

## Draft Children's Managed Care Transition MCO Requirements

### OVERVIEW

On February 1<sup>st</sup>, New York State released for stakeholder feedback a draft version of the Medicaid Managed Care Organization (MCO) Children's System Transition Requirements and Standards. This MCO Requirements document outlines the new standards and requirements Medicaid MCOs will need to meet under the Medicaid Redesign Team's (MRT) Children's Medicaid Redesign Plan. The document was jointly released by the Department of Health (DOH), Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse Services (OASAS), and Office of Children and Family Services (OCFS).

Through the Plan, the State intends to transition all children's Medicaid populations into managed care and to expand the managed care benefit package to incorporate most existing specialty children's behavioral health (BH) services as well as new State Plan Amendment (SPA) services. This is expected to expand the number of HCBS-eligible children member months from 77,000 to 329,000 within five years. The Plan includes the following components:

- Creating six new SPA services open to all children meeting medical necessity criteria;
- Establishing Level of Care (LOC) and Level of Need (LON) criteria to identify children's populations likely to benefit from additional Home and Community-Based Services (HCBS), including children with complex trauma or other risk factors for functional impairment; and
- Consolidating New York's five current children's HCBS waivers into a single waiver offering a comprehensive HCBS benefit.

The State submitted the Plan on January 9<sup>th</sup> to the Centers for Medicare & Medicaid Services (CMS) as an 1115 waiver amendment. Since this amendment is still pending approval, the timelines included in the Plan and in the MCO Requirements document are subject to change. Currently, the State expects to release a final version of the MCO Requirements document in June. The draft document can be found [here](#).

**Stakeholders may submit comments to [bho@omh.ny.gov](mailto:bho@omh.ny.gov) through April 5<sup>th</sup> at 5pm.**

### TRANSITION PROCESS

#### Benefit Carve-In

As part of the Children's Medicaid Redesign Plan, most children's BH services currently provided on a fee-for-service (FFS) basis will be carved into the mainstream Medicaid managed care (MMC) benefit. These include:

- All current children's HCBS services;
- The six new SPA services:
  - Other Licensed Practitioners (OLP);
  - Crisis Intervention;
  - Community Psychiatric Support and Treatment (CPST);
  - Psychosocial Rehabilitation (PSR);
  - Family Peer Support; and

- Youth Peer Support and Training;
- Community First Choice Option (CFCO) services; and
- The four BH Demonstration services currently included in the adult MMC benefit:
  - Outpatient addiction services;
  - Residential addiction services;
  - Services provided by licensed behavioral health practitioners; and
  - Crisis intervention services.

## Population Carve-In

The following populations will be carved into MMC:

- Exempt populations:
  - Children enrolled in the following 1915(c) HCBS waivers:
    - OMH Serious Emotional Disturbance (SED) waiver;
    - DOH Care at Home (CAH) I/II waiver;
    - OCFS Bridges to Health (B2H) SED waiver;
    - OCFS B2H Medically Fragile waiver; and
    - OCFS B2H Developmental Disability (DD) waiver; and
  - Children who are residents of Chemical Dependence Long Term Residential Programs.
- Excluded populations:
  - Adolescents admitted to Residential Rehabilitation Services for Youth (RRSY) programs;
  - Children in the care and custody of OCFS, **except** children in OCFS facilities;
  - Children in Residential Treatment Facilities (RTFs); and
  - Children in the care of a voluntary foster care agency (VFCA).
- A new expansion population:
  - Children who meet the at-risk HCBS Level of Need (LON) criteria and who are eligible for Medicaid as a Family of One.

## HCBS Eligibility

HCBS eligibility under the 1115 waiver will continue to be based on targeting criteria, risk factors, and functional limitations. To qualify, children must be determined to meet both institutional and functional criteria for Level of Care (LOC), as indicated by the relevant assessment tool:

- Children with SED: The Child and Adolescent Needs and Strengths New York (CANS-NY);
- Medically fragile children: State designated assessment protocols and tools; and
- Foster care children with intellectual/developmental disabilities (I/DD): OPWDD eligibility tool.

Attachments A and B of the MCO Requirements contain more detailed eligibility and risk criteria for LOC and LON evaluations.

## Health Home Care Management

As children are enrolled in managed care, Children's Health Homes will take on the care coordination function currently provided by children's waiver providers, unless a child's responsible party elects not to join a Health Home. Health Homes will also:

- Administer all HCBS assessments to determine functional eligibility, except for the foster care I/DD population; and

- Verify that children meet all HCBS eligibility criteria (e.g., live in a HCBS-qualifying setting).

## Timeline

This carve-in will take place on the following timeline:

- October 2017: In New York City, Long Island, and Westchester County, all of the above services and populations, **except** children in the care of a VFCA and children in RTFs;
- January 2018: In the rest of the State, all of the above services and populations, **except** children in the care of a VFCA and children in RTFs; and
- January 2019: Statewide, children in the care of a VFCA.

Children in RTFs will be phased into managed care alongside contract amendments incorporating RTF services into managed care.

## MANAGED CARE ORGANIZATION PERFORMANCE STANDARDS

### Organizational Capacity

All MMC plans must arrange for the provision of the expanded children's benefit, either directly or by contracting with qualified vendors:

- For the children's BH benefit, the plan may partner with a qualified behavioral health organization (BHO). Plans currently using a BHO to manage the adult BH benefit may either use the same BHO for the children's benefit or a different BHO. If a different BHO is used, the new Master Services Agreement must be approved by DOH.
- For HCBS for medically fragile children or foster care children with I/DD, the plan may partner with a vendor with appropriate expertise.

Section 3.1 of the MCO Requirements contains additional details on organizational capacity requirements.

### Plan Operations

Plans must demonstrate that they have adequate staff and resources to ensure that all operational functions can be met, including, among other functions:

- Network development;
- Credentialing and provider contracting;
- Utilization review;
- Quality management;
- Claims and payment reporting; and
- Review of functional assessments.

Plans must also operate two 24/7 phone lines, one to provide information on the new children's benefit and the other to provide crisis triage, referral, and follow-up services.

Plans must establish a Children's Advisory Committee that reports to the plan's governing board. The board will include youth and family members, trained/certified peers, children's service providers, VFCAs, foster care family members, and other stakeholders.

Section 3.1 of the MCO Requirements contains more detailed information on these and other operational requirements.

## Personnel Requirements

In general, plans must have staff with expertise and experience in providing a full array of services to children with complex needs. Subject to limitations, job positions and functions may be combined with other roles, as long as State requirements are met. For example, positions may be shared across the children and adult populations, or between a plan's Health and Recovery Plan (HARP) and the mainstream product.

Plans must fill at least two separate leadership roles:

- A BH medical director with overall accountability for BH services for the children's population. Either the BH medical director must be a child psychiatrist, or the plan must ensure that a child psychiatrist is separately hired with authority for implementation of children's services; and
- A BH clinical director for children's services. The BH clinical director must be a licensed BH professional. For plans with more than 60,000 children enrolled, this must be a full-time position.

Plans must also fill the following managerial roles:

- A Medicaid MCO Liaison for Medically Fragile Children, to coordinate with Health Homes providing care management to medically fragile children and their families; and
- A Medicaid MCO Foster Care Liaison, to coordinate with OCFS, local departments of social services (LDSS), and VFCAs for all children in foster care.

Attachment D of the MCO Requirements contains a full table of required staff roles and qualifications.

## Network Requirements

Plans must contract for services in all counties currently covered under the plan's current managed care contract, and meet network adequacy standards as described in Section 3.4 of the MCO Requirements.

For most services, plans are required to contract with the higher of either 50 percent of all providers or at least two providers for each BH service in each county/region, if available. This applies to:

- OMH outpatient clinics that serve children;
- OASAS outpatient clinics;
- The six new SPA services; and
- Most direct services provided under the new HCBS benefit.

For many specialty services, plans must contract with all providers in the county/region. This applies to, among others:

- OMH outpatient clinics that serve children between 0 and 5 years of age;
- Article 28 hospitals licensed for children only;
- RTFs;
- Opioid treatment programs;
- RRSYs;
- Buprenorphine prescribers; and
- Crisis intervention providers.

Table 5 of the MCO Requirements provides detailed network requirements by service.

In addition, a plan will be required to make a good-faith effort to contract with the following providers, subject to quality requirements:

- All OMH or OASAS-licensed or certified BH agencies who currently serve five or more of the plan's members under 21 years of age (for at least the first 24 months of operation);
- All licensed school-based mental health clinics in the service area;
- State-designated SPA and HCBS providers;
- All State-designated evidence-based practice (EBP) providers;
- Health Homes serving children in the plan's service area;
- At least two CFCO providers per county for each service; and
- State-determined essential community BH providers for children.

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### **Access to Care Requirements**

Plans should develop and expand their provider networks based on the anticipated needs of special populations they serve, including but not limited to medically fragile children, children with co-occurring BH and physical or I/DD conditions, medically fragile children, children being discharged from the juvenile justice system, transition-age youth (TAY) with BH needs, and other groups.

For medically fragile children, plans must authorize services in keeping with State guidance as outlined in Attachment G of the MCO Requirements.

When in-network services are not available, plans should enter Single Case Agreements (SCAs) to meet the clinical needs of children. Plans should monitor SCAs for potential network development needs.

Plans must comply with regulations on the use of non-quantitative treatment limitations, including appointment and network access standards, as required by the federal Mental Health Parity and Addiction Equity Act (MHPAEA).

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### **Additional Requirements for Children in Foster Care**

The State will implement special processes for the transition of children in foster care into managed care. DOH is currently developing a method to license VFCAs so that plans may contract with them. Once the licensure process is done, DOH will provide further guidance on VFCA network requirements, and plans will have six months to contract with VFCAs.

Plans will be required to make a good-faith effort to contract with any VFCA that serves at least one child enrolled in the plan. Contracts should last at least 24 months, and include the provision of Preventive Residential Supports and Services, an in-development service that will reimburse VFCAs for ancillary services such as nursing supports and medical escorts (i.e., foster care residual services).

Plans will be required to contract with specialty health care providers that an LDSS or VFCA designates. These providers would perform initial assessments and health activities (as outlined in Table 7 of the MCO Requirements) and provide other treatment for foster care children. If plans lack an adequate network for such services, they will be required to pay out-of-network providers.

If a plan enrollee is placed in a VFCA outside the plan's service area, the plan must reimburse the VFCA for medically necessary services it provides. If the VFCA is not licensed to provide such services, the plan must allow enrollees to access services as needed from nearby out-of-network

providers who have traditionally treated foster children. For a long-term placement outside the plan's service area, at the direction of the LDSS or VFCA, the enrollee may be transitioned to another plan.

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### **Credentialing Requirements**

State designation of BH HCBS providers will be sufficient for plans' credentialing processes. For such providers, individual staff members should not be separately credentialed. Similarly, plans should accept OMH and OASAS licenses in place of credentialing processes for individual employees.

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## **Financials and Plan Payment Requirements**

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### **Capitation**

In general, all State Plan services will be included in the capitation rate, while HCBS services will not be included for at least 24 months from the date of the carve-in. For the Community First Choice Option, some services that are similar to other State Plan services (e.g., personal care) will be included, while others that are closer to traditional HCBS (e.g., environmental modifications), will not be included.

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### **Mandatory Rates**

Plans must pay at least the Medicaid FFS fee schedule for at least 24 months for the following services:

- The six new SPA services;
- Preventive Residential Supports and Services;
- Article 31 OMH clinics;
- Article 32 OASAS clinics; and
- RRSYs.

Plans must also pay State rates for all children's HCBS services during the period that these services are not yet incorporated into the capitation; this is expected to last at least two years.

Former 1915(c) waiver care management providers who are transitioning to become Health Home providers may receive a transitional rate comparable to their previous rates for up to 24 months.

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### **Continuity of Care**

For the first 24 months of the transition, for current episodes of care ongoing during the managed care transition period, plans must allow children to continue with their current providers (including medical, BH, and HCBS providers).

No child may be required to change Health Homes at the time of the transition. If a Health Home does not contract with a plan, the plan will be required to pay on a Single Case Agreement (SCA) basis.

Plans must have policies in place to ensure continuity of care for foster care children and TAYs during discharges.

For members who are placed in OASAS residential programs located outside of the plan's service area, plans will be required to pay allied clinical service providers, either on a contract or SCA basis.

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## **Utilization Management**

Plans must use State-approved Medical Necessity Criteria (MNC) guidelines to determine the appropriateness of new or existing health care services during the children's managed care transition, with the goal of attending to children's overall needs and ensuring that access to care is uninterrupted.

Plans must identify potential or existing gaps in care, address family and quality of life goals, and support relapse prevention planning that includes crisis intervention.

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### **Requirements for Children in Foster Care**

Plans must authorize and cover all foster care intake assessments necessary at the time a child enters foster care, including initial screens, comprehensive diagnostic assessments, and additional mandated assessments.

Plans also must cover replacement durable medical equipment; medication fills, including at out-of-network pharmacies if needed based on the child's placement; and other medically necessary services.

### **Other Requirements**

The RFQ also contains further requirements in the following areas:

- Clinical management strategies;
- Network monitoring and provider training;
- Cross-system collaboration;
- Quality management; and
- Information systems and website capabilities.