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Health Home Care Management and the Integration of Early Intervention

Agenda

- Welcome and Introductions
- HH Eligibility Criteria and Appropriateness
- Health Home Referral Process
- Health Home Standards of Service Delivery
- Health Home Training
- 2018/19 Executive Budget
- CANS-NY and Training
- Service Transition Timing and Billing
- Other Requirements and Standards
- Process and Oversight
- Transition to the 1115 Waiver Services



Health Home

Eligibility Criteria and Appropriateness



Health Home *Chronic Condition* Eligibility Criteria

- The individual **must** be enrolled in Medicaid
- Medicaid members eligible to *Enrolled* in a Health Home **must** have:
 - Two or more chronic conditions (e.g., Substance Use Disorder, Asthma, Diabetes*) **OR**
 - One single qualifying chronic condition:
 - ✓ HIV/AIDS or
 - ✓ Serious Mental Illness (SMI) (Adults) or
 - ✓ Serious Emotional Disturbance (SED) or Complex Trauma (Children)

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/health_home_chronic_conditions.pdf

- Chronic Condition Criteria is NOT population specific (e.g., being in foster care, under 21, in juvenile justice etc. does not alone/automatically make a child eligible for Health Home)
- In addition, the Medicaid member **must** be appropriate for the intensive level of care management services provided by Health Home, i.e., satisfy appropriateness criteria



SED Definition for Health Home - SED is a single qualifying chronic condition for Health Home and is defined as a child or adolescent (under the age of 21) that has a designated mental illness diagnosis in the following Diagnostic and Statistical Manual (DSM) categories* as defined by the most recent version of the DSM of Mental Health Disorders *AND* has experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis

SED Definition for Health Home - DSM Qualifying Mental Health Categories*

- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma- and Stressor-Related Disorders
- Dissociative Disorders
- Somatic Symptom and Related Disorders
- Feeding and Eating Disorders
- Gender Dysphoria
- Disruptive, Impulse-Control, and Conduct Disorders
- Personality Disorders
- Paraphilic Disorders
- ADHD for children who have utilized any of the following services in the past three years:
 - Psychiatric inpatient
 - Residential Treatment Facility
 - Day treatment
 - Community residence
 - Mental Health HCBS & OCFS B2H Waiver
 - OMH Targeted Case Management

*Any diagnosis in these categories can be used when evaluating a child for SED. *However, any diagnosis that is secondary to another medical condition is excluded.*



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SED Definition for Health Home - Continued

Functional Limitations Requirements for SED Definition of Health Home

To meet definition of SED for Health Home the child must have experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis. The functional limitations must be **moderate in at least two** of the following areas or **severe in at least one** of the following areas as determined by a licensed mental health professional :

- Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
- Family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
- Social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
- Self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
- Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

❖ *Note: the DSM categories include in the definition of SED used to determine Health Home eligibility is different than the SED definition used to determine eligibility for other Medicaid services (e.g., OMH clinic, inpatient, etc.)*

Complex Trauma – Single Qualifying Condition for Health Home

This guidance on complex trauma draws upon the domains within the definition of serious emotional disturbance (SED). While there may be similarities in the condition(s) and symptoms that arise in either complex trauma or SED, the therapeutic approaches associated with the same diagnoses may vary significantly when the symptoms arising from traumatic experiences are identified as such. Trauma experts indicate that with complex trauma, the clinical diagnoses may be more severe and typically present as comorbidities or multiple diagnoses.

Definition of Complex Trauma

- a. The term complex trauma incorporates at least:
 - i. Infants/children/or adolescents' exposure to multiple traumatic events, often of an invasive, interpersonal nature, and
 - ii. the wide-ranging, long-term impact of this exposure.
- b. Nature of the traumatic events:
 - i. often is severe and pervasive, such as abuse or profound neglect;
 - ii. usually begins early in life;
 - iii. can be disruptive of the child's development and the formation of a healthy sense of self (with self-regulatory, executive functioning, self-perceptions, etc.);
 - iv. often occur in the context of the child's relationship with a caregiver; and
 - v. can interfere with the child's ability to form a secure attachment bond, which is considered a prerequisite for healthy social-emotional functioning.
- c. Many aspects of a child's healthy physical and mental development rely on this secure attachment, a primary source of safety and stability.
- d. Wide-ranging, long-term adverse effects can include impairments in:
 - i. physiological responses and related neurodevelopment,
 - ii. emotional responses,
 - iii. cognitive processes including the ability to think, learn, and concentrate,
 - iv. impulse control and other self-regulating behavior,
 - v. self-image, and
 - vi. relationships with others.



Process to Determine Health Home Complex Trauma Eligibility

Completed by Non-Licensed Professional or Licensed Professional w/o access to tools

- Complete the Complex Trauma Exposure Screen
- Referral Cover Sheet
- Other family and child history and information obtained
 - If positive for Complex Trauma (on Exposure Screen) – Referral can be made for HH

Eligibility determined by Licensed Professional with access to tools

- Complex Trauma Exposure Assessment Form
- Functional Impairment Assessment through the completion of the appropriate identified NCTSN guideline list of domain assessment tools
- Complex Trauma Eligibility Determination Form
- Other family and child history and information obtained
 - If positive *Determination* of Complex Trauma – Referral can be made for HH and Child is Eligible for Health Home under Complex Trauma single qualifying condition



Health Home Appropriateness Criteria

Individuals must meet the Chronic Condition Criteria AND be Appropriate for Health Home Care Management

Appropriateness Criteria: Individuals meeting the Health Home eligibility criteria must be appropriate for the intensive level of care management provided by Health Homes. Assessing whether an individual is appropriate for Health Homes includes determining if the person is:

- ✓ At risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)
- ✓ Has inadequate social/family/housing support, or serious disruptions in family relationships;
- ✓ Has inadequate connectivity with healthcare system;
- ✓ Does not adhere to treatments or has difficulty managing medications;
- ✓ Has recently been released from incarceration, placement, detention, or psychiatric hospitalization;
- ✓ Has deficits in activities of daily living, learning or cognition issues, or
- ✓ Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home.



Determining Health Home Eligibility

- The Health Home care manager is responsible for documenting and verifying children meet the eligibility criteria, e.g., work with health care professionals to determine and document eligibility conditions
- The State has developed a set of forms and procedures for determining if a child has complex trauma (i.e., meets the Health Home definition of complex trauma)



Crosswalk of Chronic Conditions Between Health Homes and Early Intervention

To estimate how many EI children may be potentially eligible for both EI and HH CM services, a crosswalk of eligible conditions was conducted

- HH Chronic conditions currently do not include certain developmental disabilities
- Eligibility for Early Intervention includes diagnosed conditions and developmental delays (Identified ICD-10 Codes)
- Prior to CMS authorization to expand Health Homes to Serve the IDD population, there is a limited number of Chronic Conditions that meet both EI Eligibility and HH Chronic Condition Eligibility
- Currently, approximately 2,700 EI children with 50% of the children residing in NYC are estimated to be eligible – DOH will provide County data

See appendix for a list of current EI conditions

- Launch of the IDD conditions within the HHSC chronic condition list (*tentative July 2018*)



Health Home Referral Process

Using MAPP to Refer Children to Health Home

- MAPP (Medicaid Analytics Performance Portal), a State Department of Health System, includes a Children's HH Referral Portal
- The Children's MAPP HH Referral Portal is the vehicle to record referrals (create an assignment with a referral record type), and enroll children in Health Homes
- The following entities now have access to the MAPP Children's HH Referral Portal and can make a referral
 - ✓ Managed Care Plans
 - ✓ Health Homes
 - ✓ Care Management Agencies/Voluntary Foster Care Agencies
 - ✓ Local Government Unit (LGU) / Single Point of Access (SPOA)
 - ✓ Local Departments of Social Services (LDSS) (In NYC, VFCA that contract with ACS will make Referrals on behalf of ACS)
- In the future, the State expects to expand access to the MAPP Children's HH Referral portal by identifying and authorizing other entities that are natural points of contact in the systems of care that impact children to make referrals through the MAPP Referral portal (School Districts, county probation departments, pediatricians, emergency rooms, Early Intervention initial care coordinators, etc.)



Local County Entities Access to HH MAPP Referral Portal and additional access

Currently LDSS and LGU/SPOA have access to the HH MAPP Referral Portal to make referrals

In 2018 expanded abilities will include:

- Local Districts will have Medicaid CIN look-up function within the Health Home MAPP system
- Beyond the referrer role, LDSS will be able to determine and view assignment of referrals made
- Local Department of Health (LDH) will have access to the HH MAPP Referral Portal to make referrals ***therefore EI providers would have access directly to the MAPP Referral portal*** and CIN look-up function



MAPP Functionality



Provides online interface to the Manage Care Plans (MCP), Health Homes (HH), and Care Management agencies (CMA) to collaborate in real-time and track a member's status.



Direct Communication between Health Homes and Early Intervention providers for Referrals

- ✓ Health Homes and Early Intervention Agencies are encouraged to build relationships to have direct communication with each other to make referrals and re-referrals when necessary
 - The parent, guardian and or legally authorized representatives consent is necessary when sharing information
- ✓ The Early Intervention Official (EIO) will be able to have a direct communication with Health Homes to make a referral to a Health Home when the child is not eligible for Early Intervention or transitioning from Early Intervention, once consent by the parent, guardian and or legally authorized representative is obtained
- ✓ The Health Home will have a direct communication to the County EIO to refer children that may be eligible for Early Intervention



Health Home Care Management Standards of Service Delivery



Health Homes Serving Children

- There are 32 Health Homes currently operating in New York that now serve adults
- 16 Health Homes have been designated to serve children (HHSC), 13 of those currently also serve adults
- Who are they – Health Home Serving Children Contact

Website http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm

- A list of HHSC, the counties they will be designated to serve children, and if applicable what counties they are designated to serve adults
- A list of counties and the HHSC those children



Health Home Care Management Valuable Service for High Need Children

- Health Homes provides comprehensive care management to Medicaid's highest needs, most complex children – Health Home is an optional Medicaid benefit
- Children that meet Health Home eligibility criteria receive comprehensive care management that meets all their needs – 360 degree approach
- Breaking down silos, to ensure a child receives care management regardless of the door they enter – medical, mental health, substances use, social services, etc.
 - Managed Care Plans, Lead Health Homes and Care Management Agencies working together and have a shared interest to ensure quality services and outcomes for children
- Policy goal is to enroll more eligible children in Health Home to improve their health outcomes and quality of care



Benefits of Health Home Care Management Services

- Health Homes Serving Children and EI /DOH need to continue to collaborate and build relationships that facilitate access to Medicaid children, that are eligible for Health Home
- Health Home provide important, new benefits to children
 - ✓ HH care manager is an additional member and provider to the multi-disciplinary team
 - ✓ Charged with gathering cross-system information and collaboration
 - ✓ Focus on Health Promotion and overall well-being
 - ✓ Ensures ongoing care and seamless transitional planning – critical and significant to child transitioning from EI services
 - ✓ Ensures timely access to services and providers



Overview of the Six Core Health Home Services

1. Comprehensive Care Management

- A comprehensive health assessment that identifies medical, mental health, chemical dependency and social service needs is developed.

2. Care Coordination and Health Promotion

- The Health Home provider is accountable for engaging and retaining Health Home members in care; coordinating and arranging for the provision of services; supporting adherence to treatment recommendations; and monitoring and evaluating a patient's needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services where appropriate through the creation of an individual plan of care.

3. Comprehensive Transitional Care

- The Health Home provider has a system in place with hospitals and residential/rehabilitation facilities in their network to provide the Health Home prompt notification of an individual's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.



Overview of the Six Health Home Core Services

4. Patient and Family Support

- Patient’s individualized plan of care reflects patient and family or caregiver preferences, education and support for self-management, self-help recovery, and other resources as appropriate.

5. Referral to Community Supports

- The Health Home provider identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.

6. Use of Health Information Technology (HIT) to Link Services

Health Home providers will make use of available HIT and access data through the regional health information organization/qualified entities to conduct these processes as feasible

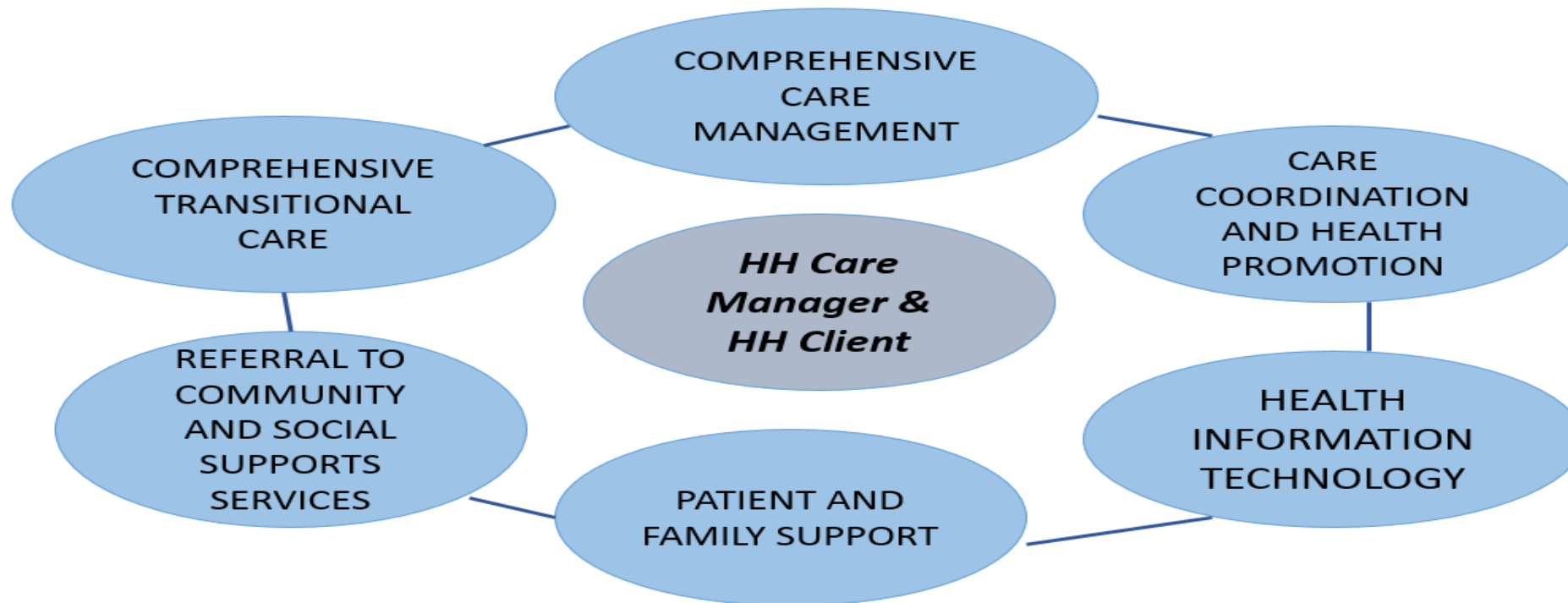
For detailed description of each core service please see:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/provider_qualification_standards.htm



Health Homes Serving Children Six Core Services

Health Homes Provide Six Core Care Management Functions



Health Home care management is “whole-person” and “person-centered” and integrates a care philosophy that includes both physical/behavioral health care with family and social supports



Health Home Services and Excluding Setting

Definition: Children in excluded settings cannot receive HH Care Management Services due to:

- Care coordination/management is part of the responsibility of the setting and therefore, Health Home CM would be a duplication of services
- Medicaid funding is utilized in the setting for specific coordination of and/or linking the member to services
- The setting is not aligned with Health Home CM which is a community based service

Excluded Settings Examples:

- Children in 1915c Waiver {OMH Home and Community Based Services, Bridges to Health, Care at Home I&II and OPWDD}
 - Inpatient hospitalization
 - Nursing Homes
 - Incarceration/Juvenile Justice Detention Facility
 - OMH Community Residence
 - Residential Treatment Facility (RTFs)
 - Residential/day treatment settings (RTCs)
 - Detox Facility
- Health Home services may only be billed for Medicaid eligible children in an inpatient/excluded setting, including RTCs, in the month of admission and discharge, **and**
- If the member is anticipated to be discharged from the excluded setting within 180 days, **and**
- At least one billable Health Home core service is provided in the month of admission and discharge from the excluded setting
- The ability to bill upon the first month of admission to an excluding setting is allowed **only** if the child/youth is already enrolled in Health Home and transitioning to an inpatient/excluded setting (i.e. RTC).



Staff Qualifications Health Home Care Managers Serving Children

- For children enrolled in the Early Intervention Program and receiving Health Home services through a provider approved under the Early Intervention Program, the minimum qualifications for EIP service coordinators set forth in Section 69-4.4 of 10 NYCRR will apply.
- If the provider was originally a HH CMA prior to becoming an EI approved provider, then the HH CM qualifications for “*high*” caseload must be followed
- The Health Home Qualification Waiver cannot be utilized by EI providers

(Health Home and Early Intervention qualifications are outlined in the Appendix)



Required Training for Health Home Care Managers and Supervisors

- ❖ Lead Health Homes are responsible for ensuring that care managers and supervisors are appropriately trained and that trainings and qualifications of care managers are appropriate and reflect the populations that care managers serve.
- ❖ Health Homes must document compliance with training requirements for Care Managers and Supervisors prior to the delivery of services and within six months of employment
- Required Training for care managers and supervisors - **Prior** to providing Health Home Care Management Services, (including outreach) to children or families
 - ✓ CANS-NY training and certification annually
 - ◆ Supervisors must be CANS-NY certified and must achieve at least a score of 80% or higher on exam
 - ◆ Care Managers must be CANS-NY certified and must achieve at least a score of 70% or higher on exam
 - ✓ Mandated Reporter training - <http://nysmandatedreporter.org/TrainingCourses.aspx> – 2 hour training is available at no cost
 - ✓ Consent - HIPPA/CFR 42/sharing of information
 - ✓ Review of webinars and guidance provided by State for Health Homes Serving Children

Required Training for Health Home Care Managers and Supervisors

- Required training for care managers and supervisors within **six months** of employment or from first date care managers or supervisor provide any Health Home care management services (including outreach).
 - ✓ Engagement and Outreach (e.g., Motivational Interviewing)
 - ✓ Safety in the Community (e.g., conducting home visits, partnering with law enforcement, carrying cell phones, communication with supervisor, awareness of surroundings)
 - ✓ *Free to providers, offered by OMH and similar training being developed by OCFS*
 - ✓ Trauma Informed Care
 - ✓ Person Centered Planning
 - ✓ Cultural Competency/Awareness
 - ✓ LGBTQ Issues – serving transgender children/adolescents and working with Lesbian/Gay/Bisexual/Transgender/Questioning Families
 - ✓ Meeting Facilitation



Overall Health Home Training

- It is the responsibility of the Lead Health Homes to provide policies and procedures surrounding all issued DOH Health Home program Standards and Policies / Procedures for their network care management agencies
 - Health Homes should have EI processes in place
- Additionally, each Lead Health Home has HIT and Billing platforms to ensure:
 - Proper documentation,
 - Compliance with Health Home requirements
 - Timely payment to providers,
 - Tracking of member services and
 - Ability to provide oversight of their network partners
- Each Lead Health Home may have different policies, procedures and oversight monitoring requirements for their Care management agencies, therefore amount and time table for training may vary
 - CMAs need to work with their Lead Health Home to determine the amount of training time will be needed



Child and Adolescent Needs and Strengths Assessment-NY (CANS-NY), Comprehensive Assessment and the Plan of Care



CANS-NY and Health Home (CANS-NY Child and Adolescent Needs and Strengths Assessment-NY)

The CANS-NY assessment tool is:

- A multi-purpose tool to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.
- Developed from a communication perspective so as to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices.
 - Provides the care coordinator, the family, and service providers with a common language to use in the development, review, and update of the child's care plan.
- Designed to give a profile of the current functioning, needs, and strengths of the child and the child's parent(s) and/or parent substitute.



CANS-NY and Health Home (CANS-NY Child and Adolescent Needs and Strengths Assessment-NY)

- The CANS-NY assessment (as modified for New York) is conducted by the Health Home care manager and used:
 - ✓ To assist in the development of the person centered care plan
 - ✓ Determine a care management acuity, using an algorithm run against the results of a completed CANS-NY, for purpose of determining Health Home per member per month rate tier (i.e., High, Medium, Low)
 - ✓ CANS-NY by itself will not determine Health Home eligibility

Note: the CANS-NY will also be employed to determine HCBS eligibility with transition to managed care



CANS-NY Training

DOH continues to provide in-person one-day CANS-NY trainings – Announcements continue to be issued regarding new 2018 scheduled trainings :

- If in-person training is completed, the on-line training is not required to test and get certified
- In-person training will **now be required** for all new providers and existing HH CM – guidance and timeline will be forth coming how to implement
- Additionally, supervisor in-person trainings are available to teach skills for supervisors to be able to assist their staff in completing the CANS-NY

On-line training is available and takes 4 to 6 hours to complete, depending on reading level. That includes reading items and watching videos, taking practice multiple choice tests and at least one practice test.

The final takes the average successful user about 45 minutes to complete



Uniformed Assessment System - UAS

The Uniformed Assessment System (UAS) is the electronic platform that houses the CANS-NY assessment tool

CANS-NY tool in the UAS interfaces with Medicaid Analytics Performance Portal (MAPP) to provide billing information for Health Home billing of the per member per month (PMPM) acuity

To beginning completing CANS-NY within the UAS, HH Care managers and staff must have a specific role identified within the UAS and completed the required training for that identified role

Estimate the UAS-NY course sequence for the CANS-NY Assessor to take about 3 ½ hours total

- This training is an overview of how to utilize the UAS and maneuver through the system
- These trainings are required to be completed prior to the system allowing the assessor the ability to add and or start a CANS-NY



LearnerNation: Transfer of Course Completion

CANS-NY training completed in LearnerNation is uploaded into the UAS-NY Training Environment on Tuesday and Friday afternoons.

Scenarios:

- If you complete your training on Monday afternoon, you will see the completed status in the UAS-NY Tuesday afternoon.
- If you complete your training on Tuesday afternoon, you will see the completed status in the UAS-NY Friday afternoon.

For a successful transfer of completion, please make sure:

1. Your HCS User ID is recorded in the External GUID ID field, and
2. You have correctly designated NYS in the Jurisdiction field in your Learner Nation Profile Page.



Service Transition Timing and Billing



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Health Home Per Member Per Month Rates for Health Homes Serving Children

Per Member Per Month HH Care Management Rates for Children under 21 (non-Legacy Providers)

| Acuity for Determining PMPM (CANS-NY Algorithm*) | Upstate | Downstate |
|---|---------|-----------|
| High | \$750 | \$799 |
| Medium | 450 | 479 |
| Low | 225 | 240 |
| Outreach | 110 | 110 |
| Assessment** | 185 | 185 |

*"Rate Build" assumes case load assumptions of High: 1:12, Medium 1:20 and Low 1:40 (**Case load assumptions were developed only for the rate build and are NOT mandated case loads**)

- Goal of keeping case load ratios as low as practicable and to provide Health Homes and care managers flexibility in assigning children with various levels of needs/acuties
 - ✓ Care managers serving "high" acuity children keep case load sizes predominantly to children of High acuity level
 - ✓ Two Health Home services provided each month, one of which must be face-to-face contact for children of Medium or High acuity

** One time assessment fee – CANS-NY is required to be updated every six months, unless significant event in child's life occurs



CANS-NY Assessments

- The CANS-NY must be completed every 6 months from the first day of the month it was completed
- A fee is paid for the initial CANS-NY only
- The CANS-NY will not be pre-populated with previous results
- A one-time assessment fee (\$185) per enrollment into a children's designated Health Home may be billed upon *completion of the CANS-NY*
- Once the child is enrolled in a Health Home, low acuity is billed for the child until the month in which the CANS-NY is completed and the acuity algorithm determines the appropriate rate (high, medium or low)
- Health Homes will be expected to meet best practice standards by completing the CANS-NY 30 days from the date of enrollment.
- If the CANS-NY is not completed by the end of the second month of enrollment, the Health Home/Plan will no longer be able to bill for any service until the month in which the CANS-NY is completed.



Health Home 5 Core Billable Services

Health Home Core Billable Services that will be identified on the Children's Billing Questionnaire and MUST be documented in the member's records and care plan, when appropriate

1. Comprehensive care management;
2. Care coordination and health promotion;
3. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
4. Individual and family support, which includes authorized representatives; and
5. Referral to community and social support services if relevant

Children with CANS-NY high or medium acuity must also have a monthly core service of a face to face contact

Billing

- If Health Home Care Management and Early Intervention Initial Service Coordination are engaged simultaneously, billing for both services can occur as EI ISC is seen as a separate, distinct and time limited service.
- When a HH CMA/OSC is assigned, Early Intervention OSC activities and Health Home services will be billed as one service under the Health Home structure of the CANS-NY acuity rate.
 - Other EI services such as OT, PT, Speech, etc. billing will remain intact according to existing EI procedures



Transition Timing and Billing

Health Home First Engaged:

- If the child is being served by the Health Home first, the HH CM should review the needs of the child and determine if a referral should be made to EI. Both HH and ISC can bill according to their respective procedures
 - If the child is eligible for EI, prior to the IFSP the EIOD and HH CMA should discuss who would be the appropriate provider to serve the child based upon designated HH CM/OSC list and service relationships already established (Parental choice and consent is key)

Initial Service Coordination First Engaged:

- If the child is being served by the EI ISC first, then the EI ISC and Multidisciplinary team should determine if the child might be eligible and appropriate for HH services. If a referral will be made for HH services, it should occur at the time of the IFSP and the parental choice for an OSC.
 - There needs to be an agreed upon transition date for the child to be enrolled in a HH and assigned to a designated HH CM/OSC and for HH billing to begin



Transition Timing and Billing - continued

On-going Service Coordination First Engaged:

- If the child is being served by the EI OSC first and a HH referral seems appropriate, with parental choice, a designated HH CM/OSC should be assigned and HH billing will begin
- If the child will be transitioning out of EI and the OSC believes the child would be eligible and appropriate for Health Home services, a referral should be made at the time of transition planning. EI OSC billing must end prior to HH billing to begin

Reminder: HH bills a Per Member Per Month (PMPM) that starts the first of the month



Other Requirements and Standards



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Quarterly Review Documenting Continued Need for Health Home Services

- No less than quarterly, care managers must actively review and document in the plan of care, the child's continued need for Health Home Care Management services
- Quarterly reviews should evaluate and consider condition/stability of the child and eligibility criteria for which they entered Health Homes:
 - The child no longer needs the intense level of care management services provided by the Health Home. Discharge planning will begin when one or more of the following exists:
 - ✓The chronic condition(s) that made the child eligible for Health Homes are being managed and or maintained,
 - ✓All parties concur the child has met the goals of his/her Plan and is stable enough to no longer require the services of a Health Home care management,
 - ✓Has service and support needs that can be met by family/guardian and services without the intensive level of HH care management
 - The Care Manager can and should review if the child needs the intense level of care management provided by a Health Home regardless of the acuity used to determine HH PMPM rate (High, Medium, Low)
 - The CANS-NY can assist with the development of the plan of care, however it does not determine when a child is discharged from a Health Home (e.g. a child with a CANS-NY medium acuity can be discharged)



Health Home Interdisciplinary Team Meeting

The Health Home provider supports care coordination and facilitates collaboration through the establishment of regular case review meetings,

- An interdisciplinary team meeting must occur:
 - during completion of the initial full CANS-NY and during subsequent CANS-NY updates to develop the plan of care
 - as frequently as needed and determined by the Health Home Care Manager
 - at the request of the Health Home Care Manager, and/or the child/parent/guardian/medical consenter (including the LDLSS), based upon new information from another provider (e.g., primary care physician).
- A team meeting must be person-centered focused and scheduled to accommodate the child and parent/guardian/legally authorized representative's attendance.
- The plan of care and other decisions should not be completed without the input of the parent/guardian/legally authorized representative's for the child.
- *The Health Home interdisciplinary meeting can account for other required meetings in various systems, as long as the appropriate attendees are invited and the meeting purpose and outcome is documented.*



10 Elements to be Included in all Plans of Care for Children

- 1) The child's Emergency Contact and disaster plan for fire, health, safety issues, natural disaster, other public emergency
- 2) The child's History and Risk Factors related to services and treatment, well-being and recovery.
- 3) The child's Functional Needs related to services and treatment, well-being and recovery.
- 4) The child's and caregivers' identified Strengths and Preferences related to services and treatment, well-being and recovery.
- 5) Medicaid State Plan and Non-Medicaid services identified to meet child's needs –must be person-centered, comprehensive and integrated to include Physical, Behavioral Community and Social Supports. Plan must also document the indication of choice of (a) Service Provider, (B) Reason for the Service and (C) Intended Goals.



10 Elements to be Included in all Plans of Care for Children

- 6) Key Informal Community Supports. This would include any supports in place for the child/family that address identified needs (Ex. Family's neighbor is available for support as needed and is aware of child/family's needs, but is not assigned a specific task to reach a goal).
- 7) Description of planned Care Management Interventions (including Services Care Management, Referral, Access, Engagement, Follow Up, and Service Coordination) and Timeframes.
- 8) The child's Transition Plan including circumstances/services needed to transition from Health Home Care Management as needed (e.g., education, living situation, employment, community functioning, hospital, treatment facility, foster care).
- 9) Documentation of participation by inter-disciplinary team (all Key Providers) in the development of the plan of care.
- 10) The Child's Medical consenter's Signature documenting agreement with the plan of care. (Referencing DOH 5201 Health Home Consent/Information Sharing/For Use with Children Under 18 Years of Age)



Process and Oversight



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Process

- Health Home eligibility and appropriateness must be determined by HH care managers according to HH's standards and policies
- Early Intervention eligibility must be determined by the EI Initial Service Coordinator and the Multidisciplinary Evaluation team according to EI program protocols
 - Evaluations, assessments and screening from either program can be utilized to assist with eligibility determination with appropriate parental consent
- Once eligibility is determined, a discussion with the family should occur to educate and assist with program information and choice of providers.
- Providers will need to work collaboratively, to develop an enrollment plan, a warm hand-off (if needed), and to establish when billing for either or both programs will occur



Process - continued

- The initial IFSP will be scheduled and billed for by the EI Initial Service Coordinator
 - HH CM can and should attend such meeting, if possible according to developed specific case processes
- Many of the responsibilities of the HH CM and the EI OSC are comparable to one another. As long as the appropriate attendees are invited, the purpose and outcome is properly documented according to each program requirements, the activity can be utilized to meet both program requirements
- Such as:
 - IFSP meetings, HH interdisciplinary team meetings and HH plan of care meetings
 - EI OSC meeting with the family and HH CM face to face requirement for high or medium and when needed
 - Meeting and discussions with involved providers
 - Linking the family to other resources and or services
 - Transitional planning meetings



Oversight

- The Lead Health Homes continue to have oversight and monitoring of their network partners and ensure compliance with all HH standards, policies and procedures
- Local municipalities and NYC EI programs continue to have oversight and monitoring of their EI providers and ensure compliance with all EI regulations, policies and procedures
 - Providers who are approved to provide HH CM/ OSC will need to comply with both oversight bodies
 - These providers will need to ensure that during an audit of their services, the HH CM/OSC provider will be able to produce exact program documentation for the specific requesting oversight body and not compromise the information of the other services area
- Lead Health Homes will be required to have policies that outlined that they have network partners that are fulfilling the role of HH CM and EI OSC and the expectation of such



Current EI and HH Integration



Department
of Health

Office of
Mental Health

Office of Alcoholism and
Substance Abuse Services

Office of Children
and Family Services

Children's Health Home Enrollment: March 2018

| Health Home | Total Enrollment | EI/HH Enrollment |
|--|------------------|------------------|
| Adirondack Health Institute Inc (AHI) | 244 | 0 |
| Children's Health Homes of Upstate New York LLC (CHHUNY LLC) | 4,616 | 12 |
| Children's Health Home of Western NY dba OISHEI Healthy Kids (CHHWNY) (OHK) | 1,190 | 24 |
| Central New York Health Home Network INC (CNYHHN INC) | 300 | 1 |
| Community Care Management Partners LLC (CCMP) | 201 | 2 |
| Coordinated Behavioral Care INC dba Pathways To Wellness Health Home (CBC) | 1,867 | 0 |
| Encompass Health Home LLC | 745 | 2 |
| Greater Rochester Health Home Network (GRHHN) | 39 | 0 |
| Hudson River Healthcare Inc (HRHCARE) | 778 | 0 |
| Institute For Family Health (IFH) | 53 | 0 |
| Montefiore Medical Center dba Bronx Accountable Healthcare Network Health Home (Montefiore) (BAHN) | 183 | 2 |
| Mount Sinai Health Home Serving Children | 242 | 0 |
| Niagara Falls Memorial Medical Center | 98 | 0 |
| Northwell Health Home | 110 | 4 |
| ST Marys Healthcare | 99 | 0 |
| Collaborative for Children and Families (CCF) | 4,397 | 9 |
| TOTAL | 15,162 | 63 |



Children's Health Home Enrollment: March 2017 – 2018 (continued)

| El/HH Quarterly Enrollment 2018 | HH | 2017 | 2018 |
|---|-----------|-----------|-----------|
| Jewish Family Services | OHK | 0 | 0 |
| Liberty Resources | CCF | 0 | 0 |
| Liberty Resources | CHHUNY | 6 | 7 |
| MercyFirst | CCF | 0 | 0 |
| NY Foundling | CCF | 0 | 0 |
| Ohel Children's Home and Family Services dba Baker Victory Services | CBC | 0 | 0 |
| People, Inc. | CHHUNY | 0 | 2 |
| People, Inc. | OHK | 15 | 24 |
| Seaman's Society for Children and Families | CCF | 0 | 0 |
| St Mary's Hospital for Children/EI- Extraordinary Pediatrics | CCMP | 0 | 2 |
| St Mary's Hospital for Children/EI- Extraordinary Pediatrics | CCF | 5 | 9 |
| St Mary's Hospital for Children/EI - Extraordinary Pediatrics | Mt. Sinai | 0 | 0 |
| St Mary's Hospital for Children/EI - Extraordinary Pediatrics | HRH | 0 | 0 |
| St Mary's Hospital for Children/EI - Extraordinary Pediatrics | Northwell | 0 | 4 |
| TOTAL | | 30 | 63 |



Health Homes Serving Children Activities

- **December 2016 to Present-** Monthly and bi-monthly calls with individual HHs currently focused on demonstration of their oversight and quality monitoring policies, procedures and tools
- **June 2017** - Early enrollment for approved EI/HH providers
- **September 2017** - Open enrollment for approved EI/HH
- **October 2017** - Enrollment Review - Low EI/HH enrollment numbers
 - Consensus: lack of program understanding among EI ISC/OSCs
- **October 2017 - February 2018** - NYS DOH/BEI held provider training for EI providers and Health Home Care Managers in NYC, Buffalo, Rochester, Binghamton and Albany
- **February & March 2018-** Four HHs site visits/chart reviews of Encompass, CHHUNY, CCF, and OSHIEHA; report findings to HHs by May/June
- **April 2018-** In-person EI provider and Health Home care manager training being scheduled for Long Island and Syracuse— **May 3rd and May 7th**



Next Steps

- In-person Education Sessions across the State for EI, HH and CMA providers
- Launch of the IDD conditions within the HHSC chronic condition list (*tentative July 2018*)

****The State will continue to seek stakeholder input throughout the continued integration of EI and HH***



Executive Budget – Requirements for Background Checks

- Effective April 1, 2018, Executive Budget includes proposal to require individuals providing Health Home services to children (individuals under 21) or individuals with intellectual and/or developmental disabilities (I/DD), or HCBS services to individuals under 21 authorized under 1115 Waiver to:
 - Receive Criminal history record checks
 - Receive State Central Register checks
 - Be Mandatory Reporters (required to report if there is reasonable cause to suspect a child is abused or maltreated)
- Proposal ensures that background check requirements that were in place prior the implementation of Health Home continue to apply to care managers that work with children



2018-19 Enacted Budget – New Background Checks, State Central Registry Checks, and Mandated Reporter Requirements

- **Background Checks** - The statute was amended to require prospective background checks and State Central Register checks for Health Home care managers (i.e., new hires) as well as for Home Community Based Services (HCBS) and CCO/HH providers that serve Medicaid children and members with I/DD.
- **Mandated Reporters** – Required that all service providers who serve Medicaid children which would include HH and HCBS providers

The State will present a webinar April 25th and May 17th to brief Health Homes on the process and procedures for meeting the background checks and other requirements included in the legislation.



Changes to Children's Timeline

- The Elements of the Children's Medicaid Redesign remain unchanged
- Changes relate to the timeline of implementing the new and expanded services and have been made to accommodate the availability of resources
- Six SPA services will be implemented over time, with three new services available in January 2019
- Expansion of Level of Care (LOC) Eligibility of Home and Community Based Services will be phased in over three years, within limits of Global Cap Spending
- The new expansion to Level of Need (LON) Home and Community Based Services population will begin following the full phase in of LOC



Overview of Children's Medicaid Redesign Timeline

Children's Medicaid Redesign Timeline

Subject to the availability of Global Cap Resources in Excess of Budget Restoration

Subject to timely CMS and other State Approvals

| | |
|--|--------------|
| <ul style="list-style-type: none"> • Implement three of Six New State Plan Services (Other Licensed Practitioner, Psychosocial Rehabilitation, Community Psychiatric Treatment and Supports) • All 1915(c) Children's Waiver Members Transition to Health Home (begins in October 2018) • Most 1915(c) Waiver Children Transition to Managed Care • New State Plan Services and New Array of HCBS in Managed Care Benefit • B2H Waiver Children Discharged from FC to Managed Care | January 2019 |
| <ul style="list-style-type: none"> • Implement Family Peer Supports State Plan Service • Three Year Phase-in of Level of Care (LOC) eligibility for HCBS Begins (within limits of Global Spending Cap) • Foster Care Population, including B2H Waiver children, transition to Managed Care • Behavioral Health Benefits transition to Managed Care | July 2019 |
| <ul style="list-style-type: none"> • Implement Remaining New State Plan Services in Managed Care Benefit (Youth Peer Support and Training and Crisis Intervention) | January 2020 |



1915(c) Waivers Transition to 1115 Waiver

- The authority for all six 1915(c) children's waivers will transition to 1115 Waiver on January 1, 2019
 - The timing is consistent with State/CMS agreement to transition to the 1115 Waiver and continue conflict free case management standards
 - The six waivers include:
 - ✓ OMH SED
 - ✓ DOH Care at Home (CAH) I/II
 - ✓ OPWDD CAH
 - ✓ OCFS Bridges to Health (B2H) SED
 - ✓ OCFS B2H Developmentally Disabled
 - ✓ OCFS B2H Medically Fragile
- HCBS will be part of Managed Care benefit on January 1, 2019
- OMH SED, DOH CAH and OPWDD Care at Home will transition to managed care on January 1, 2019
- B2H children in foster care will transition to Managed Care on July 1, 2019, i.e., at the same time the VFCA population transitions to managed care
 - Between January 1, 2019 and July 1, 2019, B2H transitioning children will receive HCBS through fee-for-service
 - A child that is in B2H, receiving HCBS services and that is no longer in Foster Care will transition to Managed Care on January 1, 2019 and will receive their HCBS from the plan on January 1, 2019
- Children that are currently receiving Crisis Intervention, Family Peer and Youth Peer services under 1915(c) waivers and that will transition to the 1115 will continue to receive these services under the 1115 authority – this ensures no break in service for these children



1915(c) Waiver Providers will Transition to Health Home Care Management under the 1115 Authority

- To preserve the expertise of existing waiver providers in the Children's Transformation and in Health Homes, all existing care managers providing care management under the six waivers will transition to Health Homes
- 1915(c) Transitioning Children that will transition to Health Home care management will transition with their current care manager/agency (by choice and with consent)
- This linkage between care managers and children and families will preserve care manager relationships with the child and their family, continuity of care and help ensure a seamless transition
- ***Work to transition children to Health Home will begin October 2018***
- ***The State will be scheduling in-person, regional transitional meetings with all waiver providers, Health Homes and Plans***
- ***A survey will be sent to 1915c Waiver providers transitioning to Health Home care management to verify proper linkages and system connections are in place and to identify providers that may need TA***





Additional Information and Support

UAS-NY Support Desk
uasny@health.ny.gov

or

518-408-1021, option 1

Monday – Friday

8:30 AM – 12:00 PM

1:00 PM – 4:00 PM

CANS-NY Training

support@CANSTraining.com

Or

www.canstraining.com and click on
contact us

CANS-NY Policy

hhsc@health.ny.gov

MAPP Customer Care Center

MAPP-

customercarecenter@cma.com

Phone: 518-649-4335

**Commerce Accounts Management
Unit (CAMU)**

866-529-1890



Subscribe to the HH Listserv

- Stay up-to-date by signing up to receive Health Home e-mail updates
- Subscribe
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/listserv.htm
- Health Home Bureau Mail Log (BML)
https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action



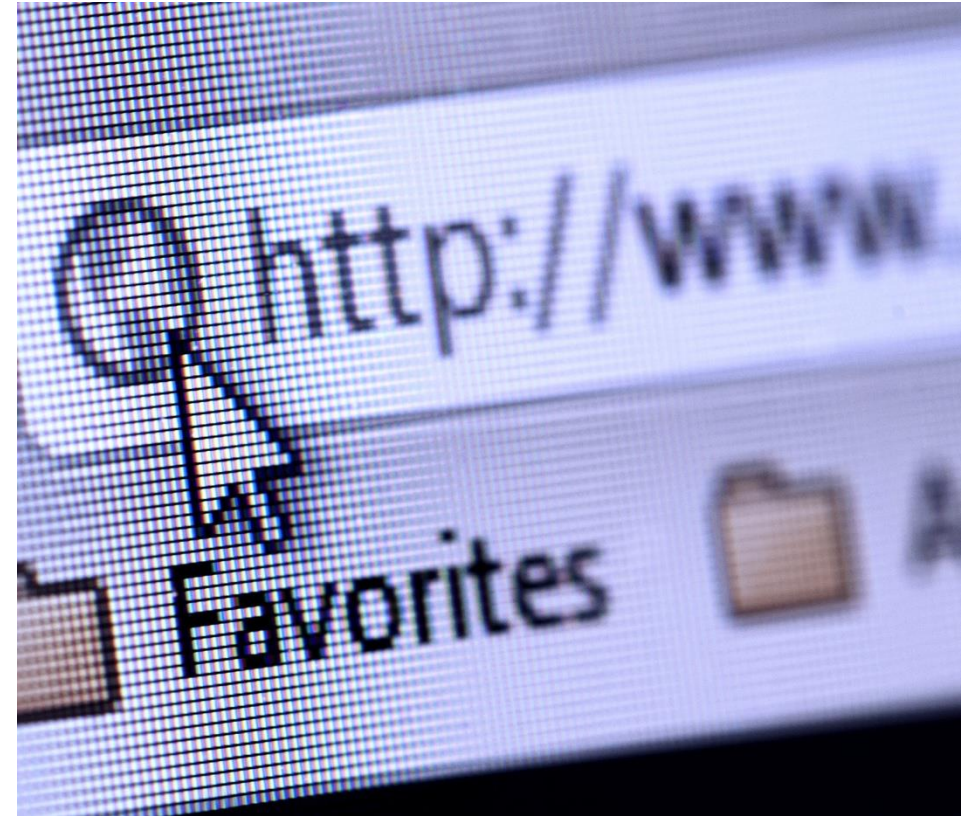
Updates, Resources, Training Schedule and Questions

Please send any questions, comments or feedback on Health Homes Serving Children to:

hhsc@health.ny.gov or contact the Health Home Program at the Department of Health at 518.473.5569

Stay current by visiting our website:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/health_homes_and_children.htm



Department
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Office of
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Office of Alcoholism and
Substance Abuse Services

Office of Children
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APPENDIX



Department
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Office of
Mental Health

Office of Alcoholism and
Substance Abuse Services

Office of Children
and Family Services

Health Homes Serving Children

List of Acronyms

- ACS: NYC Administration of Children Services
- AI: AIDS Institute
- ALP: Assisted Living Program
- ASA: Administrative Service Agreement
- BAA: Business Associate Agreement
- BHO: Behavioral Health Organization
- CAH: Care at Home
- CBO: Community Based Organizations
- CMA: Care Management Agency
- DEAA: Data Exchange Agreement Application
- EI: Early Intervention
- Emedny: Electronic Medicaid system of New York
- FFS: Fee For Service
- HCBS: Home and Community Based Services
- HCS: Health Commerce System
- HH: Health Home
- HHSC: Health Home Serving Children
- HHTS: Health Home Tracking System
- HIT: Health Information Technology
- LDSS: Local Department of Social Services
- LGU: Local Government Unit



Health Homes Serving Children

List of Acronyms

- MAPP: Medicaid Analytics Performance Portal (Health Home Tracking System HHTS)
- MCO/MCP: Managed Care Organization / Managed Care Plan
- MRT: Medicaid Redesign Team
- MMIS #: Medicaid Management Information Systems
- NPI #: National Provider Identifier
- OASAS: Office of Alcoholism and Substance Abuse Services
- OCFS: Office of Children and Family Services
- OMH: Office of Mental Health
- OMH-TCM: Office of Mental Health Targeted Case Management
- PMPM: Per Member Per Month
- SED: Serious Emotional Disturbance
- SMI: Serious Mental Illness
- SPA: State Plan Amendment
- SPOA: Single Point of Access
- SPOC: Single Point of Contact
- TCM: Targeted Case Management
- UAS-NY: Uniformed Assessment System
- VFCA: Voluntary Foster Care Agency



| Health Home | Counties Designated to Serve Children | Designated Contact for Children's Designated Health Home |
|--|--|---|
| Adirondack Health Institute, Inc. | Clinton, Essex, Franklin, Hamilton, St. Lawrence, Warren, Washington | Emily Walter ewalter@ahihealth.org (518) 480-0111 Ext. 6 Sarah Colvin scolvin@ahihealth.org |
| Catholic Charities of Broome County - Encompass Health Home | Albany, Allegany, Broome, Cattaraugus, Chautauqua, Cayuga, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Erie, Essex, Franklin, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Warren, Washington, Wayne, Wyoming, Yates | Lori Accardi laccardi@ccbc.net (607) 729-9166 Tonya Brown tbrown@ccbc.net (607) 729-9166 |
| Central New York Health Home Network (CNYHHN Inc.) | Albany, Rensselaer, Schenectady, Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, St. Lawrence | Jane Vail Jane.vail@cnyhealthhome.net (315)797-9057 ext.278 |



| Health Home | Counties Designated to Serve Children | Designated Contact for Children's Designated Health Home |
|---|--|---|
| Children's Health Home of Western New York dba Oishei Healthy Kids | Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming | Momba Chia mchia@kaleidahealth.org O:716-878-7807 C:716-359-2390 Kirsten Newby knewby@kaleidahealth.org O: 716-878-1354 C: 716-364-2380 |
| Children's Health Homes of Upstate New York, LLC (CHHUNY) | Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming, Yates | Nicole Bryl nbryl@hhuny.org O: 585-613-7644 C: 716-572-9858 Donna Fiscella dfiscella@childrenshealthhome.org O: 315-632-6195 |



| Health Home | Counties Designated to Serve Children | Designated Contact for Children's Designated Health Home |
|---|---|--|
| Collaborative for Children and Families | Bronx, Brooklyn, Manhattan, Nassau, Queens, Staten Island, Suffolk, Westchester | <p>Jodi Saitowitz jsaitowitz@ccfh.org O: 646-459-3971 C: (917) 213-0130</p> <p>Lisa Peterson Lpeterson@ccfh.org O: 646-459-3972 C: 646-799-8284</p> |
| Community Care Management Partners, LLC (CCMP) | Bronx, Brooklyn, Manhattan, Queens | <p>Phil Opatz Phil.opatz@vnsny.org O: 212-290-6467 C: 347-452-9557</p> |
| Coordinated Behavioral Care, Inc. dba Pathways to Wellness Health Home | Bronx, Brooklyn, Manhattan, Queens, Staten Island | <p>Amanda Semidey ASemidey@cbcure.org 646-930-8835</p> <p>Janelle Chambers JChambers@cbcure.org 646-930-8851</p> |



| Health Home | Counties Designated to Serve Children | Designated Contact for Children's Designated Health Home |
|--|--|---|
| Greater Rochester Health Home Network LLC | Cayuga, Chemung, Livingston, Monroe, Ontario, Seneca, Steuben, Wayne, Yates, Allegany, Genesee, Orleans, Wyoming | <p>Deb Peartree dpeartree@therihn.org (585) 737-7522</p> <p>Ann Potter apotter@therihn.org (585)-350-1408</p> |
| Hudson River HealthCare, Inc. dba Community Health Care Collaborative | Columbia, Dutchess, Greene, Orange, Putnam, Rockland, Sullivan, Westchester, Nassau, Suffolk | <p>Andrea Hopkins ahopkins@hrhcare.org 845-803-3479</p> <p>Katie Clay kclay@HRHCARE.ORG 914-734-8513</p> |
| Institute for Family Health | Ulster | <p>Michaela Frazier – Director mifrazier@institute.org O: 206-206-5200 x1360 C: 917-831-0334</p> <p>Melissa Martinez – Director mmartinez@institue.org O:845-255-2930 C:347-947-0667</p> |



| Health Home | Counties Designated to Serve Children | Designated Contact for Children's Designated Health Home |
|---|---------------------------------------|---|
| Montefiore Medical Center dba Bronx Accountable Healthcare Network Health Home | Bronx | Antonette Mentor amentor@monterfiore.org 914-378-6086 |
| Niagara Falls Memorial Medical Center | Niagara | Vicki Landes Vicki.landes@nfmhc.org (716) 278-4147 Jennifer Mruk Jennifer.mruk@nfmhc.org (716) 278-4647 |
| Northwell Health Home | Queens, Nassau, Suffolk | Christina Alonso Calonso1@northwell.edu Office Phone: (516) 600-1128 Cellular Phone: (516) 287-6046 |



| Health Home | Counties Designated to Serve Children | Designated Contact for Children's Designated Health Home |
|---|---|--|
| Mount Sinai Health Home Serving Children | Bronx, Brooklyn, Manhattan, Queens, Staten Island | <p>Alicia Korpi Alicia.korpi@mountsinai.org O:212-731-7841 C:646-856-5667</p> <p>Arhima Jacobs Arhima.jacobs@mountsinai.org 212-241-3257</p> |
| St. Mary's Healthcare | Fulton, Montgomery | <p>Katerina Gaylord Katerina.gaylord@smha.org 518-841-3676</p> <p>Charis Gray 518-841-3896 Graycm@ascension.org</p> <p>Sarah Eipp 518-841-3896 Sarah.Eipp@ascension.org</p> |



Conditions that Make a Child Eligible for the Early Intervention Program and on the Health Home Eligibility List

ICD-10 Code

ICD-10 Description

| | |
|--------|---|
| F43.10 | Post-traumatic stress disorder, unspecified |
| F43.12 | Post-traumatic stress disorder, chronic |
| P07.01 | Extremely low birth weight newborn, less than 500 grams |
| P07.02 | Extremely low birth weight newborn, 500-749 grams |
| P07.03 | Extremely low birth weight newborn, 750-999 grams |
| Q05.0 | Cervical spina bifida with hydrocephalus |
| Q05.1 | Thoracic spina bifida with hydrocephalus |
| Q05.2 | Lumbar spina bifida with hydrocephalus |
| Q05.3 | Sacral spina bifida with hydrocephalus |
| Q05.4 | Unspecified spina bifida with hydrocephalus |
| Q05.5 | Cervical spina bifida without hydrocephalus |
| Q05.6 | Thoracic spina bifida without hydrocephalus |
| Q05.7 | Lumbar spina bifida without hydrocephalus |
| Q05.8 | Sacral spina bifida without hydrocephalus |
| Q05.9 | Spina bifida, unspecified |
| Q35.1 | Cleft hard palate |
| Q35.3 | Cleft soft palate |
| Q35.5 | Cleft hard palate with cleft soft palate |
| Q35.7 | Cleft uvula |

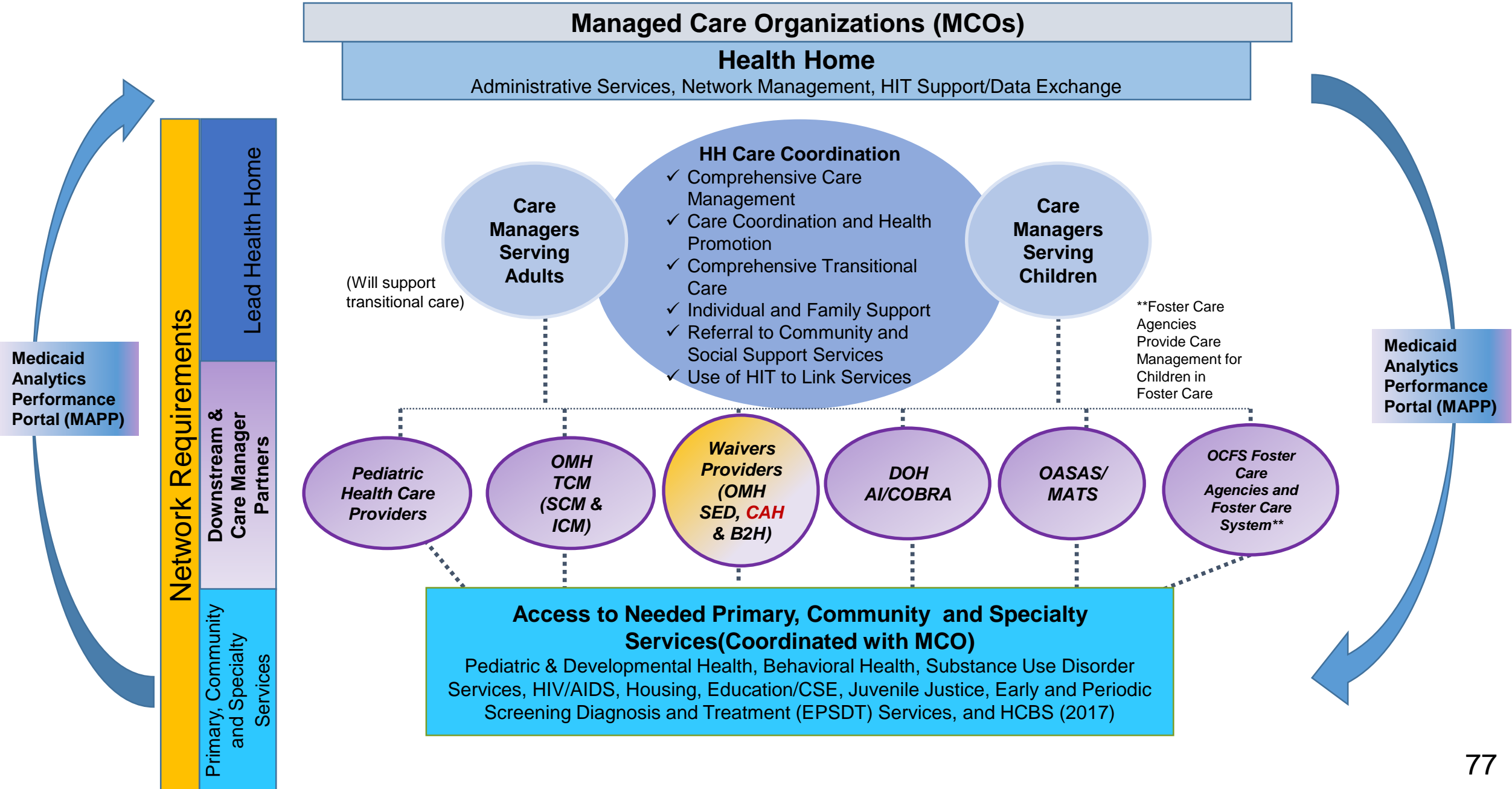


Crosswalk Conditions (cont'd)

| <u>ICD-10 Code</u> | <u>ICD-10 Description</u> |
|--------------------|--|
| Q35.9 | Cleft palate, unspecified |
| Q36.0 | Cleft lip, bilateral |
| Q36.1 | Cleft lip, median |
| Q36.9 | Cleft lip, unilateral |
| Q37.0 | Cleft hard palate with bilateral cleft lip |
| Q37.1 | Cleft hard palate with unilateral cleft lip |
| Q37.2 | Cleft soft palate with bilateral cleft lip |
| Q37.3 | Cleft soft palate with unilateral cleft lip |
| Q37.4 | Cleft hard and soft palate w/ bilateral cleft lip |
| Q37.5 | Cleft hard and soft palate w/ unilateral cleft lip |
| Q37.8 | Unspecified cleft palate w/ bilateral cleft lip |
| Q37.9 | Unspecified cleft palate w/ unilateral cleft lip |



New York State Health Home Model for Children



Standards: Six Health Home Core Services

1. Comprehensive Care Management

Policies and procedures are in place to create, document, execute and update an individualized, patient centered plan of care for each individual.

1a. A comprehensive health assessment that identifies medical, mental health, chemical dependency and social service needs is developed.

1b. The individual's plan of care integrates the continuum of medical, behavioral health services, rehabilitative, long term care and social service needs and clearly identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager and other providers directly involved in the individual's care. **1c.** The individual (or their guardian) play a central and active role in the development and execution of their plan of care and should agree with the goals, interventions and time frames contained in the plan.

1d. The individual's plan of care clearly identifies primary, specialty, behavioral health and community networks and supports that address their needs.

1e. The individual's plan of care clearly identifies family members and other supports involved in the patient's care. Family and other supports are included in the plan and execution of care as requested by the individual.

1f. The individual's plan of care clearly identifies goals and timeframes for improving the patient's health and health care status and the interventions that will produce this effect.

1g. The individual's plan of care must include outreach and engagement activities that will support engaging patients in care and promoting continuity of care.

1h. The individual's plan of care includes periodic reassessment of the individual needs and clearly identifies the patient's progress in meeting goals and changes in the plan of care based on changes in patient's need



Standards: Six Health Home Core Services - Continued

2. Care Coordination and Health Promotion

- 2a.** The Health Home provider is accountable for engaging and retaining Health Home enrollees in care; coordinating and arranging for the provision of services; supporting adherence to treatment recommendations; and monitoring and evaluating a patient's needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services where appropriate through the creation of an individual plan of care.
- 2b.** The Health Home provider will assign each individual a dedicated care manager who is responsible for overall management of the patient's care plan. The Health Home care manager is clearly identified in the patient record. Each individual enrolled with a Health Home will have one dedicated care manager who has overall responsibility and accountability for coordinating all aspects of the individual's care. The individual cannot be enrolled in more than one care management program funded by the Medicaid program.
- 2c.** The Health Home provider must describe the relationship and communication between the dedicated care manager and the treating clinicians that assure that the care manager can discuss with clinicians on an as needed basis, changes in patient condition that may necessitate treatment change (i.e., written orders and/or prescriptions).
- 2d.** The health home provider must define how patient care will be directed when conflicting treatment is being provided.
- 2e.** The Health Home provider has policies, procedures and accountabilities (contractual agreements) to support effective collaborations between primary care, specialist and behavioral health providers, evidence-based referrals and follow-up and consultations that clearly define roles and responsibilities.
- 2f.** The Health Home provider supports continuity of care and health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers.
- 2g.** The Health Home provider supports care coordination and facilitates collaboration through the establishment of regular case review meetings, including all members of the interdisciplinary team on a schedule determined by the Health Home provider. The Health Home provider has the option of utilizing technology conferencing tools including audio, video and /or web deployed solutions when security protocols and precautions are in place to protect PHI. **2h.** The Health Home provider ensures 24 hours/seven days a week availability to a care manager to provide information and emergency consultation services.
- 2i.** The Health Home provider will ensure the availability of priority appointments for Health Home enrollees to medical and behavioral health care services within their Health Home provider network to avoid unnecessary, inappropriate utilization of emergency room and inpatient hospital services.
- 2j.** The Health Home provider promotes evidence based wellness and prevention by linking Health Home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self-help recovery resources, and other services based on individual needs and preferences.
- 2k.** The Health Home provider has a system to track and share patient information and care needs across providers and to monitor patient outcomes and initiate changes in care, as necessary, to address patient need.



Standards: Six Health Home Core Services - Continued

3. Comprehensive Transitional Care

3a. The Health Home provider has a system in place with hospitals and residential/rehabilitation facilities in their network to provide the Health Home prompt notification of an individual's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.

3b. The Health Home provider has policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings, providers and community-based services to help ensure coordinated, safe transitions in care for its patients who require transfers in the site of care.

3c. The health home provider utilizes HIT as feasible to facilitate interdisciplinary collaboration among all providers, the patient, family, care givers, and local supports.

3d. The health home provider has a systematic follow-up protocol in place to assure timely access to follow-up care post discharge that includes at a minimum receipt of a summary care record from the discharging entity, medication reconciliation, timely scheduled appointments at recommended outpatient providers, care manager verification with outpatient provider that the patient attended the appointment, and a plan to outreach and re-engage the patient in care if the appointment was missed.



Standards: Six Health Home Core Services - Continued

4. Patient and Family Support

4a. Patient's individualized plan of care reflects patient and family or caregiver preferences, education and support for self-management, self-help recovery, and other resources as appropriate.

4b. Patient's individualized plan of care is accessible to the individual and their families or other caregivers based on the individual's preference.

4c. The Health Home provider utilizes peer supports, support groups and self-care programs to increase patients' knowledge about their disease, engagement and self-management capabilities, and to improve adherence to prescribed treatment.

4d. The Health Home provider discusses advance directives with enrollees and their families or caregivers.

4e. The health home provider communicates and shares information with individuals and their families and other caregivers with appropriate consideration for language, literacy and cultural preferences.

4f. The Health Home provider gives the patient access to care plans and options for accessing clinical information.



Standards: Six Health Home Core Services - Continued

5. Referral to Community and Social Support Services

5a. The Health Home provider identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.

5b. The Health Home provider has policies, procedures and accountabilities (contractual agreements) to support effective collaborations with community-based resources, which clearly define roles and responsibilities.

5c. The plan of care should include community-based and other social support services as well as healthcare services that respond to the patient's needs and preferences and contribute to achieving the patient's goals.



Standards: Six Health Home Core Services - Continued

6. Use of Health Information Technology (HIT) to Link Services

Initial Standards

6a. Health Home provider has structured information systems, policies, procedures and practices to create, document, execute, and update a plan of care for every patient.

6b. Health Home provider has a systematic process to follow-up on tests, treatments, services and, and referrals which is incorporated into the patient's plan of care.

6c. Health Home provider has a health record system which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers and which allows for population management and identification of gaps in care including preventive services.

6d. Health Home provider makes use of available HIT and accesses data through the regional health information organization/qualified entity to conduct these processes, as feasible.

Final Standards

6e. Health Home provider has structured interoperable health information technology systems, policies, procedures and practices to support the creation, documentation, execution, and ongoing management of a plan of care for every patient.

6f. Health Home provider uses an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers. If the provider does not currently have such a system, they will provide a plan for when and how they will implement it.

6g. Health Home provider will be required to comply with the current and future version of the Statewide Policy Guidance, which includes common information policies, standards and technical approaches governing health information exchange.

6h. Health Home provider commits to joining regional health information networks or qualified health IT entities for data exchange and includes a commitment to share information with all providers participating in a care plan. RHIOs/QE (Qualified Entities) provides policy and technical services required for health information exchange through the Statewide Health Information Network of New York (SHIN-NY).

6i. Health Home provider supports the use of evidence based clinical decision making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance



Staff Qualifications Health Home Care Managers Serving Children

- Staff qualifications for care managers that serve children with an acuity level of “**high**” as determined by the CANS-NY must have:
 - A Bachelors of Arts or Science with two years of relevant experience, or
 - A License as a Registered Nurse with two years of relevant experience, or
 - A Masters with one year of relevant experience.
- For children enrolled in the Early Intervention Program and receiving Health Home services through a provider approved under the Early Intervention Program, the minimum qualifications for EIP service coordinators set forth in Section 69-4.4 of 10 NYCRR will apply.

(Those qualifications are further described in the Appendix)

(The Health Home Qualification Waiver cannot be utilized by EI providers)



Early Intervention EIP Service Coordinator Qualifications

For children enrolled in the Early Intervention Program and receiving Health Home services through a provider approved under the Early Intervention Program, the minimum qualifications for EIP service coordinators set forth in Section 69-4.4 of 10 NYCRR may apply. Those qualifications are as follows:

A minimum of one of the following educational or service coordination experience credentials:

- (i) two years of experience in service coordination activities as delineated in this Subpart (voluntary or part-time experience which can be verified will be accepted on a pro rata basis); or
- (ii) one year of service coordination experience and an additional year of experience in a service setting with infants and toddlers with developmental delays or disabilities; or
- (iii) one year of service coordination experience and an Associates degree in a health or human service field; or
- (iv) a Bachelors degree in a health or human service field.

Demonstrated knowledge and understanding in the following areas:

- (i) infants and toddlers who may be eligible for early intervention services;
- (ii) State and federal laws and regulations pertaining to the Early Intervention Program;
- (iii) principles of family centered services;
- (iv) the nature and scope of services available under the Early Intervention Program and the system of payments for services in the State; and
- (v) other pertinent information.

