Subject: Process and Delivery of Services Documentation

To: 1915c Transitioning Providers, Lead Health Homes, Designated CFTSS and HCBS Providers

Health Home Serving Children Care Management Services
The Health Home care manager works with the family to identify their needs and strengths through the completion of the CANS-NY, the comprehensive assessment and the HCBS Eligibility Determination, if needed. Based on these tools, collaboration with providers, discussions with the child/family, which includes choice of services and service providers, a person-centered Plan of Care (POC) is developed.

Plan of Care (POC) – The Health Home POC is comprehensive including medical, behavioral health, community and social support, inclusive of HCBS. HCBS are included within the Health Home comprehensive POC, not a separate document. The POC must identify the services and which need is being addressed, the provider whom is delivering the service, including the planned duration of the service and how the Health Home care manager (HH CM) will assist the family with obtaining these services. Specific for HCBS frequency, scope and duration is determined by each individual HCBS provider and must be provided to the HHCM for inclusion in the POC.

Oversight – The Health Home POC is ultimately the responsibility of the HH care management agency and the lead Health Home the child is enrolled in. Contingent upon the member's consent, the POC will be made available upon request to the member's Managed Care Plan (MCP). NYS DOH Health Home division along with State agency partners have oversight of the Health Home program.

Timeframe – The person-centered POC is created concurrently with the Health Home comprehensive assessment within 60 days of enrollment for all consented Health Home members, regardless of age. For children who are determined HCBS eligible, their POC must be completed no later than 30 days of HCBS/LOC Eligibility Determination. Health Home care managers can initiate an initial POC with HCBS to meet the 30-day timeframe ensuring that a completed person-centered Health Home POC is completed with the member within the Health Home standard of 60 days from Health Home enrollment.

Home and Community Based Services
A Home and Community Based Service (HCBS) provider is designated by the State to provide specific HCBS. The HCBS provider will receive a referral from a Health Home care manager or the State Designated Independent Entity of Children and Youth Evaluation Services (C-YES) based upon the choice of the child/family of the service and provider.

Service Plan – Upon receipt of a referral from the HHCM/C-YES, the HCBS provider will conduct an intake and/or other assessments to determine the need of the child/youth and how the need will be met by the service provided (e.g. goals and objectives). The HCBS provider will also determine the frequency, scope and duration (F/S/D) for each of the HCBS they will provide to the child/youth and share the information with the HHCM or C-YES, as well as the MCP, if enrolled. The goals, objectives, and F/S/D will be included in the HCBS service plan, which will be maintained by the HCBS service provider.

Oversight – The HCBS provider agency is responsible for the development and quality of the service plan. If the MCP is involved they will provide review and oversight of services delivered. The State partner members of the NYS Provider Designation Committee and the NYS Interagency Management Team (IMT) will have oversight of all designated providers of services and HCBS performance and quality of care.

Timeframe – TBD
Best practice for the Service Plan to be developed within 30-days from the first appointment.

Children and Family Treatment and Support Services (CFTSS)
These State Plan Services are provided by State designated providers approved to provide specific designated CFTSS. Referrals can be made by a Health Home care manager or other community providers involved with the child/youth. There is no requirement for enrollment in a Health Home for a child to be referred to or receive CFTSS.

Treatment Plan – When a child's need is identified, a Licensed Practitioner of the Healing Arts (LPHA) will assess the needs of the child/youth to determine whether the CFTS service will meet their needs to determine medical necessity. If medical necessity is met, a recommendation will be made to a designated CFTSS provider. The provider will develop a treatment plan with the family which outlines the services to be delivered, how often the services will be delivered, by whom the service will be delivered and the goal/outcome of the service. If the child/youth has a Health Home care manager, the CFTSS provider would share the services being provided with the HH CM to enter in the child/youth's comprehensive POC as the CFTSS provider would be part of the care team for the child/youth.

Oversight - The CFTSS provider agency is responsible for the development and quality of the treatment plan. If the MCP is involved they will provide review and oversight of services delivered. The NYS Provider Designation Committee and the NYS Agency with which the agency is licensed and/or certified will have oversight of all designated providers of services and CFTSS performance and quality.

Timeframe – TBD

Summary
As noted above, each service provider as well as the Health Home care manager is required to have their individual record of the delivery of services and ensure that it complies with State standards, requirements and regulations. The Health Home POC is the only document that reflects other services (e.g. medical, dental, etc.) as the Health Home care manager is care coordination and linkage to services and not direct service provisions. There is the potential for a child/youth to have three separate records, as outlined above: a comprehensive HH POC, HCBS service plan and a CFTSS treatment plan, depending upon the child/youth needs and linkage to the proper services.