Children's Quarterly MRT Health & Behavioral Health Subcommittee Meeting Transcription

By the request of the meeting organizer this meeting is being recorded

People start talking at 00:58

Alright good afternoon everybody we're going to get started. Hi this is Donna the assistant commissioner of the children's division of the New York State Office of Mental Health. Welcome back to children's MRT meeting and with me is my co-chair Gail and then I think we'll do a quick go around the room here if everybody could just speak up so the people on the phone can hear. I'm not going to have people on the phone introduce themselves because there's a lot of people on the phone so let's get started.

(Unclear introductions of people present at the meeting or on the phone)

** Starts meeting at 3:20**

Well welcome again we have a fair amount of ground to cover with you today we're hoping to if at all possible get out of here before the scheduled 4:00 close time I don't think anyone would object to that but we want to cover all the material and take the questions and have a discussion as well so we're going to I think the agenda is up on the screen we'll do timeline updates we have some information for you about management of the children's benefits we have to talk about medical necessity criteria for the SPA services we want to go over network adequacy standards talk about MCTAC offerings Lana with do a health home update and then finish up with some project updates we're going to turn it over to Lana to do timeline updates. Lana if you want to come up here to have the mic so people on the phone can hear. Good afternoon everybody so I just wanted to talk a little bit about the children's transition timeline so you know the team has been working very hard you all know that because we meet frequently to tell you where our progress is but we continue to be able to work with you on making sure that our goal is that our transition be of course as smooth as possible and we get through what we need to get through and I think things that are left to do I think we need more time I want to talk a little bit about we need a little shift in our timeline we just want to talk a little bit about the key things we need to be focusing on that are going to be requiring more time one certainly is we've been waiting for feedback from CMS on conflict of interest in the environment of the impact on the waivers that are still out there today and trying to transition to build that bridge until we get to managed care and also that decision or that feedback certainly has an impact on the overall design that we're developing here so it really is important and without that feedback we're going to move forward we're going to continue to develop the overall design but you know that's an important piece I'm sorry do me a favor let her finish and if you could hold if you don't mind just hold and don't faint but we know we're ready to catch you I can see from Margaret's reactions and the others in the room we all understand the gravity of the situation here and you know we should talk about how we can gravity more directly but also you know there's the state plan and the 1115 waiver approval by CMS and so we're going to give you a little window into our timeframe because we thought about needs we also know it's important for you guys to understand the timeframes because you're the boots on the ground and you're going to have to help implement all of this and so we want to get a more clear insight as we change our timelines

but also as we think about what are some of the milestones that all of you people are going and can plan according and also help us think about what it is that you want us to be thinking about in those timelines and those milestones and those work plans come out right so I think we've been doing a lot of that but now we're at the stage we need to get more granular and so we're going to be engaging you pretty fast and furiously over the summer but I think your guys timeline will help us do that so obviously we need a RFQ for the plans right so we want to make this a pretty intensive fun filled fast RFQ RFI process with as much detail if possible for the plans heard from the medical director reporting some of those details are very important so that was reinforced today so we'll make sure to put as much in that document as possible and obviously there's a readiness and training for plans providers and stakeholders the designation process of SPA ad HCBS providers we've been talking to already about that there's a lot of work that needs to do in the area of child welfare as we think about transitioning the foster care population to managed care and you know including the discussions around developing the for the voluntary foster care agencies is also credential issues so all of those are on the forefront and are being worked on so of course you know one of the most important things that I think makes this all work which we have been doing for the past many many months is the stakeholders collaboration that I think is really helpful to the design will be really key when we get to implementation we will be continuing that right that's the goal to make sure as we implement we are in touch with what's going well but also maybe what might need some help and we stay in touch and we can be as smooth as we can there and of course you know as we continue to refine and get our arms more around the design who's it going to impact what is it going to look like we obviously need to roll up our sleeves when assessing the cost and making sure that they are within the global spending cap how can we work to take our design and fit it in within the cap so we also have just to talk a little bit about the timeline we've all been very excited about this six new state plan services and so we are going to continue our calendar has us continuing to launch those on 1/1/17 there's a change there with respect to the state plan services I think there are some pros and cons in keeping that there because it will be very close to the transition you'll see in a second to managed care but we do want to roll out the new state plans services and be available to kids who are in fee for service and are enrolled in managed care today which is most of our population and you'll see that in the next slide so where are we so were have our regional implementation scheduled still in place New York City and long island and that will happen on July 2017 so that's just moving that date from January 2017 to July 2017 and then we'll do wash rinse and repeat with the rest of the state in January 2018 and in both of those scenarios again we'll move the SPA plan services over into managed care as a part of the waiver we'll do our home and community based services we'll do the voluntary foster care population and of course we'll transition the 1915c care management program to health home and no changes to health home we're continuing to work and we'll launch a health home for children to begin to enroll in October moving ahead and I'll talk a little bit in more detail about where we are with health home after we get through some of that behavioral health transition questions can I just clarify something so when you say SPA services will move, so they will move into Medicaid managed care so SPA services will not be available to kids in NYC until July so in January 2017 SPA service they are available to every kid statewide so they'll be available whether or not you're fee for service or you're enrolled in a plan on 1/1/17 that's our current time frame ok keep going Gail said keep going so you guys have seen this slide this is just our today tomorrow you guys know that we are doing state plan services HCBS services we're doing the foster care everything I just said right so this is just our standard slide so as we talked about

just trying to be more granular on time frames we have our major milestones for SPA implementation and here's those dates and as Gail said we will get the slides to you we apologize for running around it's a short week sometimes you can't always get stuff out before but we will make sure you all get these slides so I'll talk here a little bit but you know again some of our timeframes key here we have our state plan amendment submission on July 1 so that's one of our big milestones so when you think of that that's a little less than 30 days away so we're working quickly to move forward with that and then we have our designation application release so providers should be thinking about that date as well 8/1 there's regulations that will be going along with the SPA that we need to develop so we'll be working on those and then you can see the process for designation being complete and then having the enrollment process happen towards the end of the year right before we launch so again and I apologize we'll make sure you get these slides but it really focuses on where we are with the SPA and then just a few questions is it time for Margaret yet you want to keep going whatever you want me to do Gail Margaret can you handle another couple seconds let me let me just get through the key dates and then I'll stop because that is really the conclusion with the timelines and then we can pause and take questions the last part is just focusing on the waiver pieces and really important for the plans we'll have our RFI released in September on 9/1 and then we'll have the RFQ released on 10/14 a short timeframe and a lot of work to do so we look forward to engaging all of you as well as the plans and that partnership we have HCBS provider designation applications that will be released on October 1 and then at the same time we will be submitting our waiver submission to CMS so we were I think the team has done a lot of work we have a lot of draft documents flying around were dotting the I's and crossing the T's certainly keep you posted but I think this is a good move it will give us a little bit of breathing room but keep this all on task and kind of make it as smooth as possible thank you sure Margaret I have a few concerns right now --- except the whole goal in the state was to shrink the size and the number of non for profit right so you're not going to have your provider to conflict of interest and --- we have on numerous occasions have 3 to 4 conversations right now Donna and I have partnered directly with CMS we've engaged our principles at DOH to have conversations with CMS on the conflict of interest Jason and Greg have been involved in those conversations we did a very lengthy discussion and PowerPoint where we walked them through our design how the conflict of interest provision has been implemented in the adults design how it would impact the statewide disparity if we were to go down two separate paths for what we worked on with adults with what we worked on for kids how did it completely concurrent to DSRIP PPS integration of care integrated deliberate services everything that we have engaged in close partnership to CMS to achieve that the COI really is not in keeping with those other goals so what is their rational for saying that it is a problem well I think they have a regulation in place that requires for the HCBS services that there be the COI standards I think they recognized that the COI standards that they employed through the regulatory process is or can be different than what can be implemented under a 1115 waiver environment and a managed care environment so I think they have regulatory requirements that is impacting the actual extension of the existing waivers so we can get to the bridge of managed care and if you think about the timeframe is complicated thing to implement on paper but forget on paper in reality to have a complete seat change from one standard and then potentially to a reverse standards that is less stringent is really just not going to help us achieve our goal it will capacity and it will certainty we are very concerned about is the access of services and the impact of choice as well as the impact of the quality providers right there's also a restriction of trade under pending legal questions so how much overhead is the state willing to pay because

that's going to affect your rates nobody can do business this way so can I ask a question yes but you have to ask it louder so people can hear you on the line ok I can repeat too my question is there two different branches in CMS that are creating this problem from my reading one is the waiver and the other is somebody else that health homes sent out could give a flying crap about this right well you're correct that there's many so Margaret's question there's many diverse people who are involved in this COI they're under pressure so this particular conversation you know is actually like out there in the world now our conversation and so some of it being conscious of the fact that we are in an open conversation lets be careful and be strategic about what we're asking and so the question that we're asking is what can we bring women into the room and also community based agencies so you don't need to ask permission to be an advocate right so that's good but that's a different conversation that we can have with our state partners right now can we invite them into the room and say you know this is what so that's an interesting question I'm going to put that down as a follow up question to see whether or not we might invite our CMS representatives to our MRT meeting and then figure out what that looks like and how to structure it so there's a conversation and that they leave having learned more than they already know because they already know that we have problems with conflict free so what are we supposed to do upstate because there's different rules ok so here the thing we can't resolve it now I just want donna and I have been at this table we've been partners along with all the other state agency partners it took us a month get a meeting on the calendar to make sure that every single aspect of CMS involved in this issue is present so I can give you fairly insurances that from our perspective that's what we requested from CMS all of those people the waiver people were there health home people were there regional office were there everybody was there so we have communicated that and certainly you know folks can certainly be an advocate to issues that are impacting them with CMS that's not an issue I think what you're asking we might have a better conversation with the people around the table without the state in the room because the state already had this conversation over and over and over and what you have to say and what they have to say and maybe what Jim has to say they have heard that from you they've already heard it from us and I think we should define who should be in the room for this conversation they have to sign on dotted line that we have capacity so here's the thing so I think we know what the issues are we don't have a strategy to solve it yet we do know that CMS needs to hear from us and from providers and other interested parties about the conflict free provision and we have to figure out what that looks like and who is going to organize that conversation with them or that communication with them but clearly our state partners have their role to play and they have already been in conversation with them and so now we have to figure it out and I don't have a particular solution right now why don't we just table it dully noted and then we will figure it out after offline a little bit we certainly have expressed to CMS providers have concerns and again you certainly can advocate on your behalf about your concerns to CMS good we love that who is speaking about health homes I am ok there's some issues that are timeline related sure absolutely so how are we doing are we on agenda ok thank you Ian is on next there you go okay thanks Lana. Hi everyone I just wanted to be clear about something we never went into this with a goal of reducing the number of non for profits providing services we went in to improve the services for kids and families recognizing those changes will create new opportunities for agencies to look how they're configured who they are aligned with and then be able to meet the needs of the population that they want to but we never had a goal saying that there's too many agencies out there we want to eliminate them the next part of the process is taking a look at how the plans are going to manage the various services that we have and with the process that we

went through in certifying the adult plans offered lots of opportunities for learning right Gary so we're going to take the learning that we got from the adult process and transfer it into how we go about taking a look at the plans for the kids and we did a chart here which is much too small for everybody to read but it looked at the 17 plans around the state deduction 18th one is missing because they just came into business late in 2015 and didn't actually have enrolled kids at that time so we have some major players who have over 400,000 enrolled children we have some in the middle you know between 100,000 and 200,000 and a slew of plans that have under 100,000 kids' lives that they're managing many of those managed care companies are working with the behavioral health organizations to manage the benefit to do that and so we wanted to get a sense of what's our best configuration for going forward is and one of the things that we discussed for a time was based on what we learned from adults so we need to change the configuration we have lots and lots of discussions and came the best thing for us to do was to keep the present configuration of plans and who have the option of using a BHO most of them do and then by setting really stringent RFQ standards through the model contract if there is a plan we don't believe that we can muster then we require them to use BHO so wanted to keep to that same process the things that were going to be looking in as we develop the RFQ standards keeping the provider protections those are the first two years of having the rate staffing and additional children's expertise how are we going to know if the plans are able to understand and meet the needs of kids one of the things they are going to do to bring that expertise in and have kids who people who know what kids need making those kinds of decisions what their quality strategy is certainly looking at network adequacy we want to make sure that under adequate providers we do know as we mentioned during this ramp up phase there are a lot of things that have to come into development we need to expand capacity particularly in the 6 new SPA areas and some of the HCBS services as they come along and we want to see how the plans plan to go and address those network adequacy clinical expertise utilization review staff development what are the things that they're doing for their client contacts who are the people doing client services who are the people doing utilization review what information they have been trained in in terms of working with kids we want to have advanced stakeholder arrangements because I think it was --- who pointed out in earlier meetings that when we bring kids to the table we bring a lot other stuff with us we bring the education system we bring other court systems and so wanting to be able to understand dynamics of that and how to manage it the health home interface the claims administrative readiness that will probably be much in place through the adult process but we'll want to take a look are there any things that have to be done for kids in particular and then what are some of the things that IT infrastructure particularly are they going to be tracking and monitoring anything specific to the types of kids that they're going to be working with that will fit some of the data requirements that we will have I think that's it from me thanks Steve thank you glad to be a help any other questions I had a question about the network adequacy issue cause we know now at a baseline we don't have adequate network adequacy particularly for the higher needs kids and in New York City we have a clinic system for kids and with the existing managed care so as we move these higher needs kids into these plans what are we going to do about that we're asking the MCOs to create services they don't have now and they don't have rates for and it's going to take away the access these kids have to Medicaid fee for service so I'm very concerned I think the comments about network adequacy have not been reflected in anything I've seen from the MRT we have a huge problem at baseline with the network adequacy and I think it's a fantasy that MCOs are going to create services because they don't do that they just pay for them so for those of you on the phone the concern is about generally she's

saying that there's not enough service provisions now there's not enough network adequacy at the moment particularly for high needs kids so her concern is as we move into managed care how can we send insure network adequacy going forward we work for managed care all the time can't get kids appointments with psychiatrists for months and it's a very serious problem I don't know what we're going to do about that I don't know how this is going to end the SPA services are not going to address those and she is also talking about the shortage of childhood psychiatry I had a question you said that the providers now were no longer be providers when we go to managed care why is that true yea I didn't understand that either I didn't follow that I didn't mean to say that service providers will go away and why would they go away why would they not become a managed care provider it's harder to get paid under managed care because in New York City now people actually clinical professionals in New York City can choose not to take insurance we had that conversation this morning I'm a child psychiatrist by training and I've talked about this before reality nationwide is you wait 2 to 3 months to get a psychiatrist you're not going to be able to create psychiatrists in New York City that don't exist there are creative ways to get psychiatrists to work in certain plans I've done that for 20 years we may be able to do that are we going to be able to get to where you're talking about but I think the question of network adequacy isn't to figure out how to have some programmatic response it's the fact that health insurance coverage does not create supply so that's the issue so if we know that there is an inadequate supply the question is how do we get adequate supply of clinical intervention that work timely for young people who now can on the margin find work around into treatment you're going to see more risk adjustments and figuring out who's at the top of the list get them in people further down that list may wait a little longer I mean that's the reality of what we're doing with the start as I look at it you can't create providers I agree they don't exist they don't exist whether or not but there is going to be attention around the availability of seat slots for beds for kids who need them so we know that going in and so the question of network adequacy becomes the primary question in decision making about these plans going forward and that is going to be state opt mission to ensure providers this is a baseline problem big one doesn't change right so the other issue is that health homes limit the number of specialists in an individual plan health plans decide oh I got 50 of those I don't need 60 so they only allow certain numbers in I'm a physician I've been removed from plans cause I have enough of your type I don't need you in the plan so I've been doing this in managed care for 25 years I have never shut down a network to anybody who treats an adolescent right but this is the thing the issue is that from a system planning perspective it cannot be a decision by an individual insurance company or managed care plan the state of New York needs to ensure that children have access to clinical treatment that's where we are so how that happens and the business decisions that managed care plans make are a different conversation at baseline what we're trying to create since 2011 we've been in these meetings is a system of care that actually gives kids access to what they need and when they need it that's the goal right so part of the challenge is to figure out who to do that and there's no HARP for kids what's the solution so if somebody can't respond to a psychiatric for a pediatric patient then they're going to have to pay for the plan would have to go out of network provider there you go that's the way managed care works it's a needle in a haystack if you don't you have to go purchase it and it can be you know park avenue I don't care but that has to be the rule thank you there's certain criteria in managed care you can't wait for months on end with all the horns blowing about certain plans and you know things that are developing I can't act if somebody is in Bronx network psychiatric care for NYC kids that weighs it thank you Ellie do you want to say something I want to say one thing can you put that slide back up again the one

where you had the enrollment number so there health home interface I just want to put a placeholder I don't know if we're going to talk about readiness funding again but you know the biggest concern is now revenue management and the startup of the health homes we'll talk about it later okay so I just want to thank you put a placeholder relative to the plans paying ok readiness funds for health homes and we'll get to that later in the presentation okay great I was going to ask when we talk about EPSDT that's the states responsibility not the plans responsibility is my understanding about okay my question is the state plans will require network adequacy yea correct so they have to figure out a way to do it that's right okay precisely alright who's next Angela watch the cord ok so I get to do the fun topic of medical necessity criteria and network adequacy after that conversation so you volunteered so those on the phone Maria is leaving so she actually did volunteer she's inching her way towards the door so for those on the phone this is Angela Keller from the office of mental health I just want to point out to folks we're in the process as we're going to say over and over to finalize some of the designs pieces and moving to pre-implementation so one of the things we are further along in developing at this point are medical necessity criteria we reviewed these with the behavioral health plans medial directors this morning and we'll continue the dialogue with them regrading medical necessity for those in the room you will not be able to see all the text on the slides to come but when we send out the slides you can review it and we would certainly look for feedback from all of you so the next slide is just the generic medical necessity criteria defined in New York State which I think we've gone over before everybody seems to be very familiar with and what we've done with each of the and what we're highlighting here is the SPA services what is the admission criteria so what's the medical necessity criteria to begin to take advantage of that service continue to stay so if you've engaged in that service for some period of time what would a child still need to and who serves them need to demonstrate in order for them to continue receiving that service and the discharge criteria that would indicate if it's time for either to move on to a different service or that service is no longer needed we still have some work to do on this we welcome everyone's feedback on the medical necessity criteria draft that's in these slides we would request that in the next couple of weeks if at all possible if you do plan on commenting and so just briefly under each of these services is a list of what is that admission criteria so it's for everyone these services it has to be recommended by a licensed practitioner in the healing arts operating within the scope of their practice the service needs to be included in a child treatment plan it needs to allow a child to achieve their goals articulated in that plan or to familiarize some behavioral health condition and as they licensed practitioner recommends that then it addresses the prevention diagnosis and treatment of some of those conditions so you'll notice in the format as you read it there's a lot of OR's and AND's so in order to continue receiving a service some of these you may a child may need to meet one criteria or another and and and and again we would look for feedback on that so following similarly the crisis intervention this one is a little more brief because obviously it's an emergency service continue stay is not really applicable in this context and discharge is really about what are those things that we would have expect to happen in a crisis intervention and counter adversely you know there's a phone triage someone might go out and respond in person there's an escalation of what's going on coming up with a safety plan for the family doing some follow up with the family within 24 hours of referring to other services and doing warm handoff to others who might then begin to really work on those things that presented the issue more long term for community psychiatric supports and treatment one thing I just want to point out if you get these and review these is there isn't anything that is medical necessity criteria related to the evidence based practice you all remember that under the umbrella

of CPST we will have the ability to reimburse the higher rate for those that are certified if you will or designated evidence based practices and then designated by the state and operating infidelity to those models so each of those EBPs depending on how that model is health target population what the focus of it is will have their own intake criteria medical necessity if you will so if it's a model for example for 14 referrals who are involved in the juvenile justice system that their medical necessity for that particular EBP so that's not defined in here you won't find it seeing that we're not planning on doing EBPs it's just got a little bit of a difference so CPST has a little more detail because under that umbrella is a number of different activities and services that are allowable psychosocial rehab this is a service that is delivered by a non-licensed practitioner still the service needs to be recommended by a licensed practitioner detailed in a treatment plan that a licensed practitioner has developed and then how does it relate to are they achieving their goals do they still meet the admission criteria to continue to receive that service family peer and youth peer support one thing just to caveat on as you look at this we got some feedback yesterday and did not have a chance to change the slide but the language we're using in this for the admission continued stay and discharge is very family focused as family peer support services are but we will have to tweak the language to make it clear it is for the benefit of the Medicaid beneficiary for CMS purposes so it reads how we know its practiced but the language will change just a little bit but who gets the service primarily is still the family and then youth peer again is the service for youth that are 14 years and older and what would be an indication that they need that service receive it or are ready for discharge so it's a very brief run through mostly because I know everybody in this room can't see these tiny little words on these slides but any questions about just that very quick overview Margaret I'm sorry when we started this whole adventure the state long federal spiel about every child having access to habilitated services and I think you sort of gone around the borders of it but I know you got everything right but they do have community habilitation it's a really nice instructional funding program and I thought that was mandatory so Margaret's question was she thought we have been doing habilitative services and we are in fact under the home and community based services array we're talking here about the SPA services I'm so sorry it's okay there's a lot of detail here so there's six SPA services and twelve HCBS services within the children's design okay one quick I was just going to ask a question the criteria for medical necessity doesn't include any kind of a timeframe and so how will that be translated into actual practice by the plans and so forth so will there be sort of a parameter framework for how many of each kind of service a youngster can get we will still need to develop thresholds so many of this is a guidance to say up until twenty encounters of x particular service a child could get before the plan would need to apply utilization management and make a decision whether that continues to be medically necessary so we will get to that point but not within the conversation of what we're talking about today I was going to ask about medical necessities stuff so one of the criteria is it has to be part of the child's treatment plan so in the you don't hear me often compare the adults but in the adult system if somebody is in the ER they can be assigned a peer advocate can that happen in the without the they don't have treatment plan yet team so who would it be retroactive to receive SPA services before they've been deemed medically necessary they haven't even had a team meeting to have a treatment plan so Paige's question is the treatment plan is not yet in place does a treatment plan have to be developed before SPA services are accessed and when you're discharged from the ER have you walk away with a plan what about if you're in a pediatrician office and the pediatrician takes the child part of the discharge is the pediatrician has made a plan for that child this is what the course of action that is recommendation by the licensed practitioner looking at necessity in

the definition would there be a clear indication of who it is who is designating necessity the question is will it be defined who makes the decision that something is medically necessary for any child that is enrolled in a plan the plan plays a role in that for children in free for service who cannot enroll on the plan there has to be justification in the file certainly that would be open to audit later on but there's a different process that we are still talking about in terms of is it prior authorization is it editing within the Medicaid billing system you know those kind of things so there be a number of ways that we release guidance so you have all seen the SPA service provider manual and there will continue to be information that is put in there for you regrading thresholds how is medical necessity determined what are the rules around admission continued stay and discharge so all of that detail will get in there before we watch the SPA services for in patient outpatient and specialty services similar to on the adult side guidance was provided to the plans in terms of what is kind of the state vision for medical necessity and meeting those levels of care we will have the same kind of thing for the HCBS provider manual and plans will also develop utilization management criteria and medical necessity criteria which then the state is going to review so this if we could so on slide 24 when everybody gets it are 4 questions that we want people to think about in reacting to the draft medically necessity criteria and when we send this out we will give you the email of Rachel Fitzpatrick who is sitting behind me will be the lucky recipient of all this feedback but we really looking at the guidelines in the SPA provider manual does the medical necessity criteria fit the goal of the service is it clear enough to make and support clinical decisions do providers need more information to really understand the parameters of how one might justify medical necessity for a particular service and are there other aspects of what we laid out that are confusing that we still need to put some clarity around Andrea you had a question my question was are you going to be asking for the same type of feedback from the plans and in addition will the plans of be able to individually make decisions around their own criteria that providers would have to sign contract that would be different so that question didn't make any sense so I'll give another example they may feel strongly that CPST services they have to all fall on them because they are part of the state plan but if they don't feel comfortable with authorization by licensed marriage and family therapist so can they have a contract that says they will not accept referrals from licensed marriage and family therapists how do they define the healing professional our guidelines for general in terms of licensed professional being able to make referrals and the plan will discretions that's my question then the other question is will the plans be able to make different criteria for like you said a lot of plans allow you to go to a chiropractor without a referral they may allow us to go to a family provider without a referral but not allow you to go to another licensed professional without a referral and those are going to be uniformly described the contracts are they discretionary by each individual plan so the question there's multiple questions that Andrea's asking are we asking for the plan feedback and the answer is yes so this is the second time I repeated exactly these slides today and more to come but hopefully Maria will still be here to present that we've ask the plans for feedback that we've started that dialogue and then the second question can the plans set their own criteria what the state is doing is setting a vision and guidelines and those need to be met and those standards are outlined in the model contracts so we have a number of tools that the state can use in order to let the plans know what is it that we expect so if we go back to that under OLP there are 5 or 6 different types of providers that are available we would expect there's a variety of providers available under OLP now again it still comes back to the same question to a particular county or region is are there enough marriage and family therapists you know that's another question but the expectation and guidelines are laid out and then

whatever the individual plan internal processes on how they might determine that come to the state for the state to review so we have an opportunity to say well that's not exactly fitting with what our vision was and then that's part of the process between the state and the plan I mean we can say when they give us a contract it's not quite fitted but I guess the expectation is that there are certain new things in array of services that plans may or may not feel comfortable with and does it make sense to put uniform parameters up front until they become familiar as opposed to having them pick and choose from the menu for a little while until they learn by mistake that they should have allowed those services be approved right and I think we will lay out a lot of the detail in terms of what is the vision and what we expect and guidelines I think we have the advantage of having learned from the adult roll out so things that maybe we can be clearer on things we need to be clearer on because of the unique needs of children we will have that opportunity I'm going to keep moving on the overarching Medicaid requirements in policy aren't going to change in managed care that has to pass statewide-ness --- all of those things exist even when all these benefits move to managed care what we are required to do in Medicaid system still stays in fact there's more rules because there's also managed care regulations I think Marias coming over to do hers I am so glad of that thank you Angela --- ok so we're going to talk a little bit about network standards and we asked you for feedback in February we took the feedback you gave us and sent it to the subgroups that were working on them and that's what we're going to talk a little bit about today so network requirements read like they are in the box you know in urban out patients licensed to serve children and adolescents the higher 50% of all licensed clinics or a minimum of 2 per county the feedback that we gotten from you plans require to contract with any out patients clinics oh sorry so this slide was really to show you when we look at kids only clinics or clinics that serve kids only you'll see a great disparity that's nothing this group already didn't know and then when you do kids and adults clinics we get a little bit better of a look so the new requirements they serve both after having gotten feedback the requirements changed the following so for outpatient clinic licensed to serve children and adolescents and children the urban environment the higher of 50% of all licensed clinics or minimum of 2 per county in the rural area the higher 50% of all licensed clinic are a minimum of 2 per county if you're an outpatient clinic licensed to serve only children -- but the first one should of read adults and children and then specifically for the zero to five they need to contact with all in the county or region so this is to show you that we looked into what you have to say we are trying to expand the network adequacy standards so additional changes to the draft standards that we got from you in this section it is unclear whether timeframes are measured in calendar days or business days and I believe that would relate to the referral process I'm sure and we are revisiting and taking a look at that actually asking the managed care plans to talk to us about what's realistic expectations New York State incorporated into the recommendations business days reference within the document and defined as traditional workdays including Monday Tuesday Wednesday Thursday and Friday state holidays are excluded and traditional work hours of 8 am to 6 pm so we defined it a little bit clearer MRT had feedback on current defining language is insufficient and open to interpretation so we incorporated recommendations in many areas these minimum standards will not be adequate to meet members need for access satisfactory systems of care including participating provider networks and referral processes sufficient to ensure that emergency services including crisis services can be provided in a timely manner and in the most integrated settings appropriate to meet the enrollees needs so we highlighted the facts for folks that these are a minimum set of standards and the expectation is if the minimum doesn't meet the need they need to expand and make sure they have the capacity

did I cover what you wanted me to cover and this will also be something we will send this out in a separate document if you have feedback or questions please let us know there is one important point that has to be made there no relationship between the number of clinics in a county and the availability of services you could be counting you know you don't have any sense of what the appointments are you don't have any sense of what the relationship is between the population of children and their actual need for visit so I don't know whether bed calculation per 100,000 children or per 50,000 children or whether I'm not really sure what the calculation is but I think it's clearly a step forward to say that there should be two clinics per county I get that but a clinic has to have some kind of capacity to respond to the need of the population so what might be helpful would be to look at the map and in addition to looking at the distribution of clinical services looking at the population density by county so we can kind of come to some understanding about what the baseline availability is that right did I get it all my head nodding people

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yea that's knowable within the licensing day to day you have I'm going to up move quickly through the next few slides because Lana has a lot of material to get through for health home and then we still have a number of updates thank you so I'm going to pretend to be the MCTAC staff for just a moment was not aware that Andy couldn't be here today but we wanted to make him do it again this is Angela Keller from OMH so we just wanted to let the MRT know that we completed the first round of 7 in person forums across the state this slide this children's system transformation recap the attendance what was the distribution of OASAS OMH and OCFS agencies what was the attendance at each session and the state agency worker feedback we got a lot of questions during the course of each of the forms and we are in the process of putting together a question and answer which MCTAC will be posting to their website each of the webinar slides is on the MCTAC website if there's any other plug I'm forgetting Andy just tell me but then we do also want to alert you that coming up at the end of June and into the end of July there will be 1 hour webinars on each state plan service where we will go into more depth about what is it what would we expect to see who delivers it so a lot of the content is in the provider manual but hopefully a little more practical information in depth information by service and has the registration gone up the registration has gone up It went up yesterday so it should be in everybody's mailbox we got a lot of questions do you need to plan for one of these or all of these I think if you're planning on being a health home or a health home care management agency I would sign up for these to get a sense of what the SPA services are going to be available --- If you at the agency are anticipating of offering any of the SPA services I would absolutely sign up for all the ones they are offering again to Angela's point they will be high level at this point much more intense training and the information is available as we get closer to the live but that will be on Thursday I believe and so Andy just said if you plan on being a SPA provider please sign up these you can sign up for all of them you certainly should sign up for all of them continue to be informed about what is ahead is there anything we can say to people about what the qualifications of a SPA provider are do you have to be a licensed mental health provider can you be a foster care agency I mean so who anybody the qualifications for who the provider agencies need to be the individual practitioners and the supervisor are all detailed in the provider manual that we released on March 9th ok good and there will be lots more detail to come on that ok so I am going to turn it over to Lana to go through health home and then we will conclude at the end with some generic other project updates thank you so I'm not going to try to repeat the volume of information that was included our April 7th webinar which I think was a

couple of days after this group met but that's fine so just if you didn't have a chance to participate in that as usual they're on the website they're up there either recorded you can take a look at them we did just review I'll just tell you what's in there go over some important today and then give you little updates on what happened since April 7th so you have a window into some new stuff so just where we are in the readiness activities I think folks know we're monitoring by health homes and we have monthly meetings with the contingently designated health home to see where everybody is in achieving the -- grid and there's a pretty good window into how that's going along health home state plan updates I'm going to focus on that a lot today a little bit about the enactment budget again I already talked about the contingency and readiness activities eligibility criteria I just want to give folks an update on the work we've been doing to actual operationalize complex trauma we have a list about how we'd like folks to think about prioritizing the enrollment of children in health homes when we begin launch but obviously we'll maybe look past the issue on day 1 as people try to enroll everybody we'll need to kind of do in a responsible way that and work together and you know there's lots of question around that so we'll talk a little bit about that and then on the April 7th webinar we had put out a call for some feedback on additional standards around providing health home management for children and we received your feedback and turned around that feedback so for those of you who and we got some great feedback so for those of you who took the time to do that thank you that was very helpful we did some reviews on health home consent we had a nice chat this morning with the medical directors from the plans now the consent and you know consent is a difficult and complex issue in respect to kids and were going to have a separate meeting with the plans on consent just in general as we think about the behavioral health transition so we'll be viewing that in that environment as well and then we talked about some ability rules all of this is on the website so just on April 7th on that morning we got an official email from CMS that we got state plan approval so that's like huge and a big deal take a second to say YAY like some progress that actually happened right so we did say YAY so that letter came on April 12th and just to remind folks what was important about getting that SPA was it helps us do the tailoring for what we want to do health homes for kids right so it approved our use of the modified CANS-NY for care planning but also is part of how we will pay so there will be the algorithm associated with the CANS-NY tool that will determine if you're going to get a high medium or low health homes per member per month rate you know we've used the word acuity and I kind of regret it because I think people are getting that acuity with the actual acuity of the child it's really the acuity to help us determine the level of the acuity for the purposes of providing care management so there's a subtle distinction there but I'm trying to be a little more corrective about having people make think about it in that way what's it for one thing about the rates we have rates that are high rated 700 and I think 749 upstate downstate and then there's 450 200 so if CMS had a lot of questions about our rates they came to us pretty hard on how we calculated them and we shared that information with improvements same for them so when they approved the SPA they did put kind of a date as you will on it requiring us to come back the summer of what would that be 2018 to just re-up the authorization is I think primarily around revisiting and talking to them about our rates and our capacity and use and all that good stuff so at that time I think it will either be in a position of getting an extension or hopefully making it permanent however that will play out it's part of the process they approved the whole notion of what we did for the adults the whole conversion of OMH TCM providers to health home our rate reconciliation process and the whole legacy process that we've outlined in several webinars for the TCM crew they get that we're using referral rather than assignment process so that is being endorsed as well they excepted our

early intervention approach and we did talk to both the early intervention and the health home side of CMS in getting that and that's for the health home manager would be the ongoing service provider or coordinator in the EI world and so Collette and EI team at the Department of Health has been working fast and furiously with that approval in hand to now roll up their sleeves and think about how that's actually going to be operationalized and implemented on the ground and so you know that could take some time and we made commitments that we will obviously keep to the early intervention coordinating council to the counties about working collaboratively to make sure that everybody understood how those processes were going to work and how people we're going to how the roles were going to be defined and what the responsibilities would be and that would take a little bit longer than our October 1 launch so in our prioritizing enrollment in health home for children were going to put off the enrollment of EI of kids on day 1 the group thinks that they will probably be ready all of that stakeholder collaboration having all those roles defined there's consistent work that needs to be done as well and so their tentative date is to shoot for beginning to bring EI kids into health homes in March so we think we need that much time to do all that good work what else so with the complex trauma definition I'll talk a little bit more about that we have asked CMS if they would entertain a 90/10 state match for both complex trauma and SED we got complex trauma so we got 90/10 for complex trauma that was very good news really great news congratulations and thank you it was a big team effort to get there but you know they did decline the 90 on the SED because the argument is you have SMI and --- and SMI is comparable and it was your decision to hold out enrolling kids that's to some degree fair but I think that CMS truly has been our partner in this endeavor with getting complex trauma and so I think its good news and they were very supportive and one of the things that they kindly pointed out to me is that they don't really want a September 1 date because you're going to lose two months of 90/10 share I would think about October if I were you Mark said I'll think about October thank you very much so that was for folks who wanted their practical insight that's why we moved it from September to October and so just really quickly complex trauma so I'm not going to read this definition so we went to CMS with a definition that was different than the one that was approved our definition which was not focused on a multiple approach CMS and SAMHSA as partners came back with the definition and I think you know top of the tree the dialogue really is we're implementing a complex trauma definition within a chronic condition ACA authorized health home program and there needs to be a notion of chronicity for CMS to approve which is in the rule book right with the ACA standards what that complex trauma definition would look like and so they came back with the definition and what we talked about the April 9th meeting was I think you were all here but let's implement this I think it's a victory I think we can see how it goes we can always go back to CMS for the dialogue about how this can and may be refined and I am committed to doing that with you all but what we did ask folks for is this is the definition we have and now we got some other hard work to do which we have to operationalize it and how are we doing to this and if you read the definition how are we going to do it so being the smart people that we are we thought we would ask smart people and so what we did and this is just some detail on kind of what I just went through in a more high level way what we did you guys can read the slide at some point what we did was we reached out some folks who there was a group that sent out a specific letter with recommendations around complex trauma prior to us having done the April webinar and so we reached out and Andrew is working on it with – and – is involved so we had a call the other day and there was about 12 minutes of introduction that I can tell you the credentials and qualifications of the folks who are involved in helping us think about this are tremendous and impressive and we were with national folks on

the phone and helping us do this so I feel great about that and just to have everybody come together and think about this problem is very helpful so what we ask them to do was to think about the hard question what are the tools going to be how are we going to determine who needs a screen how are we going to determine who is eligible what are the qualifications for doing this and in doing that work being mindful of the guidance that CMS provided to us so it can't be done in a vacuum it has to implement this definition clearly and it has to be mindful of the guidance that CMS has provided to us all of this stuff is on our web page so if anyone wants to read it they can go out there grab it and read it and they came back and they gave us a preliminary report I don't know Monday? Tuesday? sometime this week it was 8:30 in the morning and I think it was Tuesday after the holiday and they gave us the beginnings of their work what I committed was to have this group go off and do some work and then come back and then as we always do go back to the larger stakeholder group and have a webinar on what this group is recommending so that if you're not on the group you can and you can have a window to have some additional feedback we're shooting to have that webinar I think June 7th so if we I think our goal would be to even if we're not completely penciled down to at least report out to people on kind of what we're thinking and there may be a little bit of a process so again highly engage stakeholder process to try to implement this complex trauma definition with the health home very exciting stuff I think there's some challenges there and then once we kind of get to a steady page my goal is to bring back our operationalized procedures how our administration around the complex trauma is a definition in health home write back to CMS for their review and comments so we can make sure that we are moving in locked steps so definition that they wrote I really think they need to have the window into did we are we implementing it in a way that is consistent it's been really great work we'll continue to involve folks and provide feedback what's really strong in two ways not only were they very mindful of what CMS reaction would be to a way that we weren't interpreting their definition so they were really honest about in regards to complex trauma domains and how many times we check and the whole permicity and all of those things so these experts were very very mindful of the CMS definition but there were people on the committee who were also very mindful of the referral process and the need to not kids that might be admitted to health homes because were doing this assessment process so they were very careful to develop I think a screening instrument that will let people move on to be considered by those two criteria as opposed to getting bottlenecked into waiting for the assessment to take place so I really think that people are going to like what they hear although I think at first look at 8:30 in the morning on a Tuesday it sounds complicated it's not easy does it preclude the possibility that kids who are in foster care placement because of abuse and neglect would be grandfathered in no they do not allow that based on the inclination it's not necessarily true so that's why they have to ---- it would have to be more than an incident --- very detailed the health home eligibility criteria has never meant to be population based we just can't say because you're under 21 or you're in foster care you can be in a health home but I just figured I'd better ask somebody can the complex trauma definition be applied to adults so the complex trauma definition of adults good question it really is the definition geared towards children I think in CMS mind it is an offshoot of SED okay right so they think of it as they have a code --- pretty good DSM5 category right for complex trauma at least not yet so you know I think in their own way of being compliant of their program they think of it as falling under the offshoot of SED people don't want to say that clinically because we think there's a lot of differences there but ---- *audience muffling*---- it requires harm first which is a little bit different from how we like to think about access to services its important anyway when's the registration going to be available

for the webinar the June 8th is it up June 7th is it up I don't know I think it is because it's on my calendar as a placeholder but I don't… it's June 8th my bad June 8th sorry if it hasn't gone out it will go out shortly I know Collette is helping me today but she was talking to the early intervention council so we're conquering and dividing can I ask quick question? those are my favorite so all of us are --- in our new HIP development right you try to go into the – system and how is all this are you factoring in the electronic communications you were talking yesterday about you know there's certain things that different not everyone has their hands on care coordinator look at this stuff and you don't have access you're not going to develop the plan and I don't think any business foster care work up this or that but you have to have some --- to inform yourself and we've got 50 different HIPs out there none which talk to each other and how are we going to bridge that and come out with so the systems issue is very tough we have systems issues in health homes right now we have different care management plans out there it was how the health home programs blew up you know we're trying to solve some of those problems things like --- and MAPP and don't tell me to more than that but to answer your question we're always mindful of trying to think long term distance about systems you know MAPP is a good example of what we're trying to do its beginning to house things like health homes and DSRIP and performance dashboards and we're trying to have that window the long term vision of MAPP would talk to other systems and that segways me into the next slide so now we have another environment we have UAS where are we going to house the CANS-NY for all of New York's assessments are and the CANS-NY uniform assessment tool is going to have to talk to the Medicaid analytic performance portal in health home to take that algorithm and relate it back to billing so that certainly the things we thought of and we're trying to providing others access to systems so that we can eliminate duplications and in those environments that would be up to a lot of things like in our ideal world and you know you and I have been talking about it it will be after I retire but you know it would be great if MAPP and connections for example talked it would be great if the care system that houses CHS shelter information were connected to MAPP whatever right and so I think everybody understands that that would make our lives easier and should happen so that's always in the cards we've been talking to our folks on the EI side as well I'm not going to sit here and tell you I'm going to fix every systems issue and every system is going to talk to each other and I'm not going to tell you there's not going to be duplications because there already is today you know we built MAPP so there can be upload and download features for the care managers to for the health homes to be able to work with their system to upload and to MAPP and then we have plans MAPP do their uploads and downloads with respect to billing and I know I already heard questions about billing coming so we're continuing to problem solve and to rely upon systems to help us do this and we were able to launch MAPP some of those silly solutions are going to work but we are all over it it's part of our daily we have daily discussions on billing it's very interesting I'm kidding important! I have one other question so just going back to the fact that CMS assigned a model package for targeting case management legacy rates and the parameters around the reimbursement legacy rates and I think that I've just recently discovered maybe a small glitch in the algorithm about how to calculate those rates and it only regards a very few number of agencies but there were targeted case management programs that were being operated by agencies in 2013 that were nowhere near capacity they were going out of business and in 2013 has been transferred to other agencies the slots their rate and their number of vacancy slots are going to be based on the 2013 level even though they have clearly done a great job because they took over the program and increasing the volume so I'm just I just want to put on the table that should be a reason to revisit the

calculations or I think it's that 2013 I just want to put it in as a placeholder so we maybe can have a discussion about it just for example --- as 308 program --- took over the program timeway only had in the 2013 program 260 kids in the program they weren't doing a lot of outreach so Medicaid --- is going to be based on the billing --- legacy rate that's only for the 260 programs then there's going to be reconciliation over the 260 plus filled to 300 why wouldn't there be reconciliation over 300 and a rate calculated based on the higher number its complicated I mean one of the things we had to do a point in time and I think that if there's particular issues with particular agencies wave it to Michelle Wagner in OMH and make us aware but you know there were no matter where we drew the line if we looked at 2014 there would have been some winners and some losers but ultimately right but ultimately we expect the reconciliation to be minimal because the health home rates by and large are greater than the PCM rates and all I'm saying is if you fill those spots with medium and low you're not going to have access to the reconciliation and its really going to fall because you are not weren't operating the program then so I just have two more slides left and I'll go quickly so again MAPP is launched we are making MAPP modifications they are important we need them to go live to launch the October date it will have the children's referral portal consent so it will have do that so that's being built and obviously the algorithm that we connect between MAPP and UAS and then we have a separate system issue which is just getting the CANS-NY in the UAS environment so if you are an adult person now engaged with MAPP on the health home tracking system side and you don't see these don't freak out cause they are not here and we will have trainings right so if you are a brand new health home and you haven't had access to MAPP and you're not serving adults you will get training to access MAPP so that will all happen as well as UAS not to be confused with the fact that there is actually CANS-NY the tool itself right not training on how to access the UAS environment have to happen but now you can become trained on the modified CANS-NY tool we have training out there we recorded training that we did last summer with John Lyons there will be more training which is my next slide so oh no that's not my next slide yet so the readiness funds that was part of the budget process there is a letter out there that confirms that the Department of Health will work to identify resources startup resources for health homes serving children we have done that work we identified $7.2 million in resources that will be available for the health homes so as part of the process so I can't will like to but we can't just hand out money in the state of New York so I've had to huddle up with the lawyers to figure out what is the authorization where is the appropriation what is the process for getting the dollars out the door the last time I did this slide we I had not had those conversations yet I have had those conversations since I've done this slide so the initial read focusing highly on the word initial because I still have to do some conversations with contractual folks but is that we probably can develop a distribution formulas for the fund and probably make a series of lump sum payments that is code for I may not have to go through the very painful and long contractual process so the dollars that will go out and the funds for distributing those dollars will focus on the health homes who have not had the benefit of the health homes development funds so what does that mean so if you a health home there was $190.6 million approved under the waiver fund for health homes and health homes that are currently operating obviously those serving children have been receiving the benefit of those funds and we relaunched those funds we're reminded that health homes who come in and want to serve children that they should be thinking about using their health homes development funds for that so that $7.2 million will be focused on those who currently do not serve adults and are brand new to the health home world and to those that have significantly expanded their existing adults with to serve kids and having emphasize on

significant so I am hoping to and it is 2nd or 3rd top priority on my list actually it's really one but it's probably tied with two other things in working on right now and I am hoping to if the process remained streamlined I hope it does I'm hoping that the money can begin to go out the door in July and that's a very aggressive timeframe so I'm committed to do my best to beat it but I'm also trying to channel to you that I'm trying to move as fast as I can I say I we if I can July is soon our people will help you do it but yea its very fast hopefully I'm not here in July but I might be you never know we are moving quickly and then okay I have a question on checkbox the question is for management agencies that might be new to this whole process how do they go about accessing HVS getting the appropriate paper work filled out so they can get that rolling and when will that be filled out or where can they find that so that is presented in two or three webinars that are online but and you can try to go and fish for those but the easiest thing to do is to either send me or the health home serving children BML which hopefully is in here somewhere it's the last page yea and just say that's what you need and you check that email log everyday so send an email to that tell me who you are what it is that you want and we'll get you the information on how to get access to the HCS and if you go to the webinar I can't remember which one it is we've done it two or three times the last two webinars prior to the April 7th webinar has information on accessing HCS and there's a separate letter that went out to care management agencies I believe on the process and that should be on the webpage as well but go to that bureau mail log or shoot me an email and I can get you what you need okay and then just real quickly here the trainings we have a series of trainings a lot of it is training different folks about health homes so there's some education trainings in here for the state education department is busy helping with us you've heard a lot about systems interconnectivity and I have to say and SED and I don't mean serious emotional distrubance I mean education department watch your alphabet soup has been a real partner with us in health homes from the beginning and they have done a really great job Joanne Pat Gary has been really tremendous and we've also had a few meetings with school psychiatrists phycologist's sorry that we're going to involve in some of our training and dialogue as well so it's about educating the education system we are also going to try to be doing some stuff with the educate health homes about the education system and you'll be seeing us doing that with the criminal justice juvenile justice so educating both sides doing that educating health homes understand the juvenile system juvenile system the county probation officers or how we target that to understand health homes and so one of the challenges that I think we have in educating the different systems is particularly at launch is that I have this little fear that we do such a good job at advertising and people listen to us and then they come knocking on all of your doors and you say I don't have the capacity at the moment and you know it's like that good thing combo with the bad thing so you know I think we just have to be mindful of that I don't think that we don't educate people I think it just means making sure that people understand that the program is new we're launching it we're going to have capacity issues as we open our front doors and do all of that but we are going to go out there we are going to educate we're going to reach out to providers on both sides of the system and begin to do that so what you see in this schedule is just that happening and I will also point out that there is a series of in person CANS-NY training being repeated we got excellent feedback John Lyons himself is going to do them again so are out there on the schedule and we're also trying to work to get some trauma informed care training out there so there's ---- where are you go back one on your list of trainings ---- so our little logo covered you up what does it say oh there it is July 13th oh no it doesn't say July 27th crammed too much on that slide and if there's I think the team as you can see has been busy if there is individual folks who want specific training or there's groups you

know let me know I'm happy to go out and do a little road show to providers so if there's things here that we're missing I think we're trying to be aggressive and do as much as we can over the summer but we don't have to do it all before October 1st we're going to be implementing for a while so we're happy to continue that campaign so that's what I have --- presenter there's an acronym on the slide that is unfamiliar to us --- CAPS and SCALES I think CAPS is capital and approved provider selection and SCALES is --- thank you that's me who's next just a question can you speak to what we learned about the challenges with adults health homes rollout so yes and one of the things we've been trying to think about is making sure that our excessive processes are not overly complex we've been trying to gage the right parameter between level of specificity with respect to standards and qualifications but I think we struck a good match there we've definitely have an eye on the processes for health home as we begin to incorporate the HCBS services and the processes for determining HCBS eligibility for a lot of those kids who will likely be enrolled in health homes so we have our eye on sort of not duplicating an overly complex process that might impede connecting a member with certain HCBS services up front so you know we agreed significantly on the approach that we took on adults in terms of the processes for hooking up kids getting the person through process having the HCBS services be able to be employed prior to the completion of the full assessments given the nature of the assessment on the adult side so I think time team is carefully thinking about that process we're mindful to not have a process that's so overly complex that we have bottleneck that get created in the connectivity of the system and then there's just the practical administrative realities also I do think some of the rules of the game in terms of health homes for kids is a lot different than adults we won't be in a position that's creating some of the problems that exist in adults one being the assignment list thing the assignment list thing in the adult world is a challenge and outreach has taken on a whole different notion and we don't have outreach challenges too much for the kids right cause we know where they are need a parent to be engaged to get them in health homes because we have consent so the issues are a little bit different you know I think one of the challenge will be having people get comfortable with the referral portal and the assignments algorithms and see how that is going to happen and making sure that while we make sure that we give folks LBSSs and LDUs and stuff like that and access to the portals we're also thinking about making sure that there continuity of care management where possible as kids who are slipping in and out of foster care kids who are slipping in and out of potentially HCBS services who may remain eligible for health home you know post become eligible for health home RPS you know all of those issues you know we need to be thinking about those but I think the challenges are a little bit different but I do think we've been very mindful of you know some of the things that we've learned on the adult side and then of course just billing flow everybody's worried about billing you know we have rolled up our selves very hard on the adult side you know direct billing is scheduled to go away in September we're going to be switching over to high medium and low there's a lot of challenges working through a reasonable timeframe to get the payment from the plans and health home back down to the care manager we've launched MAPP we think we got the appropriate billing flow for MAPP that will be recreated for kids so hopefully we don't have that pain so hopefully over the summer we're working with the folks who have figured out how to do the billing flow in the adult world and there is a plan out there who have figured it out and they're sharing their best practices we have certificates from the health homes saying they can make a payment within 15 days of receiving the plan down to the care managers that requirement is in place and exists for the obviously the kids health homes that will serve adults and it will also apply to the new health home so we kind of have the benefit of a

little bit of you know working in a more mature system and then having learned from the you know little bumps in the roads that we are now struggling with so you know I think there's going to be a good balance there and I probably think we'll find our new problems we'll have to solve as well so we'll keep busy I have a series of questions I hope you don't mind maybe folks --- complex side --- so first and foremost I think we talked about this before when we looked at the algorithm that CANS is going to put all the patients into in terms of we did some beta testing changes were made to the tools to try to accommodate some of the recommendations but we still have no idea as we move forward at where these patients are going to fall in terms of the algorithm and I think it's difficult on the business side for us to invest a lot in getting started without understanding the business side of this and I'd like to suggest that and I gather you guys don't want to share the algorithms but maybe we ought to take a bunch of our cases and test them and tell us where are those kids are going to fall within the algorithm because that will help us decide to even be in this business or not because as I sit today I have no idea if I can afford to be in this business and I totally get that and I'm happy to run from kids --- in-between standing up to behavioral health and getting the health homes programs and then finding another avenue to you know carve out a whole testing thing and I'll think a little bit more about how we might be able to give folks a better window into how that algorithm is panning out but I said this before and I'll try to say it again but I think we went into the lab we did the best we could with existing data we reached out to stakeholders yourself included to try to so here's the thing if we didn't get it right we'll think about how we can fix it and I guess that folks need a level of cash flow stability you know I'm little bit on a two sided coin and I just kind of spent some time with CMS being concerned about the level of the rates and then I get concern about that level is not enough so I'm trying to work both sides here the levels the rates could be fine if the patients are categorized appropriately by the tool right and that's our evaluations from a business stand point and again I just want folks to remember that and not to be confused by the childhood self-acuity from your point of view versus the acuity from a health homes model because what we try to do in that algorithm we're really saying what level of care management right it's not about what level of medical services that this kid requires what level of care management did that kid require and what does that work like whether than look like from the care managers point of view and it takes into account things like the care giving environment that the kid is in right and so there is a lot of art and science and we --- Angela and her team and John Lyons is trying to get this right and if we didn't get it right you know we can go back at it it would be nice to do some okay and from that we're more happy to do that just have to figure out again it's a matter of whether you guys are willing to share the algorithms but we can do testing for you understood we're eager to do the testing --- so one of our problems is you know the money will be the money if you bankrupt us your screwed because you're going to have to do the work so I get that part of it but the bigger problem for us right now is how many people are not going into healthcare delivery system so some of the requirements you have for children like monthly visits when you have a ratio of 1 to 20 children right so you have 20 children that have monthly visits --- for 20 kids it's huge so for 10 kids we know that you have to do monthly visits for the 20 kids you do two so you've actually made it more confusing rather than problem solving well your comment about for kids over 20 you have to get a certain number of contacts one thing to keep in mind is that the health home rates were based on the ratio 1 to 40 1 to 20 1 to 12 for math exercise there is nowhere in the guidelines except for high where we say if you're a care manager with a predominantly high acuity case load we would like you to keep close to 12 because of the intensity I'm not arguing but let her finish cause she's making an important point so we're not

saying then there's a case load of 20 and you have to make contact with all of them if your case load has high 5 medium and 10 lows the 10 lows have contact where need exist the requirements are only when you get to the higher need which is appropriate so I get that but let's say you have that 20 that just explodes because that has happened before so there is no way mandated a bill and you have a monthly business you can successfully have those explosions and manage and do a decent job

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It's not with children who live with the family who doesn't have a huge social outlet to it----- my problem is you got that 1 to 20 ratio appeal that every single day right but there is no 1 to 20 ratio that's what we're saying I'm not there is no 10 20 40 there is no mandated case load ratios in the health homes program except if you're serving high we ask that you keep your predominately if you have a high and a medium kid you need to keep a 1 to 1 based contact a month thing right let me offer something so the questions we're getting are related to the business how do you ramp up how do you know you can afford it how do you plan with a case load to be able to meet the requirements all of these questions that I can speak because in my previous life before coming back to OMH I ran a health home those were all the questions that the adult providers graveled with and they it was painful to not know how somebody was going to score and all those kinds of things that you're going to be paid you have a lot of experienced providers out there health home care management agencies that can offer issues on all those things kids and adults but there are agencies out there there's been many health homes that could offer how did they approach to making those decisions how did they project revenue their --- so here's the thing here's the thing the issue around case mix and the issue around staffing they're critical issues but we can't really resolve them today but they are critical issues and so trying to figure out how to facilitate a conversation with people who have done it before to sort of learn from that I think would be a good step I'm not entirely sure who's going to facilitate that conversation it's probably not for here and it's not a training it's not a MCTAC training it's more a providers thing so provider people coalition people who are in the room that might be something that would be useful to have the providers have a conversation with people who have actually have spent some time thinking about staffing and caseloads and managing the flow going forward because we can't we're not going to be able to resolve it today Margret but it would be good if you could benefit from the other people's experience instead of just kind of putting your finger in the air and hoping that you can figure it out I don't know what the solution is though one question yup so from what I'm understanding now care at home existing caring home population is not going to be going to health homes until the summer is that correct they will begin in the summer of 2017 the summer of 2017 so on the medically complex side that was going to be the bulk of the population clearly that was going to go to health home so now those of us that are starting to gear up have to start to figure out what the population we're going to serve – it is a little bit of an issue that if we've been working towards this I just pointed out that the care at home children were never going to be launched with health home --- and what about there are care at home kids on a waiting list to get into care at home what are we doing in October of 2016 so the prioritizing list that we have out there says if the kids on a waiting list enroll them in health homes it's up to the parent there's choice involved clearly but the only rule we can't break is we can't take two types of care management so the person is on a waiting list for care at home and would like to benefit from health homes and not enroll in care at home they

can go ahead and enroll in health homes the waiting list the only issue there is you know the waiting list happens at care at home they get a window to HCBS that won't happen for health home until we get to July when the HCBS services are available but if that child can benefit from health homes while they are on the waiting list they certainly can do that absolutely correct ok go ahead one last thing this is going back to understanding the business model I just want to be clear I understood from the April webinar that the ratios of supervisors are somewhat flexible it's not demanding 1:5 we give them flexibility we practiced around 1 to 5 but what we did ask is you document after you got what your supervisory ratios are those are not our ratios in care at home right now what are yours can I ask 1 to 8 10 to 4 so you have flexibility to do either one of those you know what the truth is you can put down what you want but really it's such a turn over field we just did the best we can right now this field is so choked and it's the same over there I have a caseload and so I think we've given you flexibility within your current environment to manage to that and what we asked you to do is document this right okay and we have two questions left about health home if there's more you know where I live so if the young person is on the care at home waiting list receives care management through health home can they stay on the care at home waiting list until that slot becomes open and then transfer from health home yea I just wanted to confirm that yea and they have to be disenrolled from health homes and then transferred back I just wanted to confirm that so what did the chatbox say has there been any thought to eventually developing a uniform health home care plan in order to better enable the sharing of the data as far as I know it's very hard to share the plan each system uses a different plan and structure so I know that the adult team has thought about standards as we tried to develop we developed a HCBS services we developed a list of the elements of the plan of care that must be incorporated into the health homes itself plan of care we will do that same thing and repeat that kind of exercise for children we have not mandated a standard care plan I think there's a lot of national work going on how about how we can develop how a common care plan can be developed for the purposes of you know HIP promoting that exchange of information I think there's work going on on the DSRIP side think a little bit about standards plans of care so there's a lot of conversations around it we have not mandated it there are systems in place that health homes have purchased around their own care planning tools and so that's the environment in which we are in today question but we are not have not mandated it but there is national work going on around it I think it really depends upon having systems connectivity like what do you have first the uniform care plan or do you have the ability to talk to each other by system and you kind of need both of those things so another question that came into the chat box was related to CANS training so we released the list of CANS in person trainings that are happening this summer there's some indication on some of the sessions if they are quote on quote sold out just want to reiterate that the in person training is not required we are offering in person in addition to online depends on your learning style if you prefer in person you can still go online it's the same training John Lyons video from last summer is on the CANS website www.CANStraining.com I believe or .org and so either one works you get certification at the end if you pass the exam so while I'm sure there's people out there that would prefer the in person but it doesn't mean that you can't get certified prior to the launch of the health home if you will be a care management agency at that time thank you anything else there will be an extension for the managed care I think that question is applying to the foster care managed care readiness funds that I think have a July end date so I think we can certainty can think about to sending that to folks how to spend the money I'll talk to Julie when I get back and Gail yea getting into that one right can you repeat the question so the question was if the date is extended does the budget modification need to catch

up to showing that you know the timing of your spending usually yes awesome thank you alright so we'll go to just some general project updates as most people know we play musical chairs now we released an RFP in April for the CANS institute and that will be a vendor or vendors that will be rewarded a grant for up to five years in order to assist the state in making sure we are implementing and using the CANS reliably and that we are addressing technical assistance meets across the state etc. so that one came out in April questions were turned in by May 13th and responses were released yesterday so if you haven't seen them I believe they're on the grants gateway site and there's the link right there on the slide for more information and then for proposals are due on June 17th so when they come in we will work through that process of review and awarding a vendor or vendors you guys already collected the plans that redevelop care at home and I would love for development of service plans I would love for you to do a side by side comparison that would be really so the question was whether the state could do a side by side comparison of the results of the CANS and what's in the service plan and current services plans and people could see how robust they are they equally robust do you have the right tools and so I also just want to say and I think that specifically just look to the medically fragile children population we're not saying that CANS is the only tool you can use no no so there are other tools you're in charge with developing a comprehensive integrative care plan right and what we tried to do while you had us testing the CANS was to develop a plan based on the results of that plus our intake right and then walk to what we used and the difference is huge especially with our bias eyes but with every population that will use the CANS the CANS is one piece of information and everybody will gather much more that will inform what needs to be in a service plan right for sure next update yup Ellie? Did you say more than one they're not due till June 17th so they haven't come in yet I have put those questions there were quite a few questions if I don't know cause when we get them they're not listed by how many entities we just get a list of questions to answer with very strict rules around I'm just asking how many there were quite a few questions so one nice thing that we want to announce is that we now have a children transformation website that focus on the children managed care so we have our own place our own link which is on the slide and I would encourage people to go there regularly when we do release certainly new documents that's where we will put them there are historical documents there so every MRT meeting that we've had

any other webinar releasing's service manuals etc. all those information the MRT originals 2011 recommendations so it's really a compilation of where we started and where we are I would caution people that certainty as you open some of the content pay attention to what the date is because it was accurate on the date that it was written or published or whatever the date is so certainly today when we talk about timelines change have changed so if you look an old slide and say wow I thought if you get confused just please keep that in mind and if there's any content on the website that you think would be helpful that you're not seeing let us know Racheal is our keeper of the website and the designer of the content so she would be more than happy to keep adding stuff and she does a great job thank you alright so another update managed care readiness funds we had talked in our last meeting in February we were in the previous state fiscal year we were in the process of releasing HIP grants which happens before the end of March and we had indicated that they was money in the 16-17 budget $20 million of which ten of that was expected to be federal match and that we had obtained a lot of feedback from stakeholders and from the MRT about what really were the most pressing needs for providers to be prepared for the transition and we put that aside and we are now formed an advisory

committee of advocates and providers that will weigh in keep us informed what's the word out there on the street of what is needed and we'll weigh in as we make decisions about particular dollar amounts what is the focus on some of those funds and based on that first meeting and feedback we're relooking at the list you all thought in February and I would hope by the end of this month that we would come down to some final sense of what is it that we're going to dedicate some of those funds to and then what's the strategy for the federal match on which pieces of it because obviously all of this won't be eligible for a federal match and you know continue to hear from stakeholders feedback what is needed and I think every time MCTAC has a webinar on our project is another opportunity things are going to come up questions are going to be asked and needs are going to emerge that we haven't even thought about so hopefully that will just continue to be a somewhat flexible identification of how we can do that there are some particular things that are not set and stone but are completed so we have to have a sole source contract with John Lyons related to the CANS so any time we want to tweak something we do have to consult with him you know we pay for the capacity of the online training and the certification that sort of thing so there were some pieces of that dedicated support that you know we don't really have a lot of choice about and certainty that the CANS institute RFP was also a piece of that so we there's probably 100 more updates that we could give everybody there is a tremendous amount of activity being driven by lots of deadlines and moving pieces are about 35 pages long now with lots of lots of tasks so I think over the coming months the speed with which you will hear news and good news and developments is going to pick up because we're getting almost to the end of the design phase so are there other questions concerns things we didn't address today some of the things but I have to say better you then me I'm not good with -- you have done a beautiful job --- I don't know what's in your coffee but there's something in there thank you compliments super that's a great compliment it really is amazing I second thank you very much so about care management agencies that are new and are starting for the first time are asking a lot of questions of the health homes about whether MCTAC are going to be offering trainings for care managers to learn about what is a care manager so we've in her answer is correct but we've been really focused on thinking about the trauma informed care training part to leverage that notion and I think we've talked a little bit about more care management training on the adult side so it's not impossible to be thinking about but you know I think for part of that that you get and before you even say it I get need money to get training to get care management right it's all about timing and startup you know again I'm trying to work as quickly as I can to get startup funds to folks who haven't benefited from health home development money but that's in part with the health home development fund money is for right for health homes who are launching on the kids side there are resources for that startup as well so there is money out there to do this let me comment about the bump of the night yea sure having done the adult one already you're going to we all are going to have a big bump it's going to be a little bit more than some of the speedbumps that are out there but one of the things that has helped us tremendously on the adult side is that we several meetings like this we had one this morning medical record we have alternate ones where the plans and the providers get together and the thing that has worked the most as we go forward is to get away from the blame game it's not your fault it's not my fault it's easier to do that I can always find something where somebody else screwed up you know my kids used to use a thing SODDI defense some other dude did it that's the danger with having a full time house keeper all my kids say Christina lost their homework Christina did everything woman that woman is amazing but the reality is if we keep the dialogue going through those early implementation stages it really helps we've learned a lot we've done some

pilots we just did a pilot in health first with CBC health home on what doesn't and what does work in getting plans of care done we're presenting that to commissioner at OMH at the end of the month but all of the plans have been doing it all of the providers are doing it really working and having a joint dialogue and the dialogue particularly starts and I said this this morning when we go live because all of this right now is theory turn the switch before you to theory --- so why don't you guys talk about that offline so you why don't we talk about individual provider issues offline so we can say thank you to everybody Jenny do you have one last thing question where does HCM --- in what way --- thinking mostly about prevention services --- where a lot of families and kids can identify not foster care not in the ---so should there be are you suggesting that there might be training or outreach to that group of providers they are embedded in the current health home for children they are part of the collaborative I've met with them I've meet with HCS they are fully aware and we are planning on having a series of meetings with our preventative providers to talk about specifically how they fit into this whole thing we're focusing right now on the title 40 waiver foster care agencies but we'll be moving shortly --- but they have contracts with HCS and other county social service departments I think it's dually noted I think it's good to make sure that we haven't left anybody out it's a good point and not wanting to leave anybody out here's our plug for all our various email logs email boxes list serves websites and there is a new CANS mail box I think that if they're CANS specific questions that are that's also on DOH's website we do need to add that to this list I do really want to thank Ian for making the comments that he just did because you know I work on the adult behavioral health transition I do the adult health homes I do the kids health homes and doing this behavioral health transition he is absolutely right it really is about the collaborative nature and you know the past is the past we need to move forward together we need to be solution oriented problem solving if it doesn't work with this launch we need to come back to the table together we have our commitment to do that we need you to be on the other side to do that and just to really work together help each other in the process and you know it can work it's hard but it can work so that is what we have to do really appreciate you saying that okay one last question because I think that this is not your mothers managed care and many of us have been hired from provider ends I ran many children's programs in the past right so I'm new to managed care but I think that we come with a different perspective having been on the provider side so I hope that you'll many years so I think that you know you'll reach out to us when there's questions or problems I went to rest of state yesterday and I thought this was an opportunity for us to start meeting with another group right so we're all rolling this out together and this is I think the first MRT meeting where we had as many plans represented I certainly appreciate and all of us appreciate that and I think that does change the dialogue about where we're going it's really important we're all talking together very good and hearing jenny's questions and everybody else's questions alright thank you and we're hanging up on the phone thanks everybody