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HCBS RULE INTEGRATION INTO NYS HEALTH HOME

Item#	Regulatory Text	42 CFR Cite for 1915(c) (441.301(c)(x))	42 CFR Cite for 1915(i) (441.710(a)(x))	State Compliance through Health Home SPA Provider Qualification Standards
A	***Person-centered planning process:*** The individual will lead the person-centered planning process where possible. The individual's representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative. All references to individuals include the role of the individual's representative. In addition to being led by the individual receiving services and supports, the person-centered planning process:	441.301(c)(1)	441.725(a)	**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.
A.1	Includes people chosen by the individual.	441.301(c)(1)(i)	441.725(a)(1)	**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.
A.2	Provides necessary information and support to ensure that the individual directs the process to	441.301(c)(1)(ii)	441.725(a)(2)	**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

HCBS RULE INTEGRATION INTO NYS HEALTH HOME

	the maximum extent possible, and is enabled to make informed choices and decisions.			
A.3	Is timely and occurs at times and locations of convenience to the individual.	441.301(c)(1)(iii)	441.725(a)(3)	*Need to develop a standard.*
A.4	Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with §435.905(b) of this chapter.	441.301(c)(1)(iv)	441.725(a)(4)	**4e.** The heath home provider communicates and shares information with individuals and their families and other caregivers with appropriate consideration for language, literacy and cultural preferences.
A.5	Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.	441.301(c)(1)(v)	441.725(a)(5)	**2d.** The heath 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.
A.6	Providers of Home- and Community-Based Settings (HCBS) for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or	441.301(c)(1)(vi)	N/A	*(CFCM, need to put policies in places based on BIP/HCBS conversations with CMS)*

HCBS RULE INTEGRATION INTO NYS HEALTH HOME

	develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.			
A.7	Offers informed choices to the individual regarding the services and supports they receive and from whom.	441.301(c)(1)(vi)	441.725(a)(6)	**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.
A.8	Includes a method for the individual to request updates to the plan as needed.	441.301(c)(1)(viii)	441.725(a)(7)	**4b.** Patient's individualized plan of care is accessible to the individual and their families or other caregivers based on the individual's preference. **4f.** The health home provider gives the patient access to care plans and options for accessing clinical information. (**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.)

HCBS RULE INTEGRATION INTO NYS HEALTH HOME

A.9	Records the alternative HCBS settings that were considered by the individual.	441.301(c)(1)(ix)	441.725(a)(8)	*Not existing requirement*
B	***Person-centered service plan****(documentation requirements)****:*** The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State's HCBS waiver, the written plan must:	441.301(c)(2)	441.725(b)	**1a.** A comprehensive health assessment that identifies medical, mental health, chemical dependency and social service needs is developed. **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.
B.1	Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment	441.301(c)(2)(i)	441.725(b)(1)	*Not currently a Health Home requirement- need to develop a standard.*

HCBS RULE INTEGRATION INTO NYS HEALTH HOME

	and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.			
B.2	Reflect the individual's strengths and preferences.	441.301(c)(2)(ii)	441.725(b)(2)	*Need to add language specifically to strengths* **4a**.Patient's individualize plan of care reflects patient and family or caregiver preferences, education and support for self-management; self help recovery, and other resources as appropriate.
B.3	Reflect clinical and support needs as identified through an assessment of functional need.	441.301(c)(2)(iii)	441.725(b)(3)	**1a.** A comprehensive health assessment that identifies medical, mental health, chemical dependency and social service needs is developed **1d.** The individual's plan of care clearly identifies primary, specialty, behavioral health and community networks and supports that address their needs.
B.4	Include individually identified goals and desired outcomes.	441.301(c)(2)(iv)	441.725(b)(4)	**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.
B.5	Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu	441.301(c)(2)(v)	441.725(b)(5)	**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. **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.

HCBS RULE INTEGRATION INTO NYS HEALTH HOME

	of HCBS waiver services and supports.			
B.6	Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.	441.301(c)(2)(vi)	441.725(b)(6)	*Need to modify existing HH standards.*
B.7	Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.	441.301(c)(2)(vii)	441.725(b)(7)	**4e.** The heath home provider communicates and shares information with individuals and their families and other caregivers with appropriate consideration for language, literacy and cultural preferences.
B.8	Identify the individual and/or entity responsible for monitoring the plan.	441.301(c)(2)(viii)	441.725(b)(8)	**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. **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.

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B.9	Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.	441.301(c)(2)(ix)	441.725(b)(9)	**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. *Does not currently include signatures of all providers-need to modify standard.*
B.10	Be distributed to the individual and other people involved in the plan.	441.301(c)(2)(x)	441.725(b)(10)	**4b.** Patient's individualized plan of care is accessible to the individual and their families or other caregivers based on the individual's preference. *New draft standards require POC to be shared with Plans and to meet HCBS standards which would include sign off of POC requirements by HCBS provider*
B.11	Include those services, the purpose or control of which the individual elects to self-direct.	441.301(c)(2)(xi)	441.725(b)(11)	*Need to develop a standard.*
B.12	Prevent the provision of unnecessary or inappropriate services and supports	441.301(c)(2)(xii)	441.725(b)(12)	*Monitored by the MCO need to discuss process and timelines*
B.13	Documentation of modifications based on risk assessment as identified above (see B.6): A. Identify specific and individualized assessed need. B. Document the positive supports/interventions previous used that were unsuccessful to address the need C. Document less intrusive methods that have been	441.301(c)(2)(xiii)	441.725(b)(13)	*Not currently a Health Home requirement-need to develop a standard*

	previous used that were unsuccessful D. Clear description of the condition that is connected to the specific need or risk E. Collect ongoing data to monitor effectiveness of new modification			