Overview of Draft Health Home Application to Serve Children

Tailoring New York's Health Home Model to Better Serve Children

July 9, 2014

NEW YORK state department of HEALTH

New York State Office of Children & Family Services

New York State Office of Mental Health

OASAS Improving Lives.

Overview of Discussion

- Schedule
- Overview of Draft Application
  - Part I: Background and policy information regarding expectation and requirements for serving children in Health Homes
  - Part II: Draft Application
    - Process for Submitting Comments, Letter of Interest
    - Key Areas for which the State is seeking stakeholder input
- Questions and Answers

Schedule of Key Dates

Schedule for Enrolling Children in Health Homes	Due Date
Draft Health Home Application to Serve Children Released	June 30, 2014
Due Date to Submit Comments on Draft Health Home Application to Serve Children	July 30, 2014
Due Date to Submit Letter of Interest	July 30, 2014
Final Health Home Application to Serve Children Released	August 29, 2014
Due Date to Submit Health Home Application to Serve Children	September 30, 2014
Review and Approval of Health Home Applications to Serve Children by the State	October 1, 2014 to November 15, 2014
Begin Enrolling Children in Health Homes Phase-In based on Application Approvals and Network Readiness	January 2015
Behavioral Health Services and other Children's Populations Transition to Managed Care http://www.health.ny.gov/health_care/medicaid/redesign/care_management_for_all.htm	January 2016

Process for Submitting Comments to Draft Application
(Due July 30, 2014)

- To facilitate the review of comments, please use the "Form for Submitting Comments to Draft Application"
  - Form is available at: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/index.htm
  - Please submit Form electronically to HHSC@health.ny.gov
  - Form follows the content of the Application (includes both Part I and Part II) to provide an opportunity to submit comments on any section of either Part
  - Form includes three additional questions for which the State is also seeking stakeholder input:
    - Process for background checks for Health Home Staff serving children
    - Employing High Fidelity Wraparound (HFW) in Health Home and eligibility for HFW
    - Implementing uniform standards for Health Homes serving children (e.g., staff qualifications, training, encounters, etc.)

Process for Submitting a Letter of Interest

(Due July 30, 2014)

- Health Homes and other providers interested in submitting an Application are encouraged to submit a Letter of Interest
  - Submission of Letter of Interest is optional and not binding
  - To facilitate discussions between potential Applicants, network partners and care managers, Letters of Interest will be posted to the web site below
  - Form to Submit a Letter of Interest is available at: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/index.htm
  - Please submit Form electronically to HHSC@health.ny.gov

Health Home Eligibility Criteria

- Goal: Consistent with Stakeholder feedback, develop HH eligibility condition-based criteria (as required by Affordable Care Act) that captures the following children's populations:
  - Medically fragile children with complex health issues, children in foster care, children with behavioral health issues, children enrolled in current Waiver programs and other case management programs
- No changes to current eligibility criteria required to capture children with:
  - Serious Emotional Disturbance
    - Serious Mental Illness (currently a single qualifying condition for HHs) is interpreted under the ACA to include SED
    - SED will be single qualifying condition for Health Home
  - Medically Complex Conditions (Medically Fragile Children)
    - Based on information submitted by Stakeholders and discussions with clinicians, the State believes that most Medically Fragile Children with complex medical conditions that would need the intensive care management provided by a HH will have at least two chronic conditions
  - Children and adolescents with HIV

Proposed Expansions to Health Home Eligibility Criteria

- Trauma and at risk for another chronic condition
  - Definition of Trauma: Exposure to a single severely distressing event, or multiple or chronic or prolonged traumatic events as a child or adolescent, which is often invasive and interpersonal in nature. Trauma includes complex trauma exposure which involves the simultaneous or sequential occurrence of child maltreatment, including psychological maltreatment, neglect, exposure to violence and physical and sexual abuse.

  - A child or adolescent who has experienced trauma would be defined **to be at risk for another chronic condition** if they have one or more functional limitations that interferes with their ability to function in family, school, or community activities, or they have been placed outside the home.
    - Functional limitations are defined as difficulties that substantially interfere with or limit the child in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills, or for a child who experienced trauma due to child maltreatment, a functional limitation is defined as a serious disruption in family relationships necessary for normal childhood growth and development.

Transitioning Existing Care Management Programs for Children to Health Home

- OMH Children's Targeted, Supportive and Blended Case Management Programs will begin to convert to Health Home in January 2015
- Children's 1915(c) Waiver Programs will begin to convert in January 2016
  - OCFS Bridges to Health HCBS Waivers (DD, MFC and SED)
  - OMH SED HCBS Waiver
  - CAH I and II HCBS Waivers
  - Date is coincident with date behavioral health benefit and HCBS services are moved to Managed Care and such populations move to Managed Care
  - State will work on detailed plan to transition and phase-in children enrolled in Waiver Programs
- Children receiving services from the Office for People with Developmental Disabilities (OPWDD), including enrolled in the CAH III, IV and VI Waivers, will not be enrolled at this time

- *Waiver agencies and care managers are strongly encouraged to bring their care management expertise to Health Homes in 2015 by working now to join the networks of the Health Homes and to provide Health Home care management services to non-waiver children that will be enrolled in Health Homes beginning January 1, 2015.*

Foster Care and Health Homes

- Health Homes must contract with Voluntary Foster Care Agencies (VFCA) to provide care management for children in foster care
  - The Application provides VFCA the discretion/choice to not provide Health Home care management for children in their Agency (in this case, it is anticipated the Health Home will contract with a downstream care manager to provide care management to such foster care children)
- In developing care plans, VFCA providing Health Home care management will be required to comply with health care oversight mandates for children in foster care (see Working Together Health Care Services for Children) and meet the core care management requirements of the Health Home Program
- VFCA providing care management may contract with Health Homes to provide care management for children who are not placed in foster care or who were formerly enrolled in Foster Care
- Health Homes and VFCA will be required to establish agreements to ensure transitional arrangements are in place for children that transition in and out of foster care
- DOH and OCFS will work closely with Health Homes and VCFA to provide information, guidance and training

Early Intervention (EI) Program

- For the subset of infants and toddlers that are eligible for both the Early Intervention (EI) and Health Home programs, the State is proposing to maximize the expertise of the EI service coordinator and HH care managers by clearly defining the roles of each coordinator and avoiding the duplication of services
- Under this approach the:
  - EI initial service coordinator will continue to facilitate initial enrollment in the EI Program and
  - The Health Home care manager will provide ongoing care management, including the integration of EI services in the child's comprehensive care plan
- The State, including the DOH EI team, will work to provide guidance, information, and training to EI and Health Home coordinators regarding roles and responsibilities and the requirements of the EI and Health Home programs

General Education and Special Education

- The State is working with the State Education Department to provide information, guidance and training on the special education process and the services provided by the Health Home program to State Education Department staff and Health Home care managers
- The State will also be working with EI and State Education Department staff to develop ways to identify children that may be eligible for Health Home and to facilitate the referral process

High Fidelity Wraparound

- *High Fidelity Wraparound (HFW)* is a specialized planning *process* that follows a series of **prescribed steps** to help very high need children and families. The HFW process requires:
  - Low care manager to client ratio (e.g., 1:10)
  - More frequent and more intensive engagement between the care manager and child/family than standard case management models
  - A more intensive team-based approach to care coordination that includes the following elements:
    - A Child and Family Team that develops, implements and monitors an integrated plan of care across child-serving systems. The plan of care accounts for all of the child's health, behavioral health educational/vocational, child welfare and justice-related goals, plus goals to address the social services needs of the family health, and the planning process is driven by the child and family.
    - Peer support is treated as an inherent part of the HFW care coordination process, rather than as a service named in the plan of care. A Family Support Partner who helps the family to navigate the various service systems and ensure their perspective is represented throughout the process, consistent with the parents/caregivers' preferences and desires.
- HFW also requires specific training in the model to assure fidelity.

High Fidelity Wraparound (cont'd)

- The State is considering requiring Health Homes to employ the HFW approach to a small subset (e.g., one percent) of youth enrolled in Health Homes that could benefit from the specialized and intensive care management approach of HFW
  - State is considering focusing eligibility for HFW with complex behavioral health needs that are also involved in multiple child-serving systems
  - State is seeking stakeholder input on whether HFW should be employed in Health Home care management model for children and the specific eligibility criteria for HFW
  - This is one of the three questions included at the bottom of the Form for Submitting Comments
- Potential HFW implementation in NYS builds upon the HFW work of SAMSHA System of Care grantees throughout the State

CANS-NY Functional Assessment

- The State is considering requiring Health Homes to complete a functional assessment of children using the CANS-NY (Child and Adolescent Needs and Strength Assessment of New York)
  - CANS will be used to determine eligibility for proposed HCBS, it is likely HH eligible children will be eligible for one or more such services
  - Facilitate the linkage between the functional assessment process and the design of individualized service plans
  - Provides consistent tool to help evaluate the progress towards improved outcomes of children enrolled in Health Home
  - Does not preclude the use of other assessment or evaluative tools
- CANS - Developed by Dr. John Lyons (http://www.praedfoundation.org)
- Multi-purpose tool developed for children's services 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
- Currently used in New York State (B2H Waivers (SED, MFC, and DD) and OMH SED HCBS Waiver)

Work Plan to Revise CANS-NY

- June-August Pilot of Revised Algorithm in New York City
- OCFS Analysis of Revised Algorithm for 500 children in B2H
- OASAS, OCFS, OMH and DOH case review sampling to inform development of LON criteria for HCBS Services
- Discussion on utilization of tool to determine acuity levels for Health Home rate setting
- Work with author, Dr. John Lyons, to revise tool to meet transition needs

Health Home Payments and Transitional Provisions

- The State is working together to develop proposed Health Home care management rates for children
- Framework under consideration includes the following elements:
  - "Legacy" rates for Health Home rates will be developed for OMH Targeted Case Management Programs and the case management service for Waiver providers
    - Legacy rates will remain in effect for two years
  - A tiered rate structure (e.g., HFW, High, Medium, Low) that is based on acuity/functional status of the child
    - Considering using CANS-NY to determine acuity
    - Development of tiered rates will consider case load size
    - Rates would in effect 2015, and under the first two years of the shift of behavioral health benefit and HCBS services to Managed Care (2016 and 2017)
  - A flat rate for "outreach" activities

Quality Measures

- A critical component of Health Home program is to monitor performance and manage to quality outcomes
- Draft Application includes a list of proposed quality measures specifically for children
- These measures would be ***in addition*** to measures already included in the State Plan and the CMS Health Home Core Set of Quality Measures that are applicable to both children and adults
  - Links to the State Plan and HH Core Measures are included in the Draft Application and posted to the DOH Website

HH Assignment Lists

- The State is seeking input on procedures it is considering to:
  - Identify children eligible for Health Home
    - Medicaid claims data (i.e., Assignment lists)
    - Referrals to Health Homes from other entities (primary care providers, Plans, LDSS and SPOA, and the development of referral mechanisms through EI and SED)
  - Make Health Home Assignments
    - Connectivity to network of Health Home
    - Approach likely to be informed by the region/area of service Health Home Applicants propose to serve

Consent

- Draft Application recognizes the need to develop a Health Home consent form that recognizes the rights of minors to consent to certain types of health care without the permission of their parent/guardian and to whether parents/guardians or others can address their health information
- The State is developing draft uniform consent form for children to provide consent to join a Health Home and to share information with Health Home network providers
- The State is also seeking feedback on how the consent rights of minors impacts the ability of Health Homes to meet Health Home Health Information Technology (HIT) standards

Part II: Application

- Applications will be reviewed by multi-agency team (DOH, DOH AI, DHITT, OCFS, OMH, OASAS and NYC DOHMH). The team will consider the comprehensiveness of the Health Home's Application, including:
  - the required multi-system components of the provider network,
  - the inclusion of care managers and providers with the experience to serve children,
  - the demonstrated ability to tailor the delivery of the six core services to the needs of children, and
  - and overall access to children's Health Home services
- The Application (Part II) contains general instructions, information regarding the Applicant's proposed governance structure, general qualifications and experience, proposed regions of service and anticipated capacity, and network requirements (i.e., care managers and providers with expertise serving children)
- In completing the Application, Applicants should consider the information and requirements provided in Part I of the Application

Part II: Application (cont'd)

- Identifying and tailoring the six core Health Home services to meet the needs of children. The Application includes the following information:
  - Shaded boxes: Identifies the Health Home requirements for each core service as provided for in the State Plan authorizing the provision of Health Home services in New York
  - Additional requirements for providing each of the core services if HFW approach is employed (if applicable)
  - Examples of activities to be performed in providing each of the six core services
- For each of the core services, Applicants are required to describe how its Health Home plans to deliver and tailor the delivery of each of the core services and activities to serve children and to respond to the specific inquiries listed under the examples of core activities
- Specific questions regarding the instructions for completing Part II of the Application should be sent to hhsc@health.ny.gov

Questions?

- Central Mail Log for Health Homes and Children
  - HHSC@health.ny.gov
- Web Page Health Homes and Children – Stay Current
  - http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/index.htm
- Questions and Answers from Webinar Participants