Children's Transition Overview: Part 2

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Introduction

- Understanding the Interaction of Child Serving Systems and Navigating Coordinating Systems of Care
- Integrating Primary and Behavioral Health Services
- Health Home Model and Practice
- CFTSS: Family Peer Support Services (FPSS)

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Understanding the Interaction of Child Serving Systems and Navigating Coordinating Systems of Care

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Children's Behavioral Health: The American Reality

- 1 out of every 5 children in the US meets criteria for a major mental disorder.
- 50% of adult mental illness occurs by age 14; 75% by age 24.
- 13-20% of children and adolescents have a diagnosable mental, emotional, or behavioral disorder, and this costs the public $247 billion annually.
- In 2015, suicide was the third leading cause of death among youth ages 10-14 and the second leading cause of death between ages 15-34.
- 6.9% of 12 -17 year olds in the US meet the standard psychiatric criteria for substance use disorder.
- Emotional disturbance is associated with the highest rate of school dropout among all disability groups.

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Lifetime Impact

Untreated or poorly managed behavioral health problems have serious social repercussions.

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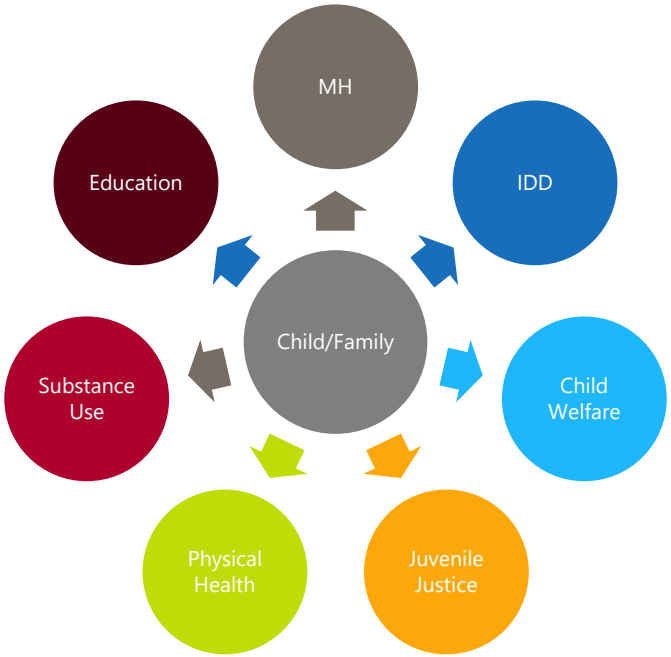
Children's System of Care

- Office of Mental Health (OMH)
- Office for People with Developmental Disabilities (OPWDD)
- Office of Children & Family Services (OCFS)
- Office of Addiction Services and Supports (OASAS)
- Department of Health (DOH)
- Juvenile Justice
- Education



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The Interaction of Systems

- Behavior problems are often apparent in school, where the child spends a good portion of their day.
- These behavioral problems are often rooted in mental health concerns, and at times families under stress may find themselves involved with the Child Welfare system.
- These various systems have a significant impact on child outcomes.

Integrating Primary and Behavioral Health Services

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The Current Healthcare System: Dis-Integrated

Providers are typically:

- In different locations
- Non-holistic
- Don't communicate/coordinate services for patients with multiple needs
- Spend their time with similarly trained practitioners
- Have their own set of regulatory, licensing and credentialing requirements
- Have little understanding of the interdependence of emotional functioning, physical health and substance use
- Unfamiliar with multi-disciplinary teamwork

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What is Integrated Behavioral Health?

The care a patient experiences as a result of a team of PC & BH clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

C. J. Peek & The National Integration Academy Council's Lexicon for Behavioral Health and Primary Care Integration (2013)

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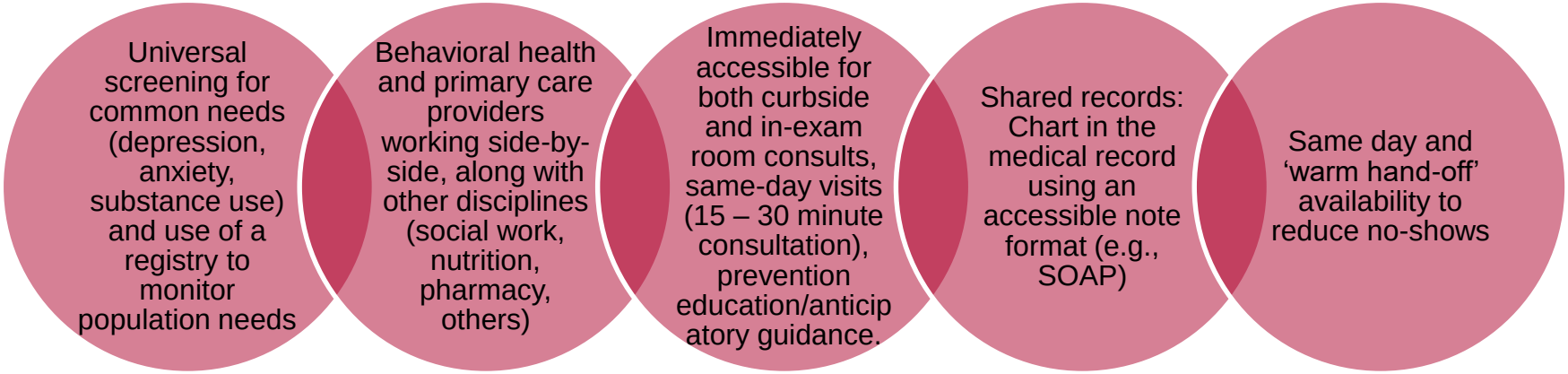
What can integration look like?



Partially adapted from Robinson, P.J. and Reiter, J.T. (2007). Behavioral Consultation and Primary Care (pp 1-16). N.Y.: Springer Science + Business Media.

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End Goal: Whole Person Care

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Health Home Model and Practice

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Background

New York State's Health Home (HH) Model was created to recognize the importance of care management, coordination and planning in order to improve the quality of care for children receiving behavioral health services.

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Goals of Health Home

- Have awareness/understanding of all physical and behavioral health (mental health & substance use) services the child is receiving
- Facilitate care coordination and communication between all the child's providers
- Ensure quality of care
- Provide person centered care
- Assist with closing key care gaps in order to help the child/family work towards optimal health outcomes

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Responsibilities of a Health Home Care Manager

- Connects child/family with providers and community supports
- Communicates with all providers
- Provides transitional care and follow-up from inpatient to other settings
- Determines and documents child's Health Home and HCBS eligibility and reassesses
- Creates individualized Plan of Care
- Conducts ongoing comprehensive care management

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Health Home Eligibility Criteria

- Must be enrolled in Medicaid
- Be appropriate for intensive level of care management that HH provides
- Have two or more chronic conditions or one single qualifying chronic condition

The Health Home care manager is responsible for documenting and verifying children meet the eligibility criteria

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Role of Health Home in CFTSS and Aligned HCBS

- New CFTSS - Child does NOT need to be enrolled in a Health Home to access these services.
- HCBS – Health Home enrollment is not mandatory.
  - If the child/family chooses to enroll in a Health Home (HH), the Health Home determines HCBS eligibility and creates/manages the Plan of Care (POC).
  - If the child/family opts out of Health Home, eligibility is determined and POC must be created by C-YES, the Independent Entity (IE), to allow access to these services.

CFTSS: Family Peer Support Services (FPSS)

Understanding Service,
Service Authorization and Medical Necessity

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Goals for CFTSS

- Provide a greater focus on prevention and early intervention.
- Allow interventions to be delivered in the home and other natural community-based settings where children/youth and their families live.
- Maintain the child at home and in the community with support and services.
- Prevent the onset or progression of behavioral health conditions and need for long-term and/or more expensive services.
- Be available to all Medicaid eligible children under the age of 21 who meet medical necessity criteria.

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What are Family Peer Support Services?

- Activities and support provided to families caring for a child with social, emotional, medical, developmental, substance use, and/or behavioral challenges.
- Provided by an individual with lived experience.
- One of the Children and Family Treatment and Support Services (CFTSS).
- Went live July 1, 2019.

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

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Timeline: Between April 1st and July 1st 2019

- Medicaid reimbursable Fee-for-Service FPSS was available to any HCBS waiver enrolled child who needed FPSS.
- Intended to ensure continuity of care.
- Only to children enrolled in HCBS.
  - If a child was not enrolled in HCBS, they would not be able to receive FPSS during this time.
- This means that when FPSS went live as CFTSS in Managed Care (July 1, 2019), some children may already have been receiving this service.

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FPSS Went Live July 1, 2019

- As of July 1, 2019: FPSS is available to all Medicaid eligible children under the age of 21 who meet medical necessity criteria.
  - This includes special populations, such as transition aged youth, individuals in foster care, etc. as long as they are Medicaid eligible and meet medical necessity criteria for FPSS.
- FPSS is billed to Managed Care.

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Pathways to Care

- There are a variety of ways in which children/youth can access FPSS.
- A behavioral health need can be identified by multiple sources including parents and other caregivers, pediatricians, care managers, school personnel, clinicians, or the young person themselves.
- Services can be utilized individually or as part of a comprehensive service package for child/youth and their families.

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Pathways to Care

- Anyone can make a **referral** for services, but the determination for access (**recommendation**) and service provision must be made by a licensed practitioner who can discern and document medical necessity.
- It is expected that the referral source link the member to the appropriate service provider.
  - **If a member reaches out to a MMCP indicating they were "referred" for services but without a connection/linkage to a provider, the member must be referred to a qualified provider to obtain a recommendation for services.**

What is Utilization Management?

- Procedures used to monitor or evaluate clinical necessity, appropriateness, efficacy, or efficiency of behavioral health care services, procedures, or settings and includes ambulatory review, prospective review, concurrent review, retrospective review, second opinions, care management, discharge planning, and service authorization.

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Authorization Summary

- The first 3 service visits with FPSS do not require authorization, however providers should notify the plan before providing services to ensure proper and timely payment.
- If more services are needed, the plan will perform concurrent review to evaluate medical necessity and authorize further services if deemed medically necessary.
- Plans are not required to perform concurrent review before the 4th visit but cannot perform earlier.
- 30-visit count should not include: a) FFS visits or visits paid by another MMCP; or b) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit.

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