



## **New York Children's Health and Behavioral Health Benefit Administration**

DRAFT Medicaid Managed Care Organization Children's System  
Transition Requirements and Standards for Stakeholder Feedback

FEBRUARY 1, 2017

DRAFT

# CONTENTS

Introduction.....	3
1.0 Background.....	5
1.1 Vision .....	5
1.2 Overview of Current Child Serving Systems .....	8
1.3 Transforming the Children’s Service Delivery System .....	8
2.0 Definitions .....	17
3.0 Performance Standards.....	27
3.1 Organizational Capacity.....	27
3.2 Personnel.....	29
3.3 Member Services .....	34
3.4 Service Delivery Network Requirements/Access to Care.....	35
3.5 Network Contracting Requirements.....	45
3.6 Network Monitoring.....	47
3.7 Network Training .....	48
3.8 Utilization Management.....	49
3.9 Clinical Management .....	53
3.10 Cross System Collaboration.....	55
3.11 Quality Management.....	57
3.12 Reporting and Performance Measurement .....	59
3.13 Claims .....	59
3.14 Information Systems and Website Capabilities.....	60
3.15 Financial Management .....	62
4.0 Readiness Requirements .....	63
Attachment A: Targeting and Functional Criteria for Children Meeting At-risk Needs- based Criteria Level of Care.....	73
Attachment B: Targeting and Functional Criteria for Children Meeting At-risk Needs- based Criteria Level of Need .....	76



**Attachment C: Current State Agency Oversight and Regulatory Functions of the Children’s System of Care.....78**

**Attachment D: Plan Staffing Requirements for Children’s Health and Behavioral Health Benefit Administration.....83**

**Attachment E: Plan Staff Training Requirements .....89**

**Attachment F: Network Development in Rural Counties.....91**

**Attachment G: Office of Health Insurance Programs Principles for Medically Fragile Children .....93**

## Introduction

The New York State (NYS/State) Department of Health (DOH), Office of Mental Health (OMH), Office of Alcohol and Substance Abuse Services (OASAS), and Office of Children and Family Services (OCFS) are accepting applications to qualify NYS Medicaid Managed Care Organizations (MMCOs) to manage the delivery of the expanded Medicaid-covered services for all Medicaid enrolled children. As discussed in detail in the Background section of this document, the transition of an expanded array of services and certain populations to Medicaid Managed Care is a key component of the Medicaid Redesign Team (MRT) Children's Medicaid Redesign Plan to fundamentally restructure and transform the health care delivery system for individuals under 21 that have behavioral health (BH) needs and that are medically complex.

### Legal Authority

Section 364-j of the NYS Social Services Law authorizes the commissioner of DOH, in cooperation with the commissioners of OMH and OASAS to establish managed care programs under the medical assistance program (Medicaid). Section 365-m of the NYS Social Services Law authorizes the commissioners of OMH, OASAS and DOH to jointly designate and oversee contracts to manage the behavioral and physical health (PH) needs of medical assistance enrollees with significant BH needs.

### Reserved Rights

The State reserves the right to amend or modify the requirements and standards contained within this document.

### Anticipated Timelines

As described in more detail in Section 1.3, the Children's MRT Redesign Plan consists of a set of initiatives that will be implemented via proposed State Plan Amendments (SPAs) (e.g., the six new SPA services) and the draft 1115 Waiver Amendment (released on January 9, 2017 for public comment) and is predicated upon the collective and timely approvals of Centers for Medicare and Medicaid Services (CMS).

The submission of the 1115 Waiver Amendment is pending review of the new Federal Administration's priorities and processes. The anticipated implementation dates included in this Standards and Requirements document, which are geographic and begin October 2017 and run through January 2019, reflect those included in the draft 1115 Waiver Amendment. Depending on the timeframes for acquiring the necessary approvals, the implementation dates included in this Standards and Requirements document will be modified accordingly. Revised timeframes will ensure there is sufficient time for the Plans to respond to the Final Standards and Requirements, conduct readiness reviews, and begin implementation with the CMS approvals in place. At the appropriate time, the State anticipates readiness reviews will begin statewide with staggered reviews for network adequacy and hiring plans due for Plans in New York City (NYC), Nassau, Suffolk, and Westchester Counties prior to Rest of State. The State reserves the right to conduct additional readiness review activities related to the inclusion of children under the care of Voluntary Foster Care Agencies (VCFAs) when they transition into managed care.

### Stakeholder Feedback Related to the Managed Care Plan Standards

Any questions, comments, or requests for clarification from MMCOs or stakeholders about the standards or information reflected in this document must be submitted only via email ([BHO@omh.ny.gov](mailto:BHO@omh.ny.gov)) by 5:00 pm EST on April 5, 2017. All feedback must cite the section and sub-section to which it refers. For example, comments pertaining to Key Personnel requirements related to the BH Medical Director should reference “Section 3.2.K.i”. Comments must be submitted as word documents (no pdfs). In June 2017, the State will release the Final Children’s System Transition Requirements and Standards to MMCOs.

**Table 1: Anticipated Timeline for Finalizing Requirements and Standards**

Key Events	Anticipated Date
Release of draft Children’s System Transition Requirements and Standards for stakeholder feedback	February 1, 2017
Deadline for submission of feedback	April 5, 2017
Release of Final Children’s System Transition Requirements and Standards to MMCOs	June 2017

# 1.0 Background

## 1.1 Vision

NYS established the MRT in 2011 to improve health outcomes, control Medicaid costs in a sustainable way, and provide care management (CM) for all Medicaid members that aligns incentives for the provision of high quality, integrated, and coordinated services. A key feature of the Medicaid Redesign initiatives is to transform the healthcare delivery system from a fee-for-service (FFS) chronic care model to a community-based Medicaid managed care model. The Children's Health and BH MRT Subcommittee, comprised of stakeholders including providers, family members, youth, advocacy groups, state and local government representatives, and health plan member associations, offered a set of recommendations designed to improve service access and provide earlier intervention for children, youth and families.

Supported by the MRT subcommittee recommendations<sup>1</sup>, the State envisions an integrated children's healthcare system where there is "no wrong door" for children/youth experiencing complex needs, including children with complex medical needs. Similar to the adult system, the children's public healthcare system includes a wide range of providers and services that are often disjointed and inefficient, with few incentives for care coordination and person centered care. A comprehensive cross-system approach is needed to achieve the MRT's goals, diminish silos of care and improve health outcomes for children well into adulthood. Key principles from the MRT report include:

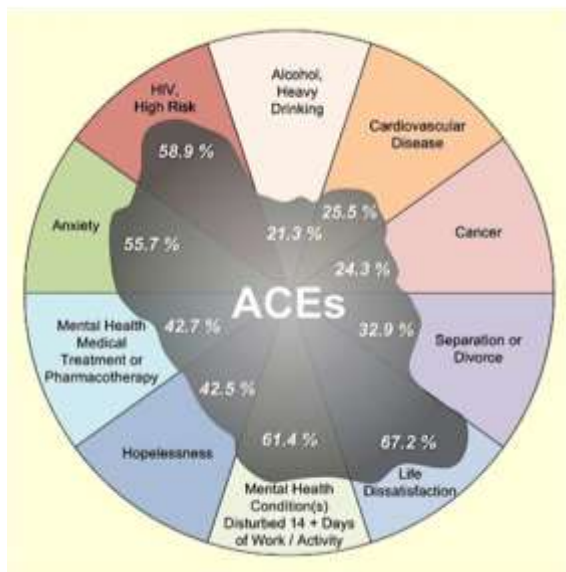
- Early identification and intervention
- Family-driven and youth-guided care planning and care management
- Focus on resilience for children and recovery for young adults building resilience
- Culturally and linguistically competent services and providers
- Limit progression into high intensity and acute services
- Person-centered, individualized and flexible care
- Availability of evidence-based, evidence-informed, and promising practices
- Establish trauma informed care principles across the entire service delivery system
- Maintaining children at home with support and services or in the least restrictive community-based settings
- Integrate the delivery of BH and health benefits
- Developing a delivery system that is free of siloes that create barriers and result in disparate access to needed services

---

<sup>1</sup>[https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/docs/mrt\\_behavioral\\_health\\_reform\\_recomm\\_end.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/docs/mrt_behavioral_health_reform_recomm_end.pdf)

The Adverse Childhood Events (ACE) study<sup>2</sup> showed powerful associations between childhood trauma and the onset of chronic conditions and associated functional deficits, which persist into adulthood. Importantly, the study also showed that often, the impact of childhood adverse events is not evident until well into adulthood (Figure 1<sup>3</sup>). These individuals have a much higher risk of developing chronic medical and BH conditions that are primary drivers of morbidity and mortality as well as high healthcare costs (Figure 2<sup>4</sup>). These findings underscore the critical need for a redesigned system of care that emphasizes early identification and integrated service delivery. These children deserve to grow into healthy adults and live full and satisfying lives.

**Figure 1**



**Figure 2**



<sup>2</sup> Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. The Adverse Childhood Experiences (ACE) Study

<sup>3</sup> <http://www.lisc-chicago.org/news/2349>

<sup>4</sup> [http://apps.who.int/adolescent/second-decade/section/section\\_5/level5\\_3.php](http://apps.who.int/adolescent/second-decade/section/section_5/level5_3.php)

Today, two million children in NYS receive their PH services through Medicaid managed care which emphasizes coordination, health outcomes, and quality of care. While much progress has been made, children and youth with mental health and substance use disorder (SUD) services are still delivered through an antiquated FFS model which reimburses based upon volume of services delivered and offers limited incentives for quality of care. A critical component of the State's vision for the Children's MRT Redesign is an effective partnership between Medicaid managed care and providers to support delivery system transformation, promote early identification, prevention, and treatment and, in turn, will reduce the need for intensive services, acute levels of care, and out-of-home placements. A well-functioning children's health system of care will not only benefit children and families, but will also provide important opportunities for improved quality and cost savings in the adult healthcare system. Managed Care Plans should view efforts to support and intervene with children and their families as a key element of value-based initiatives aimed to limit the prevalence of negative physical, emotional, and social outcomes associated with chronic conditions in adults.

In order to support this integration, create better health outcomes for children and youth, and lay the groundwork for better health outcomes for adults, the State is taking three key policy steps to stimulate the transformation:

1. The State will make available via a Medicaid SPA, six new services that were either not available in NYS previously or were only available to children who met narrow eligibility criteria.
2. The State is establishing Level of Care (LOC) and Level of Need (LON) criteria to identify subpopulations of children who are likely to benefit from an array of home- and community-based services (HCBS). The LON subpopulation will identify children prior to needing institutional care or as a step down from LOC. This population is at-risk by virtue of exposure to adverse events or symptoms leading to functional impairment in their home, school, or community. Attachments [A](#) and [B](#) reflect eligibility criteria for LOC and LON designations respectively.
3. The State is simplifying the five existing children's 1915(c) waivers into one integrated array of HCBS for an expanded number of Medicaid-eligible children allowing them to stay in their home communities and avoid residential and inpatient care.

The State envisions a future where service delivery silos are eliminated and in which MMCOs service providers, care managers, family peers, youth peers, multiple child serving systems of care (e.g., education, child welfare, juvenile justice), and State and local government agencies work together to support the physical, social and emotional development of children and youth while increasing health and wellness outcomes during childhood and into adulthood.



## 1.2 Overview of Current Child Serving Systems

DOH, OMH, OASAS, and OCFS have been responsible for the oversight of the current child serving systems that will be transitioning into managed care. Attachment [C](#) provides a detailed overview of current agency oversight and regulatory functions.

Under this design, the contract will be administered by DOH, and through the Plans, will utilize Health Homes to coordinate care.

## 1.3 Transforming the Children's Service Delivery System

### Anticipated Timelines

The Children's MRT Redesign Plan consists of a set of initiatives that will be implemented via proposed SPAs (e.g., the six new SPA services) and the draft 1115 Waiver Amendment (released on January 9, 2017 for public comment) and is predicated upon the collective and timely approvals of CMS. The 1115 Waiver Amendment, among other things, authorizes the transition the behavioral health benefits to managed care and an expansion of HCBS. The timely and collective implementation and approval of the State Plans and Demonstration amendment is necessary to ensure that all children in New York receive comparable services under the Demonstration. Because these services permit the delivery of community evidence-based practices consistent with CMS guidance, the approval of the SPAs are linked to the approval of this Demonstration amendment and ensuring that comprehensive coordination of physical health and behavioral health within Health Homes as well as appropriate utilization review over these new services within managed care occurs.

The submission of the 1115 Waiver Amendment is pending review of the new Federal Administration's priorities and processes. The anticipated implementation dates included in this Standards and Requirements document, which begin October 2017 and run through January 2019, reflect those included in the draft 1115 Waiver Amendment. Depending on the timeframes for acquiring the necessary approvals, the implementation dates included in this Standards and Requirements document will be modified accordingly. The revised timelines will ensure there is sufficient time for Plans to respond to this Requirements and Standards document, conduct readiness activities, and begin implementation in accordance with CMS approvals.

### Health Home Care Management for Children

With the regional implementation of managed care, children eligible for HCBS will be enrolled in Health Home. The care coordination service of the children's HCBS will transition to Health Home unless the child opts-out of Health Home. Health Homes will administer all HCBS assessments through the Uniform Assessment System which will have algorithms (except for the foster care developmental disability (DD) population as noted below) to determine functional eligibility criteria. In addition, the Health Home will ensure that the child meets all other eligibility criteria for HCBS (i.e., a child must live in a setting meeting HCBS settings criteria to be eligible for HCBS under either LOC or LON criteria).

Health Home is a CM service model for individuals enrolled in Medicaid with complex chronic medical and/or BH needs. Health Home care managers provide person-centered, integrated PH and BH CM, transitional CM, and community and social supports to improve health outcomes of high-cost, high need Medicaid members with chronic conditions.

In April 2016 the State received CMS approval to expand the Health Home model to serve children under 21 beginning in the Fall of 2016. The State has tailored the Health Home model to the needs of children and families through the issuance of standards and guidance as well as the designation of Health Homes authorized to serve children. Effective December 8, 2016, the Health Home program began enrolling eligible children and youth with two or more chronic conditions or a single qualifying condition of serious emotional disturbance (SED), complex trauma (a new qualifying condition approved for children), or HIV. In addition, children enrolled in the OMH Targeted Case Management (TCM) program and TCM providers have transitioned to the Health Home program. As discussed later, children enrolled in 1915(c) waivers will transition to Health Home at a later date. Most Plans have now entered into Administrative Service Agreements with Health Homes that may serve children now enrolled in Medicaid managed care and eligible for Health Home CM.

Health Home CM is a critical component of the Children's Medicaid Redesign Plan. Not only will it provide comprehensive, integrated, child and family focused CM, but it will also ensure the efficient and effective implementation of the expanded array of State Plan services and HCBS contemplated under the Redesign Plan. Please see the [Health Homes Serving Children homepage](#) for more information on the implementation of the program, Health Home standards and requirements for serving children.

### **Transition of Populations into Medicaid Managed Care**

Beginning October 1, 2017 in NYC, Nassau, Suffolk, and Westchester Counties and January 1, 2018, for the rest of the state, the state will remove the following exemptions from Medicaid Managed Care enrollment:

- Children in the following HCBS waivers with a physical, emotional or DD:
  - OMH SED 1915(c) waiver (NY.0296)
  - Bridges to Health (B2H) SED 1915(c) waiver (NY.0469)
  - Care at Home (CAH) I/II 1915(c) waiver (NY.4125)
  - B2H Medically Fragile 1915(c) waiver (NY.0471)
  - B2H DD 1915(c) waiver (NY.0470)
- Children who are residents of Chemical Dependence Long Term Residential Programs

Following the same timeframes, the state will remove the following exclusions from Medicaid Managed Care enrollment:

- Adolescents admitted to Residential Rehabilitation Services for Youth (RRSY)
- Youth in the care and custody of the commissioner of the Office of Family & Children Services except for youth in OCFS facilities and in the care and custody of the Office of Family and Children Services
- As the Residential Treatment Facility (RTF) services are phased into managed care through contract amendments, the children in RTFs will phase into the demonstration

Finally, on January 1, 2019, children/youth in the care of a VFCA will transition into managed care.

As part of the package of reform and redesign initiatives, the State is requesting CMS approval for the transition of the following new population into managed care:

1. The new Demonstration Expansion Population, which is the at-risk HCBS level of need (LON) population under Medicaid Family of One provisions (e.g., LON Family of One), will be implemented on January 1, 2019.<sup>5</sup> It is not anticipated that a large un-served population exists and will become Medicaid eligible under this amendment. Some new children may become eligible for Medicaid under the LON Family of One at risk HCBS population.

Children/youth who continue to be excluded from enrollment in a managed care plan or who are exempt and choose not to enroll will continue to receive benefits via the fee-for-service (FFS) delivery system.

### **Transition of State Plan and Demonstration Services into Medicaid Managed Care**

Existing NYS Medicaid State Plan services and HCBS covered under FFS will be included in the managed care benefit package to more fully integrate children and youth's access to PH and BH care. Under the proposed 1115 Waiver Amendment, beginning October 1, 2017 in NYC, Nassau, Suffolk, and Westchester counties, Plans will administer most children's BH services, including six new Medicaid State Plan services and the full array of children's HCBS and Community First Choice Option (CFCO) services<sup>6</sup> as well as the four BH Demonstration services. On January 1, 2018, these same benefits will transition into Medicaid managed care for counties in the rest of NYS.

The four BH Demonstration services are already included under the 1115 demonstration in managed care and will be expanded to children enrolled in managed care:

- Outpatient addiction services,
- Residential addiction services,
- Licensed Behavioral Health Practitioners, and
- Crisis Intervention.

NYS's Medicaid State Plan will be expanded to include the following new State Plan services (see the current [State Plan services manual](#) for a complete description of these services).

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

These services will be concurrently transitioned into the Medicaid managed care benefit package and will therefore be available to any Medicaid enrollee under 21 years of age who meets medical necessity criteria (MNC).

Table [2](#) lists the Medicaid State Plan and Demonstration benefits that are currently in Medicaid managed care and/or targeted for transition into managed care. Costs for all State Plan services

---

<sup>5</sup> Children eligible for Medicaid based on medical need and eligibility for HCBS and not their families incomes.

<sup>6</sup> Under the Children's design, CFCO services that are children's State Plan services under EPSDT such as personal care services are in the capitated rates but the more traditional HCBS services (e.g., environmental mods) will be non-risk with other HCBS services. More information on CFCO can be found at the following website: [https://www.health.ny.gov/health\\_care/medicaid/redesign/community\\_first\\_choice\\_option.htm](https://www.health.ny.gov/health_care/medicaid/redesign/community_first_choice_option.htm)

will be included in the capitated rates with the exception of some CFCO services, which will remain non-risk with other similar HCBS services (e.g., environmental modifications). A description of the new State Plan benefits may be found in the current [State Plan services manual](#).

**Table 2: Medicaid State Plan and Demonstration Benefits for all Medicaid Managed Care Populations under 21**

Services	Current delivery System	MMCO Benefit Package — NYC, Nassau, Suffolk, Westchester	MMCO Benefit Package — Rest of State
Assertive Community Treatment (minimum age is 18 for medical necessity for this adult oriented service)	FFS	10/1/17	1/1/18
Children's Day Treatment	FFS	Not initially in Managed Care benefit <sup>7</sup>	Not initially in Managed Care benefit
CFCO State Plan Services for children meeting eligibility criteria <sup>8</sup>	FFS	10/1/17	1/1/18
CPST <sup>9</sup>	New SPA service	10/1/17	1/1/18
Continuing day treatment (minimum age is 18 for medical necessity for this adult oriented service)	FFS	10/1/17	1/1/18
Crisis Intervention	Current Demonstration Benefit and former 1915(c) service moving into new SPA service for children	Current Benefit	Current Benefit
Family Peer Support Services	1915(c) Waiver moving to new SPA service	10/1/17	1/1/18
Inpatient psychiatric services	Current Benefit	Current Benefit	Current Benefit
Inpatient treatment	Current Benefit	Current Benefit	Current Benefit

<sup>7</sup> Currently available under FFS, to be transitioned to managed care benefit package at a later date.

<sup>8</sup> Additional benefit definition and guidance for the implementation and authorization of CFCO services will be issued.

<sup>9</sup> NYS is exploring the use of EBPs. Pending CMS approval, these services will be billed through CPST and/or OLP, depending upon provider qualifications. Additional guidance will be issued regarding provider designation as well as the rate structure.

Services	Current delivery System	MMCO Benefit Package — NYC, Nassau, Suffolk, Westchester	MMCO Benefit Package — Rest of State
Intensive Psychiatric Rehabilitation Treatment (IPRT)	FFS	10/1/17	1/1/18
Licensed Behavioral Health Practitioner (NP-LBHP) Service	Current Demonstration Benefit	Current Benefit	Current Benefit
Medically Managed detoxification (hospital based)	Current Benefit	Current Benefit	Current Benefit
Medically supervised inpatient detoxification	Current Benefit	Current Benefit	Current Benefit
Medically supervised outpatient withdrawal	Current Benefit	Current Benefit	Current Benefit
OASAS outpatient and opioid treatment program (OTP) services	FFS	10/1/17	1/1/18
OASAS outpatient rehabilitation programs	FFS	10/1/17	1/1/18
OMH State Operated Inpatient	FFS	Not initially in Managed Care benefit	Not initially in Managed Care benefit
OLP	New SPA service	10/1/17	1/1/18
Outpatient and Residential Addiction services	Current Benefit	Current Benefit	Current Benefit
Outpatient Hospital: Comprehensive psychiatric emergency program (CPEP) including Extended Observation Bed	Current Benefit and FFS service	Current Benefit	Current Benefit
Licensed outpatient clinic services (in OMH operated facilities services)	Current Benefit	Current Benefit	Current Benefit
Partial hospitalization	FFS	10/1/17	1/1/18
Personalized Recovery Oriented Services (minimum age is 18 for medical necessity for this adult oriented service)	FFS	10/1/17	1/1/18

Services	Current delivery System	MMCO Benefit Package — NYC, Nassau, Suffolk, Westchester	MMCO Benefit Package — Rest of State
PSR	New SPA service	10/1/17	1/1/18
Rehabilitation Services for residents of community residences	FFS	Not initially in Managed Care benefit	Not initially in Managed Care benefit
Residential Rehabilitation Services for Youth (RRSY)	FFS	10/1/17	1/1/18
Residential Supports and Services (New Early and Periodic Screening, Diagnostic and Treatment [EPSDT] Prevention, formerly known as foster care Medicaid Per Diem)	OCFS Foster Care	1/1/19	1/1/19
RTF	FFS	Not initially in Managed Care benefit	Not initially in Managed Care benefit
TCM (being phased out) including Intensive case management/ supportive case management	FFS Transitioning into Health Homes effective 12/8/16	N/A	N/A
Teaching Family Home	FFS	Not initially in the Benefit package	Not initially in the Benefit package
Youth Peer Support and Training	1915(c) Waiver moving to new SPA service	10/1/17	1/1/18

### Transition of Children’s HCBS to Managed Care

Services previously delivered under agency-specific 1915(c) waivers will be aligned and moved under the authority of NYS’s 1115 MRT, MRT Waiver. All reimbursement for children’s HCBS covered in the managed care benefit package will be non-risk for 24 months from the date of inclusion in the MMCO benefit package. The Plan capitation payment will not include children’s HCBS. These will be paid on a non-risk basis. The benefits are listed below (additional detail can be found in the current [HCBS Manual](#)):

- Health Home (if not otherwise eligible under the State Plan)
- Accessibility Modifications
- Adaptive and Assistive Equipment
- Caregiver/Family Supports and Services
- Community Self-Advocacy Training and Support
- Habilitation
- Non-Medical Transportation

- Palliative Care
- Prevocational Services
- Respite
- Supported Employment
- Financial Management services for the Customized Goods and Services pilot
- Customized Goods and Services (pilot)

CFCO services not included in the capitated rates will also be non-risk for children eligible for those State Plan HCBS services (e.g., environmental modifications). More information on CFCO can be found at the following website:

[https://www.health.ny.gov/health\\_care/medicaid/redesign/community\\_first\\_choice\\_option.htm](https://www.health.ny.gov/health_care/medicaid/redesign/community_first_choice_option.htm)

All HCBS under the 1115 MRT Waiver are available to any child/youth determined eligible. Eligibility is based on Targeting Criteria, Risk Factors, and Functional Limitations. Individuals must meet institutional and functional eligibility criteria for LOC as indicated by a face-to-face assessment using the assessment tool determining LOC for that population under the Demonstration: 1) the Child and Adolescent Needs and Strengths New York (CANS-NY) tool for children with SED, 2) the State designated assessment protocols and tools for children who are medically fragile and 3) the Office for People with Developmental Disabilities (OPWDD) eligibility tool for children in foster care with DD. Health Homes will provide CM to children/youth eligible for HCBS.

The total number of eligible member months for HCBS is expected to grow from 77,000 to 329,000 member months by full implementation. This growth is attributed to the removal of enrollment caps, addition of at-risk LON population, and addition of at-risk LON Family of One.

**Table 3: Current Annual enrollment by HCBS Waiver**

Waiver	Calendar Year (CY) 2014 Member Months (MMs)
OMH SED 1915(c) waiver (NY.0296)	20,266
B2H SED 1915(c) waiver (NY.0469)	34,054
Care at Home (CAH) I/II 1915(c) waiver (NY.4125)	15,194
B2H Medically Fragile 1915(c) waiver (NY.0471)	1,511
B2H DD 1915(c) waiver (NY.0470)	6,095
<b>Total</b>	<b>77,120</b>

**Note:** 28,044 MMs from the five waivers are already enrolled in managed care (i.e., approximately 2,800 children assuming a 10 month average length of stay).

**Table 4: Projected number of children eligible for HCBS<sup>10</sup>**

HCBS Population	Children's MMs Served in HCBS waivers prior to Demonstration in CY 2014	Children's MMs proposed to be eligible for HCBS under Demonstration in Demonstration Year 2023 ending 3/31/2022
Medicaid Children meeting LOC under Community Eligibility rules	65,064	147,869
Medicaid Children meeting LOC under Family of One rules	12,056	13,815
Medicaid Children meeting at-risk HCBS LON under Community Eligibility rules	N/A	131,220
New Medicaid Children meeting at-risk HCBS LON under Family of One rules	N/A	36,744
<b>Total</b>	<b>77,120</b>	<b>329,648</b>

### Transition of Children in the care of a VFCA into Managed Care

Beginning January 1, 2019, children/youth in the care of VFCAs will receive Medicaid benefits through Medicaid managed care, unless otherwise exempt or excluded. DOH and OCFS are working to transition contracting relationships between Plans and VFCAs, which includes DOH licensure of VFCAs for providing services by licensed health care practitioners under the Department of Education. The requirements of those licenses, including procedures for obtaining that licensure and the requirements of the licensure are in development.

Under the Medicaid managed care Plan, VFCAs will continue to receive reimbursement for medical or health-related Medicaid reimbursable services not otherwise included in the list of Plan contract services. These vital services include nursing, BH supports and medical escorts, as well as the clinical supervision for providing these services and supports. The details of the content of this service and reimbursement are also in development.

Children placed with VFCAs have a complex set of health and BH care needs. VFCAs have a long-standing, proven track record of being responsive to the multi-faceted needs of children, their families as well as local, state and federal regulatory mandates. The State's child welfare system is characterized by a sophisticated set of relationships that includes Local Departments of Social Services (LDSS), VFCAs and the health care system. This set of relationships requires a highly coordinated approach to achieve desired outcomes.

VFCAs will continue to be required to provide or arrange for health care services based on federal and state health care standards including the provision of trauma-informed services.

<sup>10</sup> There are 28,044 MMs from the five waivers in Medicaid Managed Care, so approximately 2,800 HCBS children are enrolled in Medicaid Managed Care.





The State recognizes that the movement of children in VFCAs into a Medicaid managed care environment represents opportunities that are not possible in a FFS environment, such as transparency of service provision through claims processing, enhanced service utilization management (UM) and care coordination. DOH and OCFS are committed to transitioning children in VFCAs to managed care in a thoughtful manner.

## 2.0 Definitions

**Advocacy:** The spirit of this work is one that promotes effective parent/caregiver-professional-systems partnerships. Advocacy in this role does not include legal consultation or representation. It is defined as constructive, collaborative work with and on behalf of families to assist them to obtain needed services and supports to promote positive outcomes for their children.

**Behavioral Health (BH):** Refers to mental health and/or SUD benefits and/or conditions.

**Behavioral Health Service (BH Service):** Any or all of the services identified in Table 2 (Medicaid State Plan and Demonstration Benefits for all Medicaid Managed Care Populations under 21) of this document.

**Behavioral Health Professional (BHP):**<sup>11</sup> An individual with an advanced degree in the mental health or addictions field who holds an active, unrestricted license to practice independently or an individual with an associate's degree or higher in nursing who is a registered nurse with three years of experience in a mental health or addictions setting. BHPs, as described in Section 3.2 (Personnel) of this document, will be specified as either a NYS or United States (U.S.) BHP. When specified as a NYS BHP, the individual must hold an active, unrestricted license to practice independently in NYS or be a registered nurse in NYS. When specified as a U.S. BHP, the individual may meet the licensure requirement with an active, unrestricted license to practice independently or be a registered nurse in any state in the U.S.

**Caregiver/legal guardian:** The adult or adults that have the legal decision making and consent authority for the child or youth in care/services. This may include the parent(s), OCFS, LDSS, etc.

**Community First Choice Option (CFCO):** Enhanced services and supports for eligible individuals who need assistance with everyday activities due to a physical, developmental or behavioral disability. These services and supports address activities of daily living, instrumental activities of daily living and health-related tasks through hands-on assistance, supervision and/or cueing. Medicaid recipients must meet HCBS setting requirements and institutional LOC criteria, as well as other eligibility criteria, to be eligible for CFCO services. CFCO services must be provided pursuant to a Person Centered Service Plan. More information is available at [https://www.health.ny.gov/health\\_care/medicaid/redesign/community\\_first\\_choice\\_option.htm](https://www.health.ny.gov/health_care/medicaid/redesign/community_first_choice_option.htm).

**Credentialed Alcoholism and Substance Abuse Counselor (CASAC):** Credentialed Alcoholism and Substance Abuse Counselor as defined by OASAS in 14 NYCRR Part 853.

---

<sup>11</sup> The term Behavioral Health Professional (BHP) is also used to describe certain direct services providers (i.e., not a Managed Care Plan employee). When referencing a crisis intervention provider, for example, BHPs include: Psychiatrist, Physician, Licensed Psychoanalyst, LCSW, LMSW, Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, or Nurse Practitioner with experience/background in treatment of mental health and/or SUDs. For other rehabilitative services where specifically noted, a BHP may include a Creative Arts Therapist, Physician Assistant, Licensed Practical Nurse and Registered Professional Nurse.

**Certified Recovery Peer Advocate-Family:** OASAS-certified peer support specialist with special “Family” training and designation.

**Certified Recovery Peer Advocate-Youth:** OASAS-certified peer support specialist with special “Youth” training and designation.

**Child and Adolescent Needs and Strengths assessment — New York (CANS-NY):**

Validated, structured, child/youth assessment tool comprised of domains relevant to determining a child/youth’s and family’s strengths and needs. This tool is used to assist with care coordination for members enrolled in Health Homes. The CANS-NY will also be used to determine certain child/youth populations’ HCBS eligibility. For more detailed information on eligibility, refer to Attachments [A](#) and [B](#).

**Child/Adolescent/Youth:** Individuals under age 21.

**Children’s Medicaid Redesign Team:** A subcommittee of the MRT commissioned by Governor Andrew Cuomo in an effort to restructure the Medicaid program. The Children’s subcommittee participated in the development and design of the children’s MRT initiatives. For more information visit:

[https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health/children/child\\_mrt.htm](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/child_mrt.htm)

**Collateral:** A person who is a member of the child/youth’s family or household, or other individual who regularly interacts with the child/youth and is directly affected by or has the capability of affecting his or her condition, and is identified in the treatment plan as having a role in treatment and/or is necessary for participation in the evaluation and assessment of the child/youth.

**Complex Trauma:** Complex Trauma is a single qualifying eligibility condition for Health Home and occurs when a child has multiple interpersonal traumatic events or at least one chronic interpersonal trauma lasting 18 months<sup>12</sup> or more. The definition of Complex Trauma was developed in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Child Traumatic Stress Network (NCTSN), [www.nctsn.org](http://www.nctsn.org). The term complex trauma incorporates at least infants/children/adolescents’ with exposure to multiple traumatic events, often of an invasive, interpersonal nature,<sup>13</sup> and the wide-ranging, long-term impact of this exposure. The nature of the traumatic events:

- Often is severe and pervasive, such as abuse or profound neglect;
- Usually begins early in life;
- Can be disruptive of the child’s development and the formation of a healthy sense of self (with self-regulatory, executive functioning, self-perceptions, etc.);
- Often occur in the context of the child’s relationship with a caregiver; and

---

<sup>12</sup> For young children (ages 0-5) a determination of “chronic” exposure can be made for periods less than 18 months

<sup>13</sup> Victimization can be defined as harm that comes to individuals because other human actors have behaved in ways that violate social norms. Even though we sometimes refer to people as “victims of hurricanes”, “cancer victims”, or “accident victims”, the more common reference for the term victimization is interpersonal victimization. In interpersonal victimization, the elements of malevolence, betrayal, injustice, and immorality are more likely to be factors than in accidents, diseases, and natural disasters. (Finkelhor, 2008, p. 23)

- Can interfere with the child's ability to form a secure attachment bond, which is considered a prerequisite for healthy social-emotional functioning.

Many aspects of a child's healthy physical and mental development rely on this secure attachment, a primary source of safety and stability. Wide-ranging, long-term adverse effects can include impairments in:

- Physiological responses and related neurodevelopment,
- Emotional responses,
- Cognitive processes including the ability to think, learn, and concentrate,
- Impulse control and other self-regulating behavior,
- Self-image, and
- Relationships with others.

**Court-Ordered Services:** Services the Plan is required to provide to enrollees pursuant to orders of courts of competent jurisdiction, provided however, that such ordered services are within the Plan's benefit package and reimbursable under Title XIX of the Federal Social Security Act, SSL 364-j(4)(r).

**Crisis Plan:** A tool utilized by providers for children/youth in order to assist in: reducing or managing crisis related symptoms; promoting healthy behaviors; addressing safety measures; and/or preventing or reducing the risk of harm or diffusion of dangerous situations. The child/youth/family will be an active participant in the development of the crisis plan. With the family's consent, the crisis plan may be shared with collateral contacts also working with that child/youth/family who might provide crisis support or intervention in the future. Sharing the crisis plan helps to promote future providers' awareness of and ability to support the strategies being implemented by the child/youth/family.

**Cultural Competency:** An awareness and acceptance of cultural differences, an awareness of individual cultural values, an understanding of how individual differences affect those participating in the helping process, a basic knowledge about the clients culture, knowledge of the client's environment, and the ability to adapt practice skills to fit the individual or family cultural context.

**Days:** Refers to calendar days except as otherwise stated.

**Demonstration:** The four BH Demonstration services already included under the 1115 demonstration in managed care and will be expanded to children enrolled in managed care:

- Outpatient addiction services,
- Residential addiction services,
- Licensed Behavioral Health Practitioners, and
- Crisis Intervention.

**Developmental Milestones:** Markers across lifespan that are typically assessed throughout childhood. Milestones include physical, emotional, cognitive, social and communication skills.

**Early and Periodic Screening, Diagnostic and Treatment (EPSDT):** Provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services.

**Evidence-Based Practice (EBP):** The Institute of Medicine (IOM) defines "evidence-based practice" as a combination of the following three factors: (1) best research evidence, (2) best clinical experience, and (3) consistent with patient values.<sup>14</sup> These factors are also relevant for child welfare. The State has adopted the IOM's definition for EBP with a slight variation that incorporates child welfare language: best research evidence, best clinical experience, and consistent with family/client values. This definition builds on a foundation of scientific research while honoring the clinical experience of child welfare practitioners, and being fully cognizant of the values of the families served.

**Family:** Family is defined as the primary caregiving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home.

**Family Member:** Parent, grandparent, sibling, aunt, uncles, etc. that is biological, foster/adoptive or invested in the care of the child/youth.

**Family of One:** A commonly used phrase to describe a child that becomes eligible for Medicaid through use of institutional eligibility rules for certain medically needy individuals. These rules allow a budgeting methodology for children to meet Medicaid financial eligibility criteria as a "family of one," using the child's own income and disregarding parental income.

**Family Peer Advocate:** OMH certified peer support specialist.

**First Episode Psychosis (FEP):** Members with FEP are individuals who have displayed psychotic symptoms suggestive of recently-emerged schizophrenia. FEP generally occurs in individuals age 16–35. FEP includes individuals whose emergence of psychotic symptoms occurred within the previous two years, who remain in need of mental health services, and who have a diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder, psychotic disorder not otherwise specified (DSM-IV), or other specified/unspecified schizophrenia spectrum and other psychotic disorder (DSM-5). The definition of FEP excludes individuals whose psychotic symptoms are due primarily to a mood disorder or substance use.

**Healthcare Effectiveness Data and Information Set (HEDIS):** The set of performance measures used in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).

**Health Home Care Management (CM):** Health Home is a care management service model for individuals enrolled in Medicaid with complex chronic medical and/or behavioral health needs. Health Home care managers provide person-centered, integrated physical and behavioral health care management, transitional care management, and community and social supports to improve health outcomes of high-cost, high need Medicaid members with chronic conditions.

In April 2016 New York State received CMS approval to expand and tailor the Health Home model to serve children under 21 beginning in the Fall of 2016. As defined and implemented by

---

<sup>14</sup> Institute of Medicine, 2001. Crossing the quality chasm: A new health system for the 21st century. Washington, DC: National Academy Press

the Medicaid State Plan, Health Home care management includes the six core functions, and the provision of required care plans for HCBS. The six core functions include:

1. Comprehensive CM
2. Care Coordination and Health Promotion
3. Comprehensive Transitional Care
4. Enrollee and Family Support
5. Referral to Community and Social Supports
6. Use of Health Information Technology to Link Services

All children receiving HCBS including CFCO are eligible for Health Home under the children's 1115 MRT waiver amendment in addition to children eligible for Health Home under the Medicaid State Plan. For children who opt-out of Health Homes, the Plan or a State Designated Entity for FFS enrolled children will conduct the HCBS assessment, plan of care (POC) development and on-going monitoring of the POC.

**Home Setting or Community Setting:** The setting in which a child primarily resides or spends time, as long as it is not a hospital nursing facility, Intermediate Care Facility (ICF), or psychiatric nursing facility. Note: this is distinguished from a HCBS. State Plan services, including the new EPSDT OLP and Rehabilitation services as well as Clinic Services, do not have to comply with the HCBS settings rule, 42 CFR 441.301 and 530.

**Inpatient Classified Settings:** Medicaid compensable 24 hour levels of care that NYS has classified as inpatient, including but not limited to acute psychiatric inpatient facilities, psychiatric RTFs, and Chemical Dependence RRSY.

**Level of Care for Alcohol and Drug Treatment Referral (LOCADTR):** LOCADTR is developed and updated, as appropriate, by OASAS and is the clinical LOC tool that assesses the intensity and need of services for an individual with a SUD. It is to be used in making all initial and ongoing LOC decisions in NYS. For more information please visit: <https://oasas.ny.gov/treatment/health/locadtr/index.cfm>

**Level of Care (LOC) populations:** See Attachment [A](#) for a description of HCBS eligibility criteria for LOC population meeting institutional admission criteria.

**Level of Need (LON) populations:** See Attachment [B](#) for description of HCBS eligibility criteria for LON population at-risk of institutionalization.

**Licensed Practitioner of the Healing Arts (LPHA):** An individual professional who is licensed as a Registered Professional Nurse, Nurse Practitioner, Psychiatrist, Licensed Psychologist, Licensed Psychoanalyst, Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Marriage & Family Therapist, Licensed Mental Health Counselor, or Physician (per OMH 599 regulations) and practicing within the scope of their State license to recommend Rehabilitation services. Clinical Nurse Specialist, LMSW, and Physician Assistants who are licensed and practicing within the scope of their State license may recommend Rehabilitation services, only where noted in the approved State Plan and most current State Plan manual.

**Local Department of Social Services (LDSS):** Each County has an LDSS that provides or administers the full range of publically funded social services and cash assistance programs. In NYC, these departments are named the Human Resources Administration and Administration for Children’s Services.

**Medicaid Managed Care Organization (MMCO):** MCOs certified by NYS to manage health and BH services for Medicaid beneficiaries who are not also eligible for Medicare. MMCOs also include HIV Special Needs Plans (HIV SNPs).

**Medically Fragile Children:** The NYS Office of Health Insurance Programs (OHIP) has historically defined Medically Fragile as children who have a chronic debilitating condition or conditions, who may or may not be hospitalized or institutionalized, and meet one or more of the following criteria: is technologically dependent for life or health sustaining functions; requires complex medication regimen or medical interventions to maintain or to improve their health status; or is in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at-risk. Chronic debilitating conditions include, but are not limited to: bronchopulmonary dysplasia, cerebral palsy, congenital heart disease, microcephaly, pulmonary hypertension, and muscular dystrophy. All health plans must comply with MFC requirements for any MFC child.

**Medically Fragile Level of Care (LOC) Population:** A child under age 21 with a documented physical disability following state demonstration protocols. A LPHA who has the ability to diagnose within his or her scope of practice under state law has determined in writing that the child, in the absence of HCBS, is at risk of institutionalization. The LPHA has submitted written clinical documentation to support the determination. The child has received a face-to-face assessment and been found to meet hospital or nursing facility admission criteria. The child is eligible to receive LOC HCBS services including CFCO services if CFCO requirements are met.

**Mental Health Parity and Addiction Equity Act (MHPAEA)<sup>15</sup>:** The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or SUD benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. In March 2016, the CMS published the final rule addressing the application of certain requirements set forth in MHPAEA to coverage offered by MMCOs, Medicaid Alternative Benefit Plans, and Children’s Health Insurance Programs.

<https://www.gpo.gov/fdsys/pkg/FR-2016-03-30/pdf/2016-06876.pdf>

**Natural Supports:** Natural supports are individuals and informal resources that a family/caregiver can access, independent of formal services. These supports are a significant source of culturally relevant emotional support and caring friendships for children and families. Natural supports can be short-term or long-term and are usually sustainable and available to the child and family/caregiver after formal services have ended. Natural supports can include, but are not limited to family members, friends, neighbors, clergy, and other acquaintances.

**New York State Department of Health:** [http://www.health.ny.gov/health\\_care/managed\\_care/](http://www.health.ny.gov/health_care/managed_care/)

---

<sup>15</sup> [https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea\\_factsheet.html](https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html)

**Non-Physician Licensed Behavioral Health Professional (NP-LBHP):** NP-LBHPs include individuals licensed and able to practice independently for which reimbursement is authorized under the Other Licensed Practitioner section of the Medicaid State Plan. Non-physician NP-LBHP include: Licensed Psychoanalysts, LCSW, Licensed Marriage & Family Therapists and Licensed Mental Health Counselors. NP-LBHPs also include the following individuals who are licensed to practice under supervision or direction of a LCSW, a Licensed Psychologist, or a Psychiatrist: LMSW. Note: Psychiatrists, Licensed Physician Assistants, Licensed Physicians, Psychologists, and Licensed Nurse Practitioners are licensed practitioners, but not referred to as NP-LBHPs.

**Office of Alcoholism and Substance Abuse Services (OASAS):** <https://oasas.ny.gov/>

**Office of Children and Family Services (OCFS):** <http://ocfs.ny.gov/main/>

**Office of Mental Health (OMH):** <https://www.omh.ny.gov/omhweb/about/>

**Person-Centered Care:** Services should reflect a child and family's goals and emphasize shared decision-making approaches that empower families, provide choice, and minimize stigma. Services should be designed to optimally treat illness, improve clinical and psychosocial outcomes, and emphasize wellness and attention to the family's overall well-being and the child's full community inclusion.

**Plan:** the MMCO.

**Plan of Care (POC):** The written plan that describes the type, level and duration of services and care necessary to treat the assessed needs for Children/Youth.

**Preventive Care:** The care or services rendered to avert disease/illness and/or its consequences. There are three levels of preventive care: primary, such as immunizations, aimed at preventing disease; secondary, such as disease screening programs aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after the disease has occurred. Commonly, the term "preventive care" is used to designate prevention and early detection programs rather than treatment programs.

**Provider Agreement:** Any written contract between the Plan and a participating service provider to provide medical care and/or services to Plan enrollees.

**Recovery-Oriented:** Services should be provided based on the principle that all individuals have the capacity to recover from mental illness and/or SUDs. Specifically, services support the acquisition of living, vocational, and social skills and are offered in home and community-based settings that promote hope and encourage each person to establish an individual path towards recovery.

**Regional Planning Consortium (RPC):** RPCs comprised of each local government unit (LGU) in a region, and representatives of mental health and SUD service providers, child welfare system, peers, families, Health Home leads, and Plans. The RPC works closely with State agencies to guide BH policy in the region, problem solve regional service delivery challenges, and recommend provider training topics.



**Resilience:** The principle that children/youth have qualities that equip them and/or can be strengthened to help them manage through the effects of adversity or trauma and help them to cope, survive and even thrive.

**Serious Emotional Disturbance (SED):** A designated mental illness diagnosis according to the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for a child or adolescent who has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. The functional limitations must be moderate in at least two of the following areas or severe in at least one of the following areas:

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

To be eligible for HCBS SED LOC, see Attachment [A](#). To be eligible for HCBS SED LON, see Attachment [B](#). To be eligible for Health Home due to SED, SED is a single qualifying chronic condition for Health Home and is defined as a child or adolescent (under the age of 21) that has a designated mental illness diagnosis in the following DSM categories<sup>16</sup> as defined by the most recent version of the DSM of Mental Disorders AND has experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis.

#### DSM Qualifying Mental Health Categories\*

- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma- and Stressor-Related Disorders
- Dissociative Disorders
- Somatic Symptom and Related Disorders
- Feeding and Eating Disorders
- Gender Dysphoria
- Disruptive, Impulse-Control, and Conduct Disorders
- Personality Disorders
- Paraphilic Disorders

---

<sup>16</sup> Any diagnosis in these categories can be used when evaluating a child for SED. However, any diagnosis that is secondary to another medical condition is excluded.

Functional Limitations Requirements for SED Definition of Health Home - To meet definition of SED for Health Home the child must have experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis

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

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/docs/4\\_29\\_2015\\_children\\_webinar.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/4_29_2015_children_webinar.pdf) (p. 16 and 17).

**Single Case Agreement:** An agreement between a non-contracted provider and the MMCO with in which the provider is reimbursed for the care for one specific child's case.

**Start-up date:** The date the Plan will begin providing health services described in this document.

**Substance Use Disorder (SUD):** A diagnosis of a SUD is a pathological pattern of behaviors related to the use of a substance. The diagnosis of SUD is based on criteria defined in the DSM and can be applied to all ten classes of drugs including: alcohol; cannabis; hallucinogens; inhalants; opioids; sedatives, hypnotics, anxiolytics; stimulants; tobacco; and other (or unknown) substances.

**Teaching Family Home:** A home which provides specially trained teaching parents who provide individualized care for up to four children/adolescents with SEDs at a time in a family setting.

**Transition Aged Youth (TAY):** Individuals under age 23 transitioning into the adult system from any OMH, OASAS or OCFS licensed, certified, or funded children's program. This also includes individuals under age 23 transitioning from State Education 853 schools (These are operated by private agencies and provide day and/or residential programs for students with disabilities).

**Trauma:** Affects a child's sense of safety, ability to regulate emotions and capacity to relate well to others. Trauma is defined as exposure to a single severely distressing event or multiple, chronic, or prolonged traumatic events as a child or adolescent which is often invasive and interpersonal in nature.

**Trauma-Informed:** Trauma-informed services are based on an understanding of the vulnerabilities or triggers experienced by trauma survivors that may be exacerbated through traditional service delivery approaches so that these services and programs can be modified to

be more supportive and avoid re-traumatization. All programs should engage all individuals with the assumption that trauma has occurred within their lives (SAMHSA, 2014).

**Treatment Plan:** A treatment plan describes the child's condition and services that will be needed for that episode of care, detailing the practices to be provided, expected outcome, and expected duration of the treatment for each provider. The treatment plan should be culturally relevant, trauma informed, and person-centered.

**Voluntary Foster Care Agency (VFCA):** A foster care agency responsible for the temporary custody and care of children/youth placed in foster care either by order of a court (involuntary) or because their parents are willing to have them cared for temporarily outside the home (voluntary). As of December 2016, there were 93 VFCAs operating in NYS.

## 3.0 Performance Standards

- A. These standards and requirements describe the responsibilities of the Plan for the delivery of the expanded Medicaid-covered services for all Medicaid enrolled children including HCBS. This will include children with BH needs, children in foster care, and medically fragile children. The purpose of this section is to detail additional standards and modifications to the existing PH and BH adult standards to which the Plan is already contractually obligated. The State expects that upon transition of the children's benefits, Plans continue to operate per the requirements in the [Medicaid Managed Care Model Contract](#), applicable guidance, and comply with all listed children's standards and requirements contained herein. Throughout this document, children/youth under the age of 21 are hereafter referred to as "children".
- B. Plans are required to develop a governance model that addresses the needs of the expanded children's benefit and additional populations.

### 3.1 Organizational Capacity

The Plan must meet the following minimum requirements:

- A. The Plan must be operating as a MMCO in NYS.<sup>17</sup> This includes HIV SNPs.
- B. The Plan may partner with a behavioral health organization (BHO) to manage the expanded BH and Demonstration benefits for children.
- Plans that choose to delegate these functions shall contract with a qualified BHO approved by DOH. Plans currently using a BHO to manage adult BH and/or BH HCBS benefits may utilize the same BHO to manage the children's BH, Demonstration and HCBS benefits that are behavioral in nature. If the Plan chooses to utilize a different BHO, DOH must review and approve the Master Service Agreement and review and approve the transition to the new management structure.
  - Plans that choose not to partner with a BHO and are determined to not meet the standards contained in this document will be required to contract with a BHO currently administering NYS Medicaid BH benefits.
- C. The Plan may partner with a qualified vendor to manage HCBS for medically fragile and developmentally disabled children in foster care, including CFCO populations.
- Plans that choose to delegate these functions shall contract with a vendor with expertise in HCBS, medically complex and developmentally disabled children necessary to manage the HCBS benefits for children without behavioral health diagnoses.
  - Plans that choose not to partner with a vendor and are determined to not meet the standards contained in this document will be required to contract with a vendor meeting these requirements.
- D. The Plan must demonstrate that it has processes and procedures to accommodate the service needs of the expanded populations as described in Section 1.

---

<sup>17</sup> A Plan merger creating a new Plan will not disqualify that new Plan from managing the children's benefits included in this transition.

- E. The Plan shall provide and/or manage the functions listed below. Unless otherwise noted, functions shall be available during business hours (8:00 am to 6:00 pm) in the NYS service center location. Functions allowed out-of-state must be provided in the U.S.
- i. Seven days a week, 365 days a year, the Plan must provide a live toll-free phone line to provide information and referral on the new benefits being added through this transition. This function may be operated out-of-state with the approval of the State. The Plan must demonstrate that the member service line staff has knowledge of the new benefits and program requirements for children, including the medically fragile and foster care populations.
  - ii. Twenty-four hours a day, seven-days a week, 365-days a year, the Plan must provide a person-staffed toll-free phone line to provide crisis triage, referral and follow-up. This function may be operated out-of-state with the approval of the State. Plans must demonstrate the efficacy of the linkage between the crisis line and local crisis responders, including the children's service providers for crisis intervention State Plan service. Plans must also modify their staff training program and provider contracting to include NYS specific rules.
  - iii. The Plan must demonstrate an adequate NYS presence of trained staff to ensure that network development, CM, provider relations and medically fragile and foster care liaison activities are sufficient to accomplish transition goals described in this document.
  - iv. The Plan must demonstrate an adequate NYS presence of trained staff to ensure the network includes sufficient providers, including CM, to understand the needs of medically fragile population.
  - v. The Plan must demonstrate an adequate amount of trained staff to accomplish necessary provider contracting and credentialing/re-credentialing. Plans are responsible for training providers on how to become credentialed and re-credentialed in their Plan. This requirement includes processes and training as identified by the State for VFCA that will become licensed. This function may be located out-of-state.
  - vi. The Plan must have provider relations staff with access to a claims reporting and payment reporting platform (claims may be administered at another location).
  - vii. The Plan must provide BH and HCBS utilization review with 24-hours a day, seven-days a week, 365-days a year access to appropriate personnel to conduct prior authorization for children's services as required by the State. Per federal guidelines, the Plan must respond to prior authorization requests for post stabilization services within one hour (24 hours a day). This service may be provided out-of-state but Plan utilization review staff must demonstrate knowledge of:
    - a. Covered services
    - b. NYS managed care rules
    - c. Approved BH and HCBS UM criteria
    - d. Approved BH and HCBS rules and requirements
  - viii. The Plan must provide BH clinical and medical management as specified in this document.
  - ix. The Plan must provide education and training on topics required in this document.

- x. The Plan must have sufficient resources to assist with quality management (QM) initiatives, financial oversight, reporting and monitoring, and oversight of any subcontracted or delegated function to related to the children's population, including children in foster care and medically fragile children.
- F. The Plan must have a reasonable plan and sufficient internal resources to review functional assessments, HCBS eligibility determinations, and plans of care, including those developed by Health Homes, for children.
- G. The Plan shall establish a Children's Advisory Committee that reports to the Plan's governing board. The committee shall include youth and family members who have been served in the child welfare and/or BH system, trained/certified peers with lived experience, children's service providers, VFCAs, foster/adoptive family members, LDSS, LGU, and other stakeholders. Representatives shall have expertise in children's services including experience with medically fragile children and the medically fragile community. The committee representatives should be chosen to reflect the entire geographic service area of the Plan. Issues related to children identified as medically fragile as well as children with BH issues must be separate standing agenda items in committee meetings.
- H. The Plan must have an established technology platform that provides technology support to comply with requirements under this document.

### 3.2 Personnel

- A. The purpose of these staffing requirements is to ensure the Plans have the required BH, PH, pharmacy, UM, QM, and CM expertise and experience to meet the needs of children with mental illness, SUD, co-occurring BH/PH challenges, foster care involvement, or medically fragile determination.
- B. Plan staff and their subcontractors must work as an integrated team with involved State agencies, Health Homes, providers and RPCs.
- C. This section outlines changes in the minimum current BH requirements for key personnel, managerial staff, and operational staff to accommodate the administration of the expanded benefits for children.
- D. Some positions are full-time, required to be located in NYS and dedicated solely to the performance of work required to achieve the requirements and standards in this document. For other positions, when specified, the Plan may employ staff located outside NYS (must be in the U.S.) and/or staff not solely dedicated to work required in this document. In those instances, the location and proportion of time dedicated to perform work related to the standards in this document must be specified and approved by the State. Attachment [D](#) summarizes personnel requirements.
- E. The Plan shall have BH and PH resources sufficient to meet all contract requirements and performance standards and shall require that all staff have the training, education, experience, orientation, and credentials, as applicable, to perform assigned job duties.
- F. The Plan shall orient and train all staff, including subcontractor staff who have involvement with children, families or service providers on the requirements and standards articulated in this document.

- i. Plans shall develop and implement a training plan that is subject to the State's review and approval. At a minimum, Plans shall incorporate the topics listed in Attachment [E](#) into the training plan and other training topics as identified by the State.
  - ii. All staff training must be completed prior to staff performing work under these standards.
  - iii. Plans are strongly encouraged to consider inclusion of members, family members, and caregivers in the development and delivery of training and education for staff, as appropriate.
  - iv. Plans shall incorporate knowledge checks and competence testing into their training plan and periodically (but not less than annually) reassess staff competency already addressed in these standards.
- G. The Plan shall maintain current organizational charts and written job descriptions for each functional area that are consistent in format and style. Organizational charts shall clearly reflect how required functions will be assigned to ensure effective service delivery to children as required under the Children's Standards.
- i. These organizational charts and job descriptions for key and managerial staff must be submitted for review and approval by the State. If applicable, the organizational chart should also clearly show how the Plan will manage subcontractors.
  - ii. The Plan shall maintain staffing levels and complete staff training to ensure the successful accomplishment of all duties outlined in this document.
  - iii. Subject to the limitations described below, positions and functions may be combined to the extent that the staff allocation and qualifications are sufficient to meet the requirements in this document, subject to the State's approval. Within the Plan, positions may be shared across the children and adult populations. In addition, if the Plan has a Health and Recovery Plan (HARP), positions allocated to the HARP may also be shared as long as all staffing requirements continue to be met. When staff is shared, the amount of time dedicated to each position or function must be reasonable in relation to the number of enrollees in each population and product line in order to support leadership functions required under these standards and requirements.
  - iv. A Plan's incumbent personnel or subcontractors may fill the personnel role required under these requirements only if the individual meets the specified requirements.
  - v. Staffing requirements described in this section are broken out into Key Personnel, Managerial Staff, and Operational Staff.
    - a. Key staff has overall accountability for ensuring access to high quality and timely care for children and are required to participate in the RPC.
    - b. Managerial staff has day-to-day responsibility for the management of children's services within the plan.
- H. **Plan BH Leadership Goals:** The Plan shall establish an organizational culture, leadership approach, and administrative structure that supports a partnership amongst Plans, providers, government, child serving systems, children, family members and advocates, and embraces the State's vision for the children's delivery system as described in this document.

- I. **Key Personnel Requirements:** The Plan shall fill two key leadership functions which must be filled by two separate individuals to oversee the delivery of services to children.
  - i. **BH Medical Director:** The Plan (or delegate) shall identify a BH Medical Director to have overall accountability for BH services for the children's population, including children in foster care and medically fragile children. This position must be reflected in the Plan's organizational chart and the identified individual must hold a NYS license as a physician and preferably be board certified in child and adolescent psychiatry. The BH Medical Director shall have a minimum of five years of experience working with children in BH managed care settings or BH clinical settings (at least two years must be in a clinical setting). This position must be located in NYS.
    - a. If the Plan proposes to fulfill the BH Medical Director responsibility with an individual who is not a child psychiatrist, a board certified child psychiatrist must be available to provide leadership and consultation to the Plan on medical and quality activities associated with the delivery of integrated BH services for children. This individual must have authority for implementation/management of children's services and be integrated within the Plan's organizational and decision making structure. This individual must be available for clinical rounds, case consultation, and to support peer reviewers. This position must meet the experience requirements of BH Medical Director as reflected in Attachment D.
  - ii. **BH Clinical Director for Children's Services:** The Plan must designate a BH Clinical Director for Children's Services. This position must be reflected in the Plan's organizational chart and the identified individual must have appropriate managerial experience. The individual shall hold a NYS license as a BHP and have at least seven years of experience in a BH managed care setting or BH clinical setting, including at least two years of managed care experience (preferably Medicaid managed care) and at least five years of experience working with children. This position must be located in NYS.
    - a. For Plans with more than 60,000 enrollees under age 21, the percent of effort must be full-time. For Plans with less than 60,000 enrollees under age 21, the percent of effort may be less than full-time.
  - iii. **Key functions (for these staffing positions):** The Plan BH Medical Director (or designee as approved by the State) and BH Clinical Director for Children's Services shall be involved in the following functions, as they relate to the provision of services to children enrolled in the Plan:
    - a. Provision of clinical oversight and leadership to UM/CM staff working with the children's population.
    - b. Development, implementation, and interpretation of clinical-medical policies and procedures (P&Ps) that are specific to BH or PH or can be expected to impact the overall health, recovery and wellbeing of children.
    - c. Ensuring strong collaboration and coordination between PH and BH care.
    - d. Clinical peer review recruitment and supervision.
    - e. Provider recruitment, education, training, and orientation.
    - f. Decision-making process for BH provider credentialing decisions.



- g. BH provider quality profile design and data interpretation.
  - h. Development and implementation of the BH sections of the QM/UM Plan, including having the BH medical director serve as the chairperson of BH committees for QM/UM and peer review.
  - i. Administration of all BH QM/UM and performance improvement activities, including grievances and appeals.
  - j. Attendance at regular (at least quarterly) Plan leadership and medical director meetings designated by the State BH contract manager.
  - k. Ensuring strong collaboration and coordination between other child serving systems, including the education system.
  - l. Attendance at RPC and other meetings as identified by the State to promote community stakeholder involvement in shaping the system of care for children.
- J. **Managerial Staff:** The Plan shall develop and maintain overall management and staffing to achieve the goals listed in Section 1.0.
- i. The Plan shall employ managerial personnel to oversee and provide the functions listed below. Refer to Attachment D for a summary of personnel requirements.
    - a. All managerial staff must demonstrate knowledge of the characteristics of the new populations (mental health, SUD, foster care and medically fragile) that are transitioning into Managed Care and of the full range of NYS benefits and requirements for children covered under these standards. Managerial staff must have knowledge of or experience related to working with children and their families using family-centered, youth-guided planning approaches and collaborating with child serving systems, including child welfare for children in foster care and coordination with local, State or federally-funded non-Medicaid service providers (e.g., education system). Ideally, the Plan should employ manager(s) with experience in NYS BH settings and, where possible, experience with children with complex medical needs. Managers should have knowledge of service delivery consistent with evidence-based and promising practices for children, including peer and family support services.
    - b. Managerial staff must also have knowledge of HCBS and related regulatory requirements including:
      - i. Timeframes for completion of assessments using State required protocols and tools, and plans of care for children who are determined eligible for HCBS;
      - ii. Compliance with procedures and State guidelines for determining medical necessity for ongoing HCBS;
      - iii. Effective and efficient monitoring of the progress of individuals receiving HCBS, including identification of any deviations from approved plans of care; and
      - iv. Coordination across departments responsible for compliance with HCBS requirements, including but not limited to reporting related to HCBS assurances and sub-assurances.
  - ii. **Managerial Staff Position Requirements:** Plans will be required to create the following positions:

- a. **MMCO Liaison for Medically Fragile Children:** Plans are responsible for ensuring there is a high-touch coordination approach for all medically fragile children including the Medically Fragile LOC population. The MMCO Liaison for Medically Fragile Children must support the staffing and functions outlined in this document and in the [Medicaid Managed Care Model Contract](#) and be a liaison with Health Homes performing CM for that population and families seeking authorization of services necessary to support children in community-based settings.
  - b. **MMCO Foster Care Liaison:** Plans are responsible for ensuring there is a high-touch coordination approach with OCFS, LDSS, and the VFCA for all shared children in foster care. The MMCO Foster Care Liaison must have experience, expertise and knowledge of the child welfare system, foster care healthcare requirements and the unique complex needs (including trauma) of this population. The MMCO Foster Care Liaison shall be the Plan's direct contact for coordinating care and services and to monitor activities for children in foster care.
    - i. The MMCO Foster Care Liaison shall be the primary contact person for LDSS/VFCA Foster Care Coordinators to assist with enrollment, disenrollment, and access to care for children in foster care.
    - ii. The MMCO Foster Care Liaison will be readily available via telephone and email to the LDSS/VFCA during regular business hours to address any issues for managed care enrollees in Foster Care. The Plan shall identify a backup contact when the MMCO Foster Care Liaison is not available.
    - iii. The MMCO Foster Care Liaison shall have the authority to assist with enrollment, disenrollment and access issues (e.g., facilitating a single case agreement when a child is placed outside of the Plan's service area), including immediate issuance of a Welcome Letter or other temporary identification showing the effective date of enrollment or a replacement insurance identification card.
  - iii. For each department listed below, the Plan shall ensure a sufficient staffing plan that includes adequate managerial resources with the expertise to meet the needs of children including PH, BH and the medically fragile population.
    - a. Care Management
    - b. Utilization Management
    - c. Network Development
    - d. Member Services
    - e. Provider Relations
    - f. Training
    - g. Quality Management
    - h. Information Systems
    - i. Governmental/Community Liaison
- K. **Operational Staff:** In addition to the key and managerial personnel, the Plan shall have a sufficient number of qualified operational staff to meet the responsibilities contained within

this document. Operational staff must work at sites located within NYS, with the exception of claims staff, UM staff, and BH clinical peer reviewers.

For each department, the Plan shall ensure staff expertise to manage services consistent with these standards and requirements. Refer to Attachment D for a summary of personnel requirements. The Plan shall have operational staff with expertise in the needs of children, at a minimum, in the following categories:

- i. UM/CM Staff
  - ii. BH Clinical Peer Reviewers
  - iii. QM Specialists
  - iv. Provider Relations Staff
- L. The Plan shall have staffing and structure necessary to support enrollees with functional limitations and chronic illnesses who need assistance to perform daily activities, including the Medically Fragile LOC population. The Plan shall have clinical leadership, peer review, and UM staff with appropriate clinical expertise to support the needs of the Medically Fragile LOC population.

### 3.3 Member Services

- A. The Plan shall ensure its call center operations respond to inquiries and conduct triage for the expanded services 24-hours per day/7-days per week/365 days per year. Member services call center operations may be located out-of-state provided staff are adequately trained on NYS requirements.
- B. The Plan shall staff its call center with a sufficient number of trained member service representatives to meet call responsiveness expectations reflected in the Plan's member services P&Ps and to competently respond to member services calls.
- C. The Plan shall revise its member service P&Ps to address the following:
- i. Information on the newly covered populations and the expanded array of benefits available to children, including where and how to access them;
  - ii. Authorization requirements for expanded benefits;
  - iii. Requirements for responding promptly to members and family members and for supporting linkages to other child-serving systems, including but not limited to LDSS, the OPWDD, OCFS, VFCA, local, State or federally funded non-Medicaid services (e.g., education system), NYS Justice Center, law enforcement, and the criminal/juvenile justice system.
  - iv. Protocols for assisting and triaging callers who may be in crisis by accessing a clinician qualified to assess children's needs. The transfer to the clinician must take place without placing the caller on hold. The qualified clinician shall assess the crisis and shall warm transfer the call to the crisis provider, call 911, refer the individual for services, refer the caller to his or her provider, and/or resolve the crisis over the telephone as appropriate.

- D. The Plan shall revise the member handbook to include information on the expanded array of children's benefits, including where and how to access them and related authorization requirements.
- E. The Plan shall submit its updated member handbook to the State for review and approval as directed by the State.

### 3.4 Service Delivery Network Requirements/Access to Care

- A. The Plan's service area shall consist of the county(ies) described in the Plan's current Medicaid managed care contract with the State.
- B. The Plan shall contract with a sufficient number of providers to meet minimum network standards as outlined in this document.
- C. Once children placed in a VFCA are transitioned to Medicaid Managed Care, the Plan is responsible for reimbursing VFCAs for all medically necessary services for which the VFCA is licensed to provide that are provided to plan enrollees. This includes reimbursement for any services paid through a State determined Preventive Residential Supports and Services rate (currently in development).
  - i. If Plan enrollees are placed in a VFCA located outside of the Plan's service area the Plan is responsible for the reimbursement of medically necessary services provided to Plan enrollees by the VFCA.
  - ii. In the event a Plan enrollee is placed in a VFCA outside of the Plan's services area and requires health care services for which the VFCA is not licensed to provide, the Plan must permit such enrollees to access medically necessary services from non-participating providers who have traditionally treated children involved in foster care located within 30 minutes/30 miles of the enrollee's placement (or next closest provider if no providers of the service are located within 30 minutes/30 miles).
- D. If an enrolled child in foster care is placed in another county, and the Plan in which he or she is enrolled operates in the new county, the Plan must allow for the child to transition to a new primary care provider and other healthcare providers without disrupting the care plan that is in place.
- E. If an enrolled child in foster care is placed outside of the Plan's service area, the plan must permit the enrollee to access providers who have traditionally treated children involved in foster care as necessary to ensure continuity of care and the provision of all medically necessary benefit package services.
- F. In the case of a long-term foster care placement outside of the Plan's service area, and solely at the direction of the LDSS or VFCA, the Plan will coordinate with the LDSS or VFCA for a smooth transition of enrollment.
- G. In addition to the provider network requirements in the [Medicaid Managed Care Model Contract](#), the Plan shall:
  - i. Develop and expand its network based on the anticipated needs of special populations included in this expansion, included but not limited to:

- a. TAY with BH needs;
  - b. Providers of Early Childhood Services (i.e., children ages 0–5);
  - c. Youth identified with FEP;
  - d. High risk groups such as children with SED, SUD or co-occurring SED/SUD and those involved in multiple service systems (e.g., education, juvenile justice, medical, and/or child welfare);
  - e. Children with intellectual/developmental disability (I/DD) in need of BH services;
  - f. Children in foster care;
  - g. Children transitioning from State Operated Psychiatric facilities and other inpatient and residential settings;
  - h. Children with SED/SUD and/or in foster care who are transitioning from detention/jail/prison/courts;
  - i. Children with co-occurring BH and PH needs;
  - j. Children with a SUD in need of medication-assisted treatment, including methadone and buprenorphine for opioid dependence;
  - k. Children deemed medically fragile; and
  - l. Children with complex trauma.
- H. The Plan must ensure that medically fragile children receive services from appropriate providers that have the expertise to effectively treat the child and must contract with providers with demonstrated expertise in caring for medically fragile children. Network providers shall refer to appropriate network community and facility providers to meet the needs of the child or seek authorization from the Plan for out-of-network providers when participating providers cannot meet the child’s needs. The Plan must authorize services in accordance with established timeframes in the [Medicaid Managed Care Model Contract](#) and in accordance with the OHIP Principles for Medically Fragile Children (Attachment [G](#)) which require appropriate MNC for children, consideration for extended discharge planning, and coverage of all services under EPSDT, HCBS and CFCO that assist medically fragile children in reaching their maximum functional capacity.
- I. Minimum network standards for each service type are shown in Table [5](#). The Plan must be in compliance with non-quantitative treatment limitations, including appointment and network access standards, per the MHPAEA found at 42 CFR 438.910(d). The Plan must meet the network requirements in Section 3.4 and Section 3.5. If contracting with required providers does not meet the minimum network standards, the Plan must contract with additional providers to meet the standard.

**Table 5. Minimum Network Standards by Service Type**

*Note: Plans are obligated to have a network sufficient to meet the needs of their members. In many areas, the minimum standards below will not be adequate to meet the Plan’s members’ need for access. Where minimum network standards in Table 5 are not adequate to meet the Plan’s members’ need for access and/or to meet appointment access standards in Table 6, the Plan shall be required to exceed the minimum network standards in Table 5. The State reserves the right to modify the minimum network standards. Regions are aligned with RPCs regions. Refer to Attachment F: Network Development in rural Counties for additional information.*

Service	Urban Counties	Rural Counties <sup>18</sup>
Outpatient Clinic — licensed to serve children and adolescents as well as adults (mental health)	The higher of 50% of all licensed clinics or minimum of 2 per county	The higher of 50% of all licensed clinics or minimum of 2 per county
Outpatient Clinic — licensed to only serve children and adolescents under 21 years old (mental health)	The higher of 50% of all licensed clinics or minimum of 2 per county	The higher of 50% of all licensed clinics or minimum of 2 per county
Outpatient Clinic — with 0–5 specificity reflected on Operating Certificate	All in county	All in region
State Operated Outpatient Programs	All in county	All in region
Article 28 Hospitals — licensed for children only	All in county (if none, then all in contiguous counties) <sup>19</sup>	All in region
Partial Hospitalization	2 per county where available	All in region where available
State Psychiatric Centers — only serving children	All in region	All in region
Residential Treatment Facility	All in region	All in region
Day Treatment and IPRT serving youth	50% of Day Treatment/IPRT, contracting with IPRT first	50% of Day Treatment/IPRT, contracting with IPRT first

<sup>18</sup> NYS public health law defines a rural county as any county having a population of less than 200,000.

<sup>19</sup> If the providers in the county are insufficient to meet network requirements, Plans must first contract with providers in neighboring counties to meet network requirements. If this is still insufficient, the Plan must then contract with providers within the RPC region. Consistent with current DOH approval processes, if the providers in the RPC region are insufficient to meet the minimum network requirement for the service, or the demand in the service area, the Plan must contract with providers in the next contiguous service area. For example, if a Plan’s service area includes Rensselaer County, and the Capital Region RPC has an insufficient number of Opioid Treatment Programs to meet the demand of the enrollees, then the Plan must contract with providers from the Mohawk Valley Region, North Country Region or Mid-Hudson Region, or any combination of regions, to build a sufficient network.

Service	Urban Counties	Rural Counties <sup>18</sup>
Comprehensive Psychiatric Emergency Program & 9.39 ERs — child specific	All per county	All per region
OTPs	All per county and for NYC — all in the City	All per region
Inpatient Treatment (SUD)	Minimum of 2 in county where available	Minimum of 2 in region where available
Detoxification (including Inpatient Hospital Detoxification, Inpatient Medically Supervised Detoxification, and Medically Supervised Outpatient Withdrawal)	2 per county	2 per region
Outpatient Clinic (SUD)	The higher of 50% of all licensed clinics or minimum of 2 per county	The higher of 50% of all licensed clinics or minimum of 2 per county
Rehabilitation services for residential SUD treatment supports (RRSY)	All per county	All per region
Buprenorphine prescribers	All licensed prescribers serving Medicaid patients	All licensed prescribers serving Medicaid patients
OCFS Licensed VFCAs	TBD	TBD
CFCO State Plan Services	2 per county for each service	2 per county for each service
Crisis Intervention	All within Plan's service area.	All within Plan's service area
CPST	The higher of 50% of all programs or minimum of 2 per county where available	The higher of 50% of all programs or minimum of 2 per region where available
OLP (reference to manual) <sup>20</sup>	The higher of 50% of each designated OLP agency or minimum of 2 per county where available	The higher of 50% of each designated OLP agency or minimum of 2 per county where available

<sup>20</sup> OLP Provider types include: A non-physician NP-LBHP who (NP-LBHP) is a NYS licensed: Psychoanalyst, Clinical Social Worker (LCSW), Marriage & Family Therapist, Mental Health Counselor, and Masters Social Worker (LMSW) (Under supervision/direction of a LCSW, licensed psychologist or psychiatrist). Plans are strongly encouraged to contract with agencies that include a variety of OLP provider types.

Service	Urban Counties	Rural Counties <sup>18</sup>
Family Peer Support Services	The higher of 50% of all programs or minimum of 2 per county where available	The higher of 50% of all programs or minimum of 2 per region where available
Youth Peer Support and Training	The higher of 50% of all programs or minimum of 2 per county where available	The higher of 50% of all programs or minimum of 2 per region where available
PSR	The higher of 50% of all programs or minimum of 2 per county where available	The higher of 50% of all programs or minimum of 2 per region where available
EBP Providers	All per county	All per region
Caregiver/Family Supports and Services	The higher of 50% of all programs or minimum of 2 per county where available	The higher of 50% of all programs or minimum of 2 per region where available
Habilitation	The higher of 50% of all programs or minimum of 2 per county where available	The higher of 50% of all programs or minimum of 2 per region where available
Respite (Crisis/Planned)	The higher of 50% of all programs or minimum of 2 per county where available	The higher of 50% of all programs or minimum of 2 per region where available
Prevocational Services	The higher of 50% of all programs or minimum of 2 per county where available	The higher of 50% of all programs or minimum of 2 per region where available
Supported Employment	The higher of 50% of all programs or minimum of 2 per county where available	The higher of 50% of all programs or minimum of 2 per region where available



Service	Urban Counties	Rural Counties <sup>18</sup>
Community Self-Advocacy Training and Support	The higher of 50% of all programs or minimum of 2 per county where available	The higher of 50% of all programs or minimum of 2 per region where available
Adaptive and Assistive Equipment	2 Fiscal Intermediaries per county	2 Fiscal Intermediaries per region
Accessibility Modifications	2 Fiscal Intermediaries per county	2 Fiscal Intermediaries per region
Palliative Care	The higher of 50% of all programs or minimum of 2 per county where available	The higher of 50% of all programs or minimum of 2 per region where available

J. The Plan shall comply with the appointment availability standards and definitions in the [Medicaid Managed Care Model Contract](#). These are general standards and are not intended to supersede sound clinical judgment as to the necessity for care and services on a more expedient basis, when judged clinically necessary and appropriate.

K. Table 6 illustrates how appointment availability standards apply to each service type.

**Table 6. Appointment Availability Standard by Service Type**

Service Type	Emergency	Urgent	Non-urgent	Follow-up to emergency or hospital discharge	Follow-up to residential services, detention discharge, or discharge from justice system placement
MH Outpatient Clinic		Within 24 hours	Within 1 week	Within 5 business days of request	Within 5 business days of request
IPRT			2–4 weeks	Within 24 hours	
Partial Hospitalization				Within 5 business days of request	
Inpatient Psychiatric Services	Upon presentation				
CPEP	Upon presentation				

Service Type	Emergency	Urgent	Non-urgent	Follow-up to emergency or hospital discharge	Follow-up to residential services, detention discharge, or discharge from justice system placement
OASAS Outpatient Clinic		Within 24 hours	Within 1 week of request	Within 5 business days of request	Within 5 business days of request
Detoxification	Upon presentation				
SUD Inpatient Rehab	Upon presentation	Within 24 hours			
OTP		Within 24 hours	Within 1 week of request	Within 5 business days of request	Within 5 business days of request
RRSY	Upon presentation	Within 24 hours	2–4 weeks	Within 5 days of request	Within 5 days of request
Crisis Intervention	Within 1 hour			Within 24 hours of MCI response	
CPST — intake/assessment/treatment plan within 72 hours		Within 24 hours (for intensive in home and crisis response services under definition)	Within 5 business days of intake	Within 72 hours of discharge	Within 72 hours
OLP		Within 24 hours of request	Within 7 days of intake	Within 72 hours of request	Within 72 hours of request
Family Peer Support Services		Within 24 hours of request	Within 1 week of request	Within 72 hours days of request	Within 72 hours of request
Youth Peer Support and Training		Within 24 hours of request	Within 1 week of request	Within 72 hours of request	Within 72 hours of request
PSR		Within 72 hours of request	Within 5 business days of request	Within 72 hours of request	Within 72 hours of request

Service Type	Emergency	Urgent	Non-urgent	Follow-up to emergency or hospital discharge	Follow-up to residential services, detention discharge, or discharge from justice system placement
Caregiver/Family Supports and Services			Within 5 business days of request	Within 5 business days of request	
Crisis Respite	Within 24 hours of request	Within 24 hours of request		Within 24 hours of request	
Planned Respite			Within 7 days of request	Within 7 days of request	
Prevocational Services			Within 2 weeks of request		
Supported Employment			Within 2 weeks of request		
Community Self-Advocacy Training and Support			Within 5 business days of request		
Habilitation			Within 2 weeks		
Adaptive and Assistive Equipment		Within 24 hours of request	Within 2 weeks of request	Within 24 hours of request	Within 24 hours of request
Accessibility Modifications		Within 24 hours of request	Within 2 weeks of request	Within 24 hours of request	Within 24 hours of request
Palliative Care			Within 2 weeks of request	Within 24 hours of request	

**L. Additional Network Requirements for Children in Foster Care:**

- i. To promote continuity of care and to ensure health care services are delivered in a trauma-informed manner, the Plan must augment its provider network where necessary to include health care providers who have traditionally treated children involved in foster care in sufficient numbers to ensure capacity to serve enrolled children placed in a VFCA.
- ii. The State, as well as LDSS and VFCAs serving Plan enrollees, will identify providers who deliver services to children in foster care. The Plan will be required to offer contracts to such providers located within the Plan's service area.
- iii. The Plan shall ensure access is available to providers that are able to complete initial diagnostic assessments upon intake into foster care and any additional assessments mandated by OCFS/LDSS/VFCA. These assessments will be provided to enrollees within the time frames specified by OCFS or the County, consistent with this document. Following these assessments, the Plan shall facilitate access to providers and coordinate care for treatment recommended. The Plan, through the MCO Foster Care liaison, shall authorize the intake screen, the complete diagnostic assessments, and any additional mandated assessments as identified by the LDSS/VFCA.
- iv. The Plan shall ensure there is sufficient network capacity to meet the timeframes for completion of required foster care initial health assessments as described in Table 7. A series of assessments, as outlined in Table 7, provides a complete picture of the foster care child's health needs and is the basis for developing a comprehensive POC. The initial health activities include:
  - a. Immediate screening of the child's medical condition, including assessment for child abuse/neglect.
  - b. Comprehensive health evaluation: The comprehensive evaluation shall include all elements of EPSDT, as required by Medicaid. Specifically for children in foster care, EPSDT screening shall be completed within 30 days of entering care in conjunction with the comprehensive health evaluation. The EPSDT screen shall include federally mandated aspects related to:
    - i. Comprehensive health and developmental history, including physical exam, immunizations, laboratory tests (including lead toxicity screening), and health education;
    - ii. Hearing;
    - iii. Dental, including on-going preventive and restorative care;
    - iv. Mental Health/SUD;
    - v. Vision;
    - vi. Follow-up health evaluation and treatments that incorporate information from the five initial assessments; and
    - vii. Ongoing efforts to obtain child's existing medical records and document medical activities.

Table 7 outlines the time frames for initial health activities, to be completed within 60 days of placement. An "X" in the Mandated Activity column indicates that the activity is required within the indicated time frame.

**Table 7: Foster Care Initial Health Services**

Time Frame	Activity	Mandated Activity	Mandated Time Frame	Who Performs
24 Hours	Initial screening/ screening for abuse/ neglect	X	X	Health practitioner (preferred) or caseworker/health staff
5 Days	Initial determination of capacity to consent for HIV risk assessment & testing	X	X	Caseworker or designated staff
5 Days	Initial HIV risk assessment for child without capacity to consent	X	X	Caseworker or designated staff
10 Days	Request consent for release of medical records & treatment	X	X	Caseworker or health staff
30 Days	Initial medical assessment	X	X	Health practitioner
30 Days	Initial dental assessment	X	X	Health practitioner
30 Days	Initial mental health assessment	X		Mental health practitioner
30 Days	HIV risk assessment for child with possible capacity to consent	X	X	Caseworker or designated staff
30 Days	Arrange HIV testing for child with no possibility of capacity to consent & assessed to be at risk of HIV infection	X	X	Caseworker or health staff
45 Days	Initial developmental assessment	X		Health practitioner
45 Days	Initial substance abuse assessment			Health practitioner
60 Days	Follow-up health evaluation			Health practitioner
60 Days	Arrange HIV testing for child determined in follow-up assessment to be without capacity to consent & assessed to be at risk of HIV infection	X	X	Caseworker or health staff

Time Frame	Activity	Mandated Activity	Mandated Time Frame	Who Performs
60 Days	Arrange HIV testing for child with capacity to consent who has agreed in writing to consent to testing	X	X	Caseworker or health staff

### 3.5 Network Contracting Requirements

- A. The Plan is required to contract with the providers listed below. In the event a required provider refuses to contract with the Plan, the Plan must notify the State and must demonstrate a good faith effort to negotiate a contractual arrangement with the provider.
  - i. OMH and OASAS licensed or certified providers who serve five or more of the Plan’s members who are under 21 years old. The Plan shall contract with these providers for at least the first 24 months of operation so long as quality of care is monitored and maintained consistent with 42 CFR 438.230(b)(4) and OASAS or OMH regulations.
  - ii. All licensed school-based mental health clinics within the Plan’s service area.
  - iii. NYS-designated SPA and HCBS providers, including HCBS providers under the former children’s waivers within the Plan’s service area or providers that may be approved by the State to provide care for medically fragile children. The former children’s waivers include:
    - a. Office of Mental Health (OMH) Serious Emotional Disturbance (SED) waiver #NY.0296.
    - b. Department of Health (DOH) Care At Home (CAH) I/II waiver #NY.4125.
    - c. Office of Children and Families (OCFS) Bridges to Health (B2H) SED waiver #NY.0469.
    - d. OCFS B2H Developmental Disability (DD) waiver #NY.0470.
    - e. OCFS B2H Medically Fragile waiver #NY.0471.
  - iv. All providers that are designated and approved by the State to offer EBP services in the Plan’s service area.
  - v. Health Homes serving children in the Plan’s service area. The Plan’s network must include a sufficient number of Health Homes serving children to serve all child enrollees eligible for Health Home services.
  - vi. A minimum of two CFCO providers per county for each service:
    - a. An exception to this requirement may be allowed. The Plan must document diligent efforts to identify service providers when there is only one willing and qualified entity available to provide services in a geographic area, such as in a rural area.

- vii. NYS-determined essential community BH providers for children (at this time these include State operated BH programs) so long as quality of care is monitored and maintained consistent with 42 CFR 438.230(b)(4).
- B. The Plan shall execute SCAs to meet clinical needs of children when in-network services are not available. The Plan shall monitor the use of SCAs to identify high-volume, nonparticipating providers for contracting opportunities and to identify network gaps and development needs.
- C. For the following essential services/providers, the Plan must pay at least the FFS fee schedule for 24 months:
  - i. New EPSDT SPA services including OLP; Crisis Intervention; CPST; PSR; Family Peer Support Services and Youth Peer Support and Training; and Preventive Residential Supports
  - ii. OASAS clinics (Article 32 certified programs)
  - iii. RRSYs
  - iv. OMH Clinics (Ambulatory Article 31 licensed programs)
- D. Providers who historically provided CM services under one of the 1915(c) waivers being eliminated, and who will provide services that are being transitioned to Health Home, may receive a transitional rate. The transitional rate may be paid for an appropriate number of CM slots in place immediately prior to the providers' transition to this waiver, for no more than 24 months. The rates will be as financially equivalent as practical to the interim rates (and as reconciled) established under the former waivers and in place immediately prior to their transition to Health Home.
- E. The Plan will be required to contract with OASAS residential programs and pay their allied clinical service providers on a single case or contracted basis for members who are placed in an OASAS certified residential program to ensure continuity of care for patients placed outside of the Plan's service area.
- F. The Plan shall ensure that all HCBS will be paid according to the NYS fee schedule as long as the Plan is not at risk for the service costs (e.g., for at least two years or until HCBS are included in the capitated rates).
- G. For continuity of care purposes the Plan must allow children to continue with their care providers, including medical, BH and HCBS providers, for the current episode of care. This requirement will be in place for the first 24 months of the transition. It applies only to episodes of care that were ongoing during the transition period from FFS to managed care.
- H. To preserve continuity of care, children enrollees will not be required to change Health Homes at the time of the transition. The Plan will be required to pay on a single case basis for Children enrolled in a Health Home when the Health Home is not under contract with the Plan.
- I. Plans that contract with clinics holding a state integrated license shall contract for the full range of services available pursuant to that license.
- J. The Plan may, subject to the State's review and approval, enter into shared savings or incentive payment arrangements with providers to incentivize access to and coordination of care and to provide improved outcomes resulting from the integration of BH and PH services.
- K. **Additional Network Contracting Requirements for Children in Foster Care:** The State is undertaking necessary steps to license VFCAs to allow Plans to contract with VFCAs to

serve children in foster care. Following this process, DOH will provide a list of licensed VFCAs to each Plan with a directive explaining minimum network requirements. At that point, Plans will be required to initiate and complete contracting with VFCAs within six months.

- i. The Plan must notify the State and must demonstrate a good faith effort to negotiate a contractual arrangement with the VFCAs licensed or certified providers who serve one of the Plan's members who are under 21 years old. The Plan shall contract with these providers for at least the first 24 months after the VFCAs children are transitioned to managed care so long as quality of care is monitored and maintained consistent with 42 CFR 438.230(b)(4) and OCFS or DOH regulations.
- ii. The Plan will be required to reimburse VFCAs according to a fee schedule transition (to be established) for at least 24 months.
- iii. The Plan will be required to contract with DOH-licensed VFCAs for the Preventive Residential Supports and Services (in development) which includes licensed and non-licensed medical services (e.g., BH counseling, nursing supports, medical escorts for care coordination) and with VFCAs that are licensed by NYS State agencies to provide (or arrange for) services of licensed practitioners under their license.
- iv. The Plan will be required to contract with LDSS/VFCA-designated specialty health care providers and shall have processes to coordinate care with these providers to perform initial assessments, annual diagnostic evaluations, mandated assessments, and to provide recommended treatment for children in foster care. If the Plan network does not include providers with such expertise, the Plan will be required to authorize services out of network until such time when the Plan has sufficient capacity of participating providers with such expertise.
- v. The Plan must reimburse LDSS/VFCA designated providers serving children in foster care according to a fee schedule transition for at least 24 months, which will be developed prior to the transition of VFCAs children to managed care.
- vi. The Plan shall execute SCAs with VFCAs as needed for children placed outside of the Plan's service area.

### 3.6 Network Monitoring

- A. The Plan must have a process for regularly monitoring the contracted network, developing strategies to ensure uninterrupted services to members, and ensuring that major components of the current network delivery system are not adversely affected by the transition to managed care.
- B. The Plan must develop a detailed network plan for review and approval that must be updated annually and submitted to the State upon request. The network plan shall include, but is not limited to the following components:
  - i. An analysis of network adequacy derived from data on enrollment, utilization, prevalent diagnoses, member demographics, access and availability survey results for the covered benefits, out-of-network utilization (i.e., SCAs), outcomes (when available), grievances, appeals, member satisfaction, provider issues that were significant or required corrective action during the prior year, and input/priorities communicated through participation in the RPC.



- ii. An explanation of how the network meets the needs of the expanded population and provides access to the covered benefits.
  - iii. Identification of any current material gaps in the BH network and specialty service providers needed to provide access to covered benefits for the expanded population, priorities for network development for the coming year and a work plan with goals, action steps, timelines, and measurement methodologies for addressing the gaps and priorities.
  - iv. Post transition, the annual network plan will be reviewed by the Children’s Advisory Committee and the Committee shall report findings to the State.
- C. State-designation of BH HCBS providers will suffice for the Plan’s credentialing process. When contracting with NYS-designated BH HCBS providers, the Plan may not separately credential individual staff members in their capacity as employees of these programs. The Plan must still conduct program integrity reviews to ensure that BH HCBS provider staff are not disbarred from Medicaid or any other way excluded from Medicaid reimbursement.
- D. When credentialing OMH-licensed, OMH-operated and OASAS-certified providers, the Contractor shall accept OMH and OASAS licenses, operation and certifications in place of, and not in addition to, any Contractor credentialing process for individual employees, subcontractors or agents of such providers. The Contractor shall still collect and accept program integrity related information from these providers, as required in the [Medicaid Managed Care Model Contract](#), and shall require that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.
- E. The Plan shall develop and submit to the State for approval a separate BH HCBS provider manual (for inclusion in the Plan’s provider manual) that includes BH HCBS operational P&Ps consistent with federal waiver requirements and relevant State P&Ps.
- F. The Plan shall develop a Health Home and provider profiling system that includes outcomes and compliance with HCBS assurances and sub-assurances.

### 3.7 Network Training

- A. The Plan shall expand its current provider training curriculum to reflect the expanded children’s benefit and populations. To the extent practical, provider training and the Plan’s annual training plan should be coordinated with the RPCs, include VFCA and Health Home providers and include any identified gaps related to the treatment of medically fragile children.
- B. An initial orientation and training shall be offered to all providers in the Plan’s network.
- i. Training and technical assistance shall be provided to the expanded array of providers on billing, coding, data interface, documentation requirements, provider profiling programs, and UM requirements.
  - ii. Training shall include processes for assessment for HCBS eligibility (e.g., Targeting Criteria, Risk Factors, Functional Limitations) and POC development and review.
- C. The State will collaborate with Plans and RPCs to develop a uniform provider training curriculum that addresses clinical components necessary to meet the needs of the expanded populations transitioning to managed care. Examples of clinical topics include:

- i. Unique needs of special populations including SED, SUD, TAY, Early Intervention (EI), medically fragile and children involved with child welfare;
- ii. Family-driven, youth-guided, person-centered treatment planning and service provision;
- iii. Recovery and resilience principles, multidisciplinary teams, member, family member/caregiver engagement including meaningful participation and member choice; and
- iv. Trauma informed care.

### 3.8 Utilization Management

- A. The Plan will use MNC guidelines approved by the State to determine appropriateness of new and ongoing services related to this transition. The State supports a family-driven, youth-guided, person-centered approach to care in which each enrollee's needs, preferences, and strengths are considered in the development of a treatment plan. Plan CMs should view each authorization for a specific service level within the larger context of the child's needs. When a child no longer meets MNC for a specific service, the Plan should work with providers to ensure that an appropriate new service is identified (if needed), necessary referrals are made, and the enrollee successfully transitions without disruption in care.
  - i. The Plan should also have processes for reviewing claims and authorization requests to determine if a child should be referred for Health Home or HCBS.
  - ii. The Plan must conduct UM for the medically fragile population in accordance with the requirements set forth by the "Office of Health Insurance Programs Principles for Medically Fragile Children" and report to the State trends in grievances, appeals and denials of requested services by medically fragile children.
- B. The Plan shall establish utilization review protocols that comport with the State's Medicaid medical necessity standards, federal regulations governing EPSDT (1905(r) of the Social Security Act), the [Medicaid Managed Care Model Contract](#), and other related standards that may be developed by DOH, OCFS, OASAS and OMH for the children's services described in this document.
- C. When conducting initial or concurrent review of the treatment plan or HCBS POC, the Plan must:
  - i. Ensure the clinical appropriateness of care based on the child's current condition, effectiveness of previous treatment, environmental and family supports, and desired outcomes.
  - ii. Address gaps in care, including appropriate use of EBPs, and request changes to treatment plans to address unmet service needs that limit progress toward treatment and quality of life goals. For children, this includes quality of life goals for the child and family as a whole.
  - iii. Promote resilience principles for children including promoting family-driven, youth-guided, culturally competent, person-centered planning, trauma informed care, and the use of certified youth peer or family support services. This includes natural supports, and other services that promote positive advancement of developmental

- milestones, family functioning and self-reliance including crisis intervention/prevention plans.
- iv. Promote relapse/crisis prevention planning that goes beyond crisis intervention to include development and incorporation of advance directives in treatment planning and the provision of treatment for individuals with an acute risk or a history of frequent readmissions, residential placement, out-of-home/child welfare placement or crisis system utilization.
- D. Plans that choose not to conduct prior authorization or concurrent review for specific ambulatory levels of care (as included in this transition) must provide the State with their data-driven plan to identify and work with providers who are outliers. The Plan must do the same for services in which prior authorization is not permitted.
  - E. The Plan shall develop and implement UM protocols for BH benefits and HCBS, including P&Ps and guidelines that comply with the following requirements:
    - i. UM protocols and MNC guidelines shall be specific to NYS for BH and HCBS benefits as defined in Table 2 consistent with State guidance.
    - ii. OASAS will identify the guidelines that all Plans must use for SUD services. The LOCADTR 3.0 tool will be used for making prior authorization and continuing care decisions for all SUD services.
    - iii. UM protocols and guidelines for BH and HCBS benefits, as well as any subsequent modifications to the protocols and guidelines shall be submitted to the State for prior review and approval.
    - iv. The Plan's review process for HCBS shall include review and approval of the POC.
      - a. HCBS must be managed in compliance with CMS HCBS Final Rule and any State guidance.
      - b. The Plan shall develop a data driven approach to identify service utilization patterns that deviate from any approved HCBS POC, conduct outreach to review such deviations, and require appropriate adjustments to either service delivery or the POC.
      - c. Prior authorization of the HCBS POC is required to determine medical necessity. UM requirements for HCBS must ensure that a person-centered POC meets individual needs.
      - d. The Plan must continue to authorize covered services in accordance with the most recent POC for children transitioning into the Plan from a 1915(c) waiver for 180 days following the date of transition. Existing HCBS Plans of Care utilization, services and HCBS providers for the population transitioning to the Plan will remain unchanged (unless such changes are requested by the enrollee) for not less than 180 days, during which time, a new POC is to be developed.
  - F. The Plan shall educate UM staff in the application of UM protocols, clearly articulating the criteria to be used in making UM decisions and describing specific CM functions. This includes the requirements in the [Medicaid Managed Care Model Contract](#) regarding medically fragile children. The Plan shall ensure that all UM staff who are making service authorization decisions and/or conducting CM have been trained and are competent in working with the specific area of service they are authorizing and populations they are

managing, including but not limited to children with MH, SUD, medical fragility, co-occurring disorders<sup>21</sup>, and individuals in foster care.

- G. The Plan shall ensure consistent application of review criteria regarding requests for initial and continuing stay authorizations for BH, medically fragile children, and HCBS benefits. At a minimum, on an annual basis, all staff performing initial and continuing stay authorizations and denial reviews shall participate in inter-rater reliability testing to assess consistency in the application of UM guidelines. Staff performing below acceptable thresholds for inter-rater reliability shall not be allowed to make independent authorization decisions until such time that they can be retrained, monitored and able to demonstrate performance that exceeds the acceptable threshold. The inter-rater reliability testing, including test scenarios and processes, shall be customized to address all Medicaid BH services and HCBS subject to prior authorization or concurrent review, as defined throughout this Section. Results shall be reported to the State annually.
- H. The Plan shall establish criteria to identify quality issues, other than medical necessity, that result in referral to a BH clinical peer reviewer for review and consultation. The Plan must develop a reasonable method, including automated online flags and UM documentation audits for confirming these criteria are consistently applied during the UM process.
- I. The Plan shall establish protocols for addressing discharge planning during initial and continued stay reviews. Protocols shall include, but are not limited to:
- i. Identifying comprehensive discharge plans that address not only treatment availability, but also community supports necessary for achievement of milestones and community integration, including but not limited to: educational concerns (inclusive of special education), family and social supports and interactions, stable housing, financial support, medical care, transportation, employment/vocational training and a crisis intervention/prevention plan;
  - ii. Identifying and reducing barriers to access and/or engagement with post-discharge ambulatory appointments, medication, and other treatment(s);
  - iii. Confirming post-discharge appointment availability and adherence. In the absence of adherence, the Plan must offer appointment options;
  - iv. Procedures for concurrent review for enrollees requiring extended care in inpatient classified settings due to insufficient response to treatment and/or placement limitations, to ensure services are authorized at the appropriate care level so that services are not inappropriately denied;
  - v. Corrective action expectations for ambulatory providers who do not follow up on members who are discharged from Inpatient Classified Settings when appointments are missed or family is not engaged;
  - vi. In addition, to the protocols established above, for the medically fragile population, the Plan must operate in accordance with the OHIP Principles for Medically Fragile Children (Attachment [G](#)) and timeframes for each of the above.
- J. The Plan shall comply with State Medicaid guidance including managed care policy documents, relevant performance improvement specification documents or manuals, and

---

<sup>21</sup> Includes co-occurring mental illness, SUDs, medical conditions and/or intellectual/developmental disabilities

policies governing prior authorization, concurrent or retrospective review. Specifically, Plans must incorporate the following into their guidance:

- i. OMH Clinic Standards of Care:  
([www.omh.ny.gov/omhweb/clinic\\_standards/care\\_anchors.html](http://www.omh.ny.gov/omhweb/clinic_standards/care_anchors.html))
  - ii. OASAS Clinical Guidance:  
(<https://www.oasas.ny.gov/AdMed/recommend/recommendations.cfm>)
  - iii. OHIP, Policy and Proposed Changes to Transition Children in Direct Placement Foster Care into Medicaid Managed Care, April 2013  
([https://www.health.ny.gov/health\\_care/medicaid/redesign/docs/policy\\_and\\_proposed\\_changes\\_fc.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_and_proposed_changes_fc.pdf))
  - iv. OCFS Working Together: Health Services for Children/Youth in Foster Care Manual  
([http://ocfs.ny.gov/main/sppd/health\\_services/manual.asp](http://ocfs.ny.gov/main/sppd/health_services/manual.asp))
  - v. OHIP Principles for Medically Fragile Children (Attachment G)
- K. The Plan shall utilize information acquired through QM/UM activities to make annual recommendations to the State on the continuation or adoption of different practice guidelines and protocols, including measures of compliance, fidelity, and outcomes. The identification of evidence-based or promising practices shall consider cultural and developmental appropriateness and be referred to the State designation process for EBPs (see the most recent State Plan manual for a description of this process). The Plan shall comply with the [Medicaid Managed Care Model Contract](#) in implementing practice guidelines.
- L. In general, denials, grievances, and appeals must be peer-to-peer — that is, the credential of the licensed clinician denying the care must be at least equal to that of the recommending clinician. In addition, the reviewer should have clinical experience relevant to the denial (e.g., a denial of rehabilitation services must be made by a clinician with experience providing such service or at least in consultation with such a clinician, and a denial of specialized care for a child cannot be made by a geriatric specialist). In addition:
- i. A physician board certified in child psychiatry should review all inpatient denials for psychiatric treatment for children under the age of 21.
  - ii. A physician certified in addiction treatment must review all inpatient LOC/continuing stay denial for SUD treatment.
  - iii. A board certified child psychiatrist must provide all Drug Utilization Review for children receiving BH medications.
  - iv. A physician must review all denials for services (e.g., private duty nursing, pharmacy) or durable medical equipment for a medically fragile child living at home and must include consideration for the family.
- M. **The following additional provisions apply to children in foster care:**
- i. For current enrollees, the Plan must authorize and cover all foster care intake assessments necessary at the time of a child's entry into foster care, including initial screens, comprehensive diagnostic assessments and any additional mandated assessments identified by OCFS and/or the LDSS/VFCA. The assessments shall be authorized either through a contracted health care provider or an out-of-network health care provider as determined by the LDSS/VFCA.
  - ii. The Plan must ensure access to medically necessary medications wherever the child is placed, including access to out of network pharmacies.

- a. The Plan must permit at least one 30 day refill within the first 90 days of a placement, whether or not the child is a new enrollee of the Plan, consistent with transitional fill requirements in the [Medicaid Managed Care Model Contract](#).
- b. For other medication requests, to the extent the Plan requires prior authorization for a prescribed medication; such authorization must be completed as quickly as required by the enrollee's condition but within no more than three business days of the request.
- c. The Plan must allow exceptions to refill timeframes and rapidly replace lost medications, as required by the enrollee's condition, when medically necessary.
- iii. The Plan shall authorize any necessary replacement of durable medical equipment including eyeglasses and contact lens, hearing aids and batteries, nebulizers, inhalers, specialized beds, wheel chairs, strollers, lifts, orthotics, supine standers, and other medically necessary equipment.
- iv. In the event of a hospitalization or inpatient stay, the Plan together with the LDSS/VFCA, hospital, and/or Health Home will coordinate an appropriate discharge plan including, if needed, identification of an appropriate living situation and timely access to medically necessary follow-up treatment services. The Plan shall coordinate needed services with the LDSS/VFCA, Health Home if applicable, and hospital.
- v. The Plan shall work with the LDSS/VFCA to provide authorization necessary for reimbursement of medically necessary covered services immediately needed by the child (i.e., urgent services).
- vi. In the event that requested services are not authorized or continued by the Plan due to medical necessity, the LDSS/VFCA may file an appeal on behalf of a child in foster care. Additionally, the LDSS/VFCA may request a Fair Hearing with Aid to Continue on behalf of the child, and/or may request an external appeal.

### 3.9 Clinical Management

- A. Over the next several years, the State will work with the Plan Associations and Plans to develop steps, including comprehensive reporting requirements, for BH and social-emotional screens to achieve integration in primary care settings. Key areas of consideration shall include:
  - i. Awareness and utilization of the Training and Education for the Advancement of Children's Health ([project TEACH](#)).
  - ii. Compliance with federal mandates for conducting and reporting BH Screening.
  - iii. Promoting integration through activities such as:
    - a. Pediatrician screening for maternal depression
    - b. Trauma Informed Care strategies and models
    - c. Monitoring the use of psychotropic medication with children (as well as examining sub-populations with special attention to children in foster care)
    - d. Planning for unique populations such as TAY or children 0–5
    - e. Screening for SUD
- B. The Plan shall augment their BH-medical integration requirements to include the following:
  - i. The Plan shall deliver orientation and ongoing training to educate its BH and medical staff about co-occurring BH and medical disorders and integrated CM principles, including the unique needs of medically fragile children and children involved with child

- welfare. The training objective is to strengthen the knowledge, skill, expertise, and coordination efforts within the respective outreach, UM, CM, pharmacy, and provider relations workforce. Per Section 3.2 of this document, the Plan shall develop and implement a training plan, which at a minimum shall incorporate the topics listed in Attachment E.
- ii. The Plan shall expand its business rules regarding screening, referral, and co-management of high risk individuals with both BH and medical conditions. The protocols shall be expanded to include processes to facilitate appropriate sharing of clinical information among providers, LDSS and VFCA as needed for coordinated care.
- C. The Plan shall include the BH Medical Director (or the State-approved designated board certified child psychiatrist) in the evaluation of BH medications and other emerging technologies for children.
- D. The Plan shall expand its capacity to develop and implement a defined pharmacy management program for BH drug classification to include the following areas for children:
- i. Specialized pharmacy management policies for BH providers, primary care providers, and other specialty provider types which include, but not limited to, polypharmacy and metabolic and cardiovascular side effects of psychotropic medications for children.
  - ii. Use of data to identify opportunities for intervention that address safety, gaps in care, utilization, and cost stratified by age group.
  - iii. Protocols to monitor the use of psychotropic medications, including the oversight of any child:
    - a. Under the age of six taking any psychotropic medications;
    - b. On more than one medication from the same class (antidepressants, antipsychotics, attention-deficit/hyperactivity disorder medications, anxiolytics/hypnotics, mood stabilizers); or
    - c. On three or more psychotropic medications; in the event that any of these prescribing methods occur.
- E. The Plan shall expand its definitive strategies to promote BH-medical integration for children, including at-risk populations defined by the State. Considerations include:
- i. Provider access to rapid consultation from child and adolescent psychiatrists;
  - ii. Provider access to education and training; and
  - iii. Provider access to referral and linkage support for their child and adolescent patients.
- F. **The Plan must meet the following additional requirements for children eligible for HCBS:**
- i. The Plan shall provide care coordination and CM services through Health Homes or other NYS-designated entities.
  - ii. The Plan shall ensure that the Health Home or other assigned care coordinator shall assist the member with accessing medical and BH services provide member and family/caregiver education and coaching to facilitate adherence to recommended treatment, develop plans of care in accordance with applicable State and Federal regulations and guidance, and monitor member outcomes.

- iii. The Plan and Health Homes will collaborate on information sharing and care coordination for high need enrollees. Nothing in this requirement shall be construed to limit, in any way, the member's right to refuse treatment.
- iv. When a child under 21 is institutionalized or otherwise in a non-HCBS, the child may not receive HCBS. However, the Plan shall coordinate with the Health Home on the discharge plan, including assessing HCBS eligibility for post discharge services and supports in the community.
- v. The Plan shall adopt, disseminate, and implement the State-selected and nationally recognized clinical practice guidelines for children listed below. The State will provide additional guidelines pertaining to EBPs.
  - a. Trauma-Focused Cognitive Behavioral Therapy
  - b. Trauma Informed Child-Parent Psychotherapy
  - c. Multi-systemic Therapy
  - d. Functional Family Therapy
  - e. Multi-Dimensional Treatment Foster Care
  - f. Dialectical Behavior Therapy
  - g. Multidimensional Family Therapy
  - h. Seven Challenges
  - i. Adolescent Community Reinforcement
  - j. Assertive Continuing Care

**G. The Plan must meet the following additional requirements for children in foster care:**

- i. The Plan shall establish protocols to monitor that the PH and BH care needs identified through the assessment process are adequately met and treatment recommendations are implemented.
- ii. The Plan shall make medical case management services available for children in foster care as determined and requested by the LDSS/VFCA Foster Care planner/manager, following an assessment or upon recommendation by a provider.

### **3.10 Cross System Collaboration**

- A. Plans shall meet with DOH, OMH, OCFS, and OASAS on BH and PH managed care issues at a frequency determined by the State. At the State's discretion, LGU, LDSS and/or Administration for Children's Services may be involved in meetings that address services for enrollees. The Plan shall participate in meetings with the State on specific issues as determined by the State, including but not limited to issues related to the foster care, medically fragile, or other identified special populations.
- B. The Plan shall meet quarterly with the RPCs in their respective regions. RPCs will be comprised of each LGU in a region and representatives of children's MH and SUD service providers, VFCAs, LDSS, peers, families, Health Home leads, schools, Plans and other stakeholders as appropriate. The RPC will work closely with the State agencies to inform BH and PH policy in the region and problem solve regional service delivery challenges. The Plan should ensure that advocates for medically fragile children are included in these meetings or



that a separate meeting occurs quarterly with representatives of the Medically Fragile LOC population as noted in 3.10.C below.

- C. The Plan shall meet quarterly, or as needed or determined by the State, with DOH, OMH, OASAS, OCFS, and representatives of medically fragile children including providers, peers, families, Health Home leads, Health Home care managers and other stakeholders as appropriate.
- D. The Plan shall work with the State to ensure that TAY are provided continuity of care without service disruptions or mandatory changes in service providers.
- E. **The Plan must meet the following additional requirements related to foster care:**
  - i. The Plan shall develop and implement a system of communication and notification that includes:
    - a. A mechanism (e.g., fax, secure email or IT solution as agreed upon by the OCFS/LDSS/VFCA) implemented through the MMCO Foster Care Liaison for receiving information including, but not limited to:
      - i. New enrollments or dis-enrollments, both from foster care and from the Plan,
      - ii. Changes in placement or address for children in foster care,
      - iii. Changes in health status or provider for children in foster care.
    - b. A mechanism for the Plan, through the MMCO Foster Care Liaison, to notify the LDSS/VFCA of any health or other concerns related to children in foster care in order to care for the child appropriately.
    - c. Use of a transmittal form for communicating between the LDSS/VFCA Foster Care Coordinator and the MMCO Foster Care Liaison. The form shall be tailored to meet the needs of both parties, have clear categories of communication and shall be reviewed and approved by OCFS.
    - d. Notification of gaps or barriers to timely access related to mandated and appropriate PH and BH services for children in foster care.
  - ii. The Plan shall implement processes to assist with the transition and enrollment of children being placed in foster care, including children who are currently enrolled with the Plan and children in foster care who will become enrolled with the Plan. The processes shall include the following elements:
    - a. For current Plan enrollees entering foster care, the Plan shall issue replacement identification cards or alternative documentation upon request of the LDSS/VFCA Foster Care Coordinator by the next business day following the request.
    - b. Per regular business rules, children in foster care and new to the Plan are enrolled prospectively. Any care required prior to the effective date of enrollment with the Plan is covered under FFS Medicaid.
    - c. The Plan must send all notices, Welcome Letters, and identification cards to the LDSS Foster Care Coordinators within 14 days of enrollment. However, the Plan must provide a form of temporary identification for a new enrollee in foster care and transmit it to the LDSS/VFCA Foster Care Coordinator by the next business day following the request or as needed to allow immediate access to services. The Plan shall not issue the temporary or replacement identification card to foster parents since the child is in the legal custody of the county. The Plan shall not require a

court order or other documentation as a condition for issuing a temporary or replacement identification card to the county.

- iii. The Plan shall establish processes to promote access to care for children in foster care or entering foster care that address the following:
  - a. MMCO Foster Care Liaison coordination with the counties and providers to streamline access to care.
  - b. MMCO Foster Care Liaison coordination with LDSS/VFCA Foster Care Coordinators and Health Home care manager, if the child is enrolled in Health Home, to monitor appropriate care and treatment.
- iv. Upon notice of a child leaving foster care, the MMCO Foster Care Liaison shall coordinate with the VFCA /LDSS Foster Care Coordinator(s) and any Health Home Care Manager throughout the discharge planning process. The Plan shall ensure continued coordination with the Health Home Care Manager.
- v. Upon disenrollment from the Plan, the MMCO Foster Care Liaison shall coordinate with the LDSS/VFCA Foster Care Coordinator(s) and any Health Home Care Manager to ensure that the LDSS/VFCA and the new Plan are aware of the transition so the current service plan/POC can be coordinated.
- vi. Upon discharge from foster care or disenrollment from the Plan, if the child is considered unstable by either the health care provider or the LDSS/VFCA, or has a chronic condition, the MMCO Foster Care Liaison shall coordinate with the LDSS/VFCA Foster Care Coordinator(s) and any Health Home Care Manager to ensure continuity of care plans are in place.

### 3.11 Quality Management

- A. The Plan shall amend its quality assurance program to address specific monitoring requirements related to the populations, benefits and services covered in this document.
- B. The Plan shall expand its existing QM committee and BH QM sub-committee functions to meet the quality requirements and standards for the populations, benefits and services for children as described in this document:
  - i. The Plan maintains an active BH QM sub-committee which shall be expanded to include, in an advisory capacity, members, family members, youth and family peer support specialists, and child-serving providers. The BH QM sub-committee shall be responsible for carrying out the planned quality activities under the standards within this document related to individuals with BH conditions who access BH benefits and/or HCBS. The BH QM sub-committee shall be accountable to and report regularly to the governing board or its designee concerning BH QM activities. The Plan's BH QM administrator shall lead the BH QM sub-committee and maintain records documenting attendance by sub-committee members, as well as committee's findings, recommendations, and actions.
  - ii. The Plan shall address requirements for medically fragile children in a QM Committee or sub-committee.
  - iii. The Plan may utilize existing QM Committee and BH QM sub-committee structures to meet these requirements, provided that:

- a. The QM committee activities (focused discussions, tracking, trending, analysis and follow-up) related to PH services for medically fragile children/complex conditions must be documented as a separate item in the QM committee agenda and in the QM committee minutes.
  - b. The BH QM sub-committee activities (focused discussions, tracking, trending, analysis and follow-up) related to BH services and HCBS for children must be documented as separate items in the QM committee agenda and in the QM committee minutes.
- C. The Plan shall expand its existing UM committee and BH UM sub-committee functions to meet the UM requirements and standards for the populations, benefits and services for children described in this document. The committees must be chaired by the Medical Director and BH Medical Director respectively and are charged with implementing processes to collect, monitor, analyze, evaluate, and report utilization data consistent with the reporting requirements defined in this document.
- i. The UM committee looking at PH services must include examination of service utilization and outcomes for children including medically fragile children. The UM committee shall review and analyze data and other metrics as determined by the State.
  - ii. The BH UM subcommittee shall review and analyze data in the following areas, interpret the variances, review outcomes, and develop and/or approve interventions based on the findings.
    - a. Under and over utilization of BH services and cost data;
    - b. Avoidable admissions and readmissions, admission and readmission rates, trends, and the average length of stay for all inpatient classified LOC;
    - c. Inpatient civil commitments;
    - d. Outpatient civil commitments;
    - e. Follow up after discharge from MH inpatient, SUD inpatient and residential levels of care facilities;
    - f. SUD initiation and engagement rates;
    - g. Emergency Department (ED) utilization and crisis services use;
    - h. BH prior authorization/denial and notices of action;
    - i. Psychotropic medication utilization with a separate analysis for children in foster care;
    - j. Rates of initiation and engagement of individuals with FEP in services;
    - k. Addiction medication utilization;
    - l. Transitional issues for youth ages 18 to 21 years; and
    - m. Other metrics determined by the State.
  - iii. For children eligible for HCBS, the UM BH subcommittee shall separately report, monitor findings and recommend appropriate action on the following additional metrics:
    - i. Use of crisis diversion and crisis intervention services;
    - ii. Prior authorization/denial and notices of action;
    - iii. HCBS utilization;
    - iv. HCBS quality assurance performance measures as determined by the State; and

- v. Enrollment in Health Home.
- D. The Plan shall ensure intervention strategies have measurable outcomes and are recorded in the UM/clinical management committee meeting minutes. Analyses shall be conducted separately for individuals under 21 years of age.
- E. The Plan shall expand its mechanisms to monitor service quality, develop quality improvement initiatives, and solicit feedback/ recommendations from key stakeholders to improve quality of care and member outcomes through the involvement of consumer and other stakeholder advisory boards. Key stakeholders shall include: children representatives of the populations served (i.e., BH, HCBS, foster care, medically fragile), family members, subcontracted Plans, RPCs, LGUs, LDSS and other child-serving agencies.

### 3.12 Reporting and Performance Measurement

- A. The Plan shall continue to submit standard reports to the State as specified in the Quality Assurance Reporting Requirements (QARR) within the timeframes provided by the [Medicaid Managed Care Model Contract](#). Performance measures shall be audited as per the [Medicaid Managed Care Model Contract](#).
- B. The Plan shall conduct at least one internal performance improvement project (PIP) on priority health care topic areas of the Plan's choosing, subject to the approval of the State. The PIP must be on a topic affecting the populations covered in this document.
- C. The Plan will separately track, trend, and report complaints, grievances, appeals, and denials related to the populations and services covered in this document.
- D. The Plan shall report to the State any deficiencies in performance and corrective action taken with respect to DOH, OMH, OASAS and OCFS licensed, approved, certified or designated providers.
- E. The Plan shall participate in consumer perception surveys for the populations covered under this document as specified by the State.
- F. The Plan shall comply with the federal HCBS quality assurance performance measure reporting requirements for children receiving HCBS as defined by the State.
- G. The Plan must report on required outcome measures, as specified by the State.

### 3.13 Claims

- A. The Plan shall have an automated claim and encounter processing system that will support the standards and requirements within this document to ensure the accurate and timely processing of claims and encounters and allow the Plan to verify services actually provided. The Plan shall offer its providers an electronic payment option including a web-based claim submission system for providers to directly data enter claims to the Plan.
- B. The Plan shall support both hardcopy and electronic submission of claims and encounters for all claim types. The Plan must be able to submit electronic 835s and hardcopy explanation of provider remittance advice in the format requested by the provider.
- C. The Plan must support hardcopy and electronic submission of claim inquiry forms, and adjust claims and encounters in the provider preferred format to process claims.

- D. The Plan shall have a system to support the additional populations, services and provider types included in this document.
- E. The Plan shall have the capability to track and pay Health Homes to administer CM for children enrolled in Health Homes.

### 3.14 Information Systems and Website Capabilities

- A. The Plan shall have information systems that enable the paperless submission of prior authorization and (if applicable) other UM related requests, and when applicable, the automated processing of said requests. The paperless submission must include the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic 278 authorization format and a web-based authorization submission system for providers to directly data enter authorizations to the Plan and review status. These systems shall also provide status information on the processing of said requests.
- B. The Plan shall maintain BH content on a website that meets the following minimum requirements:
  - i. Public and secure access via multi-level portals (such as providers and members) for providing web-based training, standard reporting, and data access as needed for the effective management and evaluation of the performance of the Plan and the service delivery system.
  - ii. The Plan shall organize the website to allow for easy access of information by members, family members, network providers, stakeholders, and the general public in compliance with the Americans with Disabilities Act. The Plan shall include on its website, at a minimum, the following information or links:
    - a. How to access services, including the detailed process to obtain crisis intervention services, crisis contact information with toll-free crisis telephone numbers and how to identify and access PH, BH and HCBS by specific program/service types.
    - b. How to access services, including PH, BH and crisis contact information, and toll-free crisis telephone numbers.
    - c. Telecommunications device for the deaf/text telephone numbers.
    - d. Information on the right to choose a qualified PH or BH service provider.
    - e. An overview of the new range of HCBS and BH services being provided. This should include descriptions of the new HCBS and the process to apply for and access these services.
    - f. A provider directory that includes PH, BH, and HCBS provider names, locations, telephone numbers, service types, non-English languages spoken for current network providers in the member's service area, providers that are not accepting new patients and, at a minimum, information on specialists and hospitals. This directory should include a list of buprenorphine providers and methadone providers. The directory should have the functionality for members and staff to conduct online provider searches by specific PH, BH and HCBS program types/services and populations served (e.g., programs serving young children [0–5]).

- g. Access to BH medical integration tools and supports, including information and tools to support provider integration initiatives and information on Project TEACH with hyperlinks to the Project TEACH website.
  - h. Access to information for TAY and members with FEP.
  - i. A library for providers and members containing comprehensive information and practical recommendations related to mental illness, addiction and recovery, life events, and daily living skills.
  - j. The Plan's member handbook and provider manual.
  - k. Information regarding community forums, volunteer activities, and workgroups/committees that provide involvement opportunities for members receiving services, family members, providers, and stakeholders.
  - l. Information regarding advocacy organizations, including how members and other family members may access advocacy services.
  - m. Hyperlinks to the DOH, OMH, OCFS, OASAS, and county/NYC DOH, LDSS, and Mental Hygiene department websites and other websites determined by the State.
  - n. Opportunities, including surveys, for children in receipt of BH benefits or HCBS, family members/caregivers, network providers and other stakeholders to provide satisfaction/complaint feedback.
  - o. Other documents as required by DOH, OMH, OASAS, or OCFS.
- iii. The Plan shall develop and implement a plan to update its Information Systems to support data-driven approaches to monitor compliance with requirements in this document, including BH network adequacy, crisis plans, psychiatric advance directives, and BH-specific reporting requirements. This includes but is not limited to the following:
    - a. Functionality to produce required or ad hoc reports by eligibility category, population, age group and/or system affiliation (e.g., foster care).
    - b. Functionality to systematically track children in foster care.
    - c. Functionality to receive and send required member level electronic notifications between MMCO Foster Care Liaison and the LDSS/VFCA, including new enrollments, disenrollment's, changes in placement, and change in address.
    - d. Functionality to support data sharing between the Plan and OCFS (i.e., services the children are receiving and being paid for by Plan).

**C. The Plan must meet the following additional requirements for children eligible for HCBS:**

- i. The Plan shall have information systems for the collection of data elements for HCBS assurances and sub assurances, such as assessment elements, POC elements, and amount, duration, and scope of services authorized and reimbursed.
- ii. The Plan IT system will include functionality for all HCBS required reporting including LOC/LON designation, POC, qualified provider, health and welfare, and fiscal accountability monitoring for children receiving HCBS. The application will provide the Plan management staff with the tools needed to perform all the Federal reporting required by the HCBS Program under the 1115 Demonstration amendment including:

- a. The system should ensure that the HCBS program has the analytical capability to: calculate performance indicators; detect data redundancy; measure data quality; and document compliance with State and federal regulations.
- b. The system should be flexible enough to accommodate the requirements as stated in the State's CMS Special Terms and Conditions and accommodate the normal changes that are identified through the quality improvement process.
- c. The system will have, at a minimum, the capability to house assessment data and electronic versions of the POC to serve as the prior authorization for any HCBS in the Plan's claims management system.
- d. The system will have the ability to create reports on any date and have a timely completion indicator, etc. for quality of care monitoring related to HCBS quality assurance measures.

### 3.15 Financial Management

- A. The Plan shall amend its financial reporting requirements as required by the State and/or by the [Medicaid Managed Care Model Contract](#) to address medical and administrative expenditures specific to new BH and HCBS benefits and new populations outlined throughout this document. This includes, but is not limited to, separate reporting for all BH or HCBS categories of aid, as defined by the State.
- B. Capitation payments made to the Plans for BH services for Medicaid recipients under the age of 21 will be monitored by the State and compared to the BH expenditure target. Plans that fail to perform up to the requirements in this document may be subject to statements of deficiency and/or funding recoupments.
- C. Plans and providers wishing to negotiate alternative payment methodologies to the provider following implementation may do so pending State approval and subject to compliance with State and federal law.

## 4.0 Readiness Requirements

The NYS OMH, OASAS, DOH, and OCFS will be working collaboratively to assess readiness to meet Children’s System Transition Requirements and Standards beginning on October 1, 2017. The review process will consist of:

- Offsite review of program materials.
- Onsite interviews with Plan staff.
- Onsite observations in a production-ready environment.

The table below details the information request for the offsite review of program materials, including anticipated due dates for initial submission and ongoing updates, where appropriate.<sup>22</sup> This information request addresses requirements under Section 3.0. When an item is requested, it is specific to these requirements and not to requirements under the [Medicaid Managed Care Model Contract](#), requirements under the expanded BH benefits for adults, or requirements under the HARP. Unless the document description specifically requests submission of a plan/strategy/approach (e.g., implementation plan, staffing plan), the Plan’s response must be evidence demonstrating the completion of the requirement (e.g., formal approved Plan policy).

Plans will receive an Excel file with detailed instructions and the templates referenced below to support the submission of required information.

Performance Standard	Document Name	Description	Due Date
N/A	Implementation Plan	Using a standard template to be provided, develop and submit an implementation plan with milestones, responsible persons, start dates, and target end dates. The implementation plan will be updated and submitted on a monthly basis to track progress toward completion.	45 days after release and monthly
3.1 Organizational Capacity	(If applicable) BHO delegation agreement(s) and DOH approval letters	Any Plan using a subcontracted BHO shall submit: <ul style="list-style-type: none"> <li>• An updated, signed BHO Subcontractor Delegation Agreement reflecting the full service array for children’s BH and HCBS functions to be provided under the subcontract and roles and responsibilities of the Plan and BHO for each delegated function.</li> <li>• Copies of signed approval letters from DOH regarding the Plan’s management services agreement with the BHO, including approval letters for all amendments.</li> </ul>	45 days after release
	Advisory committee work	Submit a work plan for developing and implementing an advisory committee for children including timelines, strategies, and key milestones.	45 days after release

<sup>22</sup> Deliverables pertaining to Foster Care will be due in conjunction with the Foster Care transition. Due dates will be shared at a later time.



Performance Standard	Document Name	Description	Due Date
	plan		
3.2 Personnel	Organizational Chart	Submit an organizational chart showing all departments and reporting structures for key personnel, managerial staff, operational staff and subcontractors.	45 days after release
	Staffing Plan	Using a standard template to be provided, identify all staffing positions expected to be involved in the administration of the children’s benefit. The template will also be used to provide monthly updates illustrating progress with filling staffing positions.	45 days after release and monthly
	Key leadership staff resumes	Provide resumes for the BH Medical Director with overall accountability for BH services for populations under the Children’s Standards <sup>23</sup> , BH Clinical Director for Children’s Services, MMCO Liaison for Medically Fragile Children, and MMCO Foster Care Liaison.	45 days after release and monthly as positions filled
	Staff Training Plan	Using a standard template to be provided, submit a staff training plan that lists all proposed orientation and training modules associated with implementation of the children’s benefit and consistent with Section 3.0. The template will also be used to provide monthly updates illustrating implementation of the training plan.	45 days after release and monthly
3.3 Member Services	Member services P&Ps	Provide updated member services P&Ps reflecting information on: <ul style="list-style-type: none"> <li>• New covered populations and expanded array of benefits available to children.</li> <li>• Authorization requirements for expanded benefits.</li> <li>• Requirements for responding to members/family members’ inquiries concerning information/referral to other children systems and supporting linkages to other children systems.</li> <li>• Dealing with crisis situations.</li> <li>• Minimum member service call center performance standards (average speed to answer, etc.).</li> </ul>	45 days after release; 90 days after release for the performance standards P&P
	Member handbook	Provide the updated member handbook to DOH highlighting new information on the expanded array of children’s benefits, how to access services,	TBD

<sup>23</sup> If an incumbent is serving in this position, please resubmit the resume for that individual. If the Plan proposes to fulfill the BH Medical Director responsibility with an individual who is not a child psychiatrist, a board certified child psychiatrist must be available to provide leadership and consultation to the Plan on medical and quality activities associated with the delivery of integrated BH services for children and youth. The resume for this individual must also be submitted.

Performance Standard	Document Name	Description	Due Date
		authorization requirements, including HCBS requirements.	
3.4–3.7 Network	Network Contracting Status Report	Using a standard template provided by the State, identify contracting status of providers serving children including: OMH/OASAS licensed/certified providers serving five or more members that are under the age of 21, State-designated providers of the new state plan services and HCBS identified in Section 3 above, VFCAs within the Plan’s service areas, and providers that are designated to offer State approved EBP services in the Plan’s service area. The template will also be used to provide monthly updates illustrating progress with contracting.	45 days after release and monthly thereafter
	Contracting timeline for new services	Submit a plan for ensuring all contracts being reported include mandated rates or a risk arrangement that is equivalent. This must include contract amendments used for new services in existing provider contracts and/or contract templates being used with new providers.	TBD
	Provider network Validation/Contract Review	Prior to the onsite readiness review a random sample of provider contracts will be selected from the Network Contracting Status Report for submission by the plan/review by the State to validate that the network is appropriately contracted with Department approved contracts that meet the requirements of this section.	TBD
	Attestation signed by Plan CEO	Submit a signed attestation statement provided by the State confirming all executed contracts listed in the Network Contracting Status Report is accurate and are in compliance with the rates requirements outlined in Section 3.	45 days after release
	Network orientation, training and support	Using a standard template to be provided, submit plan for provider training that reflects the expanded children’s benefit and populations, including: (a) initial orientation and training for all providers in the Plan’s network, and (b) training and technical assistance for the expanded array of providers on billing, coding, data interface, documentation requirements, provider profiling programs, UM requirements and processes for assessments for HCBS eligibility, and POC development and review.	45 days after release
	Provider Manual	Submit updated Provider Manual with the completed state-issued checklist identifying where required elements are addressed in the provider manual.	90 days after release

Performance Standard	Document Name	Description	Due Date
	Network P&Ps	<p>Provide updated network P&amp;Ps reflecting:</p> <ul style="list-style-type: none"> <li>• Appointment standards for the new children's benefits and timeframes for completion of required foster care initial health assessments.</li> <li>• Special accommodations and requirements for children in foster care, and allowable circumstances and mechanisms for SCAs for out of area providers.</li> <li>• Role of MMCO Foster Care Liaison and how the Plan will ensure timely access to and completion of health assessments for children in foster care.</li> <li>• Reimbursement arrangements and payment in accordance with the 24 month transition requirement.</li> <li>• Continuity of care for children to remain with their current provider for the current episode of care up to 24 months and remain with their current Health Home provider.</li> <li>• Process for establishing SCAs with non-participating providers, including VFCAs and a copy of any template SCA used by the Plan.</li> </ul>	90 days after release
3.8 Utilization Management	LOC criteria	Submit updated or new medical necessity guidelines for the children benefits.	45 days after release
	Service authorization and UM P&Ps	<p>Provide updated or new P&amp;Ps reflecting:</p> <ul style="list-style-type: none"> <li>• Process for identifying and monitoring the need for CM services, triggers and referrals for HCBS for children.</li> <li>• Process for conducting UM for the medically fragile LOC population.</li> <li>• Continuing to authorize covered services in accordance with the most recent POC for enrolled 1915(c) waiver participants.</li> <li>• Discharge planning for all children, including children determined medically fragile.</li> <li>• Denials, grievances and appeals with language around child specific peer to peer consultation, review and decision making.</li> </ul>	90 days after release
	Foster care P&Ps	<p>Provide P&amp;Ps reflecting the following for children involved in foster care:</p> <ul style="list-style-type: none"> <li>• Process for authorization of assessments.</li> <li>• Process for accessing medically necessary medication including medication replacement needs.</li> </ul>	90 days after release

Performance Standard	Document Name	Description	Due Date
	Service authorization and UM P&Ps for HCBS	<ul style="list-style-type: none"> <li>• Inpatient/hospital authorization and discharge planning and coordination.</li> <li>• Collaboration with VFCA/ LDSS for urgent needs.</li> </ul> <p>Submit P&amp;Ps (with a provided checklist that identifies where required elements are addressed) that reflect the following:</p> <ul style="list-style-type: none"> <li>• How the HCBS POC will be reviewed and used as service authorization.</li> <li>• How the HCBS POC authorization interacts with prior authorizations, denials, and notices of action.</li> <li>• Process to consider revisions to the amount, duration and scope of services as goals are met or not being met.</li> <li>• Oversight for detection of service utilization patterns that deviate from an approved HCBS POC and how they will be addressed.</li> <li>• The roles of the Plan care manager, UM staff and Health Home in monitoring HCBS service delivery.</li> <li>• How member/family member/legal guardian requests for HCBS are addressed and how member requests are processed when forwarded to UM.</li> <li>• How regular medical necessity guidelines do not apply (i.e., does not require active symptoms, the individual's preference and the presence of functional impairment is enough to support need when a medical order is not necessary).</li> <li>• HCBS POCs include both a BH and primary care contact and use a whole-person oriented, person-centered planning approach with health education/health promotion services.</li> <li>• How the content of the HCBS POCs are reviewed against HCBS regulation requirements.</li> </ul>	90 days after release
3.9 Clinical Management	Care Coordination P&Ps  Pharmacy P&Ps	<p>Submit updated P&amp;Ps reflecting expanded language around processes to facilitate appropriate sharing of clinical information among providers, LDSS and VFCAs regarding screening, referral, and co-management of high-risk children with both BH and medical conditions.</p> <p>Submit P&amp;P (or other formal Plan document such as UM Plan) reflecting enhancements to the pharmacy management program for the expanded child benefit</p>	90 days after release  90 days after release

Performance Standard	Document Name	Description	Due Date
	Care Coordination P&Ps for HCBS members	<p>and populations including additional P&amp;Ps/guidelines for providers and data evaluation, oversight and management of medications, prescribing practices, and side effects to address safety, gaps in care, utilization and cost stratified by age group.</p> <p>Submit P&amp;Ps for care coordination and management of services for children in receipt of HCBS, including use of Health Home. The P&amp;Ps should address:</p> <ul style="list-style-type: none"> <li>• Accessing services.</li> <li>• Education/coaching of enrollees and family members.</li> <li>• Developing plans of care.</li> <li>• Monitoring member outcomes.</li> <li>• Information sharing.</li> <li>• Coordination to enroll eligible enrollees post discharge from non-HCBS settings.</li> </ul>	90 days after release
	List of clinical practice guidelines and P&P	<p>Submit a list of clinical practice guidelines relevant to the expanded child benefit and populations that have been (or will be) adopted and disseminated, with a timeline for adoption and dissemination. Submit an updated P&amp;P reflecting: (a) provider types receiving guidelines, (b) how the guidelines are disseminated, and (c) how fidelity of implementation and utilization will be monitored.</p>	90 days after release
	Foster Care P&Ps	<p>Submit P&amp;Ps describing expectations for supporting children in foster care including how the Plan will monitor progress in addressing PH and BH needs identified in treatment plan and respond to requests/referrals for medical case management.</p>	90 days after release
3.10 Cross System Collaboration	Continuity of Care P&P	<p>Submit P&amp;P outlining continuity of care for children in foster care and TAY (i.e., no service disruptions or mandatory changes in service providers).</p>	90 days after release
	Foster Care P&Ps	<p>Submit P&amp;Ps specific to children in foster care that address:</p> <ul style="list-style-type: none"> <li>• System of communication and notification of new enrollments, disenrollment, placement changes, changes in health status, etc. from the LDSS/VFCA Foster Care Coordinator. System should include:               <ol style="list-style-type: none"> <li>a. Use of a transmittal form for communicating between the LDSS/VFCA Foster Care Coordinator and the MMCO Foster Care Liaison,</li> <li>b. Notification of problems with timely access to</li> </ol> </li> </ul>	90 days after release

Performance Standard	Document Name	Description	Due Date
		<p>services, and</p> <p>c. Notification to the LDSS/ VFCA of any health or other concerns relating to the child.</p> <ul style="list-style-type: none"> <li>• Transition, enrollment, and disenrollment of:               <ul style="list-style-type: none"> <li>a. Plan enrollees entering or leaving foster care,</li> <li>b. Children in foster care new to Managed Care with the Plan, and</li> <li>c. Plan enrollees in foster care that are transitioning to a new Plan. P&amp;P should address discharge planning and coordination for children in foster care.</li> </ul> </li> <li>• MMCO Foster Care Liaison roles and responsibilities to promote access to care and coordination of care.</li> </ul>	
3.11 Quality Management	QM Plan	<p>Provide updated QM plan (or P&amp;Ps) incorporating and reflecting:</p> <ul style="list-style-type: none"> <li>• Specific monitoring requirements related to the population, benefits and services covered in this document.</li> <li>• All QM committees/subcommittees and any associated advisory committees and reporting structure, delineating (for each committee/subcommittee):               <ul style="list-style-type: none"> <li>a. If it is BH-specific, PH-specific or integrated,</li> <li>b. If it is specific to adults, children or both,</li> <li>c. Frequency of meetings, and</li> <li>d. If it includes peers/family members as members.</li> </ul> </li> </ul>	90 days after release
	UM Plan	<p>Provide updated UM plan (or P&amp;Ps) incorporating and reflecting:</p> <ul style="list-style-type: none"> <li>• Specific monitoring requirements related to the population, benefits and services covered under this document.</li> <li>• All UM committees/subcommittees and reporting structure, delineating (for each committee/subcommittee):               <ul style="list-style-type: none"> <li>a. If it is BH-specific, PH-specific or integrated,</li> <li>b. If it is specific to adults, children or both, and</li> <li>c. Frequency of meetings.</li> </ul> </li> </ul>	90 days after release
3.12 Reporting and Performance Measurement	Reporting P&P	Submit an updated P&P reflecting process to separately track, trend and report on BH complaints, grievances, appeals, and denials for children.	90 days after release
	Sample Report	Submit sample, draft report demonstrating the system	90 days

Performance Standard	Document Name	Description	Due Date
		capability for reporting BH complaints, grievances, appeals, and denials separately for children.	after release
3.13–3.14 Claims; Information Systems and Website Capabilities	Description of claim and encounter processing system	<p>Submit description of:</p> <ul style="list-style-type: none"> <li>Claims system software, including version information and the party responsible for system updates to accommodate the new BH services and HCBS. Include a description and status of any significant system changes/upgrades that are planned or have been made in the past six months. Describe the system's capability to accommodate the services indicated in this document for children for payment, analysis and reporting.</li> <li>Plan processes to verify claims accuracy prior to and after go-live for the children's new benefits, any new State fee schedule programming requirements, and testing steps planned/performed already.</li> <li>How verification of clearinghouse Electronic Data Interchange processing with clearinghouses will be performed including error identification and resolution.</li> <li>The web-based claims submission system including direct data entry for professional and institutional services. If already available, please submit screen shots.</li> </ul>	45 days after release
	Project work plan	Submit a detailed project work plan with reasonable timelines for system updates for claims/eligibility to accommodate children's eligibility data and the services indicated in this document. Detail should include column headings, detailed tasks, due dates, percentage complete, and staff accountability. Subject areas should include: eligibility; benefit package; providers (contracts and fee schedules); authorizations; claims (edits and queues); reporting (internal and external reports, and encounter submissions); and testing with new providers for children's specific services. Testing must include new providers' submissions through the clearinghouse.	45 days after release
	Procedures/claims manual	Submit updated procedures/claims manual that address children's eligibility issues and services that do not require prior authorization processes.	45 days after release
	Description of hardcopy and electronic	<p>Submit description of:</p> <ul style="list-style-type: none"> <li>Ability to send hardcopy remittance advices to</li> </ul>	45 days after release

Performance Standard	Document Name	Description	Due Date
	submission of claims and encounters	<p>providers or 835 transactions to providers when requested based on 837s submitted electronically to the Plan.</p> <ul style="list-style-type: none"> <li>• Ability to receive paper and HIPAA electronic formats for claims submissions.</li> <li>• Ability to accept HIPAA and electronic 276 requests and respond with the 277 for claim inquiries.</li> <li>• Processes to allow electronic funds transfer to providers requesting electronic exchange.</li> <li>• Ability to accept electronic claim adjustments via the 837 format along with paper claim adjustments.</li> </ul>	
	Description of provider type and provider specialty taxonomy data capture	Submit description for provider type and provider specialty taxonomy data capture for the services indicated in this document including any specific providers specializing in children's services.	45 days after release
	Description of Health Home tracking and payment description	Submit description of the Plan's process to: track and pay Health Home, if required; invoice NYS for Health Home.	45 days after release
	278 authorizations description and/or work plan	Submit a description and/or work plan with feasible timelines for receipt of HIPAA 278 authorizations and automation process for handling UM-related requests, including capturing, storing, and updating authorization data for the services indicated in this document. The Plan should use the 278 to respond to authorization-related inquiries and to pay claims against authorization. The description should also include the Plan's capability for providers to submit authorization requests and receive authorizations responses through direct data entry through the website.	45 days after release
	Website project plan and screen shots	Submit project plan that includes all website enhancements that need to be implemented. Provide screen shots for any requirement already available.	45 days after release
	Description and/or work plan to update information systems to support data-driven approaches to	Submit a description and/or work plan with feasible timelines for updating its information systems to support data-driven approaches to monitor network adequacy, crisis plans, psychiatric advance directives, and BH-specific reporting requirements. Information systems should have functionality to:	45 days after release



Performance Standard	Document Name	Description	Due Date
	<p>monitor compliance</p> <p>Description of information systems to collect HCBS assurance/sub-assurances, tools, and sample report</p>	<ul style="list-style-type: none"> <li>Produce required or ad hoc reports by eligibility category, population, age group and/or system affiliation (e.g., Foster Care).</li> <li>Systematically track children/youth in Foster Care.</li> <li>Receive and send required member level electronic notifications between MMCO Foster Care Liaison and the LDSS/VFCA, including new enrollments, disenrollment, changes in placement, change in address.</li> <li>Support data sharing between the Plan and OCFS.</li> </ul> <p>Submit:</p> <ul style="list-style-type: none"> <li>Description of processes to:               <ol style="list-style-type: none"> <li>Collect assessment and POC data,</li> <li>Track services related to Children/Youth in foster care, and</li> <li>Translate POCs into authorizations.</li> </ol> </li> <li>Tools used for analytics and reporting.</li> <li>Draft reports to demonstrate system capability for HCBS reporting for children's services.</li> </ul>	45 days after release
3.15 Financial Management	<p>Financial management P&amp;Ps, documents and reports</p> <p>BH and HCBS financial reporting project plan and P&amp;Ps</p> <p>Alternative payment arrangements documentation</p>	<p>Submit financial management P&amp;Ps, Plan financial documents and reports reflecting the reporting requirement for separately identifying the benefits and populations indicated in this document. This includes capitation revenue and expenses for BH and HCBS categories of aid if applicable, as identified by the State, for which a capitation rate is paid:</p> <ul style="list-style-type: none"> <li>Annual financials</li> <li>Quarterly financials</li> <li>Other financials/reporting as required by the State</li> </ul> <p>Submit project plan and updated P&amp;Ps reflecting BH and HCBS capitation and expenditure coding as applicable for accounting or finance department for updating chart of accounts and for integrating new services and HCBS into the reporting structure. Provide timelines which include completion of chart of account additions and financial reporting by go-live date.</p> <p>If alternative payment arrangements exist prior to implementation, submit documentation in accordance with any guidance issued by the State for review.</p>	<p>45 days after release</p> <p>45 days after release</p> <p>45 days after release</p>

## Attachment A: Targeting and Functional Criteria for Children Meeting At-risk Needs-based Criteria Level of Care

*Note: To transition children's coverage and services under the five children's Section 1915(c) HCBS waivers to the 1115 Demonstration, the targeting and functional criteria from the following five waivers are included below and added under the 1115 MRT waiver:*

- OMH SED waiver #NY.0296
- DOH CAH I/II waiver #NY.4125
- OCFS Bridges to Health (B2H) SED waiver #NY.0469
- OCFS B2H DD waiver #NY.0470
- OCFS B2H Medically Fragile waiver #NY.0471

The following LOC populations are the combined eligibility of the five HCBS waivers above. Individuals must meet institutional and functional eligibility criteria for LOC as indicated by a face-to-face assessment using the assessment tool determining LOC for that population under the Demonstration: 1) the CANS-NY tool for children with SED, 2) the State designated assessment protocols and tools for Children who are Medically Fragile and 3) the OPWDD eligibility tool for FC children with DD.

DOH, through MMMCs, HIV SNPs and a State Designated Entity for FFS, will utilize Health Homes to administer all assessments through the Uniform Assessment System which will have algorithms (except for the FC DD population as noted below) to determine functional eligibility criteria. In addition, the Health Home will ensure that the child meets all other eligibility criteria for HCBS (i.e., a child must live in a setting meeting HCBS settings criteria to be eligible for HCBS under either LOC or LON criteria).

The SED diagnosis below encompasses the OMH and B2H criteria in the former 1915(c) waivers. The medically fragile determination encompasses the CAH and B2H criteria in former 1915(c) waivers. B2H DD current diagnosis and functional standards remain the same as under the current waiver. These requirements combined with the coordination/transition assurances for current children will ensure New York does not violate the Maintenance of Effort requirements for children under the Accountable Care Act. LOC continues to equal the medical institutional admission criteria into that institution in NY (hospital for SED, hospital or nursing facility for Medically Fragile, and ICF/IDD for the FC DD population). Note: Only children with DD in FC are served under this authority. Children with DD who are not in FC are served under other OPWDD authorities.

Children currently in receipt of HCBS and currently enrolled in the 1915(c) Waivers and exempt or excluded from enrollment in MMMC and HIV SNP are also included in the Demonstration to continue to receive HCBS through FFS Medicaid until those children can transition into managed care.

Children that are currently on the 1915(c) waiver at the time of transition under the 1115 waiver will continue to receive HCBS as long as they meet either the 1115 Demonstration LOC or LON

criteria. This will ensure that children on HCBS will remain in HCBS as long as they qualify under the Demonstration because it can be demonstrated that the child would have met LOC criteria under the former five HCBS waivers. This exception will also remain in place for new Family of One LOC children until such time as the LON criteria is implemented to ensure that ACA Maintenance of Effort requirements are met. Because new assessment tools and criteria are being implemented to create consistency between the children's HCBS populations, until the LON populations are implemented, DOH or its designee may place in HCBS a new Community Eligible Medicaid child meeting targeting and risk criteria who in absence of HCBS would be institutionalized.

1. SED LOC population:
  - a. Target Criteria:
    - i. Ages 0 to their 21<sup>st</sup> birthday
    - ii. SED means a child or adolescent has a designated mental illness diagnosis according to the most current DSM. Designated mental illness means a disruption of normal cognitive, emotional, or behavioral functioning, which can be classified and diagnosed using the current edition of the DSM, other than:
      1. Substance-related and addictive disorders without a co-occurring diagnosis
      2. Neurodevelopmental disorders except: attention-deficit/hyperactivity disorder and tic disorders
      3. Neurocognitive disorders
      4. Other conditions that may be a focus of clinical attention (V-codes in ICD-9 or Z-codes in ICD-10) except: V61.20 (Z62.820) parent-child relational problem
      5. Other mental disorders
  - b. Risk Factors:
    - i. Currently in an out-of-home placement, including psychiatric hospital, or
    - ii. Has been in an out-of-home placement, including psychiatric hospital within the past six months, or
    - iii. Has applied for an out-of-home placement, including placement in psychiatric hospital within the past six months, or
    - iv. Currently is multi-system involved and needs complex services/supports to remain successful in the community, and
    - v. A LPHA who has the ability to diagnose within his or her scope of practice under state law has determined in writing that the child, in the absence of HCBS, is at-risk of institutionalization. The LPHA has submitted written clinical documentation to support the determination.
2. Medically Fragile LOC population:
  - a. Target Criteria:
    - i. Ages 0 to their 21<sup>st</sup> birthday<sup>24</sup>
    - ii. The child must have a documented physical disability following state demonstration protocols.
  - b. Risk Factor:

---

<sup>24</sup> MF children may optionally transition to MLTC on their 18<sup>th</sup> birthday. Once enrolled, eligibility for a child in custody of OCFS can continue after the child is discharged from LDSS custody up to the 21<sup>st</sup> birthday so long as the child continues to meet targeting, risk, and functional criteria with no break in eligibility.

- i. A LPHA who has the ability to diagnose within his or her scope of practice under state law has determined in writing that the child, in the absence of HCBS, is at-risk of institutionalization. The LPHA has submitted written clinical documentation to support the determination.
3. DD LOC population:
  - a. Target Criteria:
    - i. Ages 0 to their 21<sup>st</sup> birthday
    - ii. A child having a DD as defined by OPWDD which: is attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment or autism; is attributable to any other condition found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior with mental retardation or requires treatment and services similar to those required for such children; is attributable to dyslexia resulting from a disability described above; has continued or can be expected to continue indefinitely; and constitutes a substantial handicap to such child's ability to function normally in society.
  - b. Risk Factor:
    - i. The child must be a FC child who enrolled in HCBS originally while in the care and custody of LDSS (counties and NYC) or a child in the custody of OCFS Division of Juvenile Justice and Opportunities for Youth (DJJOY). Once enrolled, eligibility can continue after the child is discharged from LDSS and OCFS DJJOY custody so long as the child continues to meet targeting, risk and functional criteria (no break in coverage permitted). This risk factor continues Maintenance of Effort for children up through, but not including, their 21<sup>st</sup> birthday (B2H Waiver reference).

## Attachment B: Targeting and Functional Criteria for Children Meeting At-risk Needs-based Criteria Level of Need

The following two populations are at-risk populations who will be eligible for HCBS during the second implementation phase. Individuals must meet functional needs-based criteria less than an institutional admission criteria using the CANS-NY assessment for children with SED and abuse, neglect, maltreatment and complex trauma. Generally, the child does not meet the need for institutional LOC but does have extended impairment in functioning demonstrated by the child experiencing functional limitations. An individual is eligible for LON services if he or she has a need for HCBS services as indicated by a face-to-face assessment with at least “moderate” levels of need as indicated by a State designated score on the HCBS eligibility assessment tool. The HCBS functional eligibility for LON is based on a subset of questions from the CANS-NY.

1. SED LON Population:
  - a. Target Criteria:
    - i. Ages 0 to their 21<sup>st</sup> birthday
    - ii. SED means a child or adolescent has a designated mental illness diagnosis according to the most current DSM. Designated mental illness means a disruption of normal cognitive, emotional, or behavioral functioning, which can be classified and diagnosed using the current edition of the DSM, other than:
      1. Substance-related and addictive disorders only (i.e., not co-occurring)
      2. Neurodevelopmental disorders except: attention-deficit/hyperactivity disorder and tic disorders
      3. Neurocognitive disorders
      4. Other conditions that may be a focus of clinical attention (V-codes in ICD-9 or Z-codes in ICD-10) except: V61.20 (Z62.820) parent-child relational problem
      5. Other mental disorders
    - iii. A child may not solely have a developmental disorder (299.xx.315.xx.319.xx.) or Organic Brain syndrome (290.xx.293.xx.294xx) or Autism spectrum disorder 299.00 (F84.0) (unless if co-occurring with SED ) and may not be enrolled in an OPWDD waiver
  - b. Risk Factors:
    - i. The child has a reasonable expectation of benefiting from HCBS, and
    - ii. The child requires HCBS to maintain stability, to improve functioning, to prevent relapse to an acute inpatient LOC and/or to maintain residence in the community, and
    - iii. A LPHA who has the ability to diagnose within his or her scope of practice under state law has determined in writing that the child, in the absence of HCBS, is at-risk of treatment in a more restrictive setting. The LPHA has submitted written clinical documentation to support the determination.
2. Abuse, Neglect and Maltreatment or Health Home Complex Trauma LON Population:
  - a. Target Criteria:
    - i. Ages 0 to their 21<sup>st</sup> birthday

- ii. Children who have experienced physical, emotional, or sexual abuse or neglect, or maltreatment and are in the custody of LDSS or complex trauma (as defined by in the Health Home State Plan).
- b. Risk Factors:
  - i. The child must meet the following risk factors (a and (b or c) and d and e):
    - a. The child has a reasonable expectation of benefiting from HCBS and either b or c,
    - b. The child requires HCBS to maintain stability, improve functioning, prevent relapse to an acute inpatient LOC and maintain residence in the community, or
    - c. The child who, but for the provision of HCBS, would be at-risk for a more restrictive setting, and
    - d. A LPHA who has the ability to diagnose within his or her scope of practice under state law has determined in writing that the child, in the absence of HCBS, is at-risk of treatment in a more restrictive setting. The LPHA has submitted written clinical documentation to support the determination.
  - e. And one of the following risk factors (i or ii):
    - i. Medicaid Community Eligible children such as a Temporary Assistance for Needy Families child or a child in the care and custody of LDSS; or
    - ii. A former FC child who was enrolled in HCBS originally while in the care and custody of LDSS with no break in eligibility.

## Attachment C: Current State Agency Oversight and Regulatory Functions of the Children's System of Care

### Office of Mental Health — The Mental Health System

OMH promotes the mental health and well-being of all New Yorkers. OMH's child focused mission is to support children and families in their social and emotional development and early identification and treatment of SED, and to improve the capacity of communities across New York to achieve these goals.

OMH oversees a public mental health system that includes over 1,300 community-based programs serving children and youth, including approximately 595 licensed outpatient and residential programs and 745 support programs. These programs are designed to provide early intervention, treatment and support services that build on a child's social and emotional development by engaging children along with families, schools, and communities to create a positive social support system. Each year, nearly 160,000 children receive licensed mental health services in NYS. OMH approves licenses and/or funds over 70 different types of programs that provide emergency, inpatient, outpatient, residential, and support services. In 2015 an estimated 124,000 children with SED received services from the public mental health system. Roughly, 75% of these children are reported to be enrolled in Medicaid. 95% of these children receive community-based outpatient treatment and support services.

OMH operates 10 State psychiatric centers which provide inpatient care and an array of community-based services. These services support children, youth, and their families in meeting their personal recovery and resiliency goals. These programs provide an array of acute and intermediate care. Youth are referred and admitted from their homes, EDs, other Article 28 and 31 hospitals, as well as other residential settings. OMH seeks to address the presenting mental health symptoms and to discharge the youth back to the least restrictive environment, ideally their own home and community, in the shortest time possible. OMH envisions a managed care environment in which MMCOs work with the staff of state-operated hospitals to effect successful care transitions through consultation and collaboration in the discharge planning process. OMH's intends on transitioning children's inpatient services at State Operated Psychiatric hospitals into the Medicaid Managed Care benefit package at a later date.

OMH also operates a 1915(c) HCBS waiver for children and adolescents with SED. The waiver is designed for children between the ages of 5–17 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.

### Office of Alcohol and Substance Abuse Services — The Substance Use Disorder System

OASAS oversees an addiction treatment service system that provides a full array of services to a large and culturally diverse population of approximately 250,000 unique individuals each year. In addition, over 480,000 youth receive recurring prevention services annually. Treatment services are provided in inpatient, outpatient, and residential settings. NYS' service continuum also includes school- and community-based prevention services as well as intervention, support, crisis, and recovery services.

OASAS plans, develops and regulates the State's system of SUD and gambling treatment agencies. This includes the direct operation of 12 Addiction Treatment Centers, which provided primarily inpatient rehabilitation service to approximately 350 youth aged 18–21 in 2015. In both the 12 State run programs and the over 1,000 community-based SUD treatment programs,

which OASAS certifies, OASAS strongly promotes the use of EBP and provides/sponsors multiple trainings each year to support this emphasis. This practice will be supported by the Medicaid Managed Care transition, primarily by promoting both increased EBP use and fidelity to existing EBP programs.

Adolescents and young adults require specialized treatment services designed to target their unique culture as young people as well as their developing brains and cognitive processes. In 2015, 851 OASAS certified treatment programs provided services to people under 21. The services provided included inpatient, outpatient, and residential treatment and were provided to 23,228 unique individuals. OASAS does not expect their population of youth served under the new SPA or HCB services to increase significantly. There may be an increase in youth served due to increased assessment by Health Homes and other agency providers.

Many patients with SUD are re-admitted to crisis or inpatient services within a 12 month period of their last treatment episode because they were not connected to effective community-based clinical and recovery services. In 2015, 2,680 people aged 21 and under were admitted to a crisis level of service and 2,079 were admitted to an inpatient program. Building care coordination and recovery supports in the community will reduce unnecessary readmissions and improve outcomes for patients in SUD treatment. In an effort to increase positive outcomes for adolescents, in 2016 OASAS began implementation of Youth Clubhouses across the State. These Clubhouses serve youth ages 12–21 who are in recovery from, or at-risk of, a SUD. Clubhouse services are non-clinical, and focus on peer-driven recovery support, pro-social activities and wellness. Each Clubhouse provides services specifically geared towards the youth in their community. Moreover, the youth members of each Clubhouse have an active role in running the Clubhouse and the services that are offered. It is expected that Clubhouses will serve as a resource and referral source for providers, Managed Care Plans, and care managers to assist youth in maintaining recovery.

### **Department of Health — The Care at Home I/II Waiver Program**

The CAH I/II waiver program is a statewide 1915(c) Medicaid Waiver that enables children/youth under the age of 18 who are determined to have a physical disability and require nursing home or hospital LOC to access HCBS Medicaid services. This waiver provides services to children/youth with physical disabilities, easing the emotional, social and physical responsibility of the family/guardian caring for a child/youth with a physical disability. The program offers case management, respite, home adaptations, vehicle modifications, and palliative care services. Many families need assistance in integrating their child/youth's special health care needs with the regular functioning of their household. Families/caregivers also spend significant amounts of time arranging schedules, balancing finances, and providing direct skilled care for their child/youth when professional caregivers are unavailable. The multiplicity of needs and problems faced by these children/youth and their families/guardians often cannot be addressed by any single agency or resource. The goal of the CAH I/II Program is to ease that burden and avoid unwanted institutional care for some of New York's most fragile and vulnerable citizens, its MFC.

### **Office of Children and Family Services — The Child Welfare System**

NYS has created a multi-tiered system to protect children from abuse, neglect and maltreatment that includes mandatory and voluntary reporting of suspected child abuse and maltreatment to the OCFS State Central Register; LDSS engage in child protective services investigations; and, when indicated, LDSS removal of a child and placement into custody by Family Court order.



The State's child welfare system is supervised by OCFS and locally operated by an LDSS in each of the 57 counties outside of NYC, the NYC Administration for Children's Services (serving the five Boroughs of NYC), and St. Regis Mohawk Tribe. LDSS responsibilities include: custody of children, placement decisions, permanency planning activities, working with family courts, obtaining and/or providing medical consent, facilitation of Medicaid eligibility, enrollment in Medicaid Managed Care plans, and administration of 1915(c) waivers for HCBS.

Children/youth in foster care in NYS are categorically eligible for Medicaid. The Patient Protection and ACA extended Medicaid coverage through the age of 26 for youth who were in foster care at the age of 18 and in receipt of Medicaid. As of mid-2016, LDSS contract with 92 VFCA across NYS to care for approximately 16,500 children (out of the approximately 18,500 in foster care; the remaining 2,000 are in LDSS licensed foster boarding homes). OCFS, LDSS and VFCAs adhere to the principle and practice of placing children in the least restrictive, most family-like placement appropriate to meet the needs of the child. To meet these needs, there are numerous types of foster care placement options, including:

- **Foster Boarding Homes:** a certified foster home is a home that has received a certificate to provide foster care after a home study verifies that the family meets the certification requirements. The certificate limits the number of children to be placed in the home and states any restrictions on child characteristics. They are licensed by the LDSS or the Voluntary Agencies, and may include specialized foster homes such as Therapeutic Foster Boarding homes.
- **Congregate Care:** group foster care placements operated mostly by Voluntary Agencies. Congregate care is comprised of three categories:
  - Group Homes (less than 12 beds);
  - Group Residences (12–24 beds); and
  - Institutions called Residential Treatment Centers (25+ beds).

As of mid-2015, the NYS foster care population was approximately 18,500 children, with roughly 30,000 passing through the foster care system each year. The number of children in foster care in NYS has decreased from 53,902 children in 1995 to 20,539 as of December 31, 2012 and continues to decrease with enhanced community-based prevention services as well as enhanced services to children and youth who are placed in foster care that reduce length of stay.

The average length of stay in foster care in NYS is 290 days, while in NYC it is 334 days. The median length of stay in NYS is 629 days and is correlated with age. Children under the age of one at admission have the longest length of stay. Youth between the ages of 13 and 17 at admission have the shortest length of stay, with a median duration of 257 days.

The health care standards for children placed in foster care are set by various Federal and State requirements and other standards including:

- EPSDT requirements established by the Federal government;
- The Federal Adoption and Safe Families Act;

- NYS Regulations that require the LDSS and VFCAs arrange and coordinate the health care children in foster care (which includes mandatory assessments and enhanced well child visits);
- National standards of health care developed by the American Academy of Pediatrics and the Child Welfare League of America; and
- Family courts that “court order” services for children and families, including medical evaluations and health care services for children.

Data has shown that children in the foster care system have higher rates of birth defects, developmental delay, and physical disability than children from similar socio-economic backgrounds. There is also a high prevalence of medical and developmental problems and use of inpatient and outpatient mental health services at a rate 15–20 times higher than the general pediatric Medicaid population. The impact of the trauma these children experience is profound (Source: American Academy of Pediatrics).

### Select Problems at Entry into Foster Care<sup>25</sup>

Select Problems at Entry into Foster Care	
Psychosocial Problems (with high percentage having experienced childhood adversity and trauma)	100%
Chronic PH condition	35–45%
Birth defect	15%
Mental health problem	40–95%
Significant dental condition	20%
Family problems	100%
Developmental Delay in child <5 years	60%
Special ed./underachievement	45%

<sup>25</sup> American Academy of Pediatrics Task Force on Health Care for Children in Foster Care, *Fostering Health: Health Care for Children and Adolescents in Foster Care*. (New York: American Academy of Pediatrics, 2005).; and Mark D. Simms, Howard Dubowitz and Moira A. Szilagyi, “Health Care Needs of Children in the Foster Care System,” *Pediatrics* 2000;106(4 Suppl):909-918.; and Dutton M Fiori T, Karl A, Sobelson M. Medicaid managed care for children in foster care. In: *Fund Medicaid Institute at United Hospital*, editor: UHF; 2013.

The current payment methodology for health care for the majority of VFCA is through the receipt of payment for PH and BH services for children in their care through the Medicaid Per Diem rate. Health Care Services are delivered by VFCA staff or via contract with professionals that have knowledge of the effects of abuse, neglect and trauma. The Medicaid Per Diem includes certain costs for Physicians, Psychiatrists, Psychological Services, Certified Social Workers, Dental Care, Specialists, Nursing Services, Medical Supplies & Equipment, Medical Transportation and Administrative Overhead. This model allows VFCA to integrate health care in a trauma informed environment. NYS expects to preserve this expertise and integration in a Medicaid Managed Care environment.

In response to the high needs of this population, OCFS implemented the B2H Medicaid 1915(c) Waiver Program beginning January 1, 2008. B2H is administered by each LDSS, which determine eligibility, enrollment, and continued monitoring of B2H. B2H consists of three federally-approved 1915(c) waivers serving children in foster care with three disability groups: B2H for Children with SEDs, B2H for Children with DD and B2H for Children with Medical Fragility. B2H which serves up to 3,305 children in the custody of LDSS and OCFS DJJOY at entry into B2H, but B2H services may follow children as they return home or are adopted up to the age of 21 as long as they remain eligible.

DOH received CMS approval to begin mandatory enrollment into Medicaid Managed Care for children in direct placement (foster home licensed by the LDSS) Foster Care in April 2013. The transition occurred in counties outside of NYC, and enrollment was handled by the individual LDSS. DOH and OCFS conducted several stakeholder workgroup meetings with State agencies, LDSS, and MMCOs to identify obstacles and opportunities that affect the enrollment of this population. A Policy Document was issued in April 2013, which reflects the policy decisions that were developed to provide guidance to Medicaid managed care LDSS.

For more information, follow the link to the policy paper that outlines the guidance: Policy and Proposed Changes to Transition Children in Direct Placement Foster Care into Medicaid Managed Care:

[https://www.health.ny.gov/health\\_care/medicaid/redesign/docs/policy\\_and\\_proposed\\_changes\\_f.c.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_and_proposed_changes_f.c.pdf)

## Attachment D: Plan Staffing Requirements for Children’s Health and Behavioral Health Benefit Administration

Position	Location	Adult Requirements	Children’s Requirements
<b>Key Staff</b>			
<b>BH Medical Director</b>	NYS	<ul style="list-style-type: none"> <li>NYS license as a physician.</li> <li>A minimum of five years of experience is required in a clinical or managed care setting (at least two of which are in a clinical setting).</li> <li>Appropriate training and expertise in general psychiatry and addiction disorders (e.g., board certification in general psychiatry and certification in addiction medicine or certification in the subspecialty of addiction psychiatry).</li> </ul>	<ul style="list-style-type: none"> <li>NYS license as a physician</li> <li>Board certified in child psychiatry</li> <li>Minimum of five years of experience working with children in BH managed care settings or BH clinical settings (at least two years must be in a clinical setting)</li> </ul> <p style="text-align: center;"><u>OR</u></p> <p><i>If the Plan proposes to use a physician that is not a child psychiatrist, a board certified child psychiatrist must be engaged to provide leadership and consultation for medical and quality activities associated with the delivery of the BH services for children.</i></p>
<b>BH Clinical Director (Adults)</b>	NYS	<ul style="list-style-type: none"> <li>NYS license as a physician</li> <li>A minimum of seven years of experience in BH clinical or managed care setting including at least two years of managed care experience (preferably Medicaid Managed Care).</li> </ul>	N/A
<b>BH Clinical Director for Children’s Services</b>	NYS	N/A	<ul style="list-style-type: none"> <li>NYS license as a BH professional</li> <li>Minimum of seven years of experience in a BH managed care setting or BH clinical setting, including at least two years of managed care experience (preferably Medicaid managed care) and at least five years with children.</li> <li>Knowledge of NYS child serving systems required.</li> </ul>

Position	Location	Adult Requirements	Children's Requirements
<b>Managerial Staff</b>			
<b>MMCO Liaison for Medically Fragile Children</b>	NYS	N/A	<ul style="list-style-type: none"> <li>• Experience, expertise and knowledge of the unique complex needs (including trauma) of this population.</li> <li>• Knowledge of State child serving systems, health homes, and specialty providers responsible for addressing the healthcare needs of medically needy children, including the medically needy LOC population.</li> </ul>
<b>MMCO Foster Care Liaison</b>	NYS	N/A	<ul style="list-style-type: none"> <li>• Experience, expertise and knowledge of the child welfare system, foster care healthcare requirements and the unique complex needs (including trauma) of this population.</li> <li>• Knowledge of NYS child serving systems required to effectively be responsible for coordination with OCFS, LDSS, and the VFCAs for all shared children in foster care.</li> </ul>
<b>BH CM Director</b>	NYS	<ul style="list-style-type: none"> <li>• NP-LBHP</li> <li>• BH MC or BH clinical experience</li> <li>• Knowledge and experience working with Health Homes recommended</li> </ul>	<ul style="list-style-type: none"> <li>• NP-LBHP</li> <li>• BH MC or BH clinical experience</li> <li>• Experience working with Health Homes recommended.</li> <li>• Experience working with community and family-based services and experience in working across child serving systems recommended.</li> <li>• Knowledge of NYS child serving systems required.</li> </ul>
<b>BH UM Director</b>	NYS	<ul style="list-style-type: none"> <li>• NP-LBHP</li> <li>• BH MC or BH clinical experience</li> <li>• Knowledge of BH rehabilitation and recovery services</li> </ul>	<ul style="list-style-type: none"> <li>• NP-LBHP</li> <li>• BH MC or BH clinical experience</li> <li>• Experience working with community and family-based services recommended.</li> <li>• Knowledge of NYS child serving systems required.</li> </ul>
<b>Member Services Director</b>		<ul style="list-style-type: none"> <li>• Experience in MC or clinical setting.</li> <li>• Experience managing member</li> </ul>	<ul style="list-style-type: none"> <li>• Experience in MC or clinical setting.</li> <li>• Experience managing member service call center operations.</li> </ul>

Position	Location	Adult Requirements	Children's Requirements
		<p>service call center operations.</p> <ul style="list-style-type: none"> <li>Knowledge of the provider system serving adults with BH needs</li> <li>Knowledge of the new benefits and program requirements for adult BH population.</li> </ul>	<ul style="list-style-type: none"> <li>Knowledge of the provider system serving children with BH needs, children in foster care, medically fragile children and EBPs for children.</li> <li>Knowledge of the new benefits and program requirements for children, including the medically fragile and foster care populations.</li> </ul>
<b>Network Development Director</b>	NYS	<ul style="list-style-type: none"> <li>BH MC or BH clinical setting experience</li> <li>Demonstrated experience in BH and SUD network development</li> <li>Knowledge of and experience with principles of physical-BH integration and EBPs, including but not limited to wellness self-management, supported employment, family psycho-education, Assertive Community Treatment, Assisted Outpatient Treatment, and Integrated Dual Disorder Treatment.</li> <li>Familiar with recovery-oriented services.</li> </ul>	<ul style="list-style-type: none"> <li>BH MC or BH clinical experience</li> <li>Demonstrated experience in BH and SUD network development for children.</li> <li>Knowledge of and experience with principles of physical-BH integration.</li> <li>Knowledge of family-centered, youth guided principles and development of EBPs for children.</li> <li>Knowledge of specific PH service needs of the children population including but not limited to preventive and restorative dental needs.</li> </ul>
<b>Provider Relations Director</b>	NYS	<ul style="list-style-type: none"> <li>Experience in BH MC or BH clinical setting.</li> <li>Experience managing BH provider issues including resolving grievances, coordinating site visits, and maintaining quality of care.</li> <li>Familiar with recovery-oriented services.</li> </ul>	<ul style="list-style-type: none"> <li>Experience in BH MC or BH clinical setting.</li> <li>Experience managing BH provider issues including resolving grievances, coordinating site visits, and maintaining quality of care.</li> <li>Knowledge of the provider system serving children with BH needs, children in foster care, medically fragile children and EBPs for children.</li> </ul>
<b>Training Director</b>	NYS	<ul style="list-style-type: none"> <li>Significant experience and expertise in developing, tracking, and executing BH training to the Plan's own and network provider's staff.</li> <li>Significant experience and expertise in developing training programs related to BH systems.</li> </ul>	<ul style="list-style-type: none"> <li>Significant experience and expertise in developing, tracking, and executing BH training to the Plan's own and network provider's staff.</li> <li>Significant experience and expertise in developing training programs related to BH systems for children and families.</li> <li>Knowledge of needs associated with</li> </ul>

Position	Location	Adult Requirements	Children's Requirements
		<ul style="list-style-type: none"> <li>Familiar with recovery-oriented services.</li> </ul>	medically fragile children and foster care population.
<b>QM Director</b>	No	<ul style="list-style-type: none"> <li>Experience and expertise in quality improvement for mental health and SUD services programs, ideally in publically-operated or publically-funded programs.</li> <li>Experience with managed care delivery systems.</li> <li>Familiarity with recovery-oriented services.</li> </ul>	<ul style="list-style-type: none"> <li>Experience and expertise in quality improvement for mental health and SUD services programs, ideally in publically-operated or publically-funded programs.</li> <li>Experience with managed care delivery systems.</li> <li>Familiarity with recovery-oriented services.</li> <li>Familiarity with family-centered, youth-guided service delivery for children and families.</li> <li>Knowledge of appropriate performance measures (including HEDIS and QARR) for children.</li> </ul>
<b>Information Systems Director</b>	No	<ul style="list-style-type: none"> <li>Experience and expertise in Medicaid data analytics and BH data systems.</li> <li>Knowledge of all federal and state laws governing the confidentiality and security of protected health information, including confidential mental health and SUD information.</li> </ul>	<ul style="list-style-type: none"> <li>Experience and expertise in Medicaid data analytics and BH data systems.</li> <li>Knowledge of all federal and state laws governing the confidentiality and security of protected health information, including confidential mental health and SUD information.</li> </ul>
<b>Governmental/Community Liaison Director</b>	Yes	<ul style="list-style-type: none"> <li>Must be individual with significant plan leadership responsibilities.</li> <li>The Plan must designate representative(s) to attend relevant stakeholder, planning, and advocacy meetings to ensure that the Plan is aligned with the State's vision for managed delivery of BH services and is aware of any new State or local BH initiatives.</li> </ul>	<ul style="list-style-type: none"> <li>Must be individual with significant plan leadership responsibilities.</li> <li>The Plan must designate representative(s) to attend relevant stakeholder, planning, and advocacy meetings to ensure that the Plan is aligned with the State's vision for managed delivery of BH services and is aware of any new State or local BH initiatives.</li> </ul>
<b>Operational Staff</b>			
<b>UM/CM</b>	UM — No  CM — Yes	<ul style="list-style-type: none"> <li>NP-LBHP</li> <li>CASACs (must also be NP-LBHPs) for SUD reviews.</li> <li>Experience and expertise in managing care for adults with</li> </ul>	<ul style="list-style-type: none"> <li>NP-LBHP</li> <li>CASACs (must also be NP-LBHPs) for SUD reviews.</li> <li>Experience in managing care for children and the target subpopulations described in Section</li> </ul>

Position	Location	Adult Requirements	Children's Requirements
		<p>BH needs.</p> <ul style="list-style-type: none"> <li>For UM, authorization decisions must be made by a NP-LBHP with minimum three years of experience in a BH setting.</li> <li>For HCBS, experience and knowledge with HCBS, recovery, EBPs required.</li> </ul>	<p>1 including high-risk groups, such as children with SED, with co-occurring major mental disorders and SUD, who are involved in multiple services systems (education, justice, medical, welfare, and child welfare), or in foster care; Children with medical fragility/complex medical conditions requiring significant medical or technological health supports.</p> <ul style="list-style-type: none"> <li>For UM, authorization decisions must be made by a NP-LBHP with minimum three years of experience in a BH setting.</li> <li>Knowledge and experience in Children's health and BH services, HCBS, EBPs, EPSDT services and social service programs.</li> </ul>
<b>Clinical Peer Reviewers</b>	No	<ul style="list-style-type: none"> <li>Includes panel of reviewers to conduct denial and appeal reviews, peer review of psychological testing, or complex case review and other related consultations</li> <li>Peer reviewers must include:               <ul style="list-style-type: none"> <li>Physicians board certified in adult psychiatry, physicians who hold a Certification in addiction medicine or a Certification in the subspecialty of addiction psychiatry; or</li> <li>Licensed doctoral level psychologists.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Includes panel of reviewers to conduct denial and appeal reviews, peer review of psychological testing, or complex case review and other related consultations</li> <li>Peer reviewers must include:               <ul style="list-style-type: none"> <li>Physicians who are board certified in child psychiatry; or</li> <li>Licensed doctoral level psychologists with experience treating children.</li> </ul> </li> </ul>
<b>QM Specialists</b>	No	<ul style="list-style-type: none"> <li>Experience and expertise in quality improvement for mental health and SUD services programs, ideally in publically-operated or publically-funded programs.</li> </ul>	<ul style="list-style-type: none"> <li>Experience and expertise in quality improvement for mental health and SUD services programs, ideally in publically-operated or publically-funded programs.</li> <li>Knowledge of family-centered, youth-guided service delivery for children and families with BH needs.</li> <li>Knowledge of appropriate performance measures (including HEDIS and QARR) for children.</li> </ul>
<b>Provider</b>	Yes (some)	<ul style="list-style-type: none"> <li>Experience in BH MC or BH clinical setting.</li> </ul>	<ul style="list-style-type: none"> <li>Experience in BH MC or BH clinical setting.</li> </ul>



Position	Location	Adult Requirements	Children's Requirements
<b>relations</b>	staff must be in NYS)	<ul style="list-style-type: none"> <li>• Experience managing BH provider issues including resolving grievances, coordinating site visits, and maintaining quality of care.</li> <li>• Familiar with recovery-oriented services.</li> </ul>	<ul style="list-style-type: none"> <li>• Experience managing BH provider issues including resolving grievances, coordinating site visits, and maintaining quality of care.</li> <li>• Knowledge of the provider system serving children with BH needs, children in foster care, medically fragile children.</li> </ul>

## Attachment E: Plan Staff Training Requirements

Training Topics to be completed 30 days prior to go-live	Clinical Staff	Member Services	Provider Relations
NYS's vision, mission, goals, operating principles for the children service and population expansion.	Required (R)	R	R
Understanding existing BH SPA services, new SPA services and HCBS for children.	R	R	R
Cultural competence outlining the impact of culture, ethnicity, race, gender, sexual orientation, and social class within the service delivery process.	R	R	R
HCBS eligibility requirements and protocols.	R	R	R
Services for children with FEP.	R	R	
HCBS operational requirements (e.g., needs assessment (CANS), plans of care).	R	R	R
EBPs for children.	R		R
BH/medical integration; co-occurring BH and medical disorders, co-occurring MH and SUD disorders; integrated CM principles.	R	R	R
LOC guidelines for expanded SPA benefits and HCBS and authorization requirements for those services.	R		
Network access standards for new services and HCBS.	R	R	R
New information systems, data collection tools (if applicable).	R		R
Reporting and monitoring requirements (e.g., critical incident reporting, HCBS assurances, foster care).	R		
Complaints, grievance, appeals.	R	R	R
After hours and crisis triage protocols.	R	R	R
Linkage requirements (i.e., with OMH, OASAS, OCFS, LDSS, OPWDD, foster care agencies and other non-Medicaid child serving agencies).	R	R	R
Network participation requirements (e.g., provider qualification validation).			R
Provider training and site visits.			R

Training Topics to be completed 30 days prior to go-live	Clinical Staff	Member Services	Provider Relations
Provider profiling and performance management.			R
Primary Care and BH Integration.	R		
The Health Home Model & Practice — Roles and Responsibilities	R	R	R
Understanding the interaction of child serving systems, and navigating and coordinating systems of care.	R	R	R
Trauma Informed Practices.	R		
Importance of Families and understanding how to assist families/caregivers to access services.	R	R	R
Family Psychoeducation.	R	R	R
Special Populations: I/DD.	R		
Special Populations: TAY.	R		
Special Populations: Children age 0–5.	R		

## Attachment F: Network Development in Rural Counties

Initial Network Development in Rural Counties:

**A. Rural County Definition**

For the purpose of network development, a rural county is defined as one with a population of fewer than 200,000 inhabitants.

Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Ontario, Orleans, Oswego, Otsego, Putnam, Rensselaer, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming, and Yates are rural counties.

**B. Region Definition**

For the purpose of determining the adequacy of the Contractor's network in rural counties and for Essential Community BH Providers, a region is defined as the catchment area beyond the border of a county, which includes the other counties of the State designated RPC region.

Regional Planning Consortium Regions	
<b>Western NY</b>	Allegany, Cattaraugus, Chautauqua, Erie, Niagara, Orleans, Genesee, Wyoming
<b>Finger Lakes</b>	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates
<b>Southern Tier</b>	Broome, Chenango, Delaware, Tioga, Tompkins
<b>Central NY</b>	Cayuga, Cortland, Madison, Oneida, Onondaga, Oswego
<b>Mohawk Valley</b>	Fulton, Herkimer, Montgomery, Otsego, Schoharie
<b>North Country</b>	Clinton, Essex, Franklin, Hamilton, Warren, Washington
<b>Tug Hill Seaway</b>	Jefferson, Lewis, St. Lawrence
<b>Capital Region</b>	Albany, Columbia, Greene, Saratoga, Schenectady, Rensselaer
<b>Mid-Hudson</b>	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester
<b>Long Island</b>	Nassau, Suffolk
<b>New York City</b>	Kings, Queens, Richmond, Bronx, New York

**C. Meeting Network Requirements in the Case of Insufficient County Providers**

If the providers in the county are insufficient to meet network requirements, Plans must first contract with providers in neighboring counties to meet network requirements. If this is still insufficient, the Plans must then contract with providers within the RPC region. Consistent with current DOH approval processes, if the providers in the RPC region are insufficient to meet the minimum network requirement for the service, or the demand in the service area, the Plans must contract with providers in the next contiguous service area. For example, if a Plan's service area includes Rensselaer County, and the Capital Region RPC has an insufficient number of OTPs to meet the demand of the enrollees, then the Plan must contract with providers from the Mohawk Valley Region, North Country Region or Mid-Hudson Region, or any combination of regions, to build a sufficient network.

D. ***Reimbursement of Non-Participating Providers in the Case of Inadequate Network***

Plans whose networks are inadequate, whether due to an insufficient number of contracts or an insufficient number of available appointments, will be required, upon enrollee request, to permit enrollees eligible for services to receive services at a non-participating provider and reimburse those providers at no less than the Medicaid Fee for Service (FFS) rate.

## Attachment G: Office of Health Insurance Programs Principles for Medically Fragile Children

A “medically fragile child” (MFC) is defined as an individual who is under 21 years of age and has a chronic debilitating condition or conditions, who may or may not be hospitalized or institutionalized, and meets one or more of the following criteria (1) is technologically dependent for life or health sustaining functions, (2) requires a complex medication regimen or medical interventions to maintain or to improve their health status, (3) is in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk. Chronic debilitating conditions include, but are not limited to, bronchopulmonary dysplasia, cerebral palsy, congenital heart disease, microcephaly, pulmonary hypertension, and muscular dystrophy.

Health Plans shall do at least the following with respect to MFC:

- A. In accordance with the requirements of C/THP and EPSDT as described in Section 10.4 of the DOH Model Contract, cover all services that assist a MFC in reaching their maximum functional capacity, taking into account the appropriate functional capacities of children of the same age. Health Plans must continue to cover services until that child achieves age-appropriate functional capacity.
- B. Shall not base determinations solely based upon review standards applicable to (or designed for) adults to MFC. Adult standards include, but are not limited to, Medicare rehabilitation standards and the “Medicare 3 hour rule”. Determinations have to take into consideration the specific needs of the child and the circumstances pertaining to their growth and development.
- C. Accommodate unusual stabilization and prolonged discharge plans for MFC, as appropriate. Areas plans must consider when developing and approving discharge plans include, but are not limited to: sudden reversals of condition or progress, which may make discharge decisions uncertain or more prolonged than for other children or adults; necessary training of parents or other adults to care for a MFC at home; unusual discharge delays encountered if parents or other responsible adults decline or are slow to assume full responsibility for caring for a MFC; the need to await an appropriate home or home-like environment rather than discharge to a housing shelter or other inappropriate setting for a MFC, the need to await construction adaptations to the home (such as the installation of generators or other equipment); and lack of available suitable specialized care (such as unavailability of pediatric nursing home beds or pediatric ventilator units).

MMCOs must develop a person centered discharge plan for the child taking the above situations into consideration.

- D. It is Health Plan’s network management responsibility to identify an available provider of needed covered services, as determined through a person centered care plan, to effect safe discharge from a hospital or other facility; payments shall not be denied to a discharging hospital or other facility due to lack of an available post-discharge provider as long as they have worked with the plan to identify an appropriate provider. MMCOs are required to approve the use of out of network (OON) providers if they do not have a participating provider to address the needs of the child.



- E. MMCOs must ensure that MFC receive services from appropriate providers that have the expertise to effectively treat the child and must contract with providers with demonstrated expertise in caring for the MFC. Network providers shall refer to appropriate network community and facility providers to meet the needs of the child or seek authorization from the MMCO for out-of-network providers when participating providers cannot meet the child's needs. The MMCO must authorize services as fast as the enrollee's condition requires and in accordance with established timeframes in the Medicaid Managed Care Model Contract.

July 18, 2014