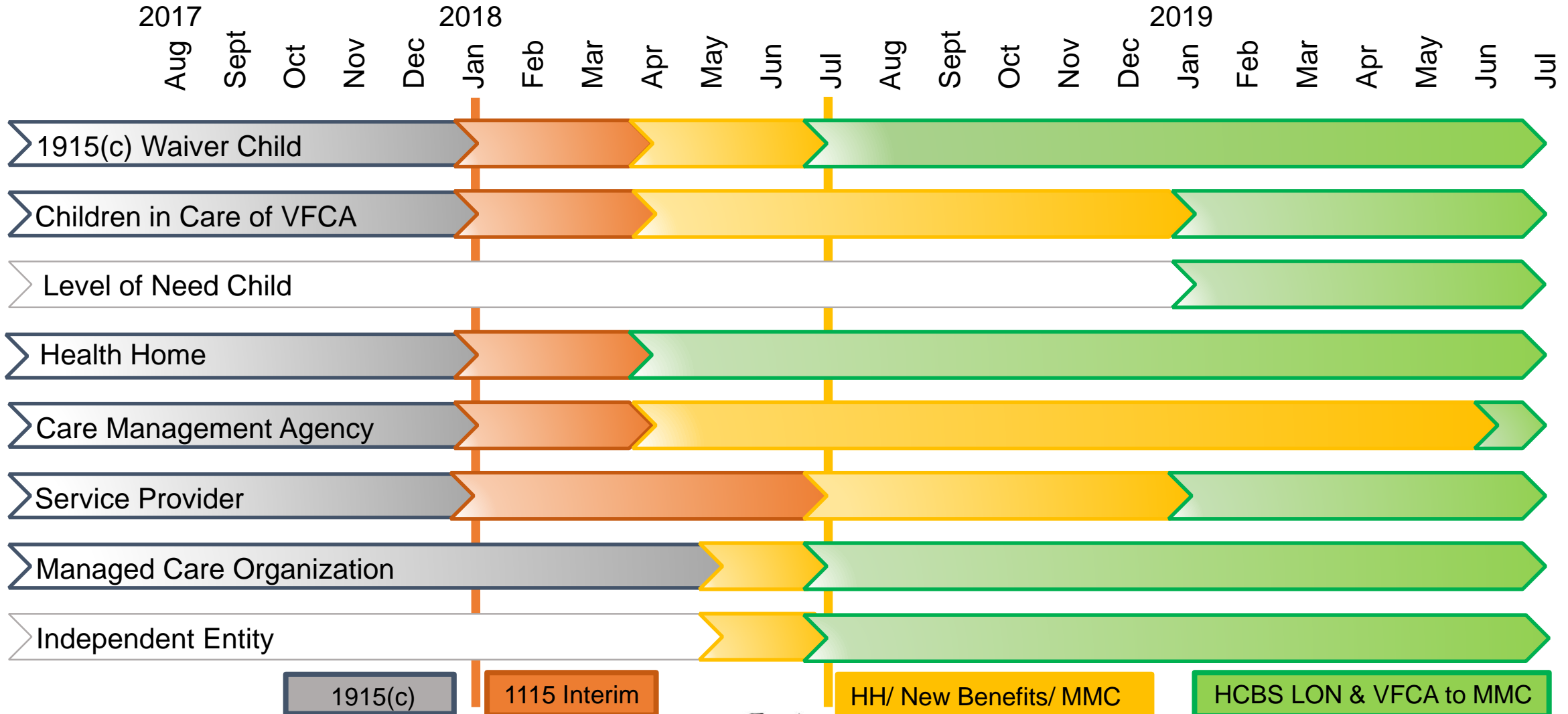
***On and after July 1, 2018 and Beginning January 1, 2019 from DRAFT Transition Plan******July 2018***

- 6 new State Plan services available statewide,
- 12 newly aligned HCBS available statewide via MMC and FFS for members exempt or excluded from Managed Care
- New Level of Care (LOC) HCBS Eligibility Determination Criteria is effective for newly identified children
- HH POCs are updated to reflect new services available as applicable
- “New to Medicaid” Family of One children are referred to Independent Entity for HCBS eligibility, and if applicable, assisting the family in completing and submitting Medicaid application to local social services district
- Eligible children referred to Health Home
  - If child opts out of HH, Independent Entity develops HCBS plan of care
  - MMCO responsible for continuity of care

***January 2019***

- Level of Need (LON) HCBS eligibility begins
  - Abuse Neglect Maltreatment or Complex Trauma
  - SED
- Exclusion from Managed Care ends for children in care of Volunteer Foster Care Agency

# Children's Medicaid System Transition Plan



Department of Health

Office of Mental Health

Office of Alcoholism and Substance Abuse Services

Office of Children and Family Services

Office for People With Developmental Disabilities

# Roles and Responsibilities



Department  
of Health

Office of  
Mental Health

Office of Alcoholism and  
Substance Abuse Services

Office of Children  
and Family Services

Office for People With  
Developmental Disabilities

## ***What you should be doing now if you represent a Health Home***

Lead Health Homes have received a list of 1915(c) Waiver providers who have a BAA with them and or operate services within the HH service area

If an existing BAA, the HH should work with the Waiver provider:

- Ascertain the number of potentially new HH care managers that will need HH system, standards and policy/procedure training
- Ascertain the number of children in the Waiver that will transition to HH care management services
- Ensure that the newly HH care managers are CANS-NY trained and certified

If no existing BAA, the HH should work with the Waiver provider in their service area:

- To build a working relationship with the provide to establish a BAA

Additionally, Lead Health Home MUST connect with the HCBS approved providers and add them to their network partner list

- Ensure their care management agencies know and understand the SPA and HCBS services
- Ensure access to SPA and HCBS services





## ***What you should be doing now if you are a 1915(c) Waiver provider***

1915(c) Waiver Providers will be receiving correspondence from DOH Health Home Team

- Does the provider have a MMIS# and NPI #
- Does the provider have a Health Commerce System (HCS) access which is the access point for MAPP HHTS and UAS-NY that houses the CANS-NY tool
  - If HCS account, Must have a role as a Health Home Care Management Agency
- Does the provider have a BAA with a Health Home
- Does the staff have HCS accounts
  - Has the staff been given a role in MAPP HHTS
  - Has the staff been given a role in UAS-NY
- Has the provider reached out to the Lead Health Home to discuss the number of staff transitioning to HH care management and their training needs
  - Has the provider talked with the Lead Health Home to discuss the number of waiver children that will be transitioning to their Health Home

***There must be alignment between the member's managed care plan, the Health Home and the Care Management Agencies***



# ***What you should be doing if you are currently a Health Home Care Manager***

- Know and understand SPA and HCBS service array and the transition to Medicaid Managed Care
- Understanding the transition of the 1915(c) Waiver children to Health Homes

## In 2018

- Be trained to determine HCBS eligibility
- Know the SPA and HCBS providers in the community
- Ensure Managed Care Plans are part of the interdisciplinary team by adding MCOs to consent
- Update Plans of Care to include HCBS Services
- Know the Plans of Care MCO approval process
- Talk with children, youth and families regarding the new available services



# Upcoming Trainings and Webinars



Department  
of Health

Office of  
Mental Health

Office of Alcoholism and  
Substance Abuse Services

Office of Children  
and Family Services

Office for People With  
Developmental Disabilities

# Upcoming Trainings and Webinars

## Medicaid Provider Enrollment

- September 29, 2017

## SPA/HCBS Draft Rates, Codes and Modifiers

- October 10, 2017

## Managed Care Contracting & Contracting Fairs with MCOs

- November 8, 2017 NYC
- November 6, 2017 Albany
- November 16, 2017 Rochester

## Principles of Revenue Cycle Management and Utilization Management

- Mid-Late December –dates and location TBD

**MCTAC will distribute additional information**



Department  
of Health

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and Family Services

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# Resources and Monthly Meeting to Keep Informed

- In addition to other key webinars and trainings, monthly Health Home Monthly Health Home and Children's Medicaid System Transformation webinars will be held
  - ✓ September 29, 2017 – 10am to noon
  - ✓ Second Wednesday of every month from 3-5 pm (October 11, 2017, November 8, 2017, December 13, 2017 – etc.)
  - ✓ Impromptu as needed, requested
  - ✓ Will include question and answer session, topical areas requested by stakeholder in advance of meeting, and other key information supporting a smooth transition
- Health Home Team – [HHSC@health.ny.gov](mailto:HHSC@health.ny.gov) 518.473.5569
- Health Home Children's Website  
[https://www.health.ny.gov/health\\_care/medicaid//program/medicaid\\_health\\_homes/health\\_homes\\_and\\_children.htm](https://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm)
- Children's Behavioral Health Transition to Managed Care  
[https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/index.htm](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/index.htm)
- List Serves (see next slide)



# Resources to Keep Informed

DOH Transition Mail Log  
[BH.Transition@health.ny.gov](mailto:BH.Transition@health.ny.gov)

Health Home Bureau Mail Log  
[https://apps.health.ny.gov/pubdoh/health\\_care/medicaid/program/medicaid\\_health\\_homes/emailHealthHome.action](https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action)

OMH Managed Care Mail Log  
[BHO@omh.ny.gov](mailto:BHO@omh.ny.gov)

Children's Designation Mail Log  
[OMH-Childrens-Designation@omh.ny.gov](mailto:OMH-Childrens-Designation@omh.ny.gov)

Subscribe to DOH Health Home listserv  
[http://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/listserv.htm](http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/listserv.htm)

Subscribe to children's managed care listserv  
<http://www.omh.ny.gov/omhweb/childservice/>



# Questions and Discussion



# *Appendix*



NEW  
YORK  
STATE

Department  
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Office of  
Mental Health

Office of Alcoholism and  
Substance Abuse Services

Office of Children  
and Family Services

Office for People With  
Developmental Disabilities



**SED Definition for Health Home** - SED is a single qualifying chronic condition for Health Home and is defined as a child or adolescent (under the age of 21) that has a designated mental illness diagnosis in the following Diagnostic and Statistical Manual (DSM) categories\* as defined by the most recent version of the DSM of Mental Health Disorders **AND** has experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis

**SED Definition for Health Home - DSM Qualifying Mental Health Categories\***

- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma- and Stressor-Related Disorders
- Dissociative Disorders
- Somatic Symptom and Related Disorders
- Feeding and Eating Disorders
- Gender Dysphoria
- Disruptive, Impulse-Control, and Conduct Disorders
- Personality Disorders
- Paraphilic Disorders
- ADHD for children who have utilized any of the following services in the past three years:
  - Psychiatric inpatient
  - Residential Treatment Facility
  - Day treatment
  - Community residence
  - Mental Health HCBS & OCFS B2H Waiver
  - OMH Targeted Case Management

\*Any diagnosis in these categories can be used when evaluating a child for SED. However, any diagnosis that is secondary to another medical condition is excluded.

**Functional Limitations Requirements for SED Definition of Health Home**

To meet definition of SED for Health Home the child must have experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis. The functional limitations must be **moderate in at least two** of the following areas or **severe in at least one** of the following areas:

- Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
- Family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
- Social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
- Self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
- Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

❖ *Note: the DSM categories include in the definition of SED used to determine Health Home eligibility is different than the SED definition used to determine eligibility for other Medicaid services (e.g., OMH clinic, inpatient, etc.)*



# Complex Trauma – Health Home

This guidance on complex trauma draws upon the domains within the definition of serious emotional disturbance (SED). While there may be similarities in the condition(s) and symptoms that arise in either complex trauma or SED, the therapeutic approaches associated with the same diagnoses may vary significantly when the symptoms arising from traumatic experiences are identified as such. Trauma experts indicate that with complex trauma, the clinical diagnoses may be more severe and typically present as comorbidities or multiple diagnoses.

## Definition of Complex Trauma

- a. The term complex trauma incorporates at least:
  - i. Infants/children/or adolescents' exposure to multiple traumatic events, often of an invasive, interpersonal nature, and
  - ii. the wide-ranging, long-term impact of this exposure.
- b. Nature of the traumatic events:
  - i. often is severe and pervasive, such as abuse or profound neglect;
  - ii. usually begins early in life;
  - iii. can be disruptive of the child's development and the formation of a healthy sense of self (with self-regulatory, executive functioning, self-perceptions, etc.);
  - iv. often occur in the context of the child's relationship with a caregiver; and
  - v. can interfere with the child's ability to form a secure attachment bond, which is considered a prerequisite for healthy social-emotional functioning.
- c. Many aspects of a child's healthy physical and mental development rely on this secure attachment, a primary source of safety and stability.
- d. Wide-ranging, long-term adverse effects can include impairments in:
  - i. physiological responses and related neurodevelopment,
  - ii. emotional responses,
  - iii. cognitive processes including the ability to think, learn, and concentrate,
  - iv. impulse control and other self-regulating behavior,
  - v. self-image,
  - vi. relationships with others, and
  - vii. dissociation



# Complex Trauma Eligibility Forms and Assessment Tools

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/health\\_homes\\_and\\_children.htm](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/health_homes_and_children.htm)

Including

- NYS State Complex Trauma Fact Sheet
- Complex Trauma Screen (CTES)
- Exposure Assessment (CTEA)
- Referral Cover Sheet

