Children’s Managed Care Design Update

Children’s MRT Behavioral Health Subcommittee
April 28, 2014
12:00 - 3:00 PM
New York City
Call Agenda

- Welcome & Roll Call (Donna Bradbury)
- Introduction of Ann Marie Sullivan, Acting Commissioner, NYS OMH
- Benefit Package Feedback (Angela Keller)
- Review of Model & Cohorts (Steve Hanson)
- Alignment of HCBS Services (Meredith Ray-LaBatt)
- 1115 Authority (Laura Velez)
- Health Home Update (Lana Earle)
- Next Steps (Angela Keller)
Recorded Meetings – Reminders

- Be sure to identify yourself the first time you speak, speak in the direction of the microphone, and use normal loudness for conversational communication. Vary pitch, rate and loudness as you normally would. Speak slowly and precisely.
- Avoid tapping the desk with fingers or feet or making extraneous noises such as paper shuffling, side conversations, and opening or closing books. Try to minimize such distractions.
- Do not interrupt other speakers or talk over any speaker. It will be important to take turns.
- Avoid whispering and having sidebar conversations.
- At the start and close of the session, be mindful of the status of the microphone. Once it has been activated and until it has been deactivated at the end of the session, all communication is recorded.
- Avoid unnecessary moving around the room, as the microphones will pick up the sounds of movement.
- Be aware that the microphone is always on and avoid touching or brushing up against it, creating loud, unpleasant sounds.
- Please put cell phones on mute or vibrate. If you need to take an incoming call, please leave the room before answering the call.
Introduction of Ann Marie Sullivan, MD
Acting Commissioner, NYS OMH

* Arriving after 12:30 PM
Benefit Package Feedback
(Feedback received from 33 sources)

- Population specificity needed
- How will children ineligible for Medicaid be served
- Number of implementation suggestions made
- More specificity needed on where services can be delivered, including for those in residential programs
Benefit Package Feedback

- Nuances for foster care children expressed
- Questions on payments and rates, including caseload sizes
- General Comments on benefit package
- Comments on specific State Plan and 1915i-like services
Next Steps with Benefit Package

- Review of feedback by State workgroup
- Revisions to some service definitions
- Development of Education Support Services definition
- Obtain Mercer feedback on revisions
- Provide a final copy of benefit package to Children’s MRT Subcommittee
- Develop provider and staff qualifications and training requirements for each service
Proposed 2016 Children’s Medicaid Managed Care Model
For all children 0-21 years old

Mainstream Medicaid Managed Care Organization: Benefit Package*

| All Health & Pharmacy Expanded Benefits | Behavioral Health State Plan Services | Potential Children’s 1915c – like Services | Children’s 1915c HCBS Waivers (OMH B2H) |

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.)

*MCOs may opt to contract with other entities (e.g., BHOs) to manage behavioral health benefits
## Children’s Populations, Services and Acuity Cohorts

### Cohort II

**Who:** Children with a history of BH service use or trauma, who are at risk of using extensive and/or deep end services. May use institutional financial eligibility criteria and “family of one” to prevent higher level of service use. May include children with system involvement including foster care who can be served in this tier.

**Acuity:** Must meet targeting & functional needs criteria (LON) and do not meet LOC for Tier III

**Services Include:** All services in Tier 1 plus newly developed 1915i-like service array to prevent/avoid institutionalization

### Cohort III

**Who:** Children who are high need. Expected to be children who have an extensive history of BH services use and multi-system involvement (including foster care) and need more intensive services than those provided in Tier II.

**Acuity:** Must meet targeting & institutional level of care (LOC) and do not meet LON for Tier II

**Services Include:** All services in Tier 1 plus the services of the OMH HCBS Waiver and the OCFS B2H Waivers (3)

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### HCBS Services

#### 1905(a) State Plan services

**Cohort 1A**

**Who:** Children who are stable in the community & able to be served in outpatient services.

**Acuity:** Includes well child care and screenings. If treatment is provided, must have medical necessity for that service (e.g., MH/SUD, developmental delay diagnosis)

**Services Include:** EPSDT, EI, ER/CPEP, MH/SU Clinics, CRs, TCM/HHS, SSHS, day treatment, School Based Clinic Services, OASAS Specialized Outpatient, Primary or Developmental Pediatric Care – Note these State Plan services may be provided to children in any of the tiers on this page

#### Cohort 1b

**Who:** Children who are unstable or experience a trauma, using high end, emergency or short term duration institutional services.

**Acuity:** Must have MH or SUD diagnosis, need out of home placement for stabilization & treatment and meet medically necessary criteria for service.

**Services Include:** RTF, RRSY, OMH IP, RTC, Article 28/31 Inpatient (assessment for 1915i and 1915c occurs during discharge planning)

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**ACUITY INCREASES**

*For OCFS, defined as “non-medical institution” and “medical institution”*
Cohort IA
Who are the Children

- Any child with or eligible for Medicaid, even if eligible via a Waiver deeming as a family of one or foster care children categorically eligible for Medicaid
Cohort IA: Acuity Level of Children

- Children who are living in the community or community settings
- Children who are primarily utilizing outpatient services
- Children who meet the medical necessity criteria for a non-institutional State Plan service
Mobile Crisis Intervention
Community Psychiatric Supports and Treatment (CPST)
Other Licensed Practitioner
Family Peer Support Services
Youth Peer Advocacy and Training

*Services may also be accessed by Cohort II and III children.*
Goals of Home and Community Based Services

1915i–like Services
- Prevent movement to higher levels of care
- Provide a transition or step down from higher levels of care
- Offer enhanced array of Medicaid services
- Create capacity for services that did not exist for children who would otherwise be on 1915c Waiver waiting lists
- Improve functioning in community

1915c Services
- Prevent, avoid or delay (medical) institutionalization
- Return to community
- Improve functioning in community
Cohort II: Who are the Children

- OMH: kids in day treatment, kids w/ ER frequency, kids ready to discharge from 1915c/RTF, kids on 1915c waiting list, kids in TCM that are in need of additional supports

- OASAS: kids with opiate use disorders, eligible for RRSY or residential, kids ready for discharge from RRSY/residential, primary service need in addictions system but likely having co-occurring needs

- OCFS: kids leaving RTC/B2H; kids in boarding homes (family FC), group residence (<25 beds), group homes (<12 beds), therapeutic homes, or AOBH; kids leaving OCFS facilities; kids returning home; kids receiving Medicaid after adoption or return home

- State Education: CPSE/CSE population (kids in 853 schools and in residential care), Kids with 504 Plans/IEP if they meet functional limitations

- Children in multiple systems: JD PINS, probation, kids w Autism Spectrum Disorder
Cohort II: Acuity Level of Children

- Must meet targeting and functional need criteria (Level of Need – LON)
- Not be eligible for institutional Level of Care
Cohort III: Who are the Children

- Children who are high need with extensive history of behavioral health, medical or multi-system use.
Children who meet the institutional Level of Care (i.e., qualify for or at risk of placement in RTF/inpatient, ICF/MR and skilled nursing facilities)
Recent Decisions on the Model

- Movement of the Family Peer Support Services and Youth Peer Advocacy and Training services from proposed 1915i to proposed State Plan

- Aligning of the 1915i and 1915c array of services into one list of HCBS services

- Staff qualifications and training requirements will be aligned from the existing B2H and OMH Waivers

- HCBS services will be available to children at differing levels of intensity

- Provider agency qualifications will be developed (e.g., children who are in foster care will receive their HCBS services from appropriate foster care agencies)
Cohort II and III: Proposed HCBS Services

- Care Coordination
- Skill Building
- Family/Caregiver Support Services
- Crisis Respite
- Planned Respite
- Prevocational Services
- Supported Employment Services
- Education Support Services
- Special Needs Community Advocacy and Support
- Residential Supports
- Non-Medical Transportation
- Day Habilitation
- Adaptive and Assistive Equipment
- Accessibility Modifications
## Summary of Cohorts and Benefits

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Who is Eligible for this Cohort?</th>
<th>Eligible for Which Level of Behavioral Health Benefits?</th>
<th>What Total Array of Services is Available to Them?</th>
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<tbody>
<tr>
<td>Cohort 3</td>
<td>Children who meet “level of care criteria” i.e., qualify for institutional level of care</td>
<td>HCBS Services</td>
<td>Medicaid State Plan + HCBS Services at intensity congruent with LOC</td>
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<tr>
<td>Cohort 2</td>
<td>Children who meet “level of need criteria,” i.e., do not qualify for institutional level of care but need enhanced supports in community</td>
<td>HCBS Services</td>
<td>Medicaid State Plan + HCBS Services at intensity congruent with LON</td>
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<td>Cohorts 1 A and B</td>
<td>All children eligible for Medicaid who don’t qualify for the either the HCBS Services</td>
<td>Medicaid State Plan if they meet medical necessity criteria of the services</td>
<td>Medicaid State Plan Services</td>
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<tr>
<td>New State Plan</td>
<td>New Aligned HCBS Services</td>
<td>Existing OMH HCBS Waiver Services</td>
<td>Existing OCFS B2H Waiver Services</td>
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<td>Existing Health Home Care Coordination as defined for children</td>
<td>Care Coordination</td>
<td>Individualized Care Coordination</td>
<td>Health Care Integration</td>
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<td>Mobile Crisis Intervention</td>
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<td>Crisis Response Services</td>
<td>Immediate Crisis Response Services</td>
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<td>Community Psychiatric Supports &amp; Treatment (CPST)</td>
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<td>• Intensive In–Home Services</td>
<td>• Crisis Avoidance, Management &amp; Training • Intensive In–Home Services</td>
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What Opportunities Do These Changes Present?

- Retain OMH Peer focused family/peer services built over two decades and the ability to expand those services to youth and families with SUD and in Foster Care

- Retaining of the B2H Family/Caregiver Support Services

- Crisis Services will be available as a State Plan Service

- New array of services for children meeting LON criteria to prevent escalation to highest levels of care and to transition out of the highest levels of care

- No loss of existing 1915c services

- Gain of new HCBS services for both OCFS and OMH populations

- Maintenance of existing provider networks with experience to service children with behavioral health and foster care needs
What Opportunities Do These Changes Present?

- For OASAS population, access to new HCBS services
- Growing provider base (current subcontractors under lead Waiver agencies)
- More choice for families
- Fewer children on waiting lists
- Less siloed approach
- Serving children more effectively – the right services, at the right time, in the right dose
Goal: Submit the 1115 Amendment to CMS by December 31, 2014

Move the array of HCBS services under the 1115, to be managed within Mainstream Plans

Target populations will be detailed in the 1115, to prioritize current 1915c populations
1115 Authority

- Intensity of HCBS Services will depend on LON or LOC determination

- We wish to use the existing processes that B2H and OMH HCBS local district/government, providers and families are familiar with in concert with MCOs

- We will need to detail the interface with MCOs and health homes in 1115 Amendment.
Health Home Update

- Eligibility Criteria
- Network Requirements
- Draft Health Home Application
- Health Home Application Release
Next Steps

◦ Data analysis to predict children in each cohort (April–May);
◦ Provider qualifications for the new services (April–May);
◦ Plan network adequacy standards (April–May);
◦ Consideration of high fidelity wraparound as a care coordination model (May);
◦ LON criteria and assessment tools (May);
Next Steps (continued)

- Training requirements for the new services (May–June);
- Medical necessity criteria for new State Plan services (June);
- Service access requirements (June);
- Financial risk model development (July);
- Plan performance and outcome measures (August); and
- Payment transition plan (Autumn).
Stay Informed

- Learn about the Latest Developments
  - Sign up for the Children’s Managed Care Listserv
  - Sign up for the Health Home Listserv
Next Meetings Scheduled

- Mid-June: Conference Call as needed
- July 28, 12:00–3:00, New York City
Questions?

Send to:
Angela.Keller@omh.ny.gov

Slides will be sent tomorrow
to MRT Subcommittee and
posted on Children’s Listserv.

Recorded Webinar will be available shortly on NYS DOH’s MRT Website.