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Redesigning Children's Behavioral Health Services in New York's Medicaid Program

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at United Hospital Fund**

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at United Hospital Fund**

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Chad Shearer
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Elizabeth Patchias

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Introduction

New York State is pursuing an ambitious set of Medicaid reform initiatives that promote a shift away from a fee-for-service (FFS) payment system and toward a system that supports care coordination and rewards value. The vision for a reformed Medicaid puts patients at the center of their care and seeks to provide timely, integrated, and cost-effective care.

This goal is particularly important for approximately 2 million children in Medicaid who are currently enrolled in managed care for their physical health services, but whose behavioral health (BH) services—services to address mental health and substance use disorders—are delivered largely under a fee-for-service model.¹ To address the fragmentation of care such bifurcation creates, New York plans to move all behavioral health services for children to Medicaid managed care beginning in 2017.²

Currently, responsibility for children’s BH services is divided among an array of State and county agencies and the care itself is provided across many different settings. Children enter through multiple doors and receive treatment and interventions in various systems with little coordination among them. Although the State offers many robust and specialized services designed for the neediest children, the actual delivery of those services is piecemeal and fragmented. Furthermore, the existing system is not well positioned to reach children with less severe needs, to meet children’s changing needs, or to identify and serve children who are at risk of illness in the future.

MRT Behavioral Health Reform Work Group, Children’s Subcommittee Finding

The current systems are “siloeed.”

“Families are often served by a disjointed, overlapping, non-comprehensive and costly series of services. Medicaid redesign must better align systems to yield continuity of care, access, and cost-efficiency, and promote greater integration of primary care and behavioral health. Special considerations may be required to address the complex needs of children in the foster care system.”

Source: Medicaid Redesign Team (MRT) Behavioral Health Reform Workgroup Final Recommendations. October 15, 2011. https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_behavioral_health_reform_recommend.pdf

1 The Substance Abuse and Mental Health Services Administration defines behavioral health as “a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol or drug addiction, serious psychological distress, suicide and mental and substance use disorders.” Substance Abuse and Mental Health Services Administration. 2013. *Behavioral Health, United States, 2012*. Washington, DC: SAMHSA. Available at <http://media.samhsa.gov/data/2012BehavioralHealthUS/2012-BHUS.pdf>

2 In this report, “children” refers to anyone younger than 21 years old, unless noted otherwise.

This report describes the current system of care for children served by Medicaid who have behavioral health needs, reviews the State’s planned approach to reforming the system, and explores several important policy considerations for stakeholders as the reforms move forward. It is based on reviews of relevant laws, regulations, policy documents, and research on Medicaid behavioral health coverage for children. Information regarding the upcoming managed care transition of BH services for children was also gathered through semi-structured interviews with stakeholders, including officials in New York State agencies, providers and provider associations, managed care representatives and consumer advocates, and from the United Hospital Fund’s roundtable discussion on children’s behavioral health held in June 2015. The analysis also includes data derived from the New York State Office of Mental Health Medicaid data warehouse and the Psychiatric Services and Clinical Knowledge Enhancement System data tables.

What Is Children’s Behavioral Health?

The concept of children’s behavioral health has evolved greatly over the years, as collective understanding of child development has become more sophisticated. While the physical characteristics of development (e.g., crawling, walking, and talking) have historically been well understood, the psychological and mental development milestones have not been. As a more holistic understanding of childhood health has emerged, the emotional growth markers along a child’s trajectory, as well as the range of experiential and environmental challenges that can impede healthy development, are now understood to be critical factors for outcomes as diverse as school readiness and adult physical and mental health.

Much of this understanding came from the Adverse Childhood Experience (ACE) study in the 1990s, which demonstrated the lasting and long-term effects of traumatic events in childhood.³ Since ACE, a growing body of research has sought to quantify the prevalence of adverse childhood experiences and illustrate their connection with negative behavioral and physical health outcomes later in life, such as obesity and other chronic diseases, alcoholism, and depression. These findings are informing best practices of treatment approaches, interventions and public policy.

With a more nuanced understanding of child health has come the realization that children have significant behavioral health needs. The National Center for Children in Poverty reports that one in five children birth to 18 have a diagnosable mental health disorder. One in ten children age 12 to 17 have a severe enough mental health problem to interfere with their

3 Felitti VJ et al. May 1998. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. *American Journal of Preventive Medicine* 14(4): 245–258. Available at [http://www.ajpmonline.org/article/S0749-3797\(98\)00017-8/abstract](http://www.ajpmonline.org/article/S0749-3797(98)00017-8/abstract)

functioning.⁴ The numbers are significantly higher for low-income children, especially those living in households below the poverty level. These conditions not only complicate children’s development but also put them at risk for lower educational achievement, greater involvement with the criminal justice system, and longer-term placements in the child welfare system. How Medicaid approaches this population can have long-term benefits for one of the most vulnerable groups of children.

Through an increased understanding of how much children’s environment (e.g., family) and experiences (e.g., exposure to trauma) affect their health, new approaches to both prevention and treatment are blossoming. Investments in promotion and prevention activities in children of all ages can have far-reaching effects on mental health and well-being. Public education campaigns and community mobilization efforts combined with early identification programs and comprehensive screenings are becoming more common. On the treatment side, behavioral health providers are elevating the role of families in their interventions. Stakeholders are also realizing the impact of working across systems and working within schools and other points of contact with children, and of bringing services into their communities.

Current Structure of Behavioral Health Services for Children in New York

About 2 million children in New York are enrolled in Medicaid, and in a given year, about 10 percent use BH services. For example, in 2013, about 216,000 children (under age 18) used BH services. Illustrative data on the range of these services—the prevalence of different diagnoses, an analysis of service utilization, and more—is included in Appendix 1. The wide variety of BH diagnoses suggests that a full array of services is required to meet these children’s needs.⁵

Because of the wide range of children’s needs as they grow and mature, federal Medicaid law requires states to provide comprehensive benefits under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirement. Included in EPSDT are services needed to “correct or ameliorate” a child’s physical and mental conditions.⁶ Under its State Plan, New York Medicaid accordingly covers a wide range of BH services, including traditional BH services of inpatient and outpatient hospital care, office-based services, medications, and

4 Stagman S and JL Cooper. April 2010. *Children’s Mental Health: What Every Policymaker Should Know*. New York: National Center for Children in Poverty. Available at http://www.nccp.org/publications/pdf/text_929.pdf

5 See Appendix 1. Research Foundation for Mental Hygiene, Inc. analysis of New York State Medicaid data for UHF using the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) data tables.

6 42 U.S.C. § 1396d(r)(5).

specialty mental health (MH) and substance use disorder (SUD) services.⁷ Specialty MH services include day treatment, rehabilitation, residential treatment facilities, and intensive case management. Specialty SUD services include residential rehabilitation services for youth, opioid replacement treatment, outpatient chemical dependence rehab, outpatient clinic, methadone maintenance, and rehab supports for community residences (see the glossary in Appendix 2 for definitions). Medicaid-eligible children who need and use these specialty BH services receive them under FFS Medicaid, regardless of whether they are enrolled in a managed care plan. These services are considered “carved out” of the Medicaid managed care benefit package and are licensed by the Office of Mental Health (OMH) and by the Office of Alcohol and Substance Abuse Services (OASAS).

The Current 1915c HCBS Waiver Programs Transitioning to Managed Care

OMH operates a waiver for children and adolescents with **serious emotional disturbance (SED)**. The waiver is designed for children between the ages of 5 and 17 with an SED diagnosis who without access to the waiver would be in a psychiatric institution. Services available through this waiver are geared toward stabilizing a child as well as building a safe environment for the child and his or her family. Specifically, the services are intensive in-home care, crisis response, respite care, family support services, and skill-building.

The Office of Child and Family Services (OCFS) operates three separate waiver programs, collectively known as the **Bridges to Health (B2H)** waivers. These waivers are for foster care children only, and each one targets a different subgroup: One is for children with SED, another is for those with medical fragility, and a third is for those with developmental disabilities. B2H services include family/caregiver supports and services, skill building, day habilitation, special needs community advocacy and support, pre-vocational services, supported employment, planned respite, crisis avoidance, management and training, immediate crisis response services, intensive in-home supports, crisis respite, adaptive and assistive equipment, and accessibility modifications.

Additionally, the New York State Department of Health (DOH) operates two **Care at Home** waivers, which target children with severe disabilities. These waivers will shift into managed care as part of the BH carve-in even though they do not necessarily serve children with substantial BH needs.

See Glossary (Appendix 2) for additional detailed service definitions.

⁷ “Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.” Substance Abuse and Mental Health Services Administration. June 2015. Substance Use Disorders. Available at <http://www.samhsa.gov/disorders/substance-use>

Additional support and community-based services are available through the home and community-based services (HCBS) waiver programs, authorized under section 1915c of the Social Security Act, which serve about 7,000 children.⁸ These waivers disregard parental income when determining a child's eligibility, and therefore reach children who would otherwise not be eligible for Medicaid.⁹ Access to the services and supports of the waiver programs is limited. Each waiver has unique eligibility criteria, based on characteristics such as age and diagnosis, and offers different services to those who qualify (see inset box on previous page). Waiver programs have caps on enrollment and therefore long waiting lists.

Although Medicaid covers many services for many children, the bifurcation of managed care and FFS, along with the complex eligibility pathways for waiver services, can lead to uncoordinated and fragmented care, as well as unmet needs for those wait-listed or ineligible for waiver services, and long waits for services such as day treatment and residential treatment facilities. Furthermore, this design and its resulting fragmented service array is insufficiently flexible to meet many children's constantly changing BH needs, complicating the goal of connecting kids to the right services in the right amount at the right time.

Special Populations of Children

Several groups of children who need and use BH services have unique complexities; to fully understand the State's approach to reform, it is important to recognize the demographic and environmental factors affecting these special populations. Understanding these children through the specific lens of their stages of development, as well as their life circumstances, highlights the opportunities and challenges associated with shifting their behavioral health services to managed care. As briefly described below, what is required to meet their needs is not necessarily generalizable to the broader population of children using BH services.

Children with Serious Emotional Disturbance (SED): While children with lesser needs may receive basic BH services in primary care settings through their managed care plan, children with SED receive specialty BH services through the FFS and waiver systems. These high-need children account for a great deal of BH service use; when the full range of BH services is carved into managed care, they are the ones who will experience the biggest change in how services are provided and reimbursed.

Children in Foster Care: As of August 2015, there were 18,500 children placed in foster care in New York. The transition of their care into managed care varies based on their current placement arrangement. Physical health services for approximately 3,000 children in foster

8 Eiken S. September 2014. *Medicaid 1915(c) Waiver Data Based on the CMS 372 Report, 2010–2011*. Washington, DC: Centers for Medicare & Medicaid Services. Available at <http://www.medicare.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/cms-372-report-2011.pdf>

9 Additionally, most of the waivers also allow children with access to third-party insurance to remain eligible for the waiver since the HCBS services are unlikely to be covered by third-party insurance.

homes licensed directly by Local Departments of Social Services (LDSS) staff already transitioned to managed care in December 2014, though BH services for this subset of foster care children are still FFS. The remaining 15,500 children in foster care, including all foster children in New York City, are placed with Voluntary Foster Care Agencies (VFCAs) by LDSS or the Administration of Children's Services in New York City.¹⁰ VFCAs are currently required to provide or arrange for physical and BH services and are reimbursed using a foster care Medicaid per diem (per child, per day). These payments are expected to cover a defined set of Medicaid services, including outpatient physical and mental health services for children placed with VFCAs. These children are outside of the managed care system. It is anticipated that the Medicaid Per Diem payments will change with the enrollment in and coverage of both physical and BH services through managed care in 2017. The movement to managed care represents a significant shift in how these children access and receive services. Taken together with the unique circumstances of foster care, this shift will make their experience more complex and will therefore require special attention.

Children Under Age 6: There is growing evidence of the significance and prevalence of mental health issues in very young children. Early childhood mental health refers to a young child's ability to "experience, regulate and express their emotion; form close and secure interpersonal relationships; explore their environment and learn."¹¹ The kinds of services and supports needed to target this population stand apart from other subpopulations. Screenings, for example, need to target the potential for socio-emotional problems in the child as well as the mental health of the parents. The availability of in-home services is also vital for the effective treatment of this population of children given their very young age.

Transition-Age Youth: Individuals who are between the ages of 18 and 21 are known as "transition-age youth" in reference to the challenges of an adolescent growing from childhood to adulthood. Such children have age-specific needs that set them apart from both adolescents and adults, though they often receive social services in the youth and adult systems simultaneously. This period is characterized by major shifts in psychosocial development and family structure: the child is attempting to form an identity outside of the family unit and may be grappling with greater independence and less parental involvement. Parent-child services take on a different context for this population, as services often need to be delivered to the youth and the parent separately. In general, this subpopulation of children is underserved, partially because they may not enroll in waiver programs, which do not allow enrollment after a child's 18th birthday.¹²

10 Number of foster care children and placement provided by the Department of Health, September 2015.

11 NYC Early Childhood Mental Health Strategic Workforce, June 2011. "Promoting the Mental Health of New York's Infants, Toddlers and Preschoolers; A Call to Action." <http://www.nyccd.org/pdfs/Promoting-the-Mental-Health-and-Healthy-Development-final-12204.pdf>

12 Children enrolled prior to their 18th birthday may stay in a waiver program until they are 21 as long as they continue to meet the eligibility criteria.

New York's Approach to Reform

With the stated goal of improving the quality of care for children with BH needs, the State is promoting early identification and intervention; implementing accountability for outcomes and quality services; integrating approaches to planning and service provision; increasing access to an enhanced service array in order to provide the full continuum of care; and ensuring the role of families in that care.¹³ As part of its larger goal of care management for all, and to most effectively provide the comprehensive service array just noted, the State is moving all specialty MH and SUD services into the managed care benefit (in addition to moving responsibility for foster children's physical care fully into managed care, as described above).¹⁴ Both of these mutually reinforcing strategies—getting more services to more kids, and paying for them differently—are described below.

In developing its approach to reform, the State has engaged multiple stakeholders, including the Medicaid Redesign Team's Children's Health and Behavioral Health Subcommittee. The Subcommittee helped identify several significant system gaps, including waiting too long to treat children, giving them treatment because it is available rather than appropriate, and using a "siloed" approach to care that does not, by its very nature, take into account the entire child and his or her context within a family unit.¹⁵

To address these issues, the State has proposed a comprehensive service array that will be available to all children. This enhanced service array is intended to provide more services to a broader range of children, allowing them to access services earlier in the progression of their behavioral health issues, and maintaining them in the least restrictive setting, preferably at home and in their communities. Implementing this reform will require a substantial financial investment from the State, both for the costs associated with delivering additional services to a broadened population and for the costs associated with moving to a new payment system.

Moving all specialty MH and SUD services into the managed care benefit will make one entity—the managed care plan—responsible for the full spectrum of services for children. The Section 1115 Waiver Amendment to establish the managed care delivery system for children is expected to be submitted to CMS shortly. This amendment will have a scheduled effective date beginning January 1, 2017 for New York City and July 1, 2017 for the rest of the state.

¹³ Ray-LaBatt M and AJ Salerno. December 2014. *Reimagining Children's Mental Health Services Part II: Gearing Up For Change*. New York: Community Technical Assistance Center. Available at <http://www.ctacny.com/part-ii-childrens-managed-care.html>

¹⁴ Community residences are not moving to managed care at this time.

¹⁵ New York State Department of Health. October 2011. *Medicaid Redesign Team (MRT) Behavioral Health Reform Work Group: Final Recommendations*. Available at https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_behavioral_health_reform_recommend.pdf

The State will put plans at financial risk for some services, while for other services plans will simply pass through payments from the State directly to providers for a transitional non-risk period. Behavioral health services currently paid on a FFS basis and new Medicaid State Plan services will get carved into the Medicaid managed care benefit, put into plan capitation rates with plans at risk for them beginning in 2017. The new HCBS benefits will be outside of plan capitation rates and non-risk for two years beginning in 2017, with state mandated pass-through rates to providers during this transition period.

In the context of this movement to managed care, the State is pursuing three main actions to achieve a comprehensive BH service array. The first is the expansion of available Medicaid services. The State is adding six new services to the Medicaid benefit package, making them more widely available, with the intent of providing intervention earlier when needed. Second is streamlining eligibility for home- and community-based services and supports by bringing all remaining waiver services under a single array that will be available to any child that meets need criteria for such services. Third is the implementation of health homes for children to coordinate care for many of the highest-need kids.

Ideally, these actions will create a single point of accountability (the managed care plan) providing a flexible service array that can meet a child's changing needs. Below is a description of steps the State plans to take to meet its objectives.

Expansion of Available Medicaid Services

In order to create a comprehensive service array for all children, the State determined that some unique and specialized services currently accessible only through waiver programs or not at all should be broadly available to all Medicaid-enrolled children because they have the potential to reach children sooner. Using its authority to provide a comprehensive benefit as required by EPSDT, New York is seeking approval from CMS to offer coverage for new services and move select waiver services into the State Plan. Specifically, six service categories are being added to the State Plan: crisis intervention, family peer support services, youth peer advocacy and training, community psychiatric supports and treatment (CPST), psychosocial rehabilitation, and services by other licensed practitioners (see descriptions below). These six categories, which encompass several current waiver services, will be made part of the Medicaid benefit package as soon as the State receives CMS approval and will therefore be available to all Medicaid-enrolled children ahead of the 2017 carve-in.

This redesigned structure makes *more* services available to *more* children. Children with substance use disorders receiving services only in the OASAS system currently have no access

to waiver services, given that none of the five waivers target them. For foster care children and children with SED, who previously had access to only the services in their respective waivers, this redesign gives them more options. As previously mentioned, waivers currently include children only up to age 18. Through the reform, services will now be available to all children up to age 21. Furthermore, for those children covered by Medicaid (but not in waiver programs), these services will be entirely new benefits.

Adding these services to the Medicaid benefit package creates pathways for the expanded use of evidenced-based practices (EBPs) for the treatment of mental health and substance use conditions that are unavailable to most children today.¹⁶ Evidence of effective strategies currently exists for many BH conditions impacting children including attention deficit hyperactivity disorder (ADHD), anxiety, and depression. However, the dissemination and implementation of these practices into children's service systems is still elusive.

Coverage and reimbursement policies have also historically stunted the adoption of EBPs. For example, some EBPs in behavioral health involve the use of both licensed and unlicensed providers (e.g., social workers and peer specialists, respectively). Under current Medicaid

Six New State Plan Services

- **Crisis intervention:** 24/7 mobile crisis with one-hour response time, team-based and in the community, includes an assessment, immediate crisis resolution/de-escalation, development of a safety plan and referral or follow-up to additional supports
- **Family peer support services:** provided by a certified and trained peer to the family
- **Youth peer advocacy and training:** training and support to engage youth in the treatment planning process and with ongoing skill development
- **Community psychiatric supports and treatment:** goal-directed and solution-focused interventions intended to achieve identified objectives in child's plan of care; includes delivery of authorized EBP delivered in the community by an unlicensed practitioner
- **Psychosocial rehabilitation:** implementing interventions outlined in treatment plan to eliminate functional deficits and other barriers associated with BH need; intent is to restore integration of individual into family or community; can be delivered by unlicensed practitioner
- **Other licensed practitioner:** the services of a licensed practitioner who participated in the delivery of one of the aforementioned evidence-based practices and any service within his or her scope of licensure

Source: Presentation given at the Children's MRT Health and Behavioral Health Subcommittee Quarterly Meeting, April 27, 2015, available at https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health_reform.htm

¹⁶ Evidence-based practices are services and interventions that have been shown to be effective through more than one randomized study.

service definitions, unlicensed providers cannot always seek reimbursement for the service provided, making it very difficult for providers to follow those EBPs. Under the redesign, several service categories will be explicitly defined to permit payment to unlicensed providers as long as the treatments and interventions are intended to achieve identified goals or objectives included in the child’s plan of care. This type of coverage is intended to promote EBP adoption, though significant barriers remain. For instance, EBPs that work in one setting may not be easily adopted in others.

Streamlining Eligibility for Specialized Services and Supports

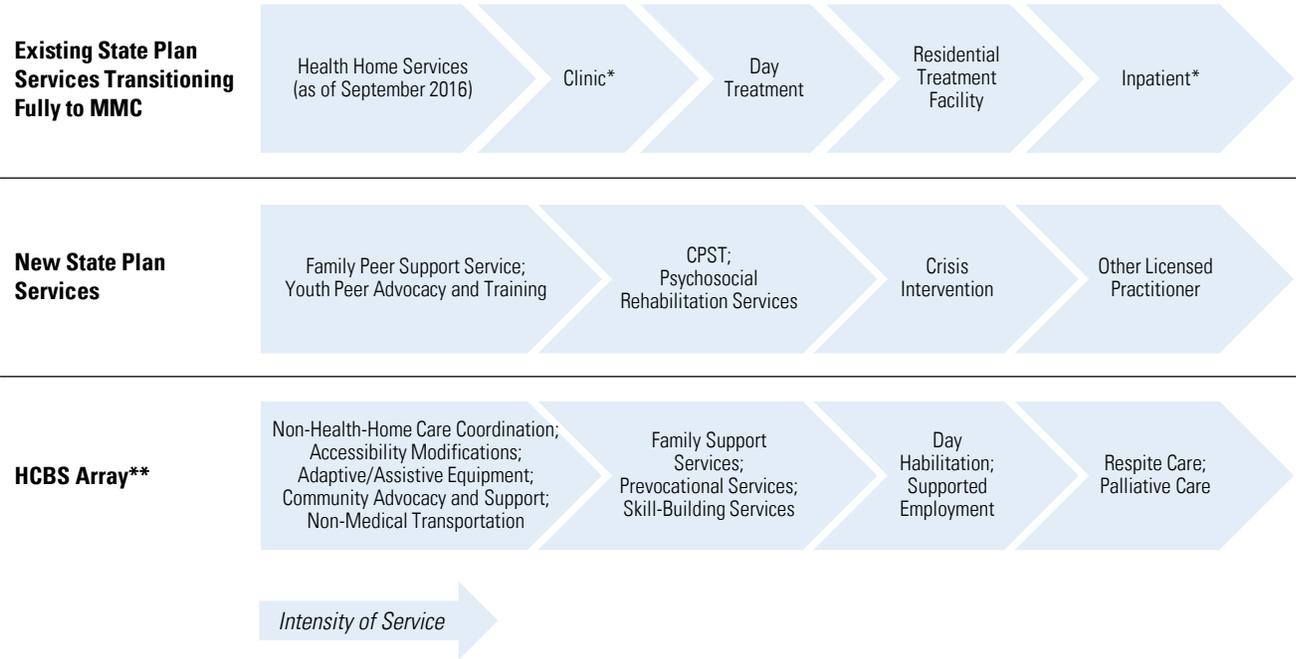
Beginning in 2017, the remaining waiver services will also become more broadly accessible, as they will make up the new HCBS array that will be available to children based on an assessment of need. This change will provide enhanced access to a full range of services to all children up to age 21 with substantial BH needs; these services are currently available only to children who enrolled in a waiver program by age 18. The details of the eligibility process are still being fleshed out, although the State has laid out a basic approach. First, a child will be evaluated for HCBS eligibility with a clinical assessment to determine whether there is a general need for services. Second, a child will undergo a comprehensive functional assessment to determine the intensity of services needed. Third, a plan of care will be developed based on those assessed needs.

At the center of eligibility for this new HCBS array is the Child Adolescent Needs and Strengths (CANS)-NY tool, which will be used for the functional assessment. Although a version of this tool has been used in some waiver programs, it has undergone a significant revision to better target and assess the diverse populations affected by the carve-in. The updated CANS tool governs HCBS eligibility by determining whether a child meets “level of care” or “level of need” criteria, which in turn determines the intensity of services a child can access. *Level of care* (LOC) children are those assessed at imminent risk of institutionalization. *Level of need* (LON) children are those with measurable impairment but not imminent risk of institutionalization. Currently, to be eligible for one of the waiver programs, a child has to be assessed with needs corresponding to LOC. If a child’s needs are assessed as being below that level, he or she drops down to State Plan services only. The addition of the new lower eligibility threshold at LON will allow for a stepped access to certain specialized services.¹⁷

¹⁷ Additionally, because current waiver programs allow the inclusion of children who traditionally would not qualify for Medicaid, New York State is proposing to allow children meeting the LOC or LON criteria to be considered for Medicaid eligibility without regard to their parental income. In many cases, these children may have third-party health insurance that does not cover the specialty HCBS array that will be available.

The eligibility pathway to these specialized services is meant to be different than the current waiver eligibility process. The goal is for all HCBS to be accessible via a single process, during which a child is adequately evaluated and recommended to services based on their current needs and not on any other characteristics. Certainly the specifics of how this process will work matter greatly, particularly for those children who are not going to be eligible for health homes, as described below.

Figure 1.
Proposed Medicaid Managed Care Services for Children with Behavioral Health Needs



* Some OMH and OASAS clinic and inpatient services are already in the managed care benefit, depending on the service recipient and the licensure of the facility. Note: Foster care per diem payments will also transition fully to Medicaid managed care.

** These services will be available to children meeting “level of care” or “level of need” criteria.

Implementing Health Homes for Children

The New York State Health Home Program was launched in 2012. Since then, health homes have been the main care management model for Medicaid's high-need adults. The State has signaled its continued commitment to this model by tailoring New York State's health home model to serve children and to recognize important differences in the approach to care management and planning for children and adults.¹⁸ Scheduled to begin in September 2016, child-specific health homes will provide care management services to many of the children who use behavioral health services. Children meeting specific eligibility and appropriateness criteria will qualify for health homes.¹⁹ Pending CMS approval, children in foster care and others who may have high BH needs are expected to be eligible under a new qualifying condition known as complex trauma.²⁰ The State's inclusion of this category acknowledges the complexity of children's experience and how that complexity affects their health. There are 16 health homes designated to provide services to children, and the State estimates that about 174,000 children will be eligible to enroll in them, including more than 100,000 with mental health and substance abuse issues.²¹

Currently, some of the waiver programs include case management services providing a high intensity level of care coordination. These services will continue to exist until 2017. At that point, all care coordination functions will shift to health homes. Health homes will conduct the CANS-NY assessments for their enrollees (those meeting the health home eligibility and either the LOC or LON criteria described earlier), develop person-centered care plans, and become the bridge to the new HCBS and Medicaid State Plan benefit service array for these children. The health home will have the critical role of connecting children to appropriate services and interventions.

Recently, the State, citing the fact that Medicaid-enrolled children with BH issues have higher rates of ER and inpatient use than children overall, began encouraging children's health homes to partner with newly created performing provider systems under Medicaid's Delivery System Reform Incentive Payment (DSRIP) program.²² A key goal of this initiative is to

18 New York Department of Health et al., *Health Home Application to Serve Children, November 2014*. Available at http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_serving_children_app_part_1.pdf

19 Individuals qualify for health homes if they have one of the following conditions: two chronic conditions, HIV/AIDS, or a serious mental illness. For children, the State has interpreted serious mental illness is to include serious emotional disturbance. Additionally, any individual with a qualifying condition must be deemed appropriate for health homes. To see the criteria the State has set for health home appropriateness, go to https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_serving_children_app_part_1.pdf

20 Complex trauma, a federally defined concept, is exposure to multiple prolonged traumatic events and includes the long-term impacts of this exposure.

21 New York State Department of Health. April 29, 2015. Tailoring Health Home Model to Serve Children: Design and Implementation Updates. Available at https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/4_29_2015_children_webinar.pdf

22 Greg Allen. Presentation at New York Health Homes Learning Collaborative Meeting #9, August 11, 2015.

reduce avoidable hospital use by 25 percent over five years by transforming the delivery system to better coordinate care and meet the needs of beneficiaries in the community. There are questions, however, about whether it is appropriate to apply this particular goal to children, as children already have very low hospitalization rates; stakeholders instead point to the need for investments in early intervention to effect change for children with BH issues.

For those children not enrolled in health homes, the State has indicated that there will be processes for the HCBS needs assessment and care management and coordination. Stakeholders have expressed concern at the lack of a concrete plan for these children, as their BH issues may not have fully manifested yet. It is these low- and moderate-need children who need to be brought into services swiftly *before* their needs and service use escalate.

Policy Considerations

The current system of care for children with behavioral health needs is complex. Care itself is often fragmented. The children's BH redesign seeks to improve the system and promote key dimensions of quality including effectiveness, client-centeredness, timeliness, appropriateness, coordination, accessibility, efficiency, and equity. The main avenues for achieving these goals, as described above, are creating a single point of accountability through managed care, broadening access to more services, including evidence-based and child- and family-focused services; removing eligibility barriers to create a more streamlined process for accessing needed services; and including more care coordination mechanisms. Collectively, these actions have the potential to become the foundation for a better system for children with BH needs.

To deliver on these reforms, the State and its stakeholders will need to address implementation challenges directly related to financing and reimbursement, provider readiness, and administrative and regulatory realities. As noted earlier, implementing this reform will require a substantial investment from the State, both for the costs associated with the new services and for the costs associated with implementing a new payment system. Delivering the expanded continuum of services also requires a strong agency, managed care, and provider infrastructure. The policy considerations that follow reflect on some of the implementation challenges related to workforce needs, information technology infrastructure, the complexity of transitioning to efficient and effective managed care, and the need for a performance measurement system to assess progress. Effectively tackling these issues will help to ensure that these policy changes fulfill their promise of getting kids the services they need when they need them.

Workforce Capacity

The behavioral workforce in New York—as in the rest of the country—is stretched thin for several reasons. First, there are not enough practitioners in the current workforce to meet the expected demand once the transition to managed care occurs. Turnover rates are high. Meanwhile, increasing continuing education requirements for some BH workers, which may help to address core competencies, come with a cost. Some stakeholders fear the time and financial constraints of additional education may drive some professionals out of the workforce entirely.

Second, the mix of professionals in the workforce may not include enough highly specialized service providers. The bulk of the current workforce is made up of social workers, psychologists, and other counselors who can conduct psychological and behavioral therapies. However, children with the most complex BH needs require child psychiatrists with a higher level of specialization. Currently in New York, children have long waits to see a child psychiatrist.²³ This limited access has created a system in which pediatricians and family physicians are often relied upon to identify and treat mental health issues. This is particularly an issue given the current trend to use medication to treat children’s mental health issues, a practice pattern, which is, in and of itself, controversial. The evidence base for the effectiveness of medications in children is limited, and the complex issues surrounding the appropriateness of certain medications, antipsychotics in particular, are beyond the scope of this issue brief.²⁴ However, the fact remains that there is a shortage of specially trained BH practitioners who can prescribe medication.

Third, there is a dearth of practitioners schooled in the latest therapeutic models. While there is broad agreement about the need for the provider community to develop core competencies in the children’s BH workforce, there is no momentum, dedicated resource, or formal effort to make this a reality. The State’s plan to cover EBPs in the Medicaid benefit and the use of unlicensed providers in the provision of some services are important steps in expanding the BH workforce, but other education and professional development needs must be addressed simultaneously.

23 Schuyler Center for Analysis and Advocacy. March 2008. *A Crisis of Care: Addressing the Shortage of Child and Adolescent Psychiatrists in New York State*. Available at http://www.scaany.org/documents/child_psychiatrist_report_08.pdf

24 For more information on this topic, please refer to the following resources: Correll CU, CJ Kratochvil, and JS March. 2011. Developments in Pediatric Psychopharmacology: Focus on Stimulants, Antidepressants, and Antipsychotics. *Journal of Clinical Psychiatry* 72(5): 655–670. Available at <http://www.psychiatrist.com/JCP/article/Pages/2011/v72n05/v72n0513.aspx>; Seida JC, JR Schouten, K Boylan, AS Newton, SS Mousavi, A Beath, B Vandermeer, DM Dryden, and N Carrey. March 2012. Antipsychotics for Children and Young Adults: A Comparative Effectiveness Review. *Pediatrics* 129(3): 771–784. Available at <http://pediatrics.aappublications.org/content/129/3/e771.full>; and Olfson M, C Blanco, S Wang, G Laje, and CU Correll. January 2014. National Trends in the Mental Health Care of Children, Adolescents, and Adults by Office-Based Physicians. *JAMA Psychiatry* 71(1): 81–90. Available at <http://archpsyc.jamanetwork.com/article.aspx?articleid=1784344&resultclick=1>

Information Technology Infrastructure

Stakeholders consistently point to the importance of health information technology (HIT) in a redesigned BH system for children. The ability to share data across players—among the various providers serving these children, the managed care plan, the health home and the State—is central to effective care for this complex population.

BH providers traditionally lag behind physical health providers in their adoption of HIT. For this provider community, mostly made up of smaller, community-based providers and clinics that may be financially underresourced, limited access to capital is a major roadblock to HIT adoption. The list of provider needs is long, and includes software for electronic health records, licensing fees, IT support and maintenance, and even the actual hardware itself. Those providers that have found resources to purchase systems report mixed results, largely because the process involved a lot of guesswork about needs. Furthermore, there has been no coordination among providers when purchasing systems, which may hinder information sharing across systems in the future.

The State has been encouraging smaller providers to pool their resources and buy joint systems, which could lead to collaboration beyond HIT. The State could facilitate these partnerships by playing a role in developing some HIT standards, especially since providers are not well versed on what they actually need in terms of functionality and interoperability. Convening providers and helping them come to some consensus on what is needed and what to purchase to meet those needs could be enormously helpful. There are also regulatory challenges, specifically those related to consent and what can be shared about an individual with other providers. These issues are complex and the provider community could benefit from guidance on how to navigate them.

For health homes, a performance management system is being developed for 2016. Known as the Medicaid Analytics Performance Portal (MAPP), it will support care management for the health home population. It will allow for more effective and streamlined billing, easier referrals between health homes, and better consent management. It will also serve to connect the health home care coordinator with the managed care plan. However, in its current conception, it is not a resource that will allow for care planning and the sharing of clinical data among non-health home providers. Furthermore, since not every child will be in a health home, it does not solve the HIT issue more broadly. Although the MAPP could someday be developed as a single point of data collection and sharing, it is not currently designed to do so.

For providers, the ability to share information about their patients is paramount. One system that could facilitate communication and information-sharing among BH clinicians is the

Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES). Developed by OMH, this application is currently used by over 400 provider agencies, county local mental health authorities, and managed care organizations statewide to support clinical decision-making and quality management. It provides clinical summaries of all Medicaid-reimbursable services for which a claim or encounter is submitted across treatment settings for individuals in the Medicaid behavioral health population.²⁵ It summarizes performance on quality indicators at state, regional, agency, and site levels. Whether this system could be adopted or leveraged to further support real-time clinical decision-making and information-sharing purposes by the BH delivery system and managed care plans is an open question.

Effective Managed Care

The successful provision of BH services for children in a managed care environment depends equally on plans and providers, and both face significant learning curves. Managed care plans have the operational expertise needed for this transition, but they lack experience with the services used by children with serious BH conditions and the multi-systems approach needed for most children. On the flip side, while the BH providers are experts on working with these children, they generally do not have significant experience providing services under a managed care contract.

Providers and advocates expressed concern that traditional managed care designs may not be able to fully support the flexible and individualized care these children require. Managed care features such as strict service authorization mechanisms and narrow medical necessity criteria could present challenges to effectively serving this population. For managed care to promote improved care it must do more than just add new administrative structures for providers. Financing a broad array of services using a new network of providers, and managing new types of services, will be challenging.

Providers acknowledge steep learning curves on managed care contracting and its effect on the very nature of *how* they work with their clients. For example, providers must learn to write new sorts of treatment plans—with concrete goals that are achievable and measurable in a specified treatment period authorized by the plan. They must also adjust workflows and treatment protocols to achieve care plan goals within specified timeframes.

The State is playing an active role in helping providers and plans get up to speed. For the upcoming managed care transition of adult BH services, the State has provided a variety of tools and training to providers through New York University's Managed Care Technical

²⁵ The Medicaid BH population is determined as any Medicaid enrollee with at least one of the following: a mental health or SUD service, a mental health or SUD diagnosis, psychotropic medication. The database includes all Medicaid enrollees (FFS claims, managed care encounter, and dual-eligible).

Assistance Center (MCTAC). These resources are available to all OMH- and OASAS-licensed providers, as well as more broadly to any organization that would like to provide home- and community-based services under the newly designed system. Specifically for child-serving agencies, MCTAC has sent out a readiness assessment to examine how prepared providers are to do business with a managed care plan. The goal for the State is to use the assessment findings to develop training programs and other tools aimed at the greatest provider needs. For the adult BH carve-in, which is much further along the road of implementation, the State used a provider designation process to identify HCBS providers. Plans report that this action was enormously helpful to them as they built their networks. Because many children's providers already provide the services comprising the HCBS array, the State has indicated it will grandfather in current providers but allow them to expand the services they provide incorporating some of the aforementioned EBPs. The State will also have a more involved process for new providers.

Finally, stakeholders and policymakers should come to a shared understanding of who will act as the key care management entity for this population. Such centralized accountability is crucial, particularly for high utilizers of BH services. Unlike with the adult BH redesign, where there is a special needs plan responsible for this specific population, no single specialized entity exists for children with the most complex BH issues. This leaves the mainstream managed care plans to manage very different populations of children at the same time. Although plans have experience managing multiple populations simultaneously, children with severe BH issues are significantly different from their mainstream counterparts. Plans may therefore need in-house specialized resources and staff to successfully manage this population. Furthermore, since the State has chosen to locate its care coordination function for these children outside the plan (i.e., in the health home), there is concern regarding potential for duplication.

Quality

There is already a strong performance measurement system in place for mainstream managed care plans that measures performance with respect to service delivery, health outcomes, and member experiences. As plans take on new populations and benefits, the State will build on existing measure sets and assessment tools already in use for managed care plans. The primary mechanism through which plan quality is assessed is the Quality Assurance Reporting Requirements, or QARR, which are drawn from many sources. Currently, there are 18 measures specifically related to children in QARR. Only four are in the domain of behavioral health, all of which are related to the use of medication.²⁶

²⁶ These measures are follow-up care for children prescribed ADHD medication, metabolic monitoring for children and adolescents on antipsychotics, use of multiple concurrent antipsychotics, and use of first-line psychosocial care for children and adolescents on antipsychotics. New York State Department of Health. October 2014. *2015 Quality Assurance Reporting Requirements: Technical Specifications Manual*. Available at https://www.health.ny.gov/health_care/managed_care/qarrfull/qarr_2015/docs/qarr_specifications_manual.pdf

Additionally, two general mental health measures—“follow-up after a hospitalization for mental illness” and “mental health utilization”—capture data related to children.²⁷ The DSRIP program includes those same children’s QARR measures and two additional measures regarding initiation and engagement in alcohol or drug dependence treatment that apply only to children age 13 and older.²⁸ Clearly, real measurement gaps exist for children.

The State’s quality measurement plan is still in development. The goal is for plans to be able to provide ongoing measurement and reporting of specific activities and outcomes—both process and outcomes measures—in categories that include beneficiary health status, functional status, patterns of utilization, and enrollee satisfaction. The development of more metrics within QARR is an option, but not in the short term. In the interim, the State—with input from its stakeholders—will add non-QARR measures with unique importance to these specific beneficiaries. In addition to drawing on QARR, the State will look to other sources of data, including an existing satisfaction survey for children in Medicaid known as Children’s CAHPS, CANS analytics, encounter claims, and data from compliance and network monitoring.

Conclusion

With its policy vision set, the State is well positioned to begin the implementation activities necessary to achieve its goals. No single redesign could immediately address all the shortcomings of the current system. Fittingly, the State has chosen to start with broadening the service array available to children with the goal of providing greater access to effective care that includes both children and their families.

More broadly, the State is working on reforming the payment system for Medicaid managed care, and it cannot achieve its goal of 80 to 90 percent of managed care payments being value based without considering this high-need population of children with behavioral health needs.²⁹ Some value-based payment (VBP) strategies may be difficult for plans and providers to implement in the near term as they focus on the logistics of providing the full array of BH services for children in a managed care environment. As capacity and expertise increases, the State, plans, and providers will need to work together to define the VBP strategies, mechanics,

27 There are two SUD-related measures—“initiation and engagement of alcohol and other drug dependence treatment” and “identification of alcohol and other drug service”—which could also capture data related to children.

28 New York State Department of Health. April 2015. *Delivery System Reform Incentive Payment (DSRIP): Measure Specification and Reporting Manual*. Available at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/dsrip_specif_report_manual.pdf

29 New York State Department of Health. June 2015. *A Path toward Value-Based Payment: New York State Roadmap for Medicaid Payment Reform*. Available at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf

and measures that will work best for ensuring effective and efficient care for this unique population.

Ultimately, to get to a better system, service and payment reform is necessary. There are many core building blocks needed to make the State's vision a reality. This report focuses on four implementation challenges related to infrastructure that must be solved as part of a successful redesign and that speak to the larger aim of creating a quality system of care for children with behavioral health issues. The upcoming children's BH redesign offers pathways to achieving significant policy goals including the strengthening and modernization of the BH workforce, the development of new HIT capacities, forging effective managed care arrangements between providers and plans, and the creation of a more robust quality measurement system. While navigating this transition will be challenging for children and families, providers, managed care plans, and the State itself, it presents an important opportunity to begin to build a high-performing system of care for children with behavioral health needs.

Appendix 1. Snapshot of Behavioral Health Service Use by Medicaid-Enrolled Children

While the transition of behavioral health services to managed care will affect all children in Medicaid, its biggest impact will be on the high-need populations that have been navigating the currently fragmented specialty BH systems. For this reason, our data analysis focused on use of emergency services and inpatient hospital care to assess differences within and across cohorts of children with high, moderate, or low utilization (see detailed methodology in the footnote).³⁰

In total, 216,072 Medicaid children and adolescents (under age 18) had a BH service or diagnosis in 2013. Only 3,181 (1.4 percent) fell into the high utilization category, while there were 6,665 (3.1 percent) moderate utilizers and the remaining 206,226 (95.4 percent) were low utilizers of emergency and inpatient hospital services. Twenty percent of high utilizers had an inpatient readmission within 30 days, and those with a readmission were more likely to have had shorter lengths of stay on their initial visit than children without a readmission.

Behavioral health diagnoses for the entire group are presented in Table 1.³¹ Some diagnoses are more prevalent among children and adolescents with high utilization compared to those with low utilization of emergency and inpatient services, including bipolar disorder (10.5 vs 0.7 percent), schizophrenia (4.7 vs 0.5 percent), and depression (34 vs. 4.3 percent). In addition to the diagnosis prevalence, 6,127 (2.9 percent) of the population also had a comorbid substance use diagnosis or service, and 17 percent of this subgroup were high or moderate utilizers of inpatient and emergency room services.

Not surprisingly, mental health clinics are a primary source of outpatient services for the majority of high (65 percent) and moderate (55 percent) utilizers. Private practitioners are important providers of MH services for children with all levels of utilization: one-third of both

³⁰ Analysis was conducted by the Research Foundation for Mental Hygiene, Inc. using New York State Office of Mental Health Medicaid data for calendar year 2013 and the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) data tables. Children under the age of 18 were analyzed, as those 18 and older generally do not have access to the behavioral health waiver services currently available for children in New York. The results are also restricted to those continuously enrolled in Medicaid for the entirety of 2013. The total cohort is any Medicaid child or adolescent under the age of 18 with a behavioral health service or diagnosis in the calendar year 2013. This includes individuals with disabilities that meet the definition of continuous enrollment with a BH service or diagnosis (40,393 of the total cohort are eligible for Medicaid in a disability aid category). Children and adolescents were categorized as high, moderate, and low utilizers of behavioral health emergency room and inpatient services based on an analysis of their service utilization in 2013. High utilizers were defined as children and adolescents with two or more inpatient visits and/or 3 or more emergency room visits. Moderate utilizers were defined as those with one inpatient visit and/or two emergency room visits. Low utilizers had zero inpatient visits and no more than one emergency room visit.

³¹ A single diagnosis was assigned to each child in the cohort using a preponderance method. Specifically, children were assigned the most frequent mental health primary diagnosis based on a review of all claims and encounter data during 2013.

high and moderate utilizers received outpatient services from individual practitioners, while a majority of low utilizers (60 percent) received services from individual practices, utilizing that setting more than any other outpatient service setting.

Over 12 percent of children and adolescents in the behavioral health population are on an antipsychotic (AP) medication. Use of APs increases as hospital usage increases: 75 percent of high utilizers, nearly 50 percent of moderate utilizers, and 10 percent of low utilizers use APs.

Table 1.
Mental Health Diagnoses of Children and Adolescents
Receiving Behavioral Health Services in 2013

Diagnoses	Number of Children	Percentage
Attention Deficit Hyperactivity Disorder	52,031	24.1%
No MH Disorder*	43,604	20.2%
Adjustment Disorder	25,303	11.7%
Learning Disorder	23,396	10.8%
Anxiety Disorder	14,339	6.6%
Other Disorder	13,689	6.3%
Depression	11,826	5.5%
Other Childhood Disorder	10,183	4.7%
Conduct	9,316	4.3%
Autism and Pervasive Developmental Disorder	6,996	3.2%
Bipolar Disorder	2,263	1.0%
Personality Disorders	1,676	0.8%
Schizophrenia	1,450	0.7%

*Note: Because the total cohort is identified by both diagnosis and BH service use, the prevalence of “no MH disorder” was not surprising, given the number of low utilizers and suggestions from stakeholders that actual BH diagnosis is underreported, even for BH service users.

Appendix 2. Glossary of Behavioral Health Services for Children and Families

Accessibility Modifications: One-time internal and external modifications to the home environment that enable individuals to live safely in homes outside the institutional setting.

Adaptive and Assistive Equipment: Devices, aids, controls, appliances, or supplies determined necessary to enable the individual to increase his or her ability to function independently and safely in a home- and community-based setting.

Care Coordination Services: Individualized services providing intake and screening, needs assessments, service plan development, linking to services, and ongoing advocacy, monitoring, and consultation.

Case Management Services: A case manager working intensively with the family, teachers, and care providers of the child to monitor and coordinate assessments, service planning, crisis intervention, and family support services for children residing in the community and their families.

Community Psychiatric Supports and Treatment (CPST): Goal-directed and solution-focused interventions intended to achieve identified objectives in the child's plan of care. CPST includes delivery of authorized evidence-based practices delivered in the community by an unlicensed practitioner.

Crisis Avoidance, Management and Training: Services, including education and training, that address specific issues that disrupt or jeopardize the child's successful functioning in the community. Focus is on the capacity to proactively identify and plan for events that may trigger a crisis or a deterioration in the child's condition.

Crisis Intervention: A mobile crisis team with a one-hour response time, available 24 hours per day and seven days per week in the community. The crisis team conducts an assessment, performs immediate crisis resolution and de-escalation, and develops a safety plan that includes referral to additional supports and follow-up.

Crisis Respite: Respite care provided on an unplanned, emergency basis.

Crisis Response: Activities aimed at stabilizing occurrences of child or family crisis where it arises. Services reinforce the safety plan that the child and family developed, including assessment, consultation, linkage, and immediate intervention wherever necessary.

Day Habilitation: Activities provided in a non-residential setting which provide assistance with the acquisition, retention, or improvement of self-help, socialization, and adaptive skills.

Day Treatment: Intensive, non-residential program designed to stabilize the adjustment to educational settings for children who live in the community but are unable to be maintained in regular classrooms. Services typically include special education in small classes along with family services, individual and group counseling, interpersonal skill development, and behavior modification.

Family Peer Support Services: Supports that address the challenges of caring for and raising a child who is experiencing social, emotional, developmental, substance use, and behavioral challenges. Services are provided by a certified and trained peer with lived experience.

Family/Caregiver Support Services: Activities designed to enhance the ability of the child to function as part of a family unit and to increase the ability of the family or caregiver to care for the child in the home and community.

Foster Care Per Diem: A daily rate received by foster care agencies that is used to pay for outpatient physical and mental health services for the children placed with that foster care agency. As it offers flexibility in use, the payment is used in a variety of ways by different agencies.

Health Home Services: Care management services provided through a dedicated care manager and a network of providers and community-based organizations.

Immediate Crisis Response Services: Crisis response services provided on an immediate basis at any location, available 24 hours per day and seven days per week. The services are of very short duration.

Inpatient: Hospital-based stays offering a full range of treatment and support services, education, and skill acquisition in an intensively supervised, structured setting. Services are generally provided through Article 28 hospitals, freestanding Article 31 psychiatric hospitals, and State Children's Psychiatric Centers.

Intensive Case Management: Case management services provided on an intensive basis for children with more complex service needs. Intensive Case Management has stricter case load and face-to-face interaction requirements than other forms of case management.

Intensive In-Home Supports: Activities aimed at providing intensive interventions in the home when a crisis response service is not enough. Specifically, they secure the health and safety of the child and caregiver following a crisis.

Methadone Maintenance: Treatment program providing long-acting medication which can prevent opioid withdrawal symptoms and allow the patient to function in required activities. Services occur in diagnostic and treatment clinics or hospitals, and may be coupled with case management, family supports, counseling, or training.

Non-Medical Transportation: Transportation services, as specified by the service plan, which are necessary to enable individuals to access home- and community-based services. Services can be delivered by and reimbursed to providers, family members, and other qualified, licensed drivers.

Opioid Replacement Treatment: Outpatient program providing medication-assisted treatment that stabilizes patients with narcotic dependence. Medication is combined with supportive services.

Other Licensed Practitioner Services: Coverage of services provided by a licensed practitioner who participated in the delivery of another evidence-based home- and community-based practice. Practitioners may include registered nurses, licensed nurse practitioners, psychologists, licensed social workers, and licensed mental health counselors.

Outpatient Chemical Dependence Rehab: Treatment of chemical dependence occurring in hospital settings on an outpatient basis, with length of stay and intensity varying based on the severity of the patient's condition. Services may include medication administration and management, complex care coordination, and peer support services.

Outpatient Clinic (MH): Traditional outpatient mental health services such as assessment, therapies, and medication management. Includes treatment from schools, community offices, and other locations.

Outpatient Clinic (SUD): Treatment of chemical dependence occurring in clinic settings on an outpatient basis. Services may include assessments, group and individual therapy, and referral to specific services.

Planned Respite: Respite care provided on a planned basis rather than in response to crisis.

Pre-Vocational Services: Services, including vocational assessment, skills training, behavior management, and the development of appropriate work habits, designed to assist an individual in acquiring and maintaining work-related skills necessary to acquire and retain paid work in an integrated setting.

Psychosocial Rehabilitation: The implementation of interventions outlined in the treatment plan to eliminate functional deficits and other barriers associated with a behavioral health need. The intent is to restore integration of the individual into their family and community. Services can be delivered by an unlicensed practitioner.

Rehabilitation [MH]: A time-limited program which focuses on building skills and developing community supports. The program assists individuals in attaining a specific residential, educational, employment, or social goal.

Residential Rehabilitation Services for Youth: Specially designed program for chemically dependent individuals under age 21, providing active treatment, including structured therapeutic activities, clinical and medical services, education, and recreation.

Rehab Supports for Community Residences [SUD]: Rehabilitative services to acquire skills for personal, social, or vocational development while living in a supervised setting and receiving ongoing clinical support for chemical dependence.

Residential Treatment Facilities: Intensively staffed residential program designed to provide individualized, active treatment to youths with SED, specifically helping to improve daily functioning, develop coping skills, support families, and ensure community linkages. Programs are less restrictive than hospital-based programs, but have a wider range of services and are more intensive than community residences.

Skill Building: Activities designed to assist the child in acquiring, developing, and improving functional skills, social supports, and environmental supports in order to enable the child to be successful in the home, community, and school.

Special Needs Community Advocacy and Support: Supports that provide family, caregivers, and community and school personnel with techniques to enable them to better respond to the needs of the child and minimize interruption in the child's education.

Supported Employment: Services, including assessment, counselling, job placement, job training, and ongoing supervision and support, which assist an individual in engaging in paid work in an integrated setting.

Youth Peer Advocacy and Training: Training and support to engage youth in the treatment planning process and to encourage ongoing skill development. Services are provided by a certified and trained peer with lived experience.

Service descriptions are based on information from the following sources:

New York State Department of Health. August 2014. Medicaid Health Homes. Available at https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

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New York State Office of Persons with Developmental Disabilities. 2011. OPWDD HCBS Waiver Manual, Policy Guidelines. Available at https://www.emedny.org/ProviderManuals/HCBSWaiver/PDFS/HCBS_Policy_Section.pdf

Medicaid Institute at United Hospital Fund

1411 Broadway

12th Floor

New York, NY 10018-3496

(212) 494-0700

www.medicainstitute.org

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