Children's Health and Behavioral Health MRT Subcommittee Quarterly Meeting

February 4, 2016
Albany, New York

Today's Agenda

DSRIP/VBP: Relating to Children's Transformation

Children's Design Updates
- Readiness Resources
- Children's Investments

Health Homes Serving Children

Medicaid State Plan Amendment (SPA)
- Other Licensed Practitioner Activities
- Medical Necessity Criteria
- Evidence Based Practice (EBP) Designation

1115 Amendment
- Serious Emotional Disturbance (SED) Level of Care (LOC) Criteria
- Network Adequacy Recommendations

CANS-NY Technical Assistance Institute Request for Proposal (RFP)

2016 Transformation Technical Assistance

NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services

Greg Allen

Director, Division of Program Development and Management

Office of Health Insurance Programs

New York State Department of Health

DSRIP/VBP: Relating to Children's Transformation

Agenda

- Introducing DSRIP

- Children's Health and DSRIP

- Children's Health and Health Homes

- Children's Health and VBP

Introducing DSRIP

What is Delivery System Reform Incentive Payment Program (DSRIP)?

- Overarching goal is to reduce avoidable hospital use – ED and inpatient– by 25% over 5+ years of DSRIP

- This will be done by **developing integrated delivery systems**, **removing silos, enhancing primary care and community-based services**, and **integrating behavioral health and primary care.**

  - *All things synonymous with the goals and design of the Children's Health and Behavioral Transition*

- Built on the CMS and State goals in the Triple AIM

  - Improving Quality of Care

  - Improving Health

  - Reducing Costs

- DSRIP does not include any explicit pediatric or child-focused projects. *However*, its holistic and integrated approach to healthcare transformation – and its overall performance goal - will require a focus on children's health outcomes and children's providers

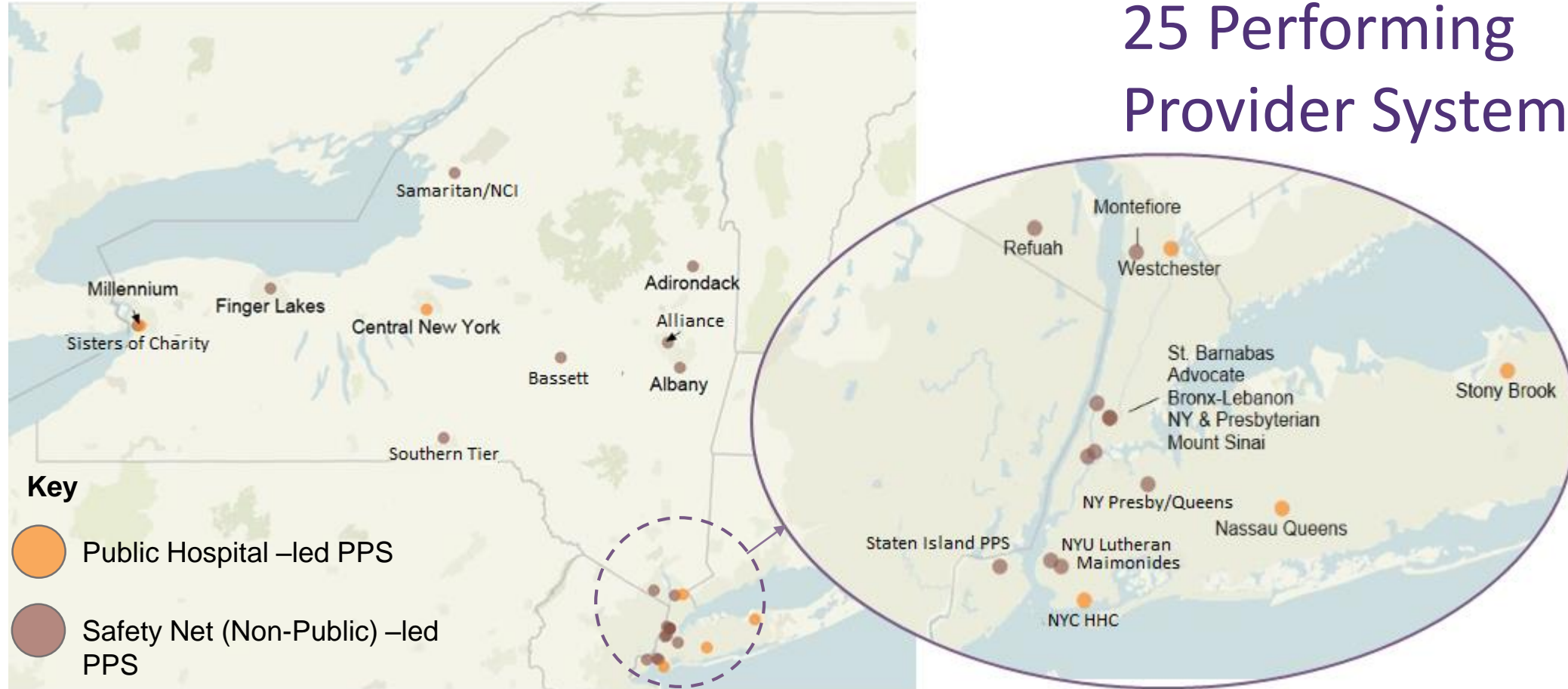NEW YORK STATE OF OPPORTUNITY. | Department of Health

25 Performing Provider Systems are Receiving Performance Based Funding to Drive Change

- Performing Provider Systems are networks of providers that collaborate to implement DSRIP projects

- Each PPS must include providers to form an entire continuum of care
  - ➢ Hospitals
  - ➢ *Health Homes*
  - ➢ Skilled Nursing Facilities (SNFs)
  - ➢ Clinics & Federally Qualified Health Centers (FQHCs)
  - ➢ *Behavioral Health Providers*
  - ➢ Home Care Agencies
  - ➢ Other Key Stakeholders

Community health care needs assessment based on multi-stakeholder input and objective data

Building and implementing a DSRIP Project Plan based upon the needs assessment in alignment with DSRIP strategies

Meeting and Reporting on DSRIP Project Plan process and outcome milestones

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Performing Provider Systems (PPS)

25 Performing Provider Systems

DSRIP Timeline – Significant Dates

April 2014 - DY0

June 26th 2014 –	*DSRIP Planning Design Grant application due*
September 29th 2014 –	*DSRIP Project Plan Application released*
December 1st 2014 –	*PPS Leads submit final partner lists in the Network Tool*
December 22nd 2014 –	*DSRIP Project Plan Application due*
January 13th 2015 –	*Independent Assessor completes DSRIP Project Plan Application review*
March 27th 2015 –	*Attribution for Performance results released to PPS Leads*

April 2015 - DY1

May 1st 2015 –	*First DSRIP Performance Payment to PPSs*
May 8th 2015 –	*Attribution for Valuation results released to PPS Leads*
July 22nd 2015 –	*DSRIP VBP Roadmap approved by CMS*
August 7th 2015 –	*PPS First Quarterly Report (April 1st 2015 – June 30th 2015) due from PPSs*
October 31st 2015 –	*PPS Second Quarterly Report (July 1st 2015 – September 30th 2015) due from PPSs*
January 30th 2016 –	*Second DSRIP Performance Payment to PPSs*
January 31st 2016 –	*PPS Third Quarterly Report (October 1st 2015 – December 30th 2015) due from PPSs*
April 30th 2016 –	*PPS Fourth Quarterly Report (January 1st 2016 – March 31st 2016) due from PPSs*
July 30th 2016 –	*Third DSRIP Performance Payment to PPSs*

We are here

April 2016 - DY2

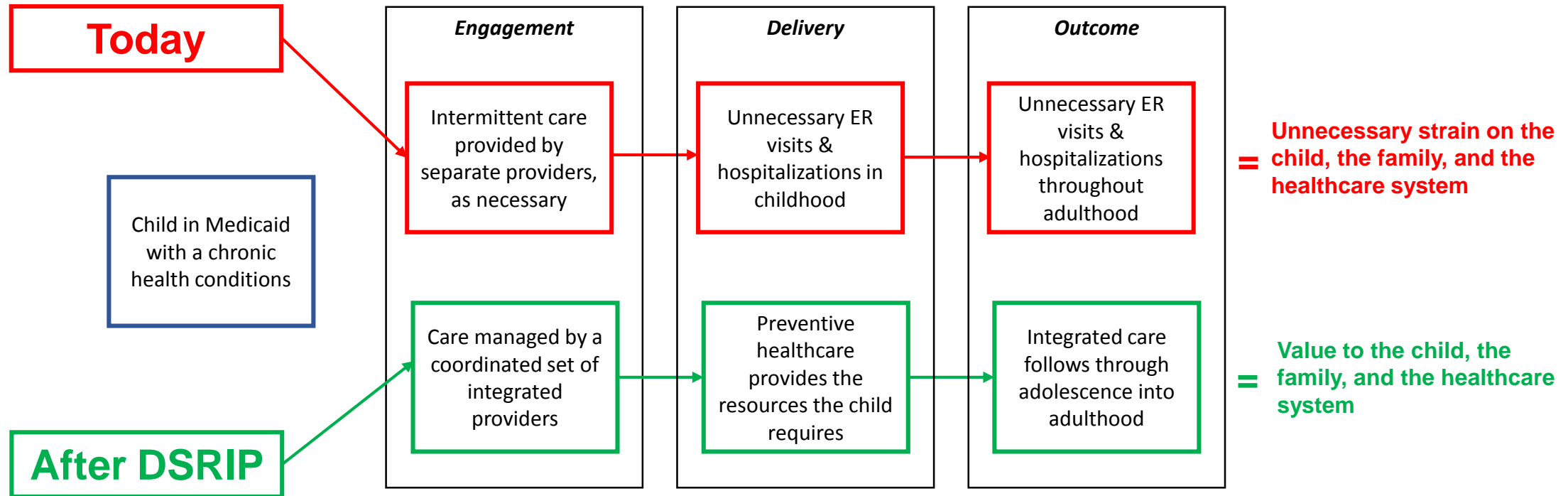|	
April 1st 2020 –	*End of the DY5 & the DSRIP program*

NEW YORK STATE OF OPPORTUNITY. | Department of Health
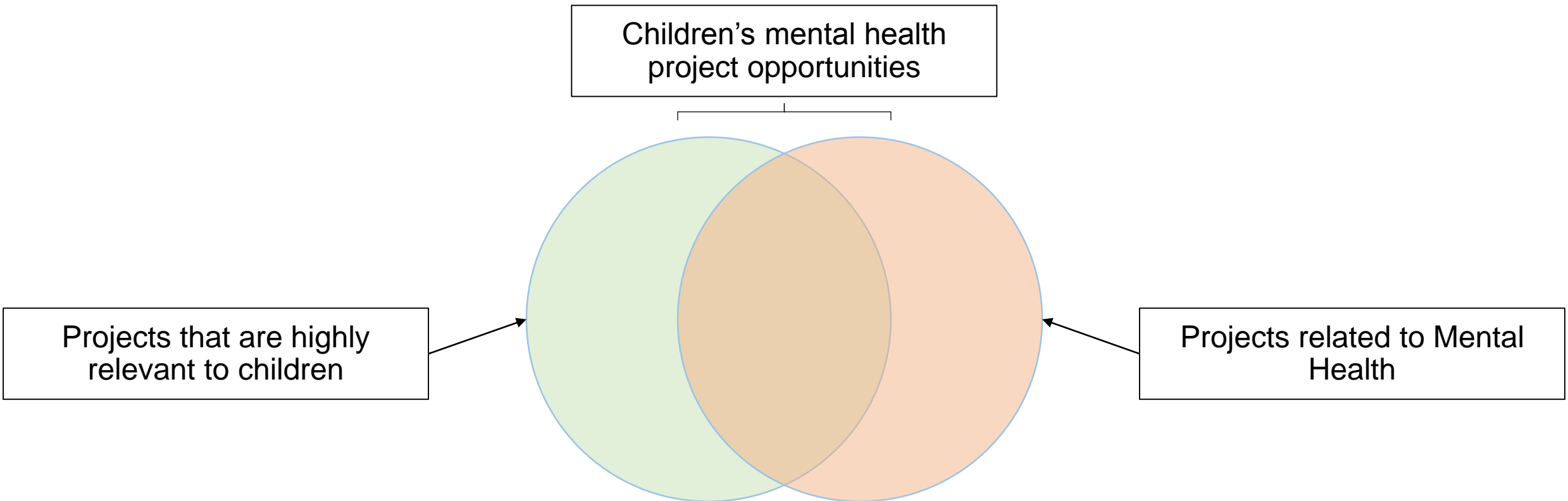
Children's Health & DSRIP

DSRIP Health Outcomes for Children

- DSRIP's healthcare transformation will likely have the greatest effect on children in Medicaid, as avoiding poor health outcomes throughout childhood will lead to a lifetime of stronger health outcomes

- The move from hospital-based care to home & community-based care is set to have a marked effect on this population by avoiding unnecessary hospitalizations and ER visits **throughout childhood and into adulthood**
  - **Expansion of HCBS services for children in MRT Design**

- Unnecessary hospitalizations will be reduced by DSRIP programs that emphasize proactive management of high risk children through early detection (asthma)

- The progression from health care and behavioral health silos to integrated delivery systems will give children access to a higher performing continuum of care and integrated behavioral health benefits within their respective PPS networks

NEW YORK STATE OF OPPORTUNITY. | Department of Health

DSRIP Health Outcomes for Children

Today

Child in Medicaid with a chronic health conditions

After DSRIP

	Engagement	*Delivery*	*Outcome*
Today	Intermittent care provided by separate providers, as necessary	Unnecessary ER visits & hospitalizations in childhood	Unnecessary ER visits & hospitalizations throughout adulthood
After DSRIP	Care managed by a coordinated set of integrated providers	Preventive healthcare provides the resources the child requires	Integrated care follows through adolescence into adulthood

= **Unnecessary strain on the child, the family, and the healthcare system**

= **Value to the child, the family, and the healthcare system**

NEW YORK STATE OF OPPORTUNITY. | Department of Health

PPS Projects and Opportunities for Children's Mental Health Providers

Children's mental health project opportunities

Projects that are highly relevant to children

Projects related to Mental Health

For projects in the overlapping area, children's mental health providers have enormous opportunities to add value to PPSs

DSRIP Projects with Greatest Impact on Children

- PPSs undergo healthcare transformation throughout their networks by choosing from a set of **DSRIP Projects**, each of which has a specific focus.

- Many of these are highly applicable to Children's Health:
  - 3.a.i: Integration of primary care services and behavioral health
  - 3.a.ii: Behavioral health community crisis stabilization services
  - 3.d.ii: Expansion of asthma home-based self-management programs
  - 3.d.iii: Evidence based medicine guidelines for asthma treatment
  - 3.f.i: Increase support programs for maternal & child health
  - 4.a.i: Promote mental, emotional, and behavioral well-being in communities
  - 4.a.iii: Strengthen mental health and substance abuse infrastructure across systems
  - 4.d.i: Reduce premature births

Children's Health and DSRIP – Metrics

Below is just a small example of some of the metrics that PPSs will be measured on. Children's Health Providers and Children's Health Homes will be vital to ensuring these metrics are met:

Domain 3 – Clinical Improvement Metrics						DY2 & DY3	DY4 & DY5
Measure Name	Measure Steward	NQF#	Source	Measure Type		P4R/ P4P	P4R/ P4P
3.a – Behavioral Health							
PPV (for persons with BH diagnosis)	3M	0283	Claims	Outcome		Performance	Performance
Antidepressant Medicaid Management	NCQA	0105	Claims	Process		Performance	Performance
Diabetes Monitoring for people with diabetes and schizophrenia	NCQA	1934	Claims	Process		Performance	Performance
Follow-up care for Children Prescribed ADHD Medications	NCQA	0103	Claims	Process		Reporting	Performance
Follow-up after hospitalization for Mental Illness	NCQA	0576	Claims	Process		Reporting	Performance
Screening for Clinical Depression and follow-up	CMA	0418	Medical Record	Process		Reporting	Performance
Adherence to Antipsychotic Medications for People with Schizophrenia	NCQA	1879	Claims	Process		Performance	Performance
Initiation of Engagement of Alcohol and Other Drug Dependence Treatment (IET)	NCQA	0004	Claims	Process		Performance	Performance

The following table was taken from STC Attachment J – Strategies and Metrics Menu

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Children's Health and DSRIP – Metrics

Below is just a small example of some of the metrics that PPSs will be measured on. Children's Health Providers and Children's Health Homes will be vital to ensuring these metrics are met:

Domain 3 – Clinical Improvement Metrics							
						DY2 & DY3	DY4 & DY5
Measure Name	Measure Steward	NQF#	Source	Measure Type		P4R/ P4P	P4R/ P4P
3.d - Asthma							
PQI # 15 Adult Asthma	AHRQ	0283	Claims	Outcome		Performance	Performance
PDI # 14 Pediatric Asthma	AHRQ	0638	Claims	Outcome		Performance	Performance
Asthma Medication Ratio	NCQA	1800	Claims	Process		Performance	Performance
Medication Managed for People with Asthma	NCQA	1799	Claims	Process		Performance	Performance
3.f - Perinatal							
PQI # 9 Low Birth Weight	AHRQ	0278	Claims	Outcome		Performance	Performance
Prenatal and Postpartum Care – Timeliness and Postpartum Visits	NCQA	1517	Medical Record	Process		Reporting	Performance
Frequency of Ongoing Prenatal Care	NCQA	1391	Medical Record	Process		Reporting	Performance
Well Care Visits in the first 15 months	NCQA	1392	Claims	Process		Reporting	Performance
Childhood Immunization Status	NCQA	0038	Medical Record	Process		Reporting	Performance
Lead Screening in Children	NCQA		Medical Record	Process		Reporting	Performance
PC-01 Early Elective Deliveries	Joint Commission	0469	Medical Record	Process		Reporting	Reporting

The following table was taken from STC Attachment J – Strategies and Metrics Menu

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Medicaid Children with Psychiatric Diagnosis and DSRIP PPS

- Children under 22 enrolled in Medicaid who have a psychiatric diagnosis from the DSM V*, which includes:
  - Neurodevelopmental Disorders
  - Schizophrenia Spectrum & Other Psychotic Disorders
  - Bipolar and Related Disorders
  - Obsessive-Compulsive and Related Disorders
  - Trauma- and Stress-Related Disorders
  - Dissociative Disorders
  - Somatic Symptom and Related Disorders
  - Feeding and Eating Disorders
  - Gender Dysphoria
  - Disruptive, Impulse-Control, and Conduct Disorders
  - Substance-Related and Addictive Disorders
- The following data is based on a DSM V population size of 294,619, and a general children's Medicaid population size of 1,745,390

Diagnostic and Statistical Manual of Psychiatry

Medicaid Hospital Use – Children's Behavioral Health

- Children enrolled in Medicaid diagnosed with a DSM-V condition are markedly more likely to have Inpatient and ER claims than the general Medicaid population of children
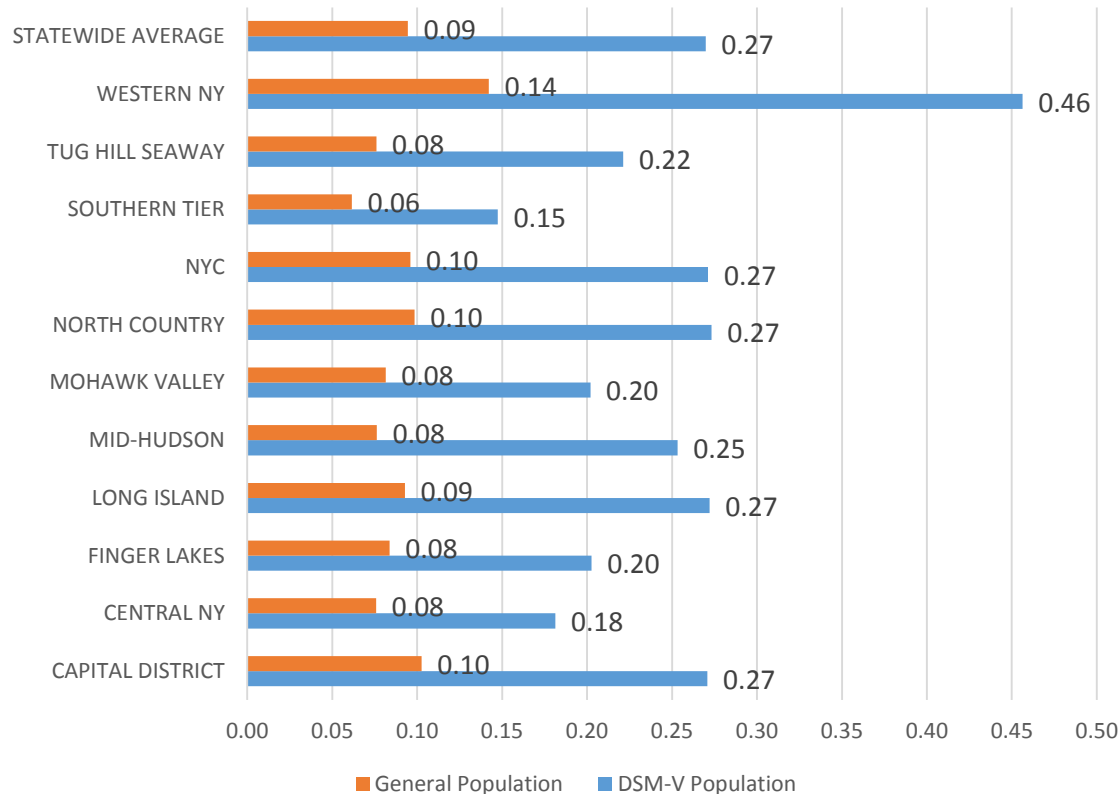
Inpatient and ER Claims & Spend Per Member*			
	DSM-V Population	General Population	Conclusion
Inpatient Claims	0.28	0.10	Children with a BH diagnosis are nearly 3 times as likely to incur ER/IP claims
ER Claims	1.43	0.90	
Inpatient Paid Amount	$1,761	$ 541	Children with a BH diagnosis cost nearly 3 times more in ER/IP costs
ER Paid Amount	$158	$ 94	

- There is ***significant room for decreasing unnecessary ER visits and hospitalizations*** by building a coordinated network between PPSs and children's behavioral health providers and children's Health Homes through DSRIP
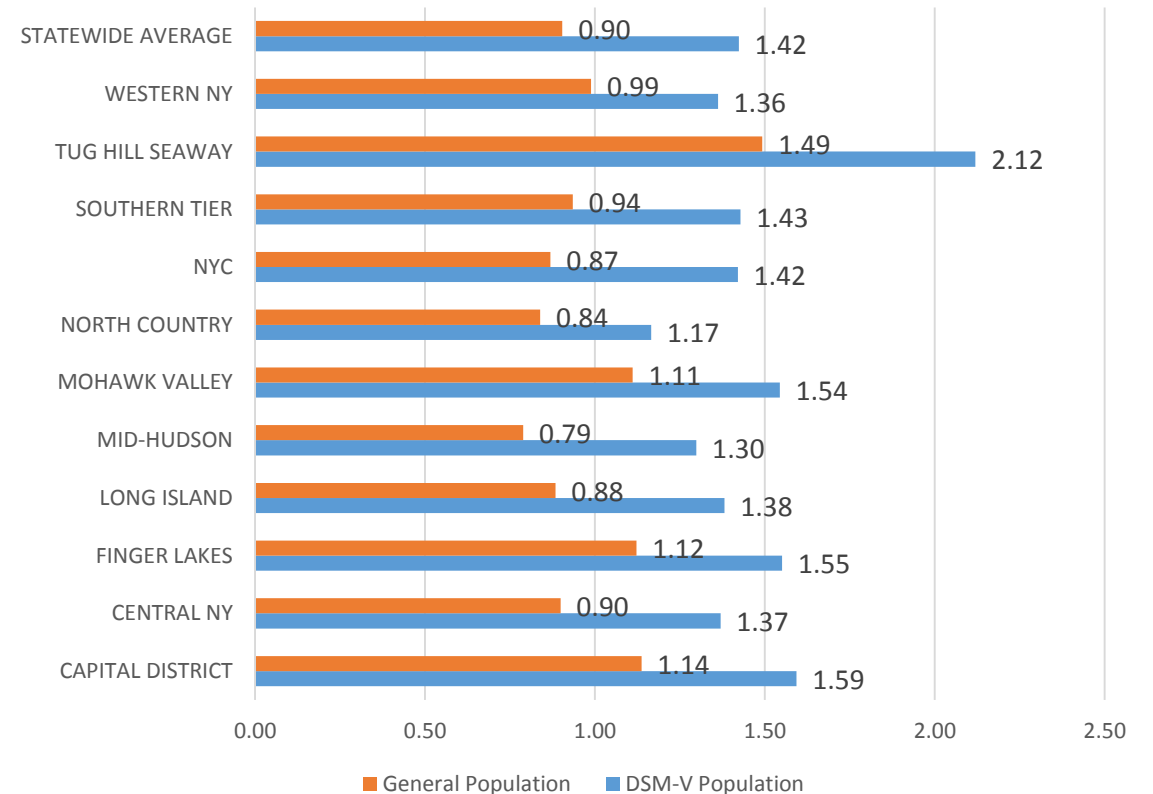
* Statewide averages in this table may include regional duplications

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Children's Behavioral Health – Claims Per Member by Region

IP Claims per Medicaid Member (under age 22)
General Population vs. DSM-V Population

Region	General Population	DSM-V Population
STATEWIDE AVERAGE	0.09	0.27
WESTERN NY	0.14	0.46
TUG HILL SEAWAY	0.08	0.22
SOUTHERN TIER	0.06	0.15
NYC	0.10	0.27
NORTH COUNTRY	0.10	0.27
MOHAWK VALLEY	0.08	0.20
MID-HUDSON	0.08	0.25
LONG ISLAND	0.09	0.27
FINGER LAKES	0.08	0.20
CENTRAL NY	0.08	0.18
CAPITAL DISTRICT	0.10	0.27

■ General Population ■ DSM-V Population

ER Claims per Medicaid Member (under age 22)
General Population vs. DSM-V Population

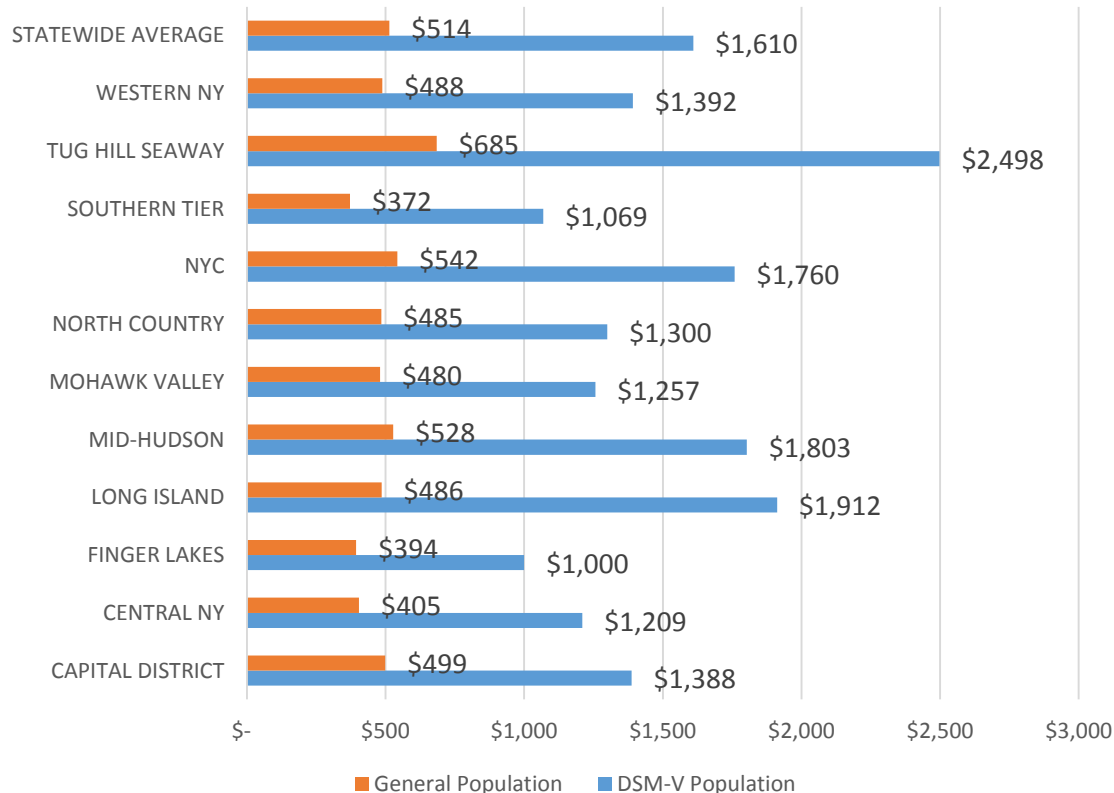| Region	General Population	DSM-V Population
STATEWIDE AVERAGE	0.90	1.42
WESTERN NY	0.99	1.36
TUG HILL SEAWAY	1.49	2.12
SOUTHERN TIER	0.94	1.43
NYC	0.87	1.42
NORTH COUNTRY	0.84	1.17
MOHAWK VALLEY	1.11	1.54
MID-HUDSON	0.79	1.30
LONG ISLAND	0.88	1.38
FINGER LAKES	1.12	1.55
CENTRAL NY	0.90	1.37
CAPITAL DISTRICT	1.14	1.59

■ General Population ■ DSM-V Population

Children with a BH diagnosis are nearly 3 times as likely to incur ER/IP claims

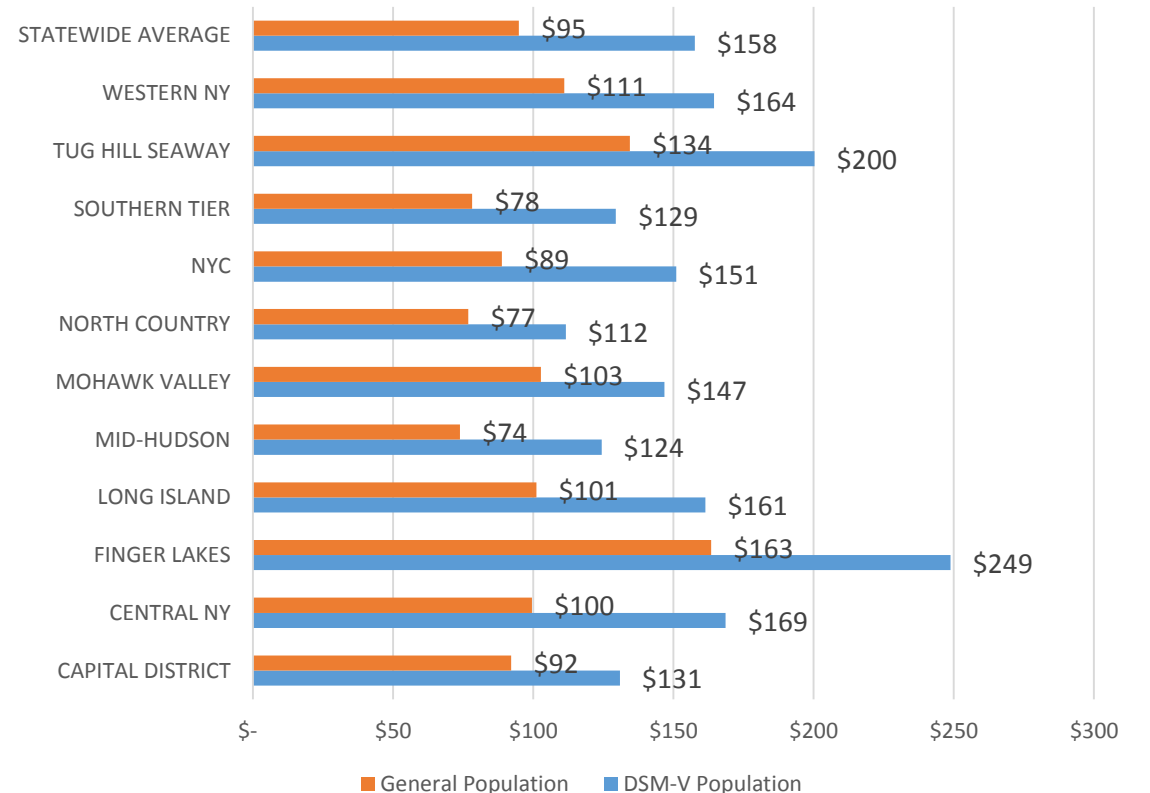*Source: Medicaid Data Warehouse, claims data within calendar year 2014*

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Children's Behavioral Health – Spending Per Member by Region

IP Spend per Medicaid Member (under age 22)
General Population vs. DSM-V Population

Region	General Population	DSM-V Population
STATEWIDE AVERAGE	$514	$1,610
WESTERN NY	$488	$1,392
TUG HILL SEAWAY	$685	$2,498
SOUTHERN TIER	$372	$1,069
NYC	$542	$1,760
NORTH COUNTRY	$485	$1,300
MOHAWK VALLEY	$480	$1,257
MID-HUDSON	$528	$1,803
LONG ISLAND	$486	$1,912
FINGER LAKES	$394	$1,000
CENTRAL NY	$405	$1,209
CAPITAL DISTRICT	$499	$1,388

ER Spend per Medicaid Member (under age 22)
General Population vs. DSM-V Population

Region	General Population	DSM-V Population
STATEWIDE AVERAGE	$95	$158
WESTERN NY	$111	$164
TUG HILL SEAWAY	$134	$200
SOUTHERN TIER	$78	$129
NYC	$89	$151
NORTH COUNTRY	$77	$112
MOHAWK VALLEY	$103	$147
MID-HUDSON	$74	$124
LONG ISLAND	$101	$161
FINGER LAKES	$163	$249
CENTRAL NY	$100	$169
CAPITAL DISTRICT	$92	$131

Children with a BH diagnosis cost nearly 3 times more in ER/IP costs

Source: Medicaid Data Warehouse, claims data within calendar year 2014

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Children's Health and Health Homes

New York STATE OF OPPORTUNITY. | Department of Health

Expanding Health Homes to Serve Children

- State is continuing its work to implement the Health Home Model for Children
  - September 2016 enrollment date will provide more time for 16 Contingently Designated Health Homes to complete readiness activities and to implement MAPP children's referral portal and other design features of the Model

- The overall Children's Health Home Design and the Children's Health and Behavioral Health MRT Initiatives make Health Homes and their network of care managers and providers ideally positioned to provide value to DSRIP projects and meeting overall State goals for DSRIP
  - Expanded Health Home Eligibility criteria, which includes SED, Complex Trauma, expanded array of State Plan services and HCBS services will provide new tools in tool box to improve health outcomes of children and meet objectives of MRT initiatives for children

Vision and Goals of Medicaid Redesign for Children
✓Keep children on their developmental trajectory
✓Focus on recovery and building resilience
✓Identify needs early and intervene
✓Maintain child at home with support and services
✓Maintain the child in the community in least restrictive settings
✓Provide the right services, at the right time, in the right amount
✓Prevent escalation and longer term need for higher end services

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Many Health Homes Planning to Serve Children are Already Affiliated with PPSs

- Children with Medicaid are attributed to a DSRIP PPS

- Contingently Designated Health Homes serving children were required to describe plans for how they will collaborate with PPSs

- Building relationships among HHs, their networks and DSRIP will be key

Health Home	Affiliated Performing Provider Systems
Greater Rochester Health Home Network LLC	Finger Lakes
CNYHHN Inc.	Adirondack Health Institute, Mohawk Valley, Samaritan Medical Center
North Shore LIJ Health Home	Nassau Queens, Stony Brook
Coordinated Behavioral Care, Inc. Health Home	Mount Sinai, Nassau Queens, New York City Health and Hospitals, Staten Island
St. Mary's Healthcare	Alliance for Better Health Care
Niagara Falls Memorial Medical Center	Millennium Collaborative Care
Catholic Charities of Broome County	Care Compass
Hudson River HealthCare, Inc. (HRHCare)	Montefiore, Nassau Queens, Stony Brook
St. Luke's-Roosevelt Hospital Center dba Mount Sinai Health Home	Mount Sinai
Community Care Management Partners, LLC (CCMP)	Bronx-Lebanon, Mount Sinai, St. Barnabas
Adirondack Health Institute, Inc.	Adirondack Health Institute
Montefiore Medical Health Home	St. Barnabas Hospital, Montefiore, Westchester, Nassau Queens, Mount Sinai

NEW YORK STATE OF OPPORTUNITY. | Department of Health

Children's Health and VBP

Moving Towards Value Based Payments

- **What are Value Based Payments (VBPs)?**
  - ➢ An approach to Medicaid reimbursement that rewards value over volume
  - ➢ Incentivizes providers through shared savings and financial risk
  - ➢ Directly ties payment to providers with quality of care and health outcomes
  - ➢ A component of DSRIP that is key to the sustainability of the Program

- By DSRIP Year 5 (2019), all Managed Care Organizations must employ value based payment systems that reward value over volume for at least 80 – 90% of their provider payments

- If VBP goals are not met, overall DSRIP dollars from CMS to NYS will be significantly reduced

Learning from Earlier Attempts: VBP as the Path to a Stronger System

VBP arrangements are not intended primarily to save money for the State, but to *allow providers to increase their margins* **by realizing value**
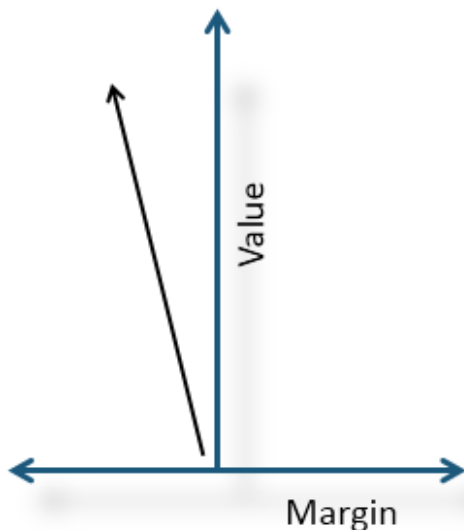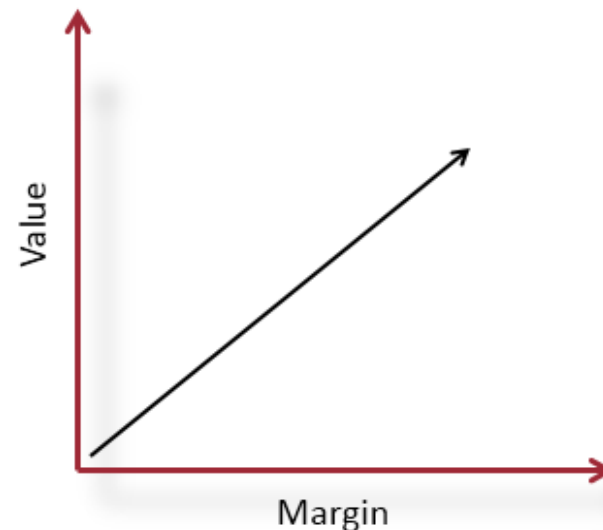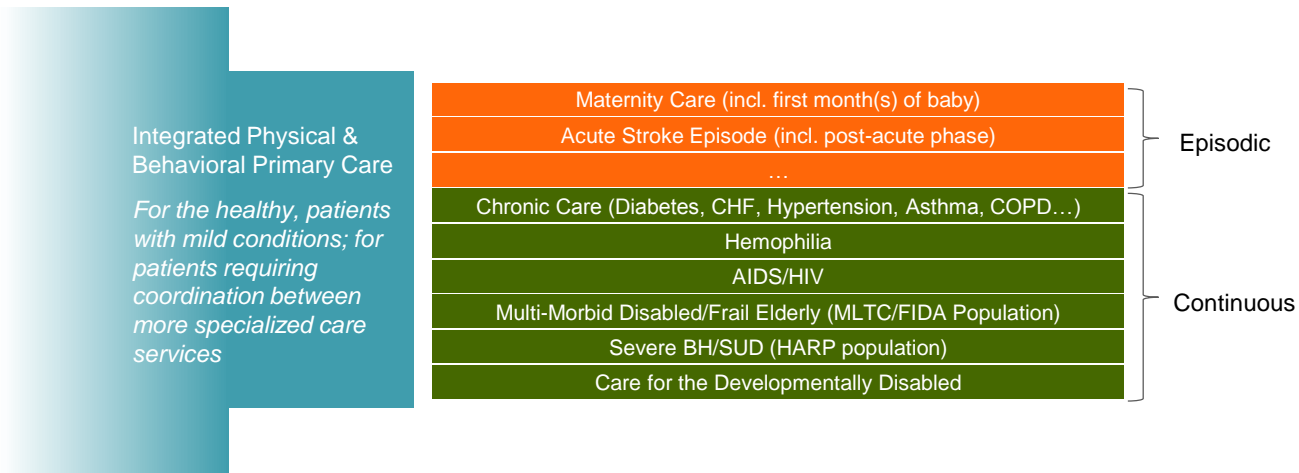

Goal – Pay for Value not Volume

The Path towards Payment Reform: A Menu of Options

There is not one path towards Value Based Payments. Rather, there will be a variety of options that MCOs and PPSs/providers can jointly choose from.

PPSs and MCOs can opt for different shared savings/risk arrangements (often building on already existing MCO/provider initiatives):

- For the total care for the total attributed population of the PPS (or part thereof) – ACO model
- Per integrated service for specific condition (acute or chronic bundle): maternity care; diabetes care
- For integrated Advanced Primary Care (APC)
- For the total care for a subpopulation: HIV/AIDS care; care for patients with severe behavioral health needs and comorbidities

Integrated Physical & Behavioral Primary Care

For the healthy, patients with mild conditions; for patients requiring coordination between more specialized care services

Maternity Care (incl. first month(s) of baby)
Acute Stroke Episode (incl. post-acute phase)
…

— Episodic

Chronic Care (Diabetes, CHF, Hypertension, Asthma, COPD…)
Hemophilia
AIDS/HIV
Multi-Morbid Disabled/Frail Elderly (MLTC/FIDA Population)
Severe BH/SUD (HARP population)
Care for the Developmentally Disabled

— Continuous

MCOs and PPSs may choose to make shared savings arrangements for the latter types of services between MCOs and groups of providers within the PPS rather than between MCO and PPS

NEW YORK STATE OF OPPORTUNITY. | Department of Health

# MCOs and PPSs can choose different levels of Value Based Payments

In addition to choosing *what integrated services* to focus on, the MCOs and PPSs can choose different levels of Value Based Payments:

Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level 2; requires mature PPS)
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/APC, FFS may be complemented with PMPM subsidy)	FFS with risk sharing (upside available when outcome scores are sufficient)	Prospective capitation PMPM or Bundle (with outcome-based component)

- Goal of ≥80-90% of total MCO → provider payments (in terms of total dollars) to be captured in Level 1 VBPs at end of DY5
- Aim of ≥ 35% of total costs captured in Level 2 VBPs or higher

What VBP means for Children's Behavioral Health Providers

In current Medicaid VBP arrangements, children's health providers are reimbursed on a Fee For Service basis, but with a potential bonus associated with each episode based on quality of care. **DSRIP in VBP goes beyond this model.**

Each service paid for separately

Plus a bonus that is awarded for high quality of care
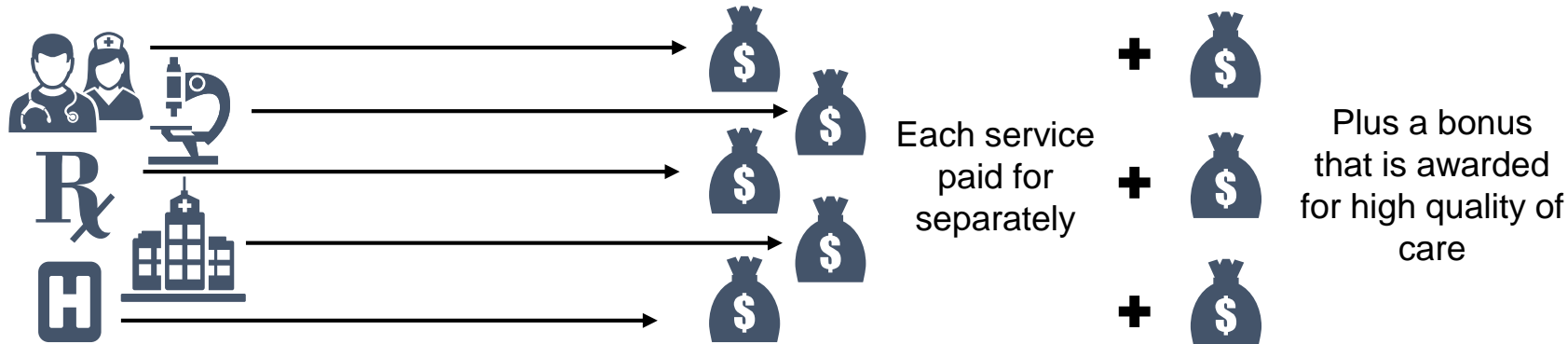
Bipolar Disorder Fee-For-Service	**Trigger**
	• Each individual Inpatient claim with bipolar disorder as principal diagnosis
	
	• Every individual claim is paid separately on a per-service basis
		Included in bundle:
		• No bundle involved in level 0 VBP
		
		• The quality bonus would involve avoidance of complications such as, but not limited to:
		   - Suicide or self inflicted injury
		   - overdose, poisoning - wrong drug
		   - accidental falls
		   - decubitus ulcer

NEW YORK STATE OF OPPORTUNITY. | Department of Health

What VBP means for Children's Behavioral Health Providers – level 1

At Level 1 VBP, children's health providers will still be reimbursed on a Fee For Service basis, along with bundled shared savings available to all providers involved in the care process, in an upside-only arrangement. Savings calculated based upon a risk-adjusted virtual budget.
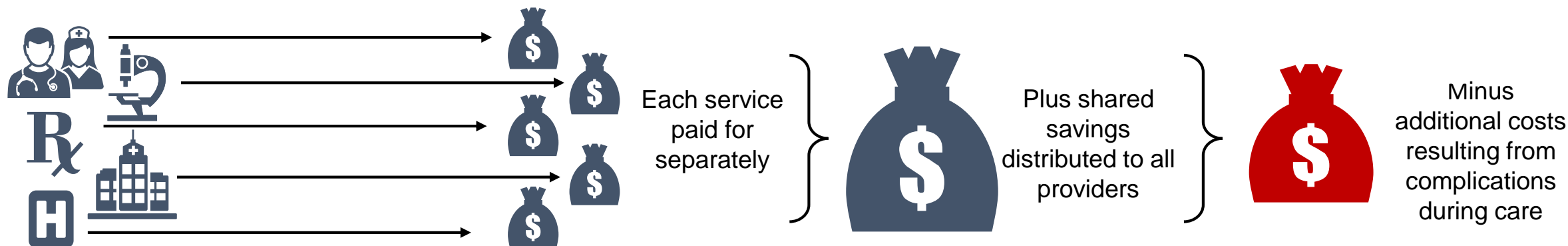

Each service paid for separately

Plus shared savings distributed to all providers

Bipolar Disorder Bundle	**Trigger** • Each individual Inpatient claim with bipolar disorder as principal diagnosis • Every individual claim is paid separately on a per-service basis	**Included in bundle:** • Shared savings are distributed among the providers when quality of care leads to cost savings in an upside-only arrangement

NEW YORK STATE OF OPPORTUNITY. | Department of Health

What VBP means for Children's Behavioral Health Providers – level 2

At Level 2 VBP, children's health providers will be reimbursed on a Fee For Service basis, as part of a risk-sharing arrangement: providers would share savings resulting from quality care, and share the costs of care complications

Each service paid for separately

Plus shared savings distributed to all providers

Minus additional costs resulting from complications during care

Bipolar Disorder Bundle

Trigger
- Each individual Inpatient claim with bipolar disorder as principal diagnosis

- Every individual claim is paid separately on a per-service basis

Included in bundle:
- Shared savings are distributed among the providers when quality of care leads to cost savings

- The cost burden of avoidable complications is shared by the participating providers

≥35% of total MCO → provider payments (in terms of total dollars) to be captured in Level 2 VBPs (or higher) at end of DY5

NEW YORK
STATE OF
OPPORTUNITY.

Department of Health

What VBP means for Children's Behavioral Health Providers – level 3

At Level 3 VBP, children's health providers will be reimbursed through a prospective Per Member Per Month (PMPM) rate for bundles of care with an outcome based component

All patient services related to the single illness

Sum of group services (based on encounter data the State receives from MCOs).

Bipolar Disorder Bundle

Trigger
- Inpatient claim with bipolar disorder as principal diagnosis

OR
- Outpatient or professional billing claim with E&M (evaluation and management) service and bipolar disorder as diagnosis

Confirming trigger
- Another trigger as stated above at least 30 days after the first trigger

Included in bundle:
- All typical and complication costs for bipolar disorder during the duration of the bundle

- Complications may include, but are not limited to:
  - Suicide or self inflicted injury
  - overdose, poisoning - wrong drug
  - accidental falls
  - decubitus ulcer

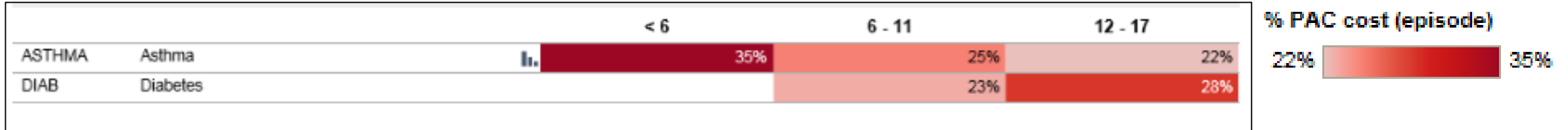NEW YORK STATE OF OPPORTUNITY. | Department of Health

Data Source

- Period: 2012-2013 Medicaid claims data

- Population: General population only (excluding HIV/AIDS, HARP, DD and MLTC)

- Costs: shadow pricing ($0 costs are replaced by a standardized amount)

- Minimum episode count: 100

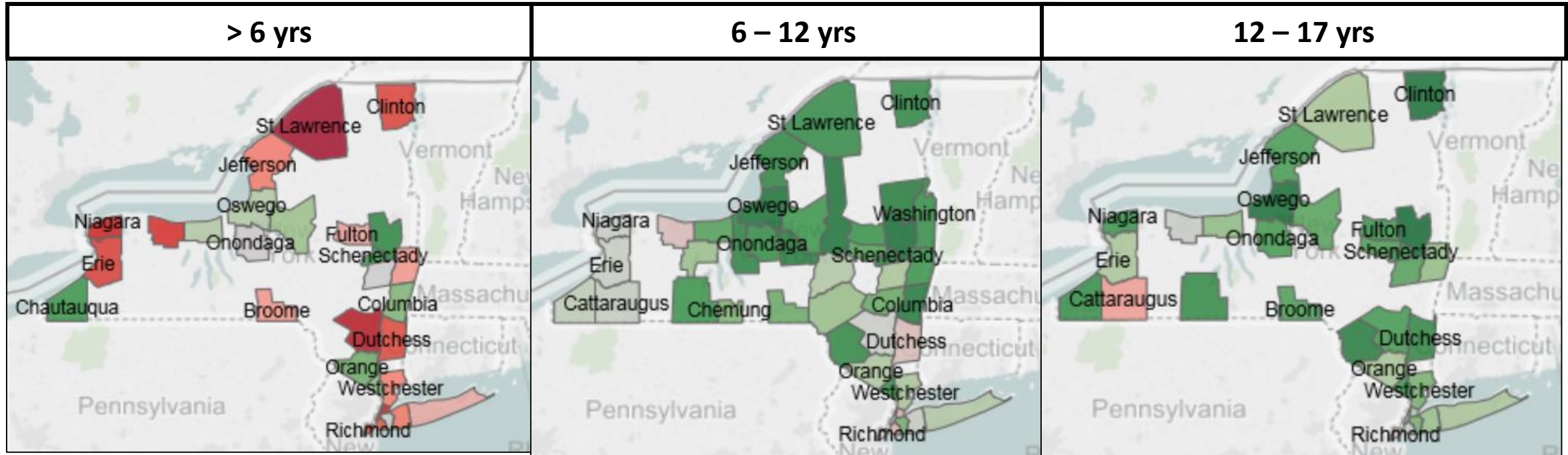# Average total costs of asthma and diabetes episode, split by age group
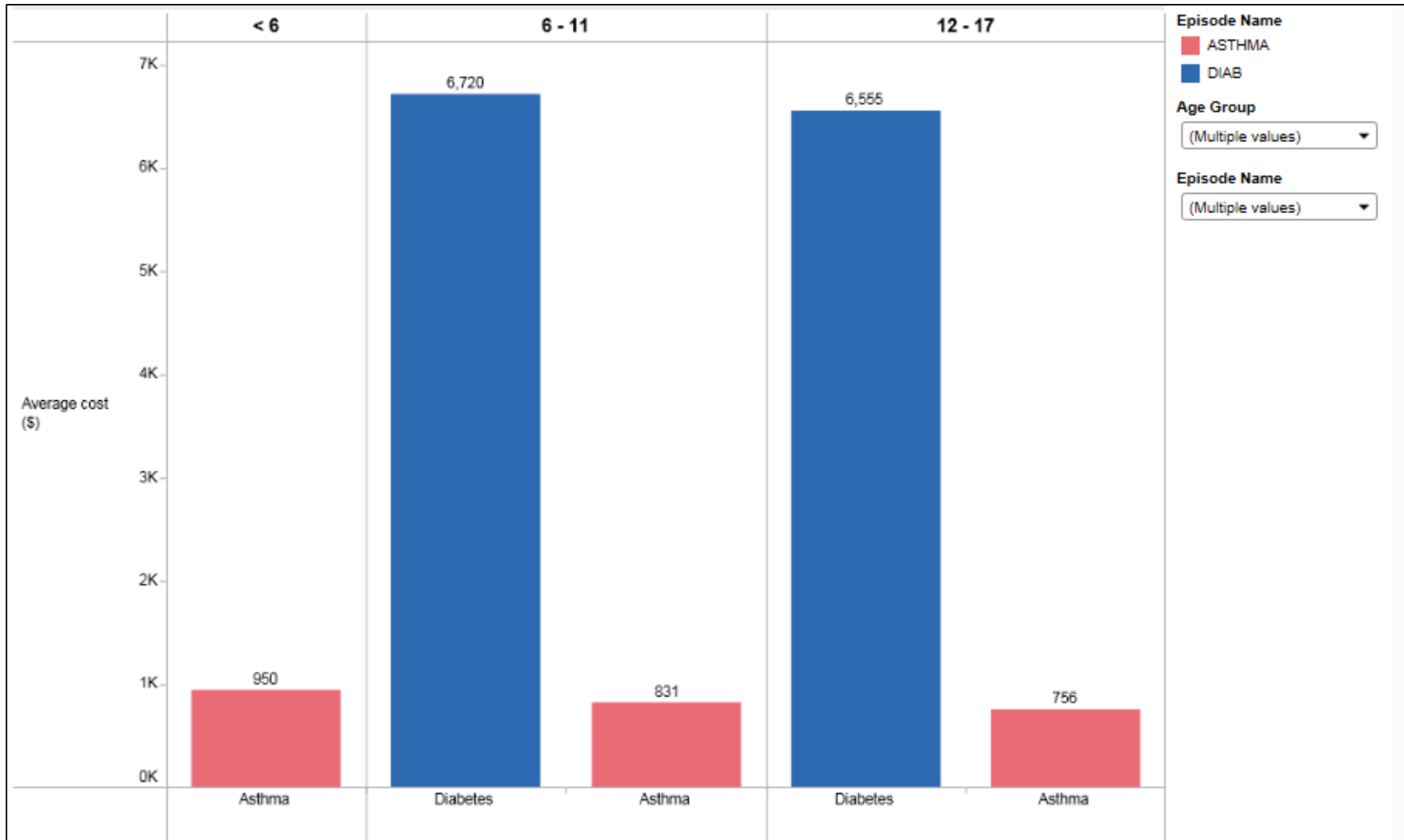
- Period: 2012-2013 Medicaid claims data

- Population: General population only (excluding HIV/AIDS, HARP, DD and MLTC)

- Costs: shadow pricing

- Minimum episode count: 100

Average % Potentially Avoidable Complication (PAC) costs per episode, split by age group

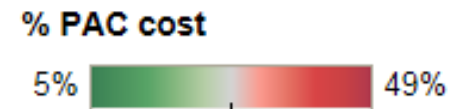|		< 6	6 - 11	12 - 17
ASTHMA	Asthma	35%	25%	22%
DIAB	Diabetes		23%	28%

% PAC cost (episode)

22% ▭ 35%

- Period: 2012-2013 Medicaid claims data

- Population: General population only (excluding HIV/AIDS, HARP, DD and MLTC)

- Costs: shadow pricing

- Minimum episode count: 100

NEW YORK STATE | Department of Health | Medicaid Redesign Team

Asthma: Average % PAC costs per episode, per county

| > 6 yrs | 6 – 12 yrs | 12 – 17 yrs |

- Period: 2012-2013 Medicaid claims data
- Population: General population only (excluding HIV/AIDS, HARP, DD and MLTC)
- Costs: shadow pricing
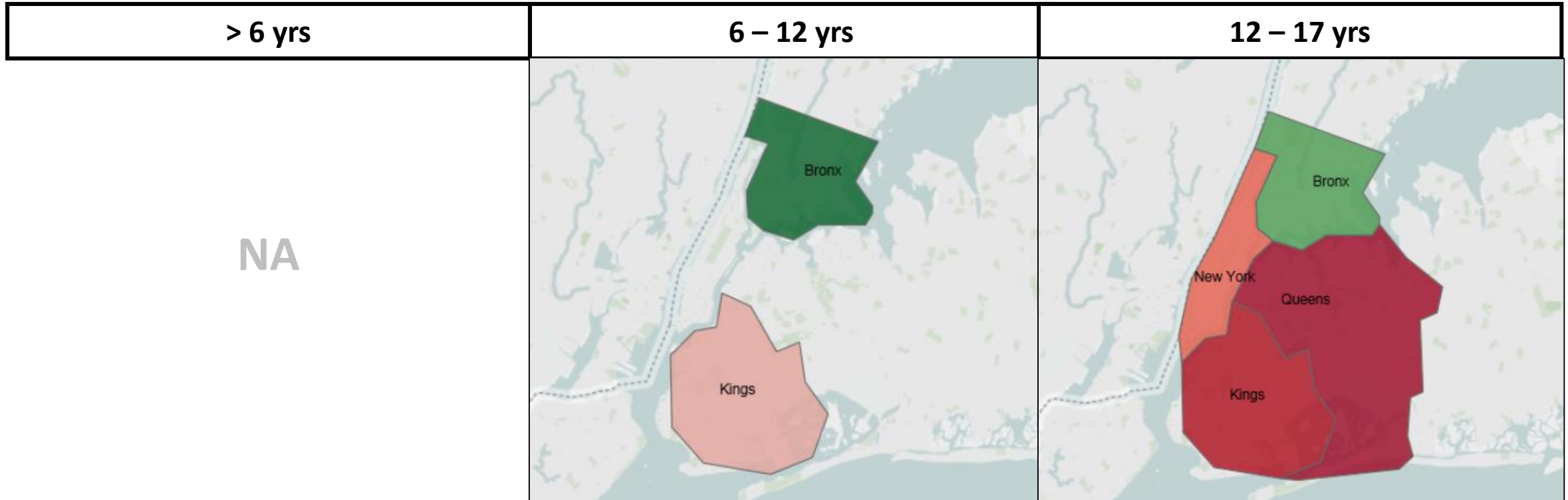- Minimum episode count: 100.

% PAC cost

5% ▬▬▬▬▬ 49%

Diabetes: Average % PAC costs per episode, per county

> 6 yrs	6 – 12 yrs	12 – 17 yrs
NA		

- Period: 2012-2013 Medicaid claims data
- Population: General population only (excluding HIV/AIDS, HARP, DD and MLTC)
- Costs: shadow pricing
- Minimum episode count: 100.

% PAC cost

20% ▬▬▬ 34%

Further Information: VBP Video

https://www.youtube.com/watch?v=94X7og_56XM&feature=youtu.be

Children's Design Updates

NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services

Key Features of Children's Medicaid Redesign Initiative to Transform the Delivery of Heath Care for Children

- Many of the details of the Design are still under development and will be implemented in phases

- Key features of the Design include:

  - ✓ **Expanding access to care management** for children with chronic conditions under the Health Home program or for children with lesser needs, through Managed Care plans or other vehicles –September 2016
    - a key to integrating care planning and service provision
  - ✓ **Authorizing Six New State Plan Services** – January 2017
  - ✓ **Transitioning children's behavioral health benefits** from fee-for-service to Medicaid Managed Care – January/July 2017
    - a key to integrating behavioral health and physical health
  - ✓ **Providing greater access to an aligned array of Home and Community Based Services** – beginning in 2017
  - ✓ Shifting the **voluntary foster care "per diem" population to Medicaid Managed Care** – January/July 2017
  - ✓ As we transition, **ensure continuity of care** for services currently provided to children

NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services

Children's Managed Care Readiness Resources

2015-16: $5 Million

- $220,000 contract with Chapin Hall for CANS-NY operational activities

- $75,000 addition to MCTAC contract for CASA Columbia to provide technical assistance to OASAS adolescent providers

- $4.7 Million in grants for HIT purposes to children's providers

NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services

HIT Grants to Children's Providers - *proposed*

- By 3/31/16, release $49,850 grants ($4.7 million) to OMH/OASAS providers serving children and operating children's programs/services that will transition to Medicaid Managed Care in 2017

- Uses of funds must be to support HIT related costs to transition the agency's children's services to Medicaid Managed Care

- Information will be released by OMH/OASAS prior to end of State fiscal year

NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services

Proposed 2016-17 Executive Budget – Global Spending Cap Investments for Children

- Includes $20 million in Managed Care Readiness Funds (assumes Federal share)

- Includes new investments of $7.5 million in 2016-17 and $30 million in 2017-18 for the six new Medicaid State Plan services, to focus on earlier intervention efforts to prevent needs from escalating to higher end, more expensive services

- Includes new investment of $30 million in 2017-18 for enhanced services (home and community based services) that will be integrated into the Medicaid Managed Care benefit package

Children's Managed Care Readiness Resources

2016-17 (Proposed – for feedback and discussion) - $20 Million

- $325,000 Sole Source Contract with Chapin Hall/John Lyons for CANS-NY user fees of on-line training and certification; in-person CANS training; future data analysis and revisions to CANS tool or algorithms

- $1 Million (1st year of 5) for CANS Institute RFP Awardee

- $300,000 to enhance the MCTAC contract for continued activities for CASA to conduct with OASAS adolescent providers for managed care

- $5 Million for HCBS start-up grants for designated HCBS providers

- An additional $5 Million for HIT grants (total $9.7 Million)

- $8.375 million for Evidence Based Practice Start Up Support

Health Homes Serving Children - Update

NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services

Health Home Enrollment Begins in 2016

- In September 2016, Health Home enrollment will begin for Medicaid children who meet Health Home eligibility criteria (two or more chronic conditions, SED, HIV, and Complex Trauma)
- 16 Health Homes have been Contingently Designated Statewide and are preparing for implementation
- Providers with care management expertise (OMH TCM providers, those that provide care management under Home and Community-Based Services, or HCBS, waivers) should continue to work with Health Homes to become Health Home care managers
  - ✓ OMH TCM Program will transition to Health Home in 2016
  - ✓ Children enrolled in HCBS waivers will be enrolled in Health Homes at a later date (2017)
- More information can be found by visiting the NYSDOH website at https://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm

NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services

Stakeholder Input on Proposed Standards and Guidance for Health Homes (HH) Serving Children

- Webinar Held on December 16, 2015 http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hhsc_webinar_12_16_2015.pdf
- Webinar provided updates on variety of topics including readiness activities of Contingently Designated HHs, HH State Plan Amendment Updates and Health Home eligibility criteria/definition of complex trauma
- Requested stakeholder feedback on additional proposed standards for Health Homes serving children, including required and proposed trainings, Plan of Care elements, requirements for Care Plan Meetings, and criteria for discharge/disenrollment from children's Health Home
- Feedback was due January 15, 2016
- State is reviewing the thoughtful and helpful feedback received and will provide follow up discussion and information at the next Webinar anticipated to be held in February
- Consent Forms for Children Have been finalized and posted to the DOH website
- State is working with CMS to finalize the HH State Plan Amendment

NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services

Children's Medicaid State Plan Amendment

Medicaid State Plan Amendment - Update

- Six New Services: Crisis Intervention, Other Licensed Practitioner, Community Psychiatric Supports and Treatment (CPST), Psychosocial Rehabilitation, Family Peer Support Services and Youth Peer Support Services

- Update: will request to be able to allow waiver of education qualifications for family peer and youth peer services

- SPA Application - in final revision stage; projected to submitted April 2016

- SPA Provider Manual – in final revision; projected to be released in February

NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services

SPA Other Licensed Practitioner

- This Medicaid reimbursement authority reimburses qualified Non-Physician-Licensed Practitioners (NP-LP) providing services within their scope of practice in a variety of settings and billed using CPT codes.

- Similar to Physician Service Authority in the Medicaid State Plan, OLP authority outlines the practitioner type licensed under state law and any prohibitions under Medicaid reimbursement.

- Unlike the Rehabilitation Authority in the Medicaid State Plan, the OLP authority does not outline every activity that Medicaid reimburses the NP-LP, and instead, only lists limitations.

- OLP is the authority that covers the services provided by the NP-LP listed in this section of the State Plan.

- It is the reimbursement authority for the services provided by the licensed practitioner.

NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services

OLP – Proposed Activities for CPT Coding

- Non-Physician-Licensed Behavioral Health Practitioners: LCSW/LMSW, LMFT, LMHC and Licensed Psychoanalyst

- Scope of Practice Activities:
  - Initial Assessment (with or without Medical Services)
  - Psychiatric Assessment
  - Psychotherapy (individual, family and group)
  - Psychotropic medication treatment
  - Psychological testing (various, neuropsychological)
  - Developmental testing

Question: Are there other activities that the practitioners routinely perform that we want to make sure is included in the coding and rate development for OLP?

Medical Necessity

- NYS Medical Necessity Definition:
  - includes any treatment that corrects or ameliorates chronic conditions that are found through an EPSDT screening OR
  - Addresses the prevention, diagnosis, and treatment of health impairments; the ability to achieve age-appropriate growth and development; and the ability to attain, maintain or regain functional capacity.

NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services

SPA Medical Necessity: Crisis Intervention

All activities must occur within the context of a potential or actual behavioral health crisis with a desired outcome of diverting an emergency room visit and/or inpatient admission, when appropriate.

NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services

SPA Medical Necessity - Discussion

- Community Psychiatric Supports and Treatment
- Psychosocial Rehabilitation
- Family Peer Support Services
- Youth Peer Support and Training

Question: Are there more specific medical necessity criteria to articulate for the four services above, that would provide more guidance than NYS' general medical necessity criteria?

NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services

Discussion: CPST Evidence Based Practice Designation *(refer to EBP Designation document)*

- Goal/aim of EBP within Medicaid State Plan CPST service
- Designation Process
- Outstanding questions
  - Is the document clear enough on what NYS' intent is with EBP?
  - Is the process for designation and what needs to be submitted clear?
  - Are there any other edits needed that could clarify the process or aim?

NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services

1115 Demonstration Waiver

NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services

1115 Amendment - Update

- Application in draft (CMS submission - Spring 2016)
- Policy issues under discussion
- HCBS Provider Manual under development
- HCBS Provider Designation process under development
- Cost and User Projections in development

NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services

SED LOC Criteria (merge of OCFS and OMH existing Waiver criteria)

To be eligible for HCBS Level of Care, a child must meet TARGET CRITERIA, RISK FACTORS, and FUNCTIONAL CRITERIA in addition to FINANCIAL eligibility (i.e., Medicaid).

The Child must meet the following Targeting Criteria:

- The child/youth is between the ages of 0-21.

- The child meets the definition for Serious Emotional Disturbance (SED) as defined by the NYS OMH.

AND (continued on next slide)

LOC SED Criteria (continued)

The child meets one of the following Risk Factors:

o   Currently resides in an institutional placement, including a hospital *as defined in subdivision 10 of section 1.03 of MHL* and has resided in such a hospital for at least 180 consecutive days **OR**

o   Had resided in an institutional placement, including a hospital *as defined in subdivision 10 of section 1.03 of MHL* within the past 6 months and was hospitalized for at least 30 consecutive days **OR**

o   Is eligible for institutional placement, including a hospital *as defined in subdivision 10 of section 1.03 of MHL,* which provides intermediate or long-term care and treatment **OR**

o   Has applied for institutional placement, including a hospital *as defined in subdivision 10 of section 1.03 of MHL,* which provides intermediate or long-term care and treatment **OR**

o   Has been determined by an appropriate entity, in the absence of HCBS Waiver Services, the child would require hospital level of care.

NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services

LOC SED Criteria (continued)

Using the CANS-NY, the Child is found to functionally need HCBS services by scoring a XXX on at least XXX dimensions of the CANS. This scoring demonstrates that:

- The child demonstrates complex health or mental health care needs (relies on Mental Health care, nursing care, monitoring, or prescribed medical or mental health therapy in order to maintain quality of life). Receives (or appears to need to receive) medical or mental health therapies, care or treatments that are designed to replace or compensate for a vital functional limitation or to avert an immediate threat to life, and are expected to extend beyond 12 months.

- The child appears to be capable of being cared for in the community if provided access to, but not limited to, the following **Home and Community Based Services (HCBS) :** Care Coordination, Habilitative Skill Building, Caregiver/Family Supports and Services, Crisis and/or Planned Respite, Prevocational Services, Supported Employment, Community Advocacy and Support, Non-Medical Transportation, Habilitation, Adaptive and Assistive Equipment, Accessibility Modifications, and/or Palliative Care.

- The child appears to have services and support needs that cannot be met by one agency/system.

NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services

Network Adequacy – Requesting Feedback

- Medicaid Managed Care Plans must meet model contract terms with regard to Network Adequacy Requirements

- Network Adequacy includes both the requirement for Plans to contract with: 1) a minimum number of providers per each benefit in order to 2) guarantee required appointment availability for each benefit for its members

- Network Adequacy is met when both are met in combination

Review proposed requirements – return feedback to Rachel.Fitzpatrick@omh.ny.gov by February 19

RFP #1645 Child & Adolescent Needs and Strengths-New York (CANS-NY) Technical Assistance Institute

Anticipated Release Date – February

Anticipated Proposal Due Date – End of March/April

Anticipated Start of Contract – July

2016 Children's Transformation Technical Assistance

Managed Care Technical Assistance Center (MCTAC)

NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services

Upcoming Offerings

- **Part I**: Transforming the Children's Medicaid System (presented on January 27, 2016 and archived on mctac.org)

Register now for Parts 2 & 3 of series at mctac.org:

- **Part 2**: Who's Included and Service Walkthroughs.
  Thursday, February 11: 12:00 – 1:00 pm
  Who's carved in and out, children's state plan amendment and HCBS.

- **Part 3**: Building Capacity and Preparing for Changes Ahead
  Thursday, February 25, 12:00 – 1:00 pm
  Identifying areas that providers will have to build knowledge/capacity around. Outlining training & technical assistance plans for the year. Lessons learned from the NYC adult system transition.

Reminder: slides and recordings from the series will be available via MCTAC.org. Questions can be sent in advance to mctac.info@nyu.edu.

Upcoming Offerings (cont.)

- In-depth transformation update events presented by state agency children's leadership team for executive/senior leadership of child-serving OMH, OASAS, DOH and OCFS providers.
    - 3/21 Long Island (PM)
    - 3/22 New York City (AM & PM offerings)
    - 3/31 Poughkeepsie (PM)
    - 4/1 Albany (AM)
    - 4/12 Buffalo (AM)
    - 4/13 Finger Lakes (AM)
    - 4/14 Syracuse (AM)

- Technical assistance will be offered for SPA, HCBS, and Managed Care transition including high-level topic introductions and in-depth implementation guidance

Preliminary Resources and Information

MCTAC Tools & Resources

- Materials from Adult Managed Care Training Series
- Glossary, top acronyms, managed care language guide, matrix, FAQ
- Stay current on the NYS DOH Website http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm
- More to come!

RESOURCES TO STAY INFORMED:

OMH Managed Care Mail Log

OMH-Managed-Care@omh.ny.gov

Subscribe to children's managed care listserv

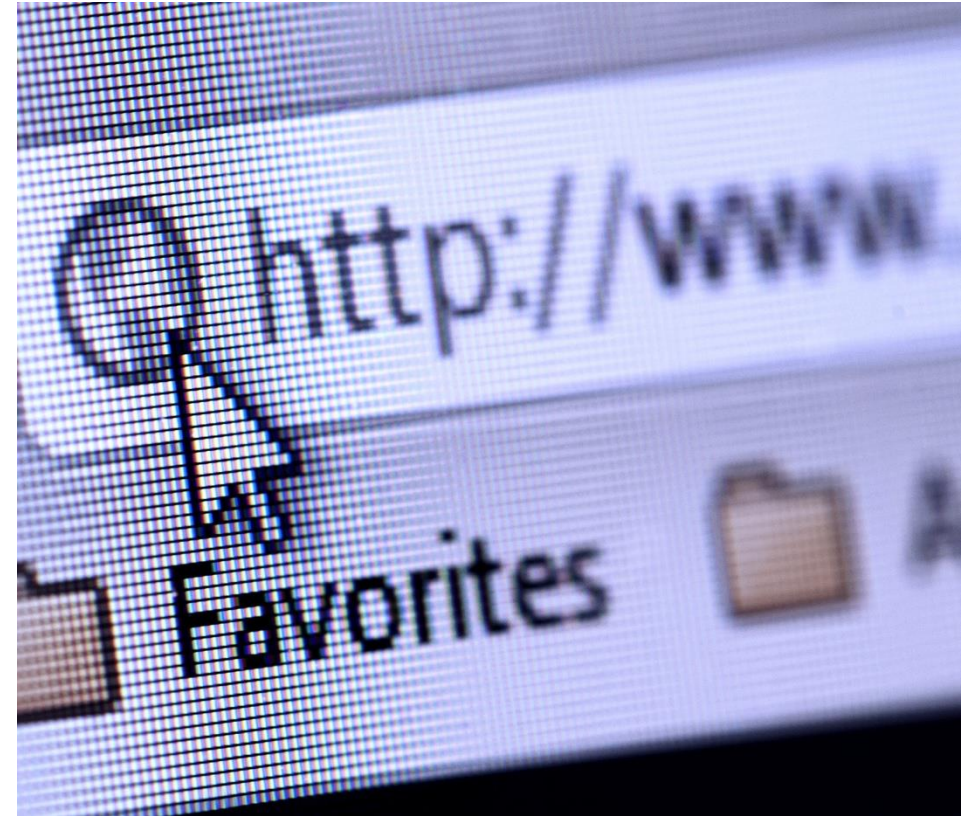http://www.omh.ny.gov/omhweb/childservice/

Subscribe to DOH Health Home listserv
[http://www.health.ny.gov/health_care/medicaid/progr am/medicaid_health_homes/listserv.htm](http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/listserv.htm)

Health Home Bureau Mail Log (BML)
[https://apps.health.ny.gov/pubdoh/health_care/medic aid/program/medicaid_health_homes/emailHealthHo me.action](https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action)

Questions & Closing Remarks

NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services