Instructions to the Applicant

This Application is for currently designated Health Homes and other Medicaid providers seeking State designation to provide care management under the New York State Health Home model as tailored to serve the unique needs of children. Responses to this Application will be used to assess your organization's ability to become a Designated Lead Health Home Serving Children. Supplemental information may be provided to and/or requested from your organization to comply with additional provisions that may be developed as the design of the Health Home model to serve children evolves, the behavioral health and Health Home benefit moves to managed care and additional program rules regulations and policies are promulgated by the Centers for Medicare and Medicaid Services (CMS) or by the State. This Application is due March 2, 2015.

Electronic Submission of Applications

All Applicants must submit this Part II of the Application and the Health Home Provider Network Form (http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_network_partner_list_template.xlsx) electronically. Due to the length of the Application, it is advised that you periodically save your work. Prior to submitting your Application please ensure that you have responded to every field. Attach the completed Application, Health Home Provider Network Form, and a signed cover letter from an authorized representative in an email addressed to hhsc@health.ny.gov. In the subject of line of the email please indicate "Submitted Application – [YOUR ORGRANIZTION'S NAME]". This Application is due March 2, 2015.

Application Information

Organization Name:

NPI#:

Corporation Name (optional):

Correspondence Address:

City:

Zip Code:

County:

Licensure /Certification Number:

Pay-To-Address:

City:

Zip Code:

Organization Contact Person:

Title:

Telephone Number:

E-mail:

Proposed Health Home Service Region: Please indicate any county (either in whole or in part) in which you intend to provide Health Home services for children.

Northern:

- ☐ Not Serving Region
- ☐ Albany
- ☐ Clinton
- ☐ Columbia
- ☐ Essex
- ☐ Franklin
- ☐ Fulton
- ☐ Greene
- ☐ Hamilton
- ☐ Montgomery
- ☐ Otsego
- ☐ Rensselaer
- ☐ Saratoga
- ☐ Schenectady
- ☐ Schoharie
- ☐ Warren
- ☐ Washington

Central:

- ☐ Not Serving Region
- ☐ Broome
- ☐ Cayuga
- ☐ Chemung
- ☐ Chenago
- ☐ Cortland
- ☐ Herkimer
- ☐ Jefferson
- ☐ Lewis
- ☐ Livingston
- ☐ Madison
- ☐ Monroe
- ☐ Oneida
- ☐ Onondaga
- ☐ Ontario
- ☐ Oswego
- ☐ Seneca
- ☐ Schuyler
- ☐ St. Lawrence
- ☐ Steuben
- ☐ Tioga
- ☐ Tompkins
- ☐ Wayne
- ☐ Yates

Western:

- ☐ Not Serving Region
- ☐ Allegany
- ☐ Cattaragus
- ☐ Chautauqua
- ☐ Erie
- ☐ Genessee
- ☐ Niagara
- ☐ Orleans
- ☐ Wyoming

Hudson Valley:

- ☐ Not Serving Region
- ☐ Delaware
- ☐ Dutchess
- ☐ Orange
- ☐ Putnam
- ☐ Rockland
- ☐ Sullivan
- ☐ Ulster
- ☐ Westchester

NYC:

- ☐ Not Serving Region
- ☐ Manhattan
- ☐ Brooklyn
- ☐ Queens
- ☐ Bronx
- ☐ Staten Island

Long Island:

- ☐ Not Serving Region
- ☐ Suffolk
- ☐ Nassau

Who May Submit a Health Home for Children Application
Current Health Homes may apply to expand their network to 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 below, Applicants will be required to meet all the qualifications of the State Plan Amendment authorizing Health Homes, including the Health Information Technology standards.

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 and qualifications to serve children; the demonstrated ability to tailor the delivery of the six core services to the needs of children in a manner that adheres to the "Principles for Health Homes Serving Children" and other provisions outlined in Part I of the Application; and overall access to children's Health Home services across the State.

Notification Process
The State will formally notify each applicant of the disposition of their Application. The State may also request applicants to submit additional information or may require applicant to take prescribed actions to demonstrate adequacy or operational readiness.

General Directions
Please note that responses to all required questions must be thorough and complete. Responses must be fully contained within this electronic Application, except where specifically otherwise indicated. In completing your Application, please consider the information and requirements provided in Part I of this Application.

Section A
Governance Structure
Please check the appropriate box:

- ☐ You are a Designated Lead Health Home (i.e., you are now operating a Lead Health Home designated by the State) and your Application to serve children does not include a change in your current governance structure. In the space provided below, please indicate if your existing governance structure includes providers that specialize in children's services and, if so, identify those providers.
- ☐ You are a Designated Lead Health Home and your Application includes an anticipated change to your governance structure to better serve children. In the space provided below, please describe in detail the nature of the change in governance and how it will improve and enhance the ability of your Health Home to serve children. Please indicate if your existing or proposed governance structure includes providers that specialize in children's services and, if so, identify those providers.
- ☐ You are an organization(s) seeking a new Lead Health Home Designation. Please describe the governance structure of your proposed Health Home to Serve Children including providers that specialize in children's services. In the space provided below, please describe in detail if your Health Home network of providers will be designed to primarily serve children or to serve children and adults, or the extent to which you plan to serve adults.

1. Please provide your response here. Limit 3,000 characters.

General Qualifications

As described in more detail below, Health Home Applicants will be required to meet the infrastructure standards and qualifications, address the Health Home functional components, and deliver the core Health Home services 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). In addition, Applicants will be required to demonstrate their ability to tailor the State Plan requirements to serve the unique needs of children.

Other general qualifications include the following:

I. Health Home providers must be enrolled (or be eligible for enrollment) in the NYS Medicaid program and agree to comply with all Medicaid program requirements.

II. Health Home providers can either directly provide, and/or subcontract for the provision of, Health Home care management services. In the case of children in foster care, Voluntary Foster Care Agencies will provide the care management (see the "Health Home Care Management for Children in Foster Care" section of this Application for additional information). The Health Home provider remains responsible for all Health Home program requirements, including services performed by the subcontractor.

III. Care coordination and integration of heath care services will be provided to all Health Home enrollees by an interdisciplinary team of providers, where each individual's care is under the direction of a dedicated care manager who is accountable for assuring access to medical and behavioral health care services and community social supports as defined in the enrollee care plan.

IV. Hospitals that are part of a Health Home network must have procedures in place for referring any eligible individual with chronic conditions who seeks or needs treatment in a hospital emergency department to a DOH designated Health Home.

V. Health Homes primarily serving children or Health Homes serving both children and adults must establish communication and transitional procedures to ensure effective communication between care managers serving children and those serving adults. Procedures must reflect and acknowledge member choice. Please see Part I of this Application for additional information.

2. Please acknowledge you have read and understand these general qualifications and provide any information or identify existing procedures or actions you will take to demonstrate you meet these qualifications.

Section B
General Experience

1. Provide a general description of the current experience your Health Home (including your lead partners) or your organization (if you are not currently a designated Health Home) has in providing integrated services to children. Limit 3,000 characters.

2. Identify the health care professionals and other members of your current interdisciplinary Health Home team that will provide care management and coordination of integrated services to children in your current Health Home network (as of the date of the release the Application) or your organization (if you are not currently a designated Health Home) with expertise in serving children. Describe the nature of their current expertise in serving children in a family and youth-driven model. Limit 3,000 characters.

3. Describe the nature of any current relationships your Health Home or your organization has established with the child welfare, local government units, education, foster care or juvenile justice systems. Limit 3,000 characters.

Section C
Capacity

1. Please provide information regarding the anticipated capacity of your Health Home to serve children (i.e., How many children can your proposed structure initially serve? How do you plan to grow capacity over time?). Limit 3,000 characters.

Section D
Network Requirements
As part of the requirements of this Application, currently designated Health Homes must affirm that the current network of providers as filed with the Department of Health is accurate and complete as of the due date of this Application. Please note it is not necessary that the network of providers on file as of the due date of this Applications include the additional providers that are identified by you in this Application to serve children. Note that as part of the Application review process, the State will collectively consider your network on file and the additional network providers submitted with this Application.

It is expected that Applicants which are currently designated Health Homes will expand their network of providers, as described in more detail below, to ensure access to care managers and services, including an interdisciplinary team, that can meet the complex needs of children.

Applicants that are not currently designated Health Homes will need to ensure their proposed Health Home networks have the breadth of providers required to serve children and/or adults as indicated by the Applicant in Section B and D of this Application. In addition to the network requirements described below for serving children, the proposed networks of Applicants who are not currently designated Health Homes should include managed care plans, medical providers (e.g., hospitals, substance use disorder providers, primary care practitioners, clinics, ambulatory care, preventive and wellness care, patient centered medical homes, pharmacies/medication management services, and Federally Qualified Health Centers, specialists, psychiatrists and psychologists, and home care services); behavioral health care providers (e.g. acute and outpatient mental health, substance use disorder treatment services and rehabilitation providers, etc.); and community based organizations and social services providers (e.g., public assistance support services, housing services, foster care agencies); and former targeted case management entities (OMH TCM, Managed Addiction Treatment Services (MATS), HIV/AIDS COBRA TCMs).

1. All Applicants must use the form provided herein to provide a comprehensive list of its Health Home provider network. The Health Home Provider Network Form, Attachment C (http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_network_partner_list_template.xlsx) requires the following network partner information: Health Home Name and Health Home Provider ID in cells B2 and B3. Below these fields, please add each partner name in a separate row with their NPI, the date the partner joined the HH network, and indicate the network partner service type with "y" for yes or "n" for no. Each network partner service type must have either a "y" or "n" for each field. If there are any blanks the worksheet will notify an error. Errors will be summarized for the Applicant in the yellow highlighted fields “Summary of line Errors”. Please include both entities (i.e. hospitals, clinics, community organizations) and individual providers (i.e. physicians, psychologist). Please do not add any additional columns to the excel worksheet. As noted above, currently designated Health Homes will not be required to restate their existing networks in the Application, provided they affirm the network partner list they have submitted to the Department of Health is both accurate and current.

The following is a list of types of service providers, developed in consultation with stakeholders, Applicants should consider in developing a comprehensive network to serve the unique and complex needs of children eligible for Health Homes. The breadth and comprehensiveness of the network (along with the proposed region of service and access to providers) will be a focus of the evaluation of each Application.

Care Managers with Expertise in Serving Children

- Persons and entities that have experience in providing care management for children, including Voluntary Foster Care Agencies, Bridges to Health (B2H), OMH Targeted Case Management providers (Intensive Case Management, Supportive Case Management, Blended Case Management), Managed Addiction Treatment Services (MATS), OMH HCBS Waiver agencies, Care at Home Waiver Agencies, and HIV COBRA TCM programs and Early Intervention service coordinators.

- Voluntary Foster Care Agencies. 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 Health Home 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 care manager for Health Home services are limited to payment for those 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 to provide a care manager in its network.

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 that transition in and out of foster care that consider continuity of care and the best interests of the child and family.

Providers with Expertise in Serving Children

- Pediatric Health Care and Specialty Providers, including:
  - Primary Care
  - Developmental Health
  - Behavioral Health
  - Substance Use Disorder Services
  - HIV/AIDS
  - Dental and orthodontics
- Children's Hospitals
- Tertiary Care Hospitals for Children
- Local Departments of Social Services (LDSS)
- Local Departments of Health and/or Mental Hygiene
- Local Governmental Units (LGUs)
- School-based Health Centers and School-based Mental Health Clinics
- Waiver Service providers (as services become authorized under the 1115 Waiver)
- Youth and Family Peer Supports
- Respite Providers
- OMH designated/certified/licensed programs (Children's Community Residences, Children's Day Treatment, Residential Treatment Facilities, Article 31 Clinics)
- OASAS certified programs(Intensive Residential Services, Chemical Dependence Inpatient Rehabilitation, Residential Rehabilitation Services for Youth, Article 32 Clinics)
- Housing providers with expertise in providing housing for families
- Obstetrics and Gynecology

Provider List

To assist Applicants, the State has prepared the attached draft list of providers (see Attachment B) with expertise in providing care management and other services to children. Please note the State worked collectively across agencies to attempt to prepare a comprehensive list of providers. However, if we have inadvertently missed a provider that should be added to the list please inform the state via email at hhsc@health.ny.gov.

Standards for Care Managers and Background Checks

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 High Fidelity Wraparound (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
- Be a Registered Nurse with two years of relevant experience, or
- A Masters with one year of relevant experience.
- 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);
(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;
(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;
(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 as these requirements are developed over the next several months.

Connectivity with Systems of Care that Impact Children

As part of building or expanding a Health Home network to serve children, Health Homes must demonstrate connectivity to the systems of care that serve children. In addition to Voluntary Foster Care Agencies and LDSS, Local Government Units, and County Single Point of Access (SPOA), Health Homes need to establish regional relationships with the juvenile justice system, Early Intervention and the educational system (i.e., Committee on Preschool Special Education (CPSE) and Committee on Special Education (CSE)).

2. Please describe how your Health Home will establish and maintain connectivity with the systems of care. Limit 3,000 characters

Definition of “Family”

For purposes of 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, 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 the age of 21.

Section E
Providing and Tailoring the Provision of Core Health Home Requirements to Meet the Needs of Children

The State Plan (please see http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/spa13-18.pdf) and Section 1945 (h) (4) of the Social Security Act defines Health Home services as "comprehensive and timely, high quality services" and includes the following Health Home services that must be provided by designated Health Home providers:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support, which includes authorized representatives;
- Referral to community and social support services, if relevant; and
- The use of HIT to link services, as feasible and appropriate

The current State Plan specifies and requires Health Homes to meet the following core Health Home requirements described below.
As indicated below, please describe how the provision of each of the following Core Health Home requirements will be delivered and tailored to meet the complex needs of children eligible for Health Homes. Your responses should clearly demonstrate the level of competency and skill that will be provided in delivering the core requirements.

1) Comprehensive Care Management
Policies and procedures are in place to create, document, execute and update an individualized, patient centered plan of care for each individual.
1a. A comprehensive health assessment that identifies medical, mental health, chemical dependency and social service needs is developed.
1b. The individual's plan of care integrates the continuum of medical, behavioral health services, rehabilitative, long term care and social service needs and clearly identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager and other providers directly involved in the individual's care.
1c. The individual (or their guardian) play a central and active role in the development and execution of their plan of care and should agree with the goals, interventions and time frames contained in the plan.
1d. The individual's plan of care clearly identifies primary, specialty, behavioral health and community networks and supports that address their needs.
1e. The individual's plan of care clearly identifies family members and other supports involved in the patient's care. Family and other supports are included in the plan and execution of care as requested by the individual.
1f. The individual's plan of care clearly identifies goals and timeframes for improving the patient's health and health care status and the interventions that will produce this effect.
1g. The individual's plan of care must include outreach and engagement activities that will support engaging patients in care and promoting continuity of care.
1h. The individual's plan of care includes periodic reassessment of the individual needs and clearly identifies the patient's progress in meeting goals and changes in the plan of care based on changes in patient's need

To the extent the High Fidelity Wraparound approach is employed for a defined subset of Health Home eligible children (see Part I of this Application for more information), Health Homes care managers would also be required to:

- Receive training and certification in High Fidelity Wraparound
- Convene a multidisciplinary Child and Family Team, which includes a family support partner consisting of both service providers and natural supports, to develop and implement an individualized, strength-based plan of care
- Ensure there is one care plan per child/family which integrates all of the child's health, behavioral health, educational/vocational, child welfare and justice-related goals, plus goals to address the social services needs of the family. It should also include strategies to help the family to identify and increasingly draw upon natural supports over time.

Examples of activities that constitute providing comprehensive care management under the Health Home model include:

- Completing a comprehensive assessment, inclusive of medical, behavioral, rehabilitative and long term care and social service needs.
- Completing and revising, as needed, the child's person centered, family-focused, plan of care with the child and family to identify the child's needs and goals, and include family members and other social supports as appropriate.
- Consulting with multidisciplinary team, primary care physician, and specialists on the child's needs and goals.
- Consulting with primary care physician and/or specialists involved in the treatment plan.
- Conducting clinic outreach and engagement activities to assess on-going and emerging needs and to promote continuity of care and improved health outcomes.
- Preparing crisis intervention plans.

Comprehensive Care Management

1. Describe how your Health Home plans to deliver and tailor the services and activities listed above to serve children. Limit 3,000 characters.

2. Provide a description of the proposed care manager position for children, including professional discipline/qualifications, and relevant education, training and experience. Please note the "Standards for Care Managers" described above. Limit 3,000 characters.

3. Describe how the approach to care management will be family-and-youth driven, and how it will support a system of care that builds upon the strengths of the child and family. Limit 3,000 characters.

4. Describe your approach to collaborating with a multi-disciplinary team to develop a plan of care and how the parent, guardian, and family will be involved in the development of the care plan. Limit 3,000 characters.

5. Describe your approach and procedures for ensuring the LDSS, (which has custody of the child while in foster care) and the Voluntary Foster Care Agency will provide care management for children in foster care and how that care manager will interact with the Health Home. Limit 3,000 characters.

6. Describe how the care manager will interact with other systems of care for children (education, juvenile justice) and how they will be incorporated in the multi-disciplinary team. Limit 3,000 characters.

2) Care Coordination and Health Promotion

2a. The Health Home provider is accountable for engaging and retaining Health Home enrollees in care; coordinating and arranging for the provision of services; supporting adherence to treatment recommendations; and monitoring and evaluating a patient's needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services where appropriate through the creation of an individual plan of care.

2b. The Health Home provider will assign each individual a dedicated care manager who is responsible for overall management of the patient's care plan. The Health Home care manager is clearly identified in the patient record. Each individual enrolled with a Health Home will have one dedicated care manager who has overall responsibility and accountability for coordinating all aspects of the individual's care. The individual cannot be enrolled in more than one care management program funded by the Medicaid program.

2c. The Health Home provider must describe the relationship and communication between the dedicated care manager and the treating clinicians that assure that the care manager can discuss with clinicians on an as needed basis, changes in patient condition that may necessitate treatment change (i.e., written orders and/or prescriptions).

2d. The 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.

2f. The Health Home provider supports continuity of care and health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers.

2g. The Health Home provider supports care coordination and facilitates collaboration through the establishment of regular case review meetings, including all members of the interdisciplinary team on a schedule determined by the Health Home provider. The Health Home provider has the option of utilizing technology conferencing tools including audio, video and /or web deployed solutions when security protocols and precautions are in place to protect PHI.

2h. The Health Home provider ensures 24 hours/seven days a week availability to a care manager to provide information and emergency consultation services.

2i. The Health Home provider will ensure the availability of priority appointments for Health Home enrollees to medical and behavioral health care services within their Health Home provider network to avoid unnecessary, inappropriate utilization of emergency room and inpatient hospital services.

2j. The Health Home provider promotes evidence based wellness and prevention by linking Health Home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self-help recovery resources, and other services based on individual needs and preferences.

2k. The Health Home provider has a system to track and share patient information and care needs across providers and to monitor patient outcomes and initiate changes in care, as necessary, to address patient need.

To the extent the High Fidelity Wraparound approach is employed for a defined subset of Health Home eligible children (see Part I of this Application for more information), Health Homes care managers would also be required to facilitate development of a child and family team and individualized plan of care; monitor and update the plan of care in conjunction with the family team, maintain a 1:10 caseload ratio, and meet specific standards for meeting with and contact with the child/family.

Examples of activities that constitute providing Care Coordination and Health Promotion under the Health Home model include:

- Coordinate with service providers and health plans to secure necessary care, share crisis intervention and emergency information.
- Coordinate with treating clinicians to assure that services are provided and to assure changes in treatment or medical conditions are addressed.
- Conduct case reviews with the child/family and interdisciplinary team to monitor/evaluate client status/service needs.
- Crisis intervention – revise care plan/goals as required.
- Advocate for services and assist with scheduling of services.
- Monitor, support, and accompany the child and family to scheduled medical appointments.
- Provide conflict free case management.

Care Coordination and Health Promotion

1. Describe how your Health Home plans to deliver and tailor the services and activities listed above to serve children. Limit 3,000 characters.

2. Describe any approaches you would take to promote the health of the child and the family as a unit, including how your Health Home would approach the delivery and coordination of care management to a child and a parent who may either be concurrently enrolled or eligible for Health Home. Limit 3,000 characters.

3. Describe your processes for ensuring there is 24 hour access to the Care Manager. Limit 3,000 characters.

4. Describe the process and time frames for providing crisis intervention for both medical and behavioral health events. Limit 3,000 characters.

3) Comprehensive Transitional Care

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

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

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

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

Examples of activities that constitute providing Comprehensive Transitional Care include:

- Follow up with hospitals/ER upon notification of child's admission and/or discharge to/from an ER, hospital/ residential/rehabilitative setting.
- Facilitate discharge planning and follow up with hospitals/ER upon notification of a child's admission and/or discharge to/from ER/ hospital/residential/rehabilitative setting.
- Link child/family with community supports to ensure that needed services are provided.
- Follow up post discharge with child and family to ensure needed services are provided.
- Notify and consult with treating clinicians, including child's primary care physician, schedule timely follow up appointments, and assure that all ordered medications are in the home and at other administering sites (e.g., schools and day care), and assist with medication reconciliation.

Comprehensive Transitional Care

1. Describe how your Health Home plans to deliver and tailor the services and activities listed above to serve children. Limit 3,000 characters.

2. Provide your approach and procedures for ensuring continuity of care for children that are entering and leaving or transitioning from one system of care to another, including education, foster care, and juvenile justice. Limit 3,000 characters.

3. Describe your approach and procedures for incorporating comprehensive discharge planning (e.g., from the hospital or other treatment facilities) in the plan of care, including the approach to involving the family in the discharge and plan of care process. Limit 3,000 characters.

4. Describe your approach to tailoring and transitioning care management for children that become adults and remain eligible for Health Home. Limit 3,000 characters.

5. In instances where it is necessary and in the best interests of the child, describe your approach and procedures for transitioning a child in foster care, or any other child, from one Health Home care manager to another. Limit 3,000 characters.

6. Describe the process that will be used to ensure the care manager and Health Home prompt notification of emergency room and inpatient facility admissions/discharges. Limit 3,000 characters.

4) Patient and Family Support

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

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

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

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

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

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

Examples of activities that constitute providing Patient and Family Support under the Health Home model include:

- Develop, review, revise child's plan of care with child and family to ensure plan reflects child/family's preferences, education, and support for self-management.
- Consult with child/family/caretaker on advanced directives and educate on client rights and health care issues as needed.
- Meet with child and family, inviting any other providers to facilitate needed interpretation services.
- Refer child and family to peer supports, support groups, social services, entitlement programs as needed.

Patient and Family Support

1. Describe how your Health Home plans to tailor the services and activities listed above to serve children. Please keep in mind the definition of family as defined in Part II, General Directions. Limit 3,000 characters.

2. Describe your approach to ensuring the plan of care is built around the strengths of the child and family. Limit 3,000 characters.

3. Describe your approach to encouraging involvement of the child and family in identifying the needs of both the child and the family. Limit 3,000 characters.

5) Referral to Community and Social Support Services

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

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

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

To the extent the High Fidelity Wraparound approach is employed for a defined subset of Health Home eligible children (see Part I of this Application for more information), Health Homes care managers would be required to assist the family to identify and build upon natural supports in their communities.

Examples of activities that constitute making referrals to Community and Social Support Services include:

- Identify resources and link child/family to community supports as needed
- Collaborate and coordinate with community based providers to support effective utilization of services based on child/family need

Referral to Community and Social Support Services

1. Describe how your Health Home plans to deliver and tailor the services and activities listed above to serve children. Limit 3,000 characters.

2. Describe how your Health Home will identify and provide linkages to community-based resources for children and their families, including peer supports and youth development services. Limit 3,000 characters.

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

Health Home providers will make use of available HIT and access data through the regional health information organization/qualified entities to conduct these processes **as feasible**, to comply with the initial standards cited in items 6a.-6d for implementation of Health Homes. In order to be approved as Health Home provider, applicants must provide a plan to achieve the final standards cited in items 6e.-6i. within eighteen (18) months of program initiation.

Initial Standards

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

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

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

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

Final Standards

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

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

6g. Health Home provider will be required to comply with the current and future version of the Statewide Policy Guidance (http://health.ny.gov/technology/statewide_policy_guidance.htm)
which includes common information policies, standards and technical approaches governing health information exchange.

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

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

As you work to achieve these nine (9) HIT Standards, please note:

Existing Health Homes applying for children's Health Home status will have 3 months from the date of Health Home designation to meet compliance with HIT standards.

Existing adult Health Homes which are fully compliant with the HIT standards will be required to:
Initial Standards:
- Resubmit initial policy and procedure documents for 6A-6D reflecting any changes in workflow around minor care planning and sharing, as well as RHIO participation.

Final Standards:
- 6E – Conduct a webinar for NYSDOH demonstrating that all new downstream providers have access to the existing care management application
- 6F – Update 6F documentation tool reflecting updated partners list
- 6I – Update listing of clinical decision making support tools used by downstream clinical providers

New children's Health Home applicants will have 18 months from date of Health Home designation meet full compliance with HIT standards:

- The Department of Health will evaluate Health Home compliance with the Initial HIT standards (6A-6D). Health Homes will be required to develop and submit policy and procedure documents covering each topic described in these four standards.

- The Department of Health will evaluate Health Home compliance with the Final HIT standards (6E-6I). For 6E, Health Homes will be required to demonstrate a live, functional, and electronically accessible care plan application via webinar. For 6F-6I, Health Homes will be required to submit DOH approved documentation verifying completion of these HIT standards.

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.

As data segmentation technology is adopted by vendors for use in Electronic Care Plan Applications as well as for use in Electronic Health Record applications, Health Homes will be required to adopt these technologies as feasible.

Any non-electronic methods of sharing patient health information should be described clearly in the submitted policy and procedure documentation for the HIT initial standards

In reference to HIT Standard 6A and 6E the Department of Health recognizes that care plan interoperability (electronic exchange of patient health information between disparate care plan systems) is not currently available for most care plan applications. In view of this, Health Home care managers may share the minor's care plans with downstream providers via other secure, electronic means. These methods may include allowing downstream providers electronic access to view the care plan via a web-based portal. When interoperable data exchange becomes incorporated into Electronic Care Plan applications, Health Homes will be required to adopt and utilize this technology as feasible.

In reference to HIT standards 6D and 6H (RHIO participation) – please note that only designated Health Homes will be required to have participation agreements with their local RHIO. All downstream providers are encouraged to join as well. The Department of Health recognizes that the ability to share information on minors may be limited via the RHIO. Check with your local RHIO to identify what information is available.

In reference to HIT standard 6F, an excel template along with instructions on the 6F documentation tool can be found on the New York State Medicaid Health Home website page for January 30, 2013 Medicaid update webinar:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/meetings_webinars_2013.htm

Questions and answers on all HIT standards may be found on the New York State Medicaid Health Home website page for the January 30, 2013 Medicaid update webinar:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/2013-01-30_hh_biweekly_session_hit_standards.pdf

The Department of Health will provide informational webinars and trainings on HIT adoption and usage as well as technical assistance in meeting the Health Home HIT standards.

Use of Health Information Technology (HIT) to Link Services

1. If you are a currently designated Health Home please confirm in your application you have met the initial standards. In addition, please confirm whether you have met the final standards. If you have not met the final standards, please confirm you acknowledge that you have an agreement in place with DOH to meet such final standards. Please provide information on how you plan to work with network providers and care managers to ensure these health IT standards are implemented. Limit 3,000 characters.

2. Please describe if your health IT systems now recognizes and accommodates the rights of minors to consent to certain types of health care (minor consented services) without the permission of their parent / guardian, and whether parents/guardians or others can access their health information. If your health IT systems do not accommodate the ability to segregate health care information in this manner, please described how your organization accommodates the consent rights of minors. Limit 3,000 characters.

3. If you are an organization seeking a new Health Home designation, please provide information regarding your capability to meet the initial and final health IT standards described above. In addition, please provide your organization's plan for achieving final health IT standards within eighteen (18) months of your Health Home designation. Please provide information on how you plan to work with network providers and care managers to ensure these health IT standards are implemented and how you intend to accommodate the rights of minors to consent to certain types of health care without the permission of their parent/ guardian, and whether parents/guardians or others can access their health information. Limit 3,000 characters.

Section F
CMS Health Home Provider Functional Requirements

As described in the CMS State Medicaid Director's Letter, 10-024 (https://www.cms.gov/smdl/downloads/SMD10024.pdf) designated providers of Health Home are expected to address the functions listed below. Applicants will be required to attest in Section G of this Application they will address the issues below.

- Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services.
- Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines.
- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
- Coordinate and provide access to mental health and substance abuse services.
- Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care.
- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families.
- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services.
- Coordinate and provide access to long-term care supports and services.
- Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services.
- Use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate.
- Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

1. Please provide any additional information that is not otherwise addressed in this Application to demonstrate how you will provide these functions in the family and youth driven Health Home model for children. Limit 3,000 characters.

Section G
Attestation
Please indicate that as the Health Home Applicant, you attest to providing or meeting the following requirements.

1. The Health Home will provide the core Health Home requirements, tailored to meet the needs of children, as described in this Application.

2. The Health Home will provide the following services:
a) Coordination of care and services post critical events, such as emergency department use, hospital inpatient admission and discharge;
b) Language access (written translation and spoken interpretation) capability;
c) 24 hour 7 days a week telephone access to a care manager;
d) Crisis intervention;
e) Links to acute and outpatient medical, mental health and substance abuse services;
f) Links to community based social support services-including housing; and
g) Beneficiary consent for program enrollment and for sharing of patient information and treatment.
3. The Health Home will, to the extent required, collect data and report on specific quality measures required by the State and/or CMS, including those defined under Part I of this Application under “Quality Measures” and “Data Collections and Tracking Requirements.”

4. The Health Home has approached the providers listed in this Application and has obtained the providers’ commitment to be part of the Health Home network. Formal evidence of this commitment will be required prior to designation. Contractual agreements must be in place with all organizations for which there is a financial arrangement prior to the first request for reimbursement when partnerships involve a financial arrangement.

5. Payments which are subject to State mandated rates and other transitional provisions and rates implemented by the State will be made at rates which are not less than those mandated rates. Health Homes and Managed Care Plans have the option of negotiating alternative payment arrangements if the Health Home, Plan and the State agree to such an alternative.

6. Health Home Provider applicants must submit a written attestation that the services specified above will be provided in accordance with the Health Home functional components referenced in the CMS State Medicaid Director’s Letter, 10-024 (https://www.cms.gov/smdl/downloads/SMD10024.pdf) and described earlier in Part II of this Application.

By checking the box below, the Health Home applicant attests and certifies that the information submitted in this Health Home Provider Application and any attached pages is true, accurate, and complete. In addition, the Health Home applicant agrees to comply with all current and future Health Home Program rules, payment structures and operational policies, regulations and directives of the NYS Department of Health (DOH) and Centers for Medicare and Medicaid Services (CMS). The Health Home applicant also agrees to immediately notify the Department of Health of any changes that may occur either as a Health Home provider or with any changes of providers/ subcontractors within the Health Home network.

☐ As an authorized representative of this Organization, I attest and certify to the conditions stated above and do so on behalf of this Organization.

Section H
Rights of the State
The rights of the State provided below are unchanged from the rights included in the Health Homes Application governing the initial designation of all Health Homes.

1. The State reserves the right to assign beneficiaries to specific Health Home.

2. The State reserves the right to cancel a Health Home provider's approved status based on upon failure of the provider to provide Health Home services in accordance with the NYS Health Home Provider Qualification Standards, provide quality Health Home services to its clients, or upon other significant findings determined by the State.

3. The State reserves the right to cancel the program at any time for lack of funding, and/or if, after evaluation of the program, desired results in quality, efficiency and decreased costs are not shown, or any other reason determined by the State.

4. The State confirms that the rights of minors to consent to certain types of health care without the permission of parent/guardian and to whether parents/guardians or others can access their health information as per State law/ regulation.

Notice to Applicant: In order to ensure the application it completed in its entirety, please use the application check list below.

Health Home Serving Children Application Check List:

#	Item
1	Health Home Serving Children Application Part II
2	Health Home Provider Network Form
3	Signed Cover Letter