



PROTECT CHILDREN IN MEDICAID REDESIGN

In New York State, Medicaid is delivered to eligible children through three different plans:

1) Child Health Plus A (Children's Medicaid - under age 19 who meet income and immigration criteria); 2) Child Health Plus B (under age 19 whose family income is above Medicaid's rate or who do not meet Medicaid immigration criteria) and 3) Family Health Plus (relevantly, 19 and 20 year olds who meet income and immigration criteria). The Governor established a Medicaid Redesign Team to eliminate \$2.3 billion from the Medicaid budget while streamlining the provision of services to improve both service delivery and service outcomes.

Children have unique health and behavioral health care needs due to their age, growth and development, which are distinct from those of adults. It is essential that Medicaid Redesign provides coverage options that protect and address the specific needs of all children, including children served by waiver programs due to fragile health, behavioral health issues or developmental disabilities, as well as children in foster care. CCC's support or opposition to specific Medicaid Redesign proposals is grounded in this frame of reference.

- **CCC supports Medicaid Redesign Proposal #1021, which would enable DOH, OMH, OASAS, and OPWDD facilities to add services licensed by another agency to facilitate the integration of physical, behavioral and developmental services.** Currently, the State Department of Health (DOH) regulates physical health services and behavioral health services are regulated by three state agencies: Office of Mental Health (OMH) and Office of Alcoholism and Substance Abuse Services (OASAS). The Office of People with Developmental Disabilities (OPWDD) regulates developmental disability services. As each agency has its own set of regulations, there are obstacles to co-locating these services.
 - Proposal #1021 proposal will reduce existing regulatory obstacles and allow for integrated service delivery thus greatly facilitating access to needed services for children and their families.
- **CCC supports Medicaid Redesign Proposal #93, which would establish interim regional Behavioral Health Organizations (BHOs) to manage carved out behavioral health services. CCC recommends that there be a child and adolescent specific BHO developed to address the multiple needs and service integration issues of children and adolescents.** Managed health care plans have historically done a very poor job addressing children's behavioral health needs.
 - Proposal #93 would establish regional health organizations to manage carved out behavioral health services. In states where this approach to managed care has been implemented, BHOs have resulted in better planning for these special populations, improved education and training for service providers, increased access to a broader array of needed services, and improved care coordination with mainstream health care plans as well as non-Medicaid services. Significant savings have also been achieved under these models in other states.

- **CCC opposes Medicaid Redesign Proposal #26, which places utilization controls on behavioral health clinic visits for children and decreases the reimbursement rates from 100% to 75% to 50% of the rate depending on the number of visits.** Children’s mental health care requires not only that a child see a clinician, but also that the clinician make collateral contacts with important individuals in the child’s life, e.g., parents, teachers, and or other significant persons. Currently, collateral contacts made while treating children are reimbursed as a “visit” under the children’s Medicaid.
 - Proposal #26 runs counter to best medical practice and would unfairly limit children’s access to needed mental health treatment.

- **CCC recommends, that as a component of Medicaid Redesign Proposal #1458, a children’s workgroup be created to inform whether or how to implement managed care for special populations of children. CCC recommends that if special populations of children are required to enter managed care plans, benefit packages be developed that meet their complex health and behavioral health needs.** Currently, there are children who do not participate in Medicaid managed care because of the complex and multiple needs they present, such as children who are in foster care, and children who are developmentally delayed, disabled, mentally ill, or medically fragile. Some of these children participate in the Care at Home Waivers, Bridges to Health Waivers or other home-based waiver programs.
 - Proposal #1458 states that special populations of children may shift into managed care plans. Given the level of need demonstrated by these special populations of children, we recommend the creation of a children’s workgroup to inform whether and how to implementation managed care plans for special populations and should managed care be required, that benefits packages must meet their complex needs.

- **CCC opposes Medicaid Redesign Proposal #104, which would impose additional co-payments under Child Plus B.** Currently, patients are not required to pay co-pays and there are legal limits on the amount of money that can be collected as co-payments under Child Health Plus B.
 - Proposal #104 may be particularly harmful to children as parents who do not have the money for co-payments may decide not to seek preventive care for their child. Additionally, while there are legal limits on the amount of money that can be collected via co-payments, there is no method to track co-payments to ensure that patients contributions do not exceed legal limits.

- **CCC opposes Medicaid Redesign Proposals #15E and #15H that lift prescriber prevails protections as medications are not necessarily clinically interchangeable and therefore prescribers must be able to select the most appropriate, clinically indicated medications for their patients.**
 - Proposals #15 E and 15 F may be particularly harmful to children with special needs (behavioral health and chronic conditions) as the inability to access the most appropriate medications can lead to higher rates of emergency department visits, hospitalizations and use of other health services.