Dear Lana:

We appreciate all you have done to reach out to stakeholders as you work on enhancing the health home program so that it will offer children improved care coordination opportunities. With the draft Health Home Request for Information for children schedule for release in the next several weeks, we are providing these recommendations for your consideration.

Agencies with a longstanding commitment, expertise and service to New York's children, youth and their families, came together to draft these suggestions. The agencies represent children, youth and families who face serious challenges and barriers in their lives either because of serious emotional disturbance, substance abuse, HIV, developmental disabilities, trauma, special education needs and many of whom have experience with the foster care system, juvenile justice, the Court system, Committees on Special Education and those who may be homeless and runaway youth.

We embrace the principles laid out for children in Health Homes and Managed Care in the March 4, 2014 presentation, Tailoring New York’s Health Home Model for Children. We endorse the goals of the health home, - to improve the well being of children, improve the quality of services, better integrate services in the community and improve access. We also endorse the goal to improve quality of care and outcomes while reducing health care costs.

Two of the most important principles are specifically inclusive of families:

- Ensure managed care and care coordination networks provide comprehensive, integrated physical and behavioral health care that recognizes the unique needs of children and their families
- Provide care coordination and planning that is family-and-youth driven, supports a system of care that builds upon the strengths of the child and family

It is our commitment to these two principles that leads us to believe that health homes for children and youth have to include different considerations than those that primarily serve adults because of the importance of family engagement and inclusion. The significance of family as well as the complexity of
working with families dictates that issues related to eligibility, acuity, rate setting and case load size be developed with this complexity and context in mind.

**Eligibility**

The way in which eligibility is determined is critical to assuring children get the services they need. We agree with the eligibility proposal, targeting over 200,000 children and adolescents as Health Home eligible. However, determining eligibility for children will be significantly more complex than with adults as:

- functional status changes over time,
- children live in the context of a family,
- children attend schools and
- children typically interact with multiple child serving systems
  - including substance use,
  - child welfare
  - mental health
  - juvenile justice and the courts
  - many sectors/providers in the health care system

Historic Medicaid claims data does not provide a comprehensive picture of children’s services utilization. Involvement in these multiple systems confounds the historic utilization picture, but must be considered to reach the children who can benefit from Health Home services.

**Presumptive Eligibility**

Determining eligibility for health homes therefore needs to be flexible and assure a wide net for screening of potentially eligible children and youth. It is in the best interest of children to allow them to be presumptively eligible based on certain criteria and until an assessment can be completed. Such criteria should consider their involvement in the foster care, juvenile justice (including Family Court and Youth Court), mental health and special education systems. Presumptive eligibility should also include those with substance abuse history as well as those who are homeless and/or runaway. For example, children who have been identified as seriously emotionally disturbed (SED) by the RBHO should be considered presumptively eligible. Children who are placed in a residential program for substance use or Residential Treatment Centers (RTCs) should be presumed eligible. Children in the foster care system should also be presumed eligible.

While we understand that Federal participation in HH payments is tied to approved eligibility criteria, it is important to hold the provider harmless for good faith efforts to engage high-risk, high-need youth in Health Homes. Since utilization data itself will not be a reliable marker for health home eligibility, it will be important for the State to explicitly presume eligibility during an outreach and screening period in order to encourage providers to engage the largest group of potentially eligible youth in the services of the health home.

**Comprehensive Eligibility Screening and Determination**

Eligibility determinations should include child development, family issues, trauma, attachment, functional impairment, as well as diagnosis. Children in early childhood special education system and classified by Committees on Pre-school Special Education (CPSE) should be screened. and those in the child welfare system receiving preventive services should also be screened.
We know from the Kaiser Permanente Adverse Childhood Experiences (ACEs) study that children who experience two or more adverse experiences are at risk of having both health and behavioral health difficulty throughout their lives. The probability rises exponentially with more adverse experiences. We strongly recommend trauma, as determined by a reliable screening instrument be considered for eligibility.

**Eligibility Instrument**

If assessment tools are to be identified to determine eligibility, we strongly recommend more than one instrument be identified at the onset of the Health Home expansion. At a minimum, the imprecise nature, lack of consensus in current use and lack of familiarity with a single mandated instrument will contribute to inconsistent implementation. We recommend a transitional period with regard to the assessment instrument to assure competence and training during which time alternative tools can be used. Should only one instrument be mandated, we request the State review the efficacy of the tool and consideration of other acceptable tools within a reasonable time period after implementation.

The selected tool must:
- Include clear eligibility criteria
- Allow providers to confirm eligibility quickly (in a single session during the outreach and engagement phase)
- Allow for the role of informed clinical opinion (especially for those working with infants, toddlers and pre-school aged children)

**Acuity**

Acuity levels are critical in determining rates. We recommend an acuity determination process that is simpler than what is currently employed for adults in the health home program. Acuity determinations must include factors beyond functional assessment scores, including trauma history, family functioning and the involvement in multiple systems, as well as the potential for developmental change with children.

As with eligibility determination, we recommend piloting more than a single or specific tool/method for determining acuity. Most child assessment instruments are imprecise, and difficult to administer without extensive training. During the initial implementation stage, we recommend Health Homes be open to several approved acuity measurement tools.

We suggest the creation of a clinical advisory team that will monitor and advise regarding the use of appropriate instruments and make recommendations about necessary adjustments after implementation.

**Discharge Criteria**

As with the determination of eligibility criteria and acuity levels, we recommend the identification of specific discharge criteria. Discharge criteria for children cannot be wholly determined on “scores” on clinical instruments. When developing discharge standards, again we suggest that family functioning and system involvement, as well as child placement and educational stability be considered.
While acuity levels and therefore payment levels may change, we recommend maintaining child eligibility as long as possible. This approach recognizes that developmental changes, educational placement and family status are not static and can change rapidly resulting in functional impairment. Maintaining Health Home eligibility will allow rapid response to changing circumstances, thereby enhancing the long-term benefits for children and their families. Discharge criteria are not synonymous with “outcome measures”. Outcome measures can be evaluated while youth are still engaged in the Health Home.

The ongoing needs of children engaged in the foster care system need to be considered when determining acuity levels and Health Home discharge. The care manager will have unique interface requirements with birth families, foster families, local departments of social services and often the court system, whenever acuity level reviews are undertaken and prior to discharge.

The transfer of care coordination responsibility for youth between care coordinators and in fact in certain circumstance between Health Homes must be seamless. There will need to be guidelines for transfer from one Health Home to another, given movement of children and youth in and out of the system as well as geographically. The assignment of two care coordinators might need to be established. The criteria should be for the Health Home to exhibit capacity to address the child’s and families’ needs. Health homes for children need to exhibit the capacity to have teams that specialize in early childhood development, aging out youth, first break psychosis, foster care to name a few. Age appropriate service linkages will be a key factor for transitioning aging out youth who may be receiving services from both the adult and child-serving systems simultaneously.

Rates

The establishment of adequate rates will be critical to the success of the program. Rates must be determined based upon the unique characteristics of the children determined eligible for the Health Home. For example, children and youth may move in and out of Health Homes more fluidly and more frequently than adults, based not only upon their Medicaid eligibility, but also changing living circumstances and the eligibility assessment tools utilized.

We recommend maintaining Legacy rates for 24-36 months after implementation for programs that currently provide Targeted Case Managed (TCM) or care coordination as part of the 1915(c ) Waivers. We recommend adequate rates from the beginning for all new Health Home coordinators; rates that recognize the challenges of startup and the fiscal fragility of the agencies who are critical providers of care management for children; and as is the case for substance use providers, have not previously provided care coordination as a Medicaid service.

We recommend a specialty rate when a care manager is assigned to a family that has more than one child determined eligible for Health Home. This will not only assure that care coordination is provided in a way that is sensitive to family needs, but also increase the flexibility of the care coordinator to integrate the individually developed care plans into a single family plan.

Adequacy of rates is particularly tied to the notion that caseload size needs to be smaller for children’s care coordination (than for adults) to take into consideration that children’s care coordination involves families and multiple child serving systems.

Knowledge of the rates is essential for agency planning. It is recommended and requested that rate information be made available with the draft RFI.
**Case Load**

We recommend tying caseload size to acuity. The evidence-based care management model for high needs children and youth (i.e. high fidelity wrap around) mandates a caseload limit of 10:1 to meet the evidence-based standard. The OMH Home and Community Based Waiver model has an 8:1 caseload limit and the OCFS B2H model has a 6:1 caseload limit.

As acuity levels decrease, we recommend flexibility in caseload size, and a range based on a number of factors, but especially including agency case mix, the multi-system complexity (i.e. Juvenile justice, Courts, Special education) of care coordination for children and the uniqueness of family engagement. We recommend all this be taken into consideration for establishing case load size.

Knowledge of expected case load ratios is essential for agency planning. It is recommended and requested that case load information be made available with the draft RFI.

**Medicaid Eligibility and Deeming**

Deeming is a tool currently used to allow a child with a disability to be deemed Medicaid eligible as a “family of one”. We encourage expanded use of the deeming process to reduce the chance of a “one month enrolled; next month dis-enrolled” scenario for this population of extremely vulnerable children.

We recommend expansion of deeming for children in residential care referred by Committees on Special Education, children with substance abuse problems placed into residential treatment, juvenile justice related youth, and children with specific CSE classifications. Once “deemed” Medicaid eligible due to placement in Waiver, residential or other settings, we recommend continued eligibility for up to 12 months regardless of placement.

Included in this recommendation would be to make care coordination/management available to any child at the highest acuity levels (e.g. those with equivalent needs to current waiver eligible children) – to prevent the need for residential placement in order to be eligible for Medicaid services.

**Outreach, engagement and consent**

We recommend that the assumptions to determine the outreach and engagement time period and rates take into account the unique factors relating to children and families. We encourage the use of the outreach and engagement rate for case finding, determination of eligibility and also for obtaining consent.

Obtaining consent and initiating services will be more complex than what has been the experience for adults in Health Homes. Specific differences include:

- Defining the age at which a teen can provide or disagree with consent
- Defining whether who may consent for foster care youth (county, legal guardian, notification to biological family, foster care agency) and whether multiple consents are necessary;
- Defining what constitutes consent in shared custody situations

**Information Technology, Training and HH Technical Assistance**
We recommend that the RFI describe the array of information technology and technical assistance funding that will be available to both Health Home lead agencies and downstream providers. Pertaining to technical assistance, we have already identified a training concern around staff familiarity and conversion to assessment and acuity instruments. We recommend training funding be available through the various trade associations to address workforce needs.

**SAVINGS**

When evaluating health care savings, the metrics must be designed to go beyond Medicaid spend for this children’s population. The savings will accrue to multiple children’s service delivery systems, as well as significant savings from reducing future health care costs to this population as adults.

In conclusion, we look forward to reviewing an RFI that describes:

- The Health Home eligibility criteria for the expanded Health Home population
- The use of Presumptive Eligibility for certain conditions and circumstances exhibited by the expanded Health Home population
- The identification of screening, eligibility and acuity tools or instruments for the expanded Health Home population
- The discharge criteria and outcome measures to be applied to the expanded Health Home populations
- The identification of rate ranges and case load limits for the expanded Health Home populations
- The identification of unique Medicaid eligibility determinations and expanded use of Medicaid Deeming for certain portions of the expanded Health Home population
- The recognition of unique Outreach, Engagement and Consent circumstances that will apply to the expanded Health Home population
- The description of available IT, TA and training supports that will be available to both Health Homes and the downstream providers who will be engaging the expanded Health Home population
- The recognition that savings achieved through expanding the Health Home population will be broader than Medicaid expenditures.

Sincerely,

The Member Agencies of
*The Council of Family & Child Caring Agencies*
*The Coalition of Behavioral Health Agencies, Inc.*
*NYS Coalition for Children’s Mental Health Services*

attachments