Health Home Application to Serve Children

November 3, 2014

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Introduction

The New York State Department of Health (DOH) (including the Office of Health Insurance Programs (OHIP), the Center for Community Health, Division of Family Health and the AIDS Institute (DOH AI)) and its State Agency partners (the Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS), and the Office of Children and Family Services(OCFS)), hereafter collectively referred to as "the State," is seeking Applications from designated Health Homes and other Medicaid providers to provide care management to children with Medicaid who have complex physical and/or behavioral health conditions under the New York State Health Home model as tailored to serve the unique needs of children. While children are currently eligible for Health Home enrollment, it has been the intent of the State to work with existing Health Homes and other providers to tailor New York State's Health Home model (e.g., the expansion of network and eligibility requirements, the delivery of the core Health Home services) to better serve children and to recognize the important differences in the approach to care management and planning for children and adults. The State anticipates it will phase-in the enrollment of children in Health Homes beginning **October 2015.** The State intends for the information contained in this Application, including the vision for serving children in Health Homes, to assist and encourage designated Health Homes, health care providers, community based and human service providers, and care managers with expertise in serving children to continue to engage in collaborations and network discussions that will be the foundation for serving children in Health Homes.

Important Dates for Review and Submission of Health Home Applications to Serve Children

This Application, along with other informational materials presented with its release, reflects many comments received from more than 40 stakeholders, including Health Homes, Medicaid providers, children's advocates and associations who were provided the opportunity to review and provide comments on the Draft Application dated June 30, 2014. Stakeholder comments related to operationalizing the policy design of the Health Home model for children as discussed in this Application and that will be developed over the next several months (e.g., rate development, training activities, State Plan Amendments) will be addressed in the November 5, 2014 Webinar, future Webinars with stakeholders and other training and information sessions. The State appreciates the comments received and will continue to work with and seek stakeholder input as the elements of the design of the Health Home model to serve children continues to evolve.

To be responsive to stakeholder comments requesting that the State provide more time to conduct the work required to thoughtfully tailor the Health Home model to better serve children (including reviewing the large volume of comments received by stakeholders on the Draft Application), at the end of August 2014, the State extended the schedule to begin enrollment of children in Health Homes to July 2015. Based upon further analysis of the

work required to implement elements of the design of the Health Home model for children (e.g., CANS-NY modifications, development of the Medicaid Analytics Performance Portal (MAPP) for Health Homes) and to avoid duplication of efforts (i.e., training pre and post the development of MAPP) the State has further extended the date to begin to phase-in the enrollment of children to **October 2015**.

Anticipated Schedule for Expanding Health Homes to Better Serve Children	
Activity	**Due Date**
Draft Health Home Application to Serve Children Released	June 30, 2014 **Completed**
Due Date to Submit Comments on Draft Health Home Application to Serve Children	July 30, 2014 **Completed**
Due Date to Submit Letter of Interest*	July 30, 2014 **Completed**
Final Health Home Application to Serve Children Released	November 3, 2014 **Completed**
Due Date to Submit Health Home Application to Serve Children	March 2, 2015
Review and Approval of Health Home Applications to Serve Children by the State	March 2, 2015 to June 15, 2015
Health Home and Network Partner Readiness Activities	June 15, 2015 to September 30, 2015
State Webinars, Training, and Other Readiness Activities	Through September 30, 2015
Begin Phasing in the Enrollment of Children in Health Homes	October 2015
Children's 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
*Letters of Interest have been posted to the Department's website and can be viewed at: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children_letters_of_interest.htm	

Background Information and the Application

The Application consists of two documents, Part I and Part II.

Part I: Background and Policy Information for Serving Children in Health Homes

Part I includes background and policy information for stakeholders and providers that may be interested in submitting an Application to serve children in Health Homes. Information included in this Part includes principles and provider expectations for serving children in Health Homes, proposed expanded Health Home eligibility criteria, systems of care that impact children, and the status of the development of other programmatic and Health Home information (e.g., Health Home rates, and quality measures) relevant to tailoring the design of the Health Home model for children.

Part II: Health Home Application to Serve Children

Part II is the Health Home Application to Serve Children

All Applicants must submit Part II of the Application and the Health Home Provider Network Form electronically. Please see http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm and Part II of the Application for instructions to submit this Application electronically. Applications are due March 2, 2015. The Application includes the following Attachments.

Application Attachments	
Attachment A (Part I)	New York State Health Home Model for Children
Attachment B (Part II)	List of Providers with Expertise Serving Children
Attachment C (Part II)	Health Home Provider Network Form

Part I
Background and Policy Information for Serving Children in Health Homes

Principles for Health Homes Serving Children

Applications to serve children in Health Homes must reflect the following principles and demonstrate the ability to implement and adhere to such principles. The principles were developed by the State in consultation with stakeholders.

- Ensure care coordination networks provide comprehensive, integrated physical and behavioral health care that recognizes the unique needs of children and their families.
- Provide care coordination and planning that is family-and-youth driven, and supports a system of care that builds upon the strengths of the child and family/caregiver.
- Ensure care coordinators are trained in working with families and children with unique, complex health needs.
- Ensure continuity of care and comprehensive transitional care from service to service and across and within systems (education, foster care, juvenile justice, child to adult).
- Incorporate a child/family specific assent/consent process that recognizes the legal right of a child to seek specific care without parental/guardian consent as well as the legal right of a child to refuse care.
- Track clinical and functional outcomes using standardized tools that are validated for the screening and assessment of children.
- Adopt child-specific and nationally recognized measures to monitor quality and outcomes.
- Ensure smooth transition from current care management programs to Health Homes, including transition plan for care management payments.

Attachment A provides a diagram of the State's vision for tailoring the Health Home model to serve children. As explained in more detail throughout the remaining sections of this Application, the Health Home model for children reflects the expansion of care management network requirements to include health care providers, community support services, and care managers with expertise in serving the unique and diverse needs of children who will be eligible for Health Home and their families.

As used throughout this Application and in the context of Health Home, "family" is defined as the primary care-giving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive or self-created unit of people residing together, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren). Persons within this unit share bonds, culture, language, practices and a significant relationship. Birth parents, siblings and others (relatives, grandparents, guardians, foster parents) with significant attachment to the individual living outside the home are included in the definition of family. A "child" is defined as an individual under age 21. However, as discussed in more detail throughout this Application, Health Homes are expected to provide care planning that includes comprehensive transitional care within and across systems for children that age into adulthood and continue to be eligible for Health Home.

The State's vision for serving children in Health Home is family and child/youth driven, and the family/caregiver is recognized as the "natural care manager." In this model, the expertise of the family/caregiver is considered primary and decisions regarding goal priorities are set by the family/caregiver. Delivering family and child/youth driven care management requires a unique skill set on the part of Health Homes and care managers, recognizing that it is not just the identified child but the entire family/caregiver unit that is engaged in the service planning and delivery process.

Importantly, the model establishes the need to connect and partner with the multiple systems that serve children (including foster care, juvenile justice and educational systems). Effectively delivering Health Home care management services to children will require knowledge of and capability to coordinate and work simultaneously as a team with multiple systems (e.g., foster care, education, Early Intervention, juvenile justice) and providers. Care managers will need to have cultural and linguistic competency in the populations they serve, knowledge of child serving systems and how to advocate/plan for service access with the child's developmental needs in mind. A high level of flexibility is needed in order to make service or plan of care changes as children grow and develop and to accommodate for the high rate of geographical transitions and movements of some populations (including foster care).

In addition to demonstrating an adequate network of children's providers and connectivity to the children's systems of care, applicants will be required to recognize and demonstrate the ability to tailor the way in which the Health Home core services are delivered to children and their families, as well as meeting the general functional requirements related to the provision and coordination of Health Home services.

Regional Approach to Health Homes Serving Children

The goal of the State is to designate qualified Applicants to ensure access and services for all Health Home eligible children in New York State. Currently there are 33 designated Health Homes which collectively provide access to Health Home care management to eligible individuals located in every county of the State. For more information about New York's designated Health Homes and the counties they serve please see

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

The State envisions Health Homes serving children will operate across regions. Health Homes designated to serve children may serve areas or regions that may be broader or different than the county-based regions served by existing Health Homes. For example, two or more currently designated Health Homes serving different counties of the State may submit an Application with a governance structure that forms a single Health Home to serve children in their collective areas of service, or newly formed Health Homes may serve a combination of regions that are different than those currently served by existing Health Homes. This approach recognizes that the delivery system of care management for children, while locally based, will be a mix of county and regional based providers and services.

Who May Submit a Health Home Application to Serve Children

Current Health Homes may apply to tailor and expand their Network to better serve children. While this is the preferred approach because it leverages the existing infrastructure of Health Homes and provides the "built-in" care management capacity to transition children to adult care management, the State will accept and review Applications from Medicaid providers that intend to build a network of predominantly children's providers to primarily serve children. As described in more detail throughout this Application, Health Home Applicants will be required to meet the infrastructure standards and qualifications and deliver the core Health Home services as described in the State Plan (a copy of the State Plan can be reviewed at http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/spa13-18.pdf) and will be required to demonstrate their ability to tailor the State Plan requirements to serve the unique needs of children.

The State strongly encourages applicants to form partnerships and governance structures that leverage existing Health Home infrastructure to maximize the use of existing administrative and technology investments and to mitigate and minimize start up efforts. Applicants seeking to form a new Health Home should carefully consider the administrative requirements described throughout this Application (e.g., Health Information Technology (HIT) requirements, contractual and/or sub-contractor arrangements with downstream providers, data collection, reporting and member tracking requirements and on the State's Health Home website http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/) related to starting up and operating a Health Home and whether becoming part of the governance structure of an existing Health Home or establishing administrative relationships with an existing Health Home are paths to incorporating your strengths and abilities to serve children in Health Homes.

Application Review Process

Applications will be reviewed by a multi-agency team including staff from State and Local Agencies, including DOH (including the Office of Health Insurance Programs, the Center for Community Health, Division of Family Health and the AIDS Institute), OCFS, OMH, OASAS

and NYC DOHMH. In reviewing Applications, the review team will consider (among other things) the comprehensiveness of the Health Home's Application, including the required multi-system components of the provider network, the inclusion of care managers with the experience to serve children, the demonstrated ability to tailor the delivery of the six core services to the needs of children, and overall access to children's Health Home services.

Health Home Eligibility Requirements

The State intends to expand the current Health Home eligibility criteria to serve those children most in need of the intensive care management provided by the Health Home program. Based upon discussions with stakeholders and to the extent possible, it is the policy goal of the State to ensure that the condition-based eligibility criteria for Health Homes would make children in foster care, medically fragile children with complex health conditions, children currently receiving care management under the State's waiver programs (e.g., OCFS Bridges to Health, OMH HCBS Waiver, DOH Care at Home) and case management programs (e.g., OMH Children's Targeted Case Management Programs) that need the level of care management provided by the Health Home model (see appropriateness criteria below) eligible for Health Home.

The State and stakeholders have identified the populations of children described above as those which have experienced traumatic and adverse childhood events, have or are at risk for developing chronic physical and behavioral health conditions, and/or developmental delays as a group of children which need and will significantly benefit from the comprehensive care management services provided by the Health Home model. Further, it is expected that the person-centered care planning and family-based Health Home model, as tailored to serve children, will be consistent with the "Triple Aim" and will result in improved health outcomes, reduced health care costs, and the prevention of adverse health outcomes in a child's later and adult years (e.g., development of other chronic physical conditions, substance use disorders, depression and anxiety, self- harming behaviors and other psychiatric disorders).

Current Health Home Eligibility Requirements

Under the current eligibility criteria for Health Homes, an individual must be enrolled in Medicaid and have two or more chronic conditions or one single qualifying condition of HIV/AIDS or serious mental illness (SMI); *and must be appropriate for Health Home care management.*

Chronic conditions (from the following major categories of 3M™ Clinical Risk Groups (CRGs)) include: Alcohol and Substance Abuse, Mental Health Condition, Cardiovascular Disease (e.g., Hypertension), Metabolic Disease (e.g., Diabetes), Respiratory Disease (e.g., Asthma), and Body Mass Index BMI >25, and other chronic conditions.

Medicaid members that do not have the single conditions of SMI or HIV/AIDS must have at least **two** chronic conditions to be eligible for Health Home. For additional information regarding the major categories and the associated CRG categories of chronic and behavioral and medical conditions listed below, and for a list of Health

Home chronic conditions please see the State Plan outlining Health Home eligibility requirements at:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/spa13-18.pdf and
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/09-23-2014_eligibility_criteria_hh_services.pdf

Health Home Appropriateness Criteria
Individuals meeting the Health Home eligibility criteria must also be appropriate for Health Home care management, i.e., require the level of comprehensive care management provided by the Health Home model. Assessing whether an individual is appropriate for Health Homes includes determining if the individual is at risk for an adverse event (e.g., death, disability, inpatient or nursing home admission); has inadequate social/family/housing support; has inadequate connectivity with healthcare system; does not adhere to treatments or has difficulty managing medications; has recently been released from incarceration or psychiatric hospitalization; has deficits in activities of daily living; or has learning or cognition issues.

Serious Emotional Disturbance
As noted above, serious mental illness (SMI) is currently a single qualifying condition for Health Home. Under the Affordable Care Act and the current State Plan for Health Homes, SMI is interpreted to include both children with a Serious Emotional Disturbance (SED) and adults with SMI. Thus, SED is already a single qualifying condition for Health Home and additional approvals are not required to make this a single qualifying condition for Health Home.

As requested by stakeholders, the State is working to clarify how SED will be defined for the purpose of determining Health Home eligibility. In the definition the goal was to be consistent with the OMH SED definition, which relies upon the Diagnostic and Statistical Manual of Mental Health Disorders (DSM) and the chronic condition eligibility requirements of the Health Home Program.

Serious Emotional Disturbance (SED): A child or adolescent (under the age of 21) that has a designated mental illness diagnosis as defined by the most recent version of the DSM and, as grouped by the 3M™ Clinical Risk Groups (CRGs), is a chronic condition AND has experienced functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis.

The State is finalizing work to cross-reference the most recent DSM list (DSM-5) of designated mental health diagnoses to the OMH SED definition and then to the list of chronic conditions as determined by the 3M™ Clinical Risk Groups (CRGs). Currently, it is expected that that SED definition for Health Home will include diagnoses from the following DSM-5 categories:

- Bipolar and Related Disorders

- Depressive Disorders
- Feeding and Eating Disorders
- Schizophrenia Spectrum and Other Psychotic Disorders
- Obsessive-Compulsive and Related Disorders
- Disruptive, Impulse Control, and Conduct Disorders
- Personality Disorders

The State anticipates the Child and Adolescent Needs and Strengths – NY (CANS-NY) tool (as modified), in addition to other documented, clinical determinations, can be used to help evaluate if the child has experienced the functional limitations. Please see "Functional Assessments and CANS-NY" of Part I of this Application for more information regarding the use of the CANS-NY tool. These functional limitations must exist in the following areas:

- 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).

Medically Fragile Children

Based upon discussions with stakeholders, and other information about medically fragile children with complex health conditions (see the February 2013 Medically Fragile Work Group Report for more information - http://www.health.ny.gov/health_care/medicaid/redesign/docs/2013-01-24_final_mfc_wrkgrp_rpt.pdf), the State believes that children with complex medical conditions (as defined in the Work Group Report) generally have at least **two** chronic debilitating conditions that make an individual eligible for the Health Home program under the current eligibility criteria. For a comprehensive list of Health Home chronic conditions please see the following link: (http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/09-23-2014_eligibility_criteria_hh_services.pdf)

Expanding Health Home Eligibility Requirements to Better Serve Children

To achieve the policy goal described above of ensuring children who are most in need of intensive care management are eligible for Health Homes and consistent with the Centers for Medicaid and Medicare (CMS) requirements for developing condition-based eligibility criteria for Health Homes, the State, in consultation with stakeholders, proposes to expand

the Health Home eligibility criteria to include "trauma and at risk for another chronic condition."

In addition, the State is proposing to amend the chronic condition "BMI>25" to "BMI at or above 25 for adults or at or above the 85 percentile for children of the same age and sex" to reflect the appropriate comparable "overweight" measure for children and adults. Children and adults that meet this revised definition and have one other chronic condition would be eligible for Health Home.

Trauma and at risk for another chronic condition

Trauma refers to exposure to a negative event or events that produce distress in a person, either physically, psychologically, or both. Complex trauma has been variously described as "exposure to multiple or prolonged traumatic [negative] events" (Department of Health and Human Services July 11, 2013 State Director letter - http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf), or to both the exposure to multiple events AND the long-term impacts of this exposure (National Child Traumatic Stress Network - http://www.nctsnet.org/trauma-types/complex-trauma).

Trauma and complex trauma includes exposure to the distressing event(s) only, with the understanding that complex trauma exposure in childhood has been shown to impair brain development and the ability to learn and develop social and emotional skills during childhood, consequently increasing the risks of developing serious or chronic diseases in adolescence and adulthood. Children who have experienced trauma and who are not old enough to have experienced long-term impacts are uniquely vulnerable.

Childhood exposure to child maltreatment, including emotional abuse and neglect, exposure to violence, sexual and physical abuse are often traumatic events that continue to be distressing for children even after the maltreatment has ceased, with negative physical, behavioral, and/or psychological effects on the children. Since child maltreatment occurs in the context of the child's relationship with a caregiver, the child's ability to form secure attachment bonds, and their sense of safety and stability are disrupted. Without timely and effective intervention, a growing body of research shows that "a child's experience of these events [simultaneous or sequential maltreatment] can create wide-ranging and lasting adverse effects on developmental functioning, and physical, social, emotional or spiritual well-being" (Department of Health and Human Services July 11, 2013 State Director letter).

Trauma is defined as 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 interfere 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. The State anticipates the CANS-NY tool (as modified), in addition to other documented, clinical determinations, can be used to help evaluate whether a child has experienced trauma as defined above and to evaluate if they meet the functional limitations that may place a child at risk for another chronic condition. Please see "Functional Assessments and CANS-NY" of Part I of this Application for more information regarding the CANS-NY tool.

The proposed expansion of the Health Home eligibility criteria to include comparable overweight measures for children and adults and "Trauma and at risk for another Chronic Condition" is subject to State Plan approval by the Centers for Medicare and Medicaid Services (CMS). Adding trauma to the Health Home eligibility criteria is consistent with the Department of Health and Human Services July 11, 2013 State Director letter which similarly defines trauma and references Health Homes as an option for delivering services to children and youth who have experienced complex trauma.
http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf

In addition to amending the Health Home eligibility criteria as described above, the State is augmenting the current Health Home appropriateness criteria to include whether a child and the family/caregiver are concurrently eligible or enrolled in Health Home, at risk for out of home placement, mandated preventive services or serious disruptions in family relationships, or experienced a recent release from a placement or detention.

Summary of Health Home Eligibility Criteria if Proposed Criteria Approved by CMS

If the proposed expansion to the current Health Home eligibility criteria of "trauma and at risk for another condition" is approved by CMS, the new eligibility criteria for the Health Home program would be as follows:

Eligibility Criteria
Person must be enrolled in Medicaid and have:

- ✓ Two or more chronic conditions

  OR
- ✓ One single qualifying condition of
  - o HIV/AIDS or
  - o Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) (as defined)

  OR
- ✓ Trauma and at risk for another chronic condition
  - o At risk is defined as one or more defined functional impairments or an out of home placement

  AND
- ✓ Meet the Health Home Appropriateness Criteria

Appropriateness Criteria
Individuals meeting the Health Home eligibility criteria must be appropriate for Health Home care management. 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.

Chronic Conditions include:

- Alcohol and Substance Abuse
- Mental Health Condition
- Cardiovascular Disease (e.g., Hypertension)
- Metabolic Disease (e.g., Diabetes)
- Respiratory Disease (e.g., Asthma)
- BMI at or above 25 for adults, or at or above the 85 percentile for children of the same age and sex
- Other chronic Conditions

General Enrollment and Discharge Information

Children Currently Enrolled in Health Homes which Do Not Become Designated to Serve Children
Health Home care management is an optional benefit and individuals have the right to choose a Health Home. The Application process to tailor the Health Home model to serve children is not intended to disrupt the continuity or provision of Health Home services that are now being provided to those children. However, Health Homes that currently serve children that do not choose to become a designated Health Home serving children will be required to disclose this information to the child/caregiver. These Health Homes will also be required to discuss with the child/caregiver and determine whether there is agreement that the Health Home is meeting the care management needs of the child and can continue to do so, or if it is in the best interests of the child to be reassigned to a Health Home designated to serve children. Effective October 1, 2015, Health Homes that do not become designated to serve children may not enroll new members that are children (i.e., under the age of 21), unless there are documented extenuating circumstances (e.g. patient choice/preference, service needs of patient, patient circumstances, caregiver enrolled)

indicating the provision of care management services by the non-child designated Health Home is in the child's best interest.

Concurrent Enrollment of Child and Caregiver in Health Homes
In instances where both the caregiver and the child each meet the Health Home eligibility requirements, it is expected that Health Homes that serve both children and adults will offer Health Home care management to both the child and the caregiver and the care management will be appropriately coordinated. Health Homes designated to primarily serve children and thus do not have the care management expertise and a network sufficient to meet the needs of the care giver (i.e., the adult) must disclose this to the caregiver and the child and offer the child and caregiver the option of enrolling in another Health Home that can serve them both. Regardless of whether the child or caregiver are ultimately enrolled in the same or different Health Home, the Health Home or Health Homes must support the presentation of options and document the family's choice and decision making process, and must collaborate to coordinate care management for the family and caregiver as appropriate.

Transitional Care Planning
As described in more detail in Part II of this Application, as part of the core Health Home services, care managers must provide comprehensive transitional care planning. This includes ensuring that children that no longer meet the Health Home eligibility and/or appropriateness criteria are transitioned to appropriate levels of care (e.g., HCBS care management, care management provided by Managed Care Plans, patient centered medical home). In addition, Health Homes will be responsible for transitioning children to care managers and/or Health Homes that serve adults. The approach to this transition must involve member consent, attempts to preserve continuity of care management where appropriate, and be in the best interests of the member.

Discharge from Health Home
Children that no longer meet the criteria for enrollment, including whether they meet the appropriateness criteria and other functional criteria (i.e., as defined for Trauma and SED) and thus do not need the intensive level of care management provided by Health Homes, should be discharged from Health Home and transitioned to another level of appropriate care (e.g., patient centered medical home, HCBS care management).

Transitioning Existing Care Management Programs for Children to Health Home
The OMH Children's Targeted Case Management (TCM) Programs (Intensive Case Management, Supportive Case Management, and Blended Case Management) are expected to begin to convert to Health Home in October 2015. Similar to the approach used to transition Adult OMH TCM Programs to Health Home, OMH and DOH will work over the coming months to provide information to facilitate a smooth transition to Health Home.

The care coordination services under the Children's 1915(c) HCBS Waiver programs i.e., the OCFS Bridges to Health Programs (for SED, Medically Fragile Children, and Developmentally Disabled), OMH HCBS Waiver, and DOH Care at Home I/II Waiver, will begin to convert to Health Home on January 1, 2016. This date is coincident with the date

the children's behavioral health benefit, other children's populations, and the proposed HCBS services described elsewhere in this Application move into Medicaid Managed Care. The State will be working to develop a detailed plan to transition and phase-in children enrolled in Waivers to Health Homes and Managed Care.

Children receiving services from the Office for People with Developmental Disabilities (OPWDD), including children in the Care at Home III, IV, and VI Waivers will not be prioritized at this time for enrollment into Health Home. The State will continue to work with OPWDD on the transition to "Care Management for All," for the OPWDD population, including developing a timeframe for the enrollment of both children and adults in Health Homes. The DOH is continuing to work with OPWDD to discuss approaches for beginning to enroll children that have a developmental delay diagnosis and one other Health Home chronic condition or a single qualifying Health Home chronic condition and require the level of care management services provided by Health Home and who are ***not*** currently receiving OPWDD services that require OPWDD service coordination in Health Homes.

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 October 1, 2015.

Phasing in the Enrollment of Children into Health Homes

As indicated earlier in this Application, the State anticipates it will begin enrolling children into Health Home beginning October 1, 2015. Some stakeholders have suggested the State consider phasing in enrollment. The State agrees that a phase-in approach to enrollment should be implemented and will work in collaboration with stakeholders on a plan to phase-in enrollment. Considerations for developing such a plan will include: the timing of Health Home designations, the "readiness" of designated Health Homes to begin serving children, and identifying regions or populations under which to implement a phase-in approach.

As indicated earlier in Part I of this Application, children enrolled in the OCFS Bridges to Health Waivers, the OMH SED Children's Waiver, and the DOH Care at Home I/II Waiver, will begin to convert to Health Home on January 1, 2016. The State will be working to develop a detailed plan to transition and phase-in children enrolled in Waivers to Health Homes and managed care.

Health Home Assignment Lists for Children and Eligibility

The State is considering procedures for identifying children and making initial assignments to Health Homes. Methods for identifying potentially eligible children include using Medicaid claims data and referrals from various entities (e.g., Early Intervention, primary care providers, Managed Care Plans, Local Departments of Social Services (LDSS), Local Government Units (LGU), Single Point of Access (SPOA) and Pre Admission Certification Committee (PACC)). In addition, and unlike adults, there are many systems of care (e.g., child welfare, foster care, education, Early Intervention, juvenile justice) which connect to children (often on a daily basis) and thus are natural "hubs" for identifying and referring

children that may be eligible for Health Homes. In recognition of this, the State is incorporating in the design of the Medicaid Analytics Performance Portal (MAPP) an Internet portal that authorized users in these and other systems can access to make referrals to Health Homes.

Methods for determining Health Home assignments include connectivity to the Health Home and its network of providers (e.g., primary care, specialty providers, and foster care agencies). As has been anticipated in the Health Home model, the Managed Care Plans, taking into account connectivity to Health Homes, will make assignments to Health Homes. Children not enrolled in a Managed Care Plan will be assigned to a downstream care management agency by the Health Home. Each type of assignment will take into account existing relationships with health care providers or systems, geography and qualifying condition(s).

The payer of Health Home Services (Managed Care Plans for Plan members, Health Homes for fee-for-service members) is ultimately responsible for verifying Health Home eligibility. However, this responsibility can be delegated by the Managed Care Plan to the Health Home, provided the Health Home keeps contemporaneous documentation of member eligibility in the care management plan for verification by the State and the Managed Care Plan as appropriate.

New York State Systems of Care and Programs that Impact Children

Applicants will be required to demonstrate that their Health Home has established partnerships with the various systems that involve children, including the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services, and the Office of Children and Family Services, New York City Department of Health and Mental Hygiene (as applicable), Local Departments of Social Services (LDSS), Local Government Units (LGU), Single Point of Access (SPOA), Voluntary Foster Care Agencies, juvenile justice system, pediatric HIV/AIDS providers and the education system. Health Homes are expected to develop relationships with these entities as well as local county resources such as Preventative Services, and Local Health Departments. Applicants must also develop a network of health, behavioral health and community based providers as described in section D in Part II of this Application. It should be noted that Health Home networks are not closed networks and Health Homes and Managed Care Plans are not limited to the providers in their respective network when a specialty service is required to meet a child's needs.

Health Homes will be expected to transition children between Health Homes or to different providers as their needs change and as appropriate (see General Enrollment and Discharge Information). Health Homes working with Transition Age Youth (TAY) will also need to be familiar with the various services and supports available to this population. The TAY population has special vocational, educational, employment and housing needs. Connecting and transitioning this population to needed adult services and resources is critical for their success and stability in the community.

New York State Child Welfare System
The New York State Child Welfare System is supervised by the Office of Children and Family Services (OCFS) and locally operated by LDSS. The Family Court Act transfers the care and custody of children to the Commissioner of the LDSS through Article 3 for Juvenile Delinquents; Article 7 Persons In Need of Supervision (PINS); Article 10 (abuse and neglect); Article 10-C (destitute child), Social Services Law (SSL) Section 358-a (surrendering of a child for adoption); or SSL Section 384-b (deceased parents).

LDSS are responsible for custody of children, placement decisions, medical consent, the facilitation of Medicaid eligibility, enrollment of children in Managed Care Plans, and working with Family Courts in relation to determining a permanency plan for each child.

Foster Care
Children in foster care in New York State are categorically eligible for Medicaid until age 26. (Note: effective January 1, 2014, the Affordable Care Act extended Medicaid coverage through the age of 26 for youth who were in foster care at the age of 18 and in receipt of Medicaid). New York State regulations require the LDSS and voluntary agencies arrange and coordinate the health care of children in foster care.

In the Fall of 2013, there were approximately 20,000 children in foster care (with roughly 30,000 passing through the foster care system each year). LDSS contract with 87 Voluntary Foster Care Agencies across New York State for the placement of and services for approximately 16,500 children in foster care. The remaining children in foster care (approximately 3,500) are placed in foster homes licensed by the LDSS. Children in foster care may be placed in certified foster boarding homes (i.e., with a foster family in the community) licensed by the LDSS, or in the Voluntary Agencies or placed in Congregate Care. Congregate Care is group foster care placements operated primarily by Voluntary Agencies with size limits [Group Homes: less than 12 beds; Group Residences (12-24 beds); and Institutions (i.e., Residential Treatment Centers having 25+beds)].

- ✓ The median length of stay in foster care is approximately 12 months;
- ✓ The average length of stay in foster care in New York State is 290 days, while in New York City it is 334 days;
- ✓ Children under the age of one at admission have the longest length of stay (median length of stay 629 days);
- ✓ Youth between the ages of 13 and 17 at admission have the shortest length of stay (median lengths of stay is 257 days);
- ✓ Approximately 15 percent of children exit the system and re-enter it again.

Health Home Care Management for Children in Foster Care
Health Homes that submit Applications to serve children must contract with Voluntary Foster Care Agencies to provide the care management for children in foster care. It is expected that contracts between Voluntary Foster Care Agencies and Health Homes will make it the responsibility of the Voluntary Foster Care agency to ensure that the requirements and delivery of Health Home care management by its Voluntary Foster

Care Agency care manager comply with statutory and regulatory mandates for health care oversight for children in Foster Care. Please see "Working Together Health Care Services for Children in Foster Care" at:
http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp
In addition, the contract between the Voluntary Foster Care Agency care manager and the Health Home will need to establish that the Voluntary Foster Care Agency care manager will provide all the Health Home care management services required to be provided under the Health Home Program. Health Home payments made to the Voluntary Foster Care Agency for Health Home services are limited to payment for care management services and are not for other non-Health Home services the care manager may provide as an employee of the Foster Care Agency.

If individual Voluntary Foster Care Agencies choose not to provide the care management for children under their care and custody, Health Homes will contract with a downstream care management provider in its network to provide care management.

Health Homes and Voluntary Foster Care Agencies may also agree to contract to provide care management for Health Home children who are not placed in foster care or were formerly placed in foster care. In addition, Health Homes and the Voluntary Foster Care Agencies will be required to establish agreements to ensure transitional arrangements are in place for children who transition in and out of foster care that consider continuity of care and the best interests of the child and family. Health Home care management can continue to be provided to a child that has been discharged from foster care as long as the child meets the Health Home eligibility and appropriateness criteria described above. Foster care placement in itself does not make a child eligible for Health Home. (See General Enrollment and Discharge Information).

The DOH and OCFS will work closely with Health Homes and care managers to provide information, guidance and training regarding the programmatic, regulatory and statutory requirements associated with providing Health Home care management to children placed in foster care.

Preventive Services
Local Departments of Social Services (LDSS) are required to provide services to children and families at risk of placement into foster care. Preventive Service broadly include services to prevent foster care, expediting reunification from foster care, or reducing the likelihood of foster care re-entry after reunification. LDSS may opt to provide eligible children and family services directly, or work with community-based service organizations on their behalf.

These services range from casework contacts, homemaking services, parent training, housing services, child care (day care services), provision of emergency cash or goods and referrals to health care services, including health insurance options. Given the complexities of Preventive Services cases, children and families are likely to have one or more chronic conditions (e.g., behavioral health care needs and/or substance abuse

diagnoses) that may make them eligible for Health Home services. Health Home care managers will need to establish relationships with LDSS.

Services under the Federal Individuals with Disabilities Education Act (IDEA)

Early Intervention Program for Infants and Toddlers with Disabilities

The Department of Health is the State agency responsible for the Early Intervention Program (EIP). Children are eligible for the EI Program if they are under three years old and have a disability or developmental delay. For purposes of the EI Program a disability means that a child has a diagnosed physical or mental condition (such as Downs Syndrome, Autism Spectrum Disorder, Cerebral Palsy, vision or hearing impairment), with a high probability of developmental delay. A developmental delay means that a child has a developmental delay in one or more of the following areas of development: physical development (growth, gross and fine motor abilities), cognitive development (learning and thinking), communication development, social-emotional development or adaptive development. To be eligible for the EIP based on developmental delay, the child's developmental delay must meet criteria established in 10 NYCRR Section 69-4.23.

The EIP offers therapeutic and support service(s) such as: family education and counseling, home visits, and parent support groups; special instruction; speech pathology and audiology; occupational therapy; physical therapy; psychological services; nursing services; nutrition services; social work services; vision services; and assistive technology devices and services.

Service coordination services are a federally-required component of the EIP. All children and families participating in the EIP must have a service coordinator responsible for coordinating services across agency lines; and, serving as the single point of contact in helping parents to obtain the services and assistance they need (10 NYCRR Section 69-4.6(a)).

There are two types of service coordinators in the EIP – initial and ongoing service coordinators. Early Intervention Program regulations at 10 NYCRR Section 69-4.6 contain the standards for initial and ongoing service coordinators in the EIP and 10 NYCRR Section 69-4.7 contains specific information about the responsibilities of EIP initial service coordinators. The initial service coordinator is assigned to the family by the municipal agency responsible for administering the EIP upon referral to the EIP, and their responsibilities include explaining the EIP to the family and facilitating the evaluation process to determine the child's eligibility for the EIP, and, if eligible, facilitating the development of an Individualized Family Service Plan (IFSP) that includes outcomes for the child and family and reflects the family's priorities, concerns and resources.

The ongoing service coordinator is selected by the family and may or may not be the same agency or individual as the initial service coordinator. The ongoing service

coordinator is responsible for implementing the child's IFSP and all service coordination activities articulated in 10 NYCRR Section 69-4.6.

A child must exit the EIP and transition to other services by his or her third birthday, unless the child is eligible for preschool special education services under Section 4410 of the Education Law. Children found eligible for services under Section 4410 of the Education Law before their third birthday may transition to preschool special education services or remain in the EIP up to age 3 years 8 months, depending on the child's third birthday. The service coordinator is responsible for facilitating the child's transition from the EIP to preschool special education and/or other early childhood services.

It is anticipated that a subset of infants and toddlers eligible for the EIP also will be eligible for Health Home. The Health Home care management and EI service coordination roles and responsibilities for children eligible for both Health Home and EI will need to be determined. Options for defining Health Home and EI roles need to ensure that roles are clearly defined, duplicate Medicaid payments are not made for the same service, and there is no confusion (either from the Health Home or EI care provider, the family, or education system) about care management responsibilities.

The State is pursuing an approach under which the initial service coordinator role would be performed by the EI service coordinator and the ongoing service coordination function would be performed by the Health Home care manager. This approach would facilitate initial enrollment in the EI program and ensure that role resides with coordinators that currently have a full breadth and understanding of the EI program, while also allowing the Health Home care manager to fully integrate ongoing EI services into the overall care management plan (i.e., a plan that includes more than EI services) for the child.

Service coordination is an integral component of the EIP. Health Home care managers serving children enrolled in the Early Intervention Program will be required to adhere to all federal and state law and regulations pertaining to the delivery of EI service coordination.

The State Agency Partners will work closely with the DOH EI Team, the Early Intervention Council and local governments, including the New York State Association of County Health Officials, to provide information, guidance and training to the EI service coordinators and Health Home care managers regarding the programmatic requirements of the Health Home program and the EI program, the roles of the Health Home care manager and the EI initial service coordinator, and procedures regarding the transition between roles. It is anticipated that there will be paths for existing EI service coordinators to become Health Home care managers, and for Health Home care managers to obtain necessary DOH approval to provide ongoing EI service coordination.

School-Age Children

School-age students (between the ages of 5-21) participate in the educational system and are eligible to attend school until the end of the school year in which they turn 21 or receive a high school diploma, whichever occurs first. Students with disabilities may receive services and supports to address how the student's special needs related to his/her disability will be met within the context of an educational environment and to assist them in participating and progressing in the curriculum. These supports may be provided through an Individualized Education Plan (IEP) consistent with IDEA or through a Section 504 plan under the Rehabilitation Act of 1973.

Medicaid eligible children, including those with and without disabilities, who meet the eligibility requirements of the Health Home program, and their families, can benefit from the comprehensive care management services available through the Health Home program.

To operationalize this, education and training will be necessary for care managers to understand the special education process and for New York State Education Department (NYSED) staff (special education policy staff, regional associates, and others) and Directors of Special Education at the school district levels to understand the care management services offered under the Health Home Program.

Specifically, Health Home Program care managers would need to become familiar with the special education process, including the roles and responsibilities of the Committee on Preschool Special Education (CPSE) in the case of preschoolers or the Committee on Special Education (CSE) for children ages 5-21 years as related to evaluation and determination of student eligibility for special education programs and services and development, implementation and annual review of the students' IEP. In New York City, there may also be interface with the School Based Support Team.

In addition, the Health Home care manager would need an understanding of the special education system process for evaluation of students with special needs and development of IEPs that include recommendations for special education programs and services required by a student with a disability to succeed in the school environment. Health Home care coordinators would need to be familiar with relevant federal and State educational requirements for serving students with disabilities and the types of services that may be available for such students, including the procedures for referral for consideration of a review of their educational program.

Finally, under the Medicaid State Plan, Medicaid reimbursement is available for certain services provided to Medicaid eligible preschool and school age children receiving IEP services. This program is known as the Preschool/School Supportive Health Services Program (collectively, "SSHSP"). It is possible that some children who meet the Health Home eligibility criteria may also be receiving SSHSP services. Medicaid-reimbursable services under New York's SSHSP, for children with disabilities who are eligible for Medicaid, include:

- Physical therapy services

- Occupational therapy services
- Speech therapy services
- Psychological evaluations
- Psychological counseling
- Skilled nursing services
- Medical evaluations
- Medical specialist evaluations
- Audiological evaluations
- Special transportation services

The State will work with NYSED to provide training for NYSED staff and Health Homes.

The State will also be working with EI and SSHP to discuss ways in which those programs can help identify children eligible for Health Home, facilitate the Health Home referral process and develop the role of the Health Home care manager in coordinating EI and SSHSP services.

OASAS Treatment System

The OASAS Treatment system serves over 200,000 people a year with 29,000 of those being under the age of 21. These youth and young adults are served in a variety of settings: outpatient, inpatient rehabilitation, short and long term residential, as well as detoxification programs. Many of them have co-occurring mental health and/or physical health issues. Additionally, many have histories of physical/emotional trauma, family conflict or dysfunction, educational issues and involvement with the juvenile/criminal justice systems. Admission to OASAS treatment programs are based on the use of the Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) tool. The LOCADTR will serve as the only addiction treatment Level of Care determination tool approved for use with Medicaid Managed Care. OASAS regulations also require that all admissions have a LOCADTR assessment. It is anticipated that Health Homes may make referrals to the OASAS services based on a child CANS assessment, most of the time a referral to an outpatient program would be appropriate.

OASAS services focus on discontinuing substance/alcohol use, stabilization of crisis, adopting healthy lifestyles and choices, and successful integration with family and community. Participation in OASAS treatment programs is, by regulation, voluntary.

Youth 12 – 21 years of age can access the following types of services:

<u>OASAS Residential/Inpatient Services</u>
Substance Use Disorder Residential Rehabilitation Services for Youth (RRSY)
The RRSY program is designed specifically to serve youth with Substance Use Disorder and typically provide stabilization, rehabilitation and re-integration services to youth up to the age of 21. RRSY services are medically driven and Medicaid funded.

Substance Use Disorder Residential Services
Residential services provide an array of services for persons diagnosed with Substance Use Disorder. This service is currently not a Medicaid funded service, however, OASAS is currently in the process of submitting a State Plan Amendment that proposes to make the clinical portions of these services eligible for Medicaid reimbursement.

Substance Use Disorder Inpatient Services
These are traditional medically driven inpatient programs. There are a limited number of youth over the age of 16 who are treated in these programs each year.

OASAS Outpatient Services
Substance Use Disorder Outpatient and Opioid Treatment Programs
Substance Use Disorder Outpatient programs treat individuals with substance use disorders and /or co-occurring mental health disorders and their family member and/or significant others. There are no specific standards for youth programs, however, there are a number of programs that use evidenced based practices for youth and many only serve youth.

Other OASAS Services
Substance Use Disorder Withdrawal and Stabilization Services
Substance Use Disorder withdrawal and stabilization services are designed to provide a range of service options, that are the most effective and appropriate level of care, to persons who are intoxicated or incapacitated by their use of alcohol and/or substance. The primary purpose of withdrawal and stabilization services is the management and treatment of alcohol and/or substance withdrawal, as well as disorders associated with alcohol and/or substance use, resulting in a referral to continued care. Certified providers of alcohol/substance use withdrawal and stabilization services can be authorized to provide one or more of the following: medically managed withdrawal and stabilization services; medically supervised inpatient withdrawal and stabilization services; medically supervised outpatient withdrawal and stabilization services; and/or medically monitored withdrawal and stabilization services. Currently, there are a limited number of these programs that serve youth.

HIV/AIDS Services
Health Homes and Care Management providers working with children and adolescents who have been exposed to or infected with HIV need to be aware of treatment guidelines (http://www.hivguidelines.org) in the care and treatment of these youth. Keeping them engaged in care and treatment is essential to their continued health and ability to prevent the spread of infection. In addition, the transition to adult HIV services is critical to the young adult's ongoing stability.

Juvenile Justice System
Children eligible for Health Home may also be or may have been engaged with the juvenile justice system. Youth in New York State come into contact with the juvenile justice system in many ways. Some may be arrested or issued appearance tickets for breaking the law or some for the commission of "status" offenses (activities such as breaking curfew, drinking,

driving under the legally permissible age). In addition, youth who experience significant disciplinary concerns with their parents, guardians, or other authorities may access probation services at the request of their parents or the police as Persons in Need of Supervision (PINS).

Youth who are arrested for criminal offenses may be released, or detained in a local juvenile detention center. The County Probation Offices conduct assessments on both PINS and arrested youth, and some will be diverted from further processing. Arrested youth age 15 or younger and PINS youth less than age 18 may have a petition filed with family court. Youth who commit very serious offenses may be processed in adult criminal court.

Youth who are adjudicated juvenile delinquents may be placed on probation, assigned to an alternative to probation, placed with OCFS Division of Juvenile Justice and Opportunities for Youth (DJJOY) or Local Departments of Social Service (LDSS). The majority of youth placed with OCFS DJJOY or through the LDSS are released into the community and often have one or more chronic conditions (e.g., behavioral health care needs and/or substance abuse diagnoses) that may make them eligible for Health Home services.

The State is exploring mechanisms to establish connectivity between Health Homes and the juvenile justice population. Health Home care managers will need to establish relationships with OCFS DJJOY, LDSS and County Probation Offices.

Office of Mental Health Services

Health Home Care Coordinators will need to familiarize themselves with the NYS Office of Mental Health treatment and community support system, to provide the best services for Health Home members.

Treatment Services

> **Clinic treatment** programs offer traditional outpatient mental health services such as assessment, individual, family, and group therapies and medication management. Treatment is offered from a variety of sites including schools, community offices and other locations.
>
> **Day treatment programs** provide services designed to stabilize children's adjustment to educational settings, to prepare children to return to educational settings, and to transition children to educational settings. The programs are characterized by a blend of mental health and special education services provided in a fully integrated, community-based program. Typically, these programs include special education in small classes with an emphasis on individualized instruction, individual and group counseling, family services such as family counseling, crisis intervention, interpersonal skill development, and behavior modification. Children and adolescents receiving day treatment services live at home or in the community but are identified by their school district as seriously emotionally disturbed and cannot be maintained in regular classrooms.

Residential Treatment Facilities are designed to provide individualized, active mental health treatment to children and adolescents with a severe emotional disturbance within an intensively staffed residential setting.

Inpatient services are hospital-based programs that offer a full range of treatment and support services, client education, and skill acquisition in an intensively supervised, structured setting. Programs exist in general hospitals (Article 28), freestanding psychiatric hospitals (Article 31) and State Children's Psychiatric Centers.

Community Support Services

Home and Community Based Services Waiver (HCBS) enable children to remain at home, and/or in the community, thus decreasing institutional placement. The target population of children eligible for the waiver are children with a diagnosis of serious emotional disturbance who without access to the waiver would be in psychiatric institutional placement. The HCBS waiver includes services not otherwise available in Medicaid: Crisis Response Service; Intensive In-home Services; Respite Care; Family Support Services; and Skill Building Services.

Single Point of Access (SPOA) for children and families is to identify those children with the highest risk of placement in out-of-home settings and to develop appropriate strategies to manage those children in their home communities. Each local government in New York State has designated a SPOA for Children and Families.

Community Residences provide a supervised, therapeutic environment for six to eight children or adolescents, between the ages of 5 and 18 years, that includes structured daily living activities, problem solving skills development, a behavior management system and consistent adult interactions.

Family support services programs provide an array of services to support and empower families with children and adolescents having serious emotional disturbances. Services include but are not limited to education and information, individual advocacy, family support groups, respite, and family recreation events.

Home and Community Based Services (HCBS) and State Plan Services

The Children's Medicaid Redesign Team (MRT) Behavioral Health Subcommittee has made recommendations that will make a wider array of services available to children eligible for Medicaid.

The MRT Subcommittee has recommended the Medicaid benefits authorized in the State Plan (and available to all children/youth enrolled in Medicaid) be expanded to include Crisis Intervention, Community Psychiatric Supports and Treatment (CPST), Other

Licensed Practitioner, Family Peer Support Services, Youth Peer Advocacy and Training, and Psychosocial Rehabilitation. In addition, the Subcommittee has recommended the following list of Home and Community Based Services be made available to children who meet Level of Need criteria and are not eligible for medical institutional care (to be determined) and children who qualify for institutional Level of Care or are at risk of medical institutional placement.

> **Recommended HCBS Services:** Skill Building, Family/ Caregiver Supports and Services, Crisis Respite, Planned Respite, Prevocational Services, Supported Employment, Community Advocacy and Support, Non-Medical Transportation, Day Habilitation, Adaptive and Assistive Equipment, Accessibility Modifications, Palliative Care and Care Coordination (for children not enrolled in or eligible for Health Home). The intensity of service to be provided has not yet been determined. However, it is anticipated the intensity of services to be provided will be congruent with functional criteria and that most of the children eligible for Health Home will be eligible for such services.

The State plans to submit to CMS the 1115 Behavioral Health Children's Amendment in early 2015 and a State Plan Amendment that will include the new State Plan services (for which all Medicaid children would be eligible) and the eligibility criteria for the HCBS services listed above. Subject to CMS approval, it is anticipated that these services will be available as part of the transition to Managed Care on January 1, 2016.

As these services will be helpful in implementing a comprehensive care management plan for children in Health Homes, Health Homes will be expected to become familiar with HCBS services and providers, include HCBS providers in their network, and include the services in the development of care plans where appropriate. The State will also provide training regarding the requirements of Health Home care managers that provide care planning to members that are eligible for and receive HCBS services.

Other Health Home for Children Design Considerations

Functional Assessments and CANS-NY

Consistent with input received from stakeholders children enrolled in Health Homes will be required to be assessed using the Child and Adolescent Needs and Strengths Assessment of New York (CANS-NY). The CANS-NY is a decision support tool with standardized language that will assist the care manager in developing a care plan and determining appropriateness for Health Home. The use of the CANS-NY does not preclude the use of other clinical or health assessment or evaluative tools by care managers or other providers to assist them in developing care plans or determining Health Home eligibility, and evaluating the need for services on an ongoing basis.

The State has begun to work collaboratively with the author of the CANS-NY to revise the tool to assist with eligibility determination for new HCBS services, needs and strengths identification that incorporates all domains (and child serving systems), that will guide the plan of care development and acuity level (see discussion below regarding Health Home

Payments). To better capture the various children's populations that would be eligible for Health Home and HCBS services, modifications to CANS-NY now being developed include:

- Modules specific to the 0-5 and 6-21 age groups;
- Inclusion of a module related to sexuality and sexual orientation;
- Modules relating to Activities of Daily Living and Instruction on Activities of Daily Living to be in compliance with the Balancing Incentive Program; and
- Enhancements to better assess medically fragile children.

This work will also help better inform the development of the Health Home per member per month rates which will use the CANS-NY to determine levels of acuity (High, Medium, Low). (See Health Home Payments, Case Load Size and Transitional Provisions for more information.)

High Fidelity Wraparound Care Management

As part of the Draft Application, the State sought stakeholder input on whether Health Homes should employ the High Fidelity Wraparound (HFW) care management 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. HFW is consistent with the delivery of the core Health Home services described in this Application, but it requires a low care manager to child ratio (1:10); frequent and intensive engagement between the care manager and child/family; and certification, training and monitoring to ensure fidelity to the model. HFW Care coordination also uses:

- A care manager who facilitates the formation of a child and family team that develops, implements and monitors one integrated plan of care across child-serving systems. The care planning process, which is driven by the child and family, results in a plan of care which accounts for all of the child's health, behavioral health educational/vocational, child welfare and justice-related goals, in addition to goals that address the social services needs of the family.
- A Family Support Partner who helps the parent(s)/caregiver(s) navigate the various service systems and ensure that their perspective is represented throughout the process, consistent with the parents/caregivers' preferences and desires. The Family Support Partner is treated as an inherent part of the HFW care coordination process, rather than as a service named in the plan of care.

Stakeholders generally endorsed employing the High Fidelity Wraparound model. The State will work to explore how the High Fidelity Wraparound model may be integrated and phased into the Health Home model. Considerations for integrating the High Fidelity Wraparound model include developing, eligibility criteria, operational and cost considerations for developing a program and providing statewide access to small group of children, and evaluation and quality monitoring (i.e., maintaining fidelity to the model). For more information on HFW please see http://www.nwi.pdx.edu.

Health Home Payments, Case Load Size and Transitional Provisions
The State is continuing to develop Health Home care management rates for children. The framework under which the proposed rates are being developed includes the following considerations:

- Similar to the approach used to transition Adult Targeted Case Management Programs to Health Home, legacy care management payments will be developed for OMH Children's Targeted Case Management Programs and those rates will remain in effect for two years. In addition, legacy care management rates for Waiver providers will be developed for the programs that will begin to transition to Health Home in January 2016 and those rates will remain in effect for two years.

- A tiered rate structured (e.g., High, Medium, Low) is being developed that is based upon, and would be responsive to changes in, the acuity/functional status of the child.
    - As described in more detail above, the State is working to modify the current CANS-NY assessment tool and to develop an algorithm or methodology that will use the CANS-NY to determine acuity and assignment to a rate tier.
    - Development of the tiered rates will consider acuity as determined by the CANS-NY algorithm now under development, case load size (lower case loads tied to higher acuity and higher rates, higher caseloads tied to lower acuity and lower rates).
    - The tiered rate structure would be effective beginning October 2015 and would be the mandated government rates in effect under the first two years of Managed Care (i.e., 2016 and 2017, with 2016 being the effective date for moving the behavioral health benefit and HCBS services into Managed Care).
- The current per member per month rate for "outreach" activities will be modified to be flat rate and will also apply to outreach activities for children. Billing procedures for outreach activities will reflect current rules and guidance regarding outreach.

Health Homes/and Managed Care Plans have the capability to negotiate alternative payment arrangements if the Health Home, Managed Care Plan and State agree to such alternative.

Standards for Care Managers and Background Checks
Stakeholders generally supported establishing qualifications for care managers and other standards of engagement, including requiring background checks. Stakeholders also raised the need to preserve flexibility to make operational decisions that best reflect the mix of children served at individual Health Homes and were cautious about requirements that were administratively burdensome and time consuming.

Given the desired approach to keep case load ratios as low as practicable, particularly for those children with more intensive needs (acuity level of high or that may be in HFW when implemented) and the level of experience required to meet the care management needs of this group, the State is requiring that care managers that serve children with acuity level of "high" as determined by the CANS-NY or in HFW when implemented 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 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.

In addition, care managers providing services to:

- High acuity children (as determined by the CANS-NY as modified) would be required to keep their caseload mix predominantly to children of the High acuity level (and HFW when implemented)
- Medium and high acuity children (as determined by the CANS-NY tool as modified) will be required to provide two Health Home services per month, one of which must be a face-to-face encounter with the child.

As New York reviews the proposed 1115 amendment with CMS and negotiates terms and conditions, it is anticipated that some of the HCBS requirements will impact the responsibilities of Health Home Care Coordinators and may require a change in the standards described above. HCBS requirements that may impact Health Home care managers could include training requirements for care managers, and specific aspects of patient centered planning (e.g., who must sign the service plan). Health Homes will be informed of these requirements as soon as they are

determined and will be provided necessary training and information related to HCBS services and such requirements.

The State is also interested in exploring establishing consistent requirements regarding background screening (i.e., Criminal History Records Checks against the NYS Division of Criminal Justice Services (DCJS) database, the NYS DCJS Sex Offender Registry, the Statewide Central Register of Child Abuse and Maltreatment (SCR), and the Medicaid Exclusion and Termination list) for any care coordinator that will be serving children. Currently, there are requirements across the State agencies' programs and authorities that do not provide the desired consistency. The State will continue to update and consult with Health Homes, providers and stakeholders as these requirements are developed over the next several months.

Data Collection and Tracking Requirements and the Development of Medicaid Analytics Performance Portal

Health Homes and their network partners serving children will be expected to have the capability to submit files documenting enrollment status through the existing Health Home Member Tracking System (HHMTS). Specifications for the HHMTS may be found at http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_information.htm.

In addition, Health Homes and their network partners serving children will be required to submit, on a quarterly basis, process data on the delivery of Health Home care management services through the Health Home - Care Management Assessment and Tracking Systems (HH-CMART).

In addition, Health Home will, to the extent necessary, be required to collect data and report on specific quality measures required by the State and/or CMS, including those defined below under "Quality Measures."

Note that both the HHMTS and the HH-CMART will begin transitioning to a comprehensive web-based portal, known as the Medicaid Analytics Performance Portal (MAPP) that is now under development. The MAPP will also include a comprehensive set of tools for performance and population management. Health Homes and care managers will be provided with training and technical assistance to utilize these tools and to transition member tracking and reporting to the MAPP. The design of MAPP anticipates the development of features for children, including Health Home rates for children and connectivity to the CANS-NY assessment tool, a referral portal, and the incorporation of children's quality measures. It is anticipated these features will be available for testing and training prior to the October 2015 enrollment of children in Health Homes.

Currently, Health Homes are required to complete and submit scores on a functional assessment known as the FACT-GP as well as a brief functional Health Home questionnaire. These tools have not been validated for children. The State anticipates that the CANS-NY tool, including modifications now being developed, will be conducted for Health Home children, in lieu of the FACT-GP and functional Health Home questionnaire.

Quality Measures
A critical component to providing effective care management to children will be the ability of Health Homes, care managers, Managed Care Plans, systems of care, families, providers and the State to effectively evaluate and monitor the quality of care and health outcomes of children.

In addition to the quality measures included in the current State Plan and Health Home Core Set of Quality Measures required by CMS which can be applied to or measured for children, the State is considering using the following list of quality measures to track performance and help Health Homes, care managers and Managed Care Plans manage to quality outcomes. Please see the link below to review the CMS Health Home Core Set of Quality Measures:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/smd-13-001-hh-qm.pdf
Please see the link below to review the State Plan quality measures:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/spa13-18.pdf.

Some or the entire list could be added to the list of quality measures included in the State Plan, but the intent would be to use all the quality measures below to help evaluate performance. The list of measures provided in the table below are measures for which data is available and thus no additional data collection efforts are necessary.

The State anticipates that the list of quality measures will evolve over time and that the development of MAPP will also facilitate the collection and analysis of performance and quality measures. The measures below have been modified from those presented in the draft application to include three new anti-psychotic medication use measures that have been added to QARR. In addition, the State intends to integrate CANS-NY assessment tool in to systems (i.e., UAS, Medicaid Analytics Performance Portal) that will further facilitate the ability to use information from the CANS-NY to evaluate outcomes of children enrolled in Health Home and other children enrolled in Medicaid evaluated by the use of CANS-NY.

NEW Quality Measures	
Measure Name	**Measure Source/Other Programs that Use Measure**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents	QARR, CMS Pediatric Recommended Core Measures, CHIPRA
Appropriate Treatment for Children with Upper Respiratory Infection	QARR, CMS Pediatric Recommended Core Measures
Appropriate Treatment for Children with Pharyngitis	QARR, CMS Pediatric

NEW Quality Measures	
Measure Name	**Measure Source/Other Programs that Use Measure**
	Recommended Core Measures, CHIPRA
Childhood Immunization Status	QARR, CMS Pediatric Recommended Core Measures
Immunization for Adolescents (Combination 1)	QARR
Annual Dental Visit	QARR
Well-Child Visits in the First 15 Months of Life	QARR
Well-Child Visits in the 3rd, 4th, 5th & 6th Year	QARR
Adolescent Well-Care Visits and Preventative Care	QARR
Lead Testing	QARR
Follow Up After Hospitalization for Psychiatric Reasons	QARR
Medication Management for Asthma 75% (ages 5 – 18)	QARR
Asthma Medication Ratio (ages 5 - 18)	QARR
Follow Up Care for children Prescribed ADHD Medication: Initiation and Continuation	QARR
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	QARR
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	QARR
Metabolic Monitoring for Children and Adolescents on Antipsychotics	QARR

Consent Procedures and Meeting Health Information Technology Core Service Requirements

Currently, the Health Home program uses a uniform Health Home Patient Information Sharing Consent form for Medicaid members to provide their consent to join a Health Home and to authorize the Health Home and the partners listed on the form to receive and exchange all of the Medicaid member's health information. (The current form may be viewed at http://www.health.ny.gov/forms/doh-5055.pdf).

The State will be working to develop a Health Home Patient Information Sharing Consent form for children. The State's goal, to the extent possible, is to develop a uniform consent form. The form will recognize the rights of minors to consent to certain types of health care without the permission of their parent/guardian/authorized representative and to whether parents/guardians/authorized representatives or others can access their health information.

The Department of Health recognizes that technology does not currently allow for segmentation of electronic health care information. This can be a barrier to electronic

sharing of sections of a Health Home member's care plan. With this in mind, it may be necessary for Heath Home care managers to share patient health information for minors using non-electronic means. These non-electronic means can be temporarily used until technology allows for the segmentation of electronic health care information. See Part II, section E, "Use of Health Information Technology (HIT) to Link Services" of this Application for additional information and requirements.

To authorize the Department to share certain information (e.g., assignment lists) with lead Health Homes prior to member consent, newly Designated Health Homes will be required to complete and submit a Data Exchange and Application Agreement (DEAA) with the Department. In addition, Health Home network partners that may receive member lists prior to member(s) consenting to Health Home services will also be required to complete a DEAA subcontractor packet with the designated Health Home.
Please see the following link for Health Home Medicaid Provider Enrollment Requirements:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/medicaid_enroll_prov-led_hh_rev.htm