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Health Homes Serving Children Update: Readiness for Enrolling Children

December 16, 2015

Overview of Today's Webinar

- ✓Status of Readiness Activities of Contingently Designated Health Homes Serving Children
- ✓Readiness Activities for Providing Access to MAPP for Lead Health Homes and children's Care Management Agencies
- ✓State Plan Amendment (SPA) Update
  - ➢Health Home Eligibility Criteria
- ✓Proposed Standards for Health Homes Serving Children
- ✓Health Home Enrollment Prioritization
- ✓Consent Forms

Enrollment of Children in Health Homes to Begin September 2016

The Status of Readiness Activities of the Contingently Designated Health Homes to Serve Children and the Impact of Phase 1 on the timeline for launching Phase 2 of MAPP prompted schedule change for in enrollment date from January 2016 to September 2016

Readiness Activities	Due Date
Health Homes Contingently Designated to Serve Children	June 15, 2015
Health Homes Signed Letters Accepting Designation and Agreement to Address Contingencies	June 30, 2015
Contingency Response Letters Due	August 17, 2015
Other Readiness Activities of Contingently Designated HHs Serving Children (DEAAs, BAAs, CMA Network Lists, Provider Network Lists, Billing Readiness, HIT Requirements)	Ongoing
Various Training Webinars 10+ Webinars (Design Updates, Consent, MAPP/Referral Assignment Process, Transitioning TCM Providers to Health Homes, in Person CANS-NY Trainings)	Began in Early 2015 and ***Ongoing***
Enrollment of Children in Health Homes	***September 2016***

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Overview of the Status of Readiness Activities of Contingently Designated Health Homes Serving Children (CD-HHSC)

Changes in Approved List of Contingently Designated Health Homes Serving Children (CD- HHSC)

- 16 Health Homes accepted their Contingent Designation on August 17, 2015. Since that time the following changes have occurred:
- VNS of Northeastern New York dba Care Central has decided not to expand its Health Home to Serve Children – but looks forward to working in partnership with other HHSC to make referrals
- The Partnership, which consisted of a governance structured to be formed among Montefiore-Bronx Accountable Health Network HH, Hudson River Health Care, Inc. (already a separately designated HHSC), Hudson Valley Coalition, Institute for Family Health, and had intended to serve children in Bronx, Columbia, Dutchess, Greene, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester has changed its proposed governance structure to seek three separate Health Home Serving Children designations as shown in the table to the right
- Each of the 3 entities plans to closely collaborate

Proposed Health Home Serving Children	Children's Service Area
Montefiore - BAHN	Bronx
Hudson River Healthcare, Inc. – Will now include Hudson Valley Care Coalition in its Governance Structure	Columbia, Dutchess, Greene, Orange, Putnam, Rockland, Sullivan, Westchester, Nassau, Suffolk
Institute for Family Health	Ulster County

✓ All 3 Health Homes will be re-submitting separate/ revised as appropriate, Health Home Applications to Serve Children on or before January 15, 2016

✓ State will review on or before March 1, 2016

Overview and Status of Readiness Activities of Contingently Designated Health Homes Serving Children (CD-HHSC)

- 3 Webinars: June 24, 2015, July 9, 2015, September 24, 2015
- Contingently Designated Health Homes welcomed extra time in the schedule to complete readiness activities
- State has had periodic meetings with some of the CD-HHSC, including “new” HH that have not previously served adults
- Outstanding readiness activities primarily revolve around:
  - HIT Compliance – Updated written HIT policies, care management software
  - Billing Readiness – Billing software
  - BAAs (as discussed above) – State will also be focusing on BAAs with OMH TCM providers that will transition to Health Homes – need 100% linkage to ensure smooth transition and Voluntary Foster Care Agencies that will be care managers for children in foster care that may also be eligible for and enrolled in HH
  - Administrative Service Agreements (revised, and for new CD- HHSCs) with Managed Care Plans

Overview and Status of Readiness Activities of Contingently Designated Health Homes Serving Children (CD-HHSC)

- Links to updates on the Status of Readiness Activities by Health Home : http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm
- State will continue to have periodic meetings with CD-HHSC to review and monitor status of readiness activities, CD-HHSC may also request a “readiness consultation”
- State will also consider relevant information from Site Re-designation Visits of Existing Health Homes serving adults in its evaluation of “readiness”
- Upon the satisfaction of deliverables, the State will issue a formal final approval letter to each of CD-HHSC

Overview of Readiness Activities of CD-HHSC
Administrative Services Agreement with Managed Care Plans

- Administrative Services Agreements (ASA) are required between Health Homes and Managed Care Plans
- Options for entering into ASAs include:
  - Using the DOH standard template, as is with no changes http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/administrative_health_home_services_agreement.pdf
  - Using the DOH standard template with modifications
  - Using DOH key provisions to develop customized contract http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/mco_contract_provisions.pdf
- The DOH standard template, was amended in October to include the following changes:
  - Incorporation of language to allow MCOs to share data with Care Management Agencies;
  - Elimination of the 3% administrative withhold by MCOs from the Health Home PMPM;
  - Reference to the need for Health Homes to conduct State-required assessments, ***for children*** and HARP enrollees,
  - Edits and revisions for clarity around the terms for contract termination.

Overview of Readiness Activities of CD-HHSC Administrative Services Agreement with Managed Care Plans

- Health Homes and MCOs newly entering into ASAs, including ***Health Homes newly designated to serve children***, will be required to use the revised version of the DOH template or Key Provisions to develop customized contract and must submit the ASA for review and approval by the Department.
- MCOs and Health Homes that make any material amendments to their ASA, in addition to the required DOH revisions, will be required to resubmit the amended ASA for review and approval by the Department.
- MCOs and Health Homes that make only the DOH revisions to an existing DOH approved ASA will be permitted to simply file the revised ASA with the Department.
- MCOs with existing approved ASAs have from the date of notice (November 20, 2015) 60 days to incorporate and file DOH revisions.
- MCOs and HHSC should work together now to complete ASAs.

Overview of Readiness Activities of CD-HHSC Administrative Services Agreement with Managed Care Plans

- Additional information regarding the MCO Roles and Responsibilities and the contracting process can be found at the Managed Care tab of the Health Home website: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/managed_care.htm
- A complete list of Managed Care Plans, service areas and member service telephone numbers can be found at the link below: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/mc_plan_member_tel_number.pdf
- List of MCO Contacts for Health Homes can also be found at the link below: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_manage_care_contacts.pdf

Overview of Readiness Activities of CD-HHSC

- The following link provides a check list of the status of the major readiness activities by CD-HHSC as of today
- http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hhsc_11_25_2015_readiness_review.pdf
- Lead CD-HHSC should review – if you have any questions or comments please contact the Health Home Team at 518-473-5569 or send an email to our Bureau Mail Log: hhsc@health.ny.gov

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Status of Readiness Activities for Providing Access to Medicaid Analytics Performance Portal for Lead Health Homes and Health Home Care Managers Serving Children

Medicaid Analytics Performance Portal (MAPP)

- March 2016 Phase 1 Implementation of MAPP Health Home Tracking System (MAPP HHTS), implement core functionality (See Appendix and MAPP Website: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_mapp.htm
- September 2016 Phase 2 Implementation will include MAPP Functionality for Children
  - ✓ CANS-NY Assessment tool will be integrated into UAS Environment and MAPP
  - ✓ Billing, rate information and CANS-NY algorithms (High, Medium, Low)
  - ✓ Referral Portal for Children (under 21)
    - ❖ Community Referral (by LGU/SPOA and LDSS, and eventually others) for Assignment
    - ❖ Assignment and Enrollment by Health Homes, Plans and Care Managers
  - ✓ Consent Management
    - ❖ Consent to Refer
    - ❖ Consent to Enroll
    - ❖ Consent to Share Information (Protected Services)

Access to Medicaid Analytics Performance Portal (MAPP) – Children's Lead Health Homes and Children's Health Home Care Managers

- See Webinars:
  - June 24, 2015 Health Homes Designated to Serve Children – Next Steps
  - July 9, 2015 Connecting to the Health Commerce System
- Reminders included in those Webinars:
  - Contingently Designated Lead Health Homes Serving Children (HHSC) and Children's care managers need MMIS number to access HCS and MAPP
  - Care Managers Access to MAPP:
    - HHSC have been providing DOH lists of CMAs they have relationships with (BAAs)
    - DOH is using that list to work directly with Health Home Care Management Agencies Serving Children to help them secure a "Health Home CMA" Org Type in HCS
    - CANS-NY will be housed in UAS and integrated in MAPP – HCS access required to conduct assessments (CANS-NY)

Access to Medicaid Analytics Performance Portal (MAPP) – Training for Children's Lead Health Homes and Children's Health Home Care Managers

There are three general types of training that will be available:

1) CANS-NY – Training is offered and currently available by Learner Nation/Praed Foundation and is focused on helping learners to understand and use the assessment instrument.
   - ➢ All assessors must be certified through Learner Nation/Praed Foundation in order to conduct to the CANS-NY
2) MAPP Health Home Tracking System – Online training and instructor led webinars are offered depending upon the users role. Current courses focus on how to navigate and use the MAPP Health Home Tracking System (training does not include MAPP modifications for children).
3) UAS-NY Application – Training is offered through online, self-paced courses that are focused on how to use the UAS-NY web-based application.

✓ Additional information on access to training for MAPP and UAS-NY modifications will be disseminated beginning in April/May 2016. Training will be available at least 30 days prior to implementation

Status of Readiness of Health Home Care Management Agencies in Accessing HCS/MAPP

As of December 8th:

- There are 512 Health Home-Health Home Care Management Agency affiliations. A Health Home Care Management Agency may have affiliations with multiple Health Homes, each affiliation is "counted" in the total.
  - 266 of the 512 have executed BAA's that have been submitted to DOH.
  - 246 of the 512 ***do not*** have executed BAA's.
- Children's Health Homes have identified 345 unique Health Home Care Management Agencies.
  - 270 of the 345 have active MMIS Provider IDs.

Health Home Care Management Agencies in Accessing HCS/MAPP – Next Steps

HH CMA with HCS Access – Next Steps

- ✓ Ensure that a Business Associate Agreement (BAA) is in place with each Health Home it provides care management/care coordination.
- ✓ Work with respective Health Home to have executed BAA submitted to DOH no later than **January 8, 2016**.

HH CMA not in HCS – Next Steps

- ✓ Obtain new NPI
- ✓ Obtain MMIS Provider ID *(could take up to 90 days).*
- ✓ Work with all affiliated Health Homes to submit an executed BAA to DOH no later than **January 8, 2016**.
- ✓ Notify DOH no later than **February 29, 2016** of new MMIS Provider ID. DOH will create an HCS organization account for the Health Home CMA.

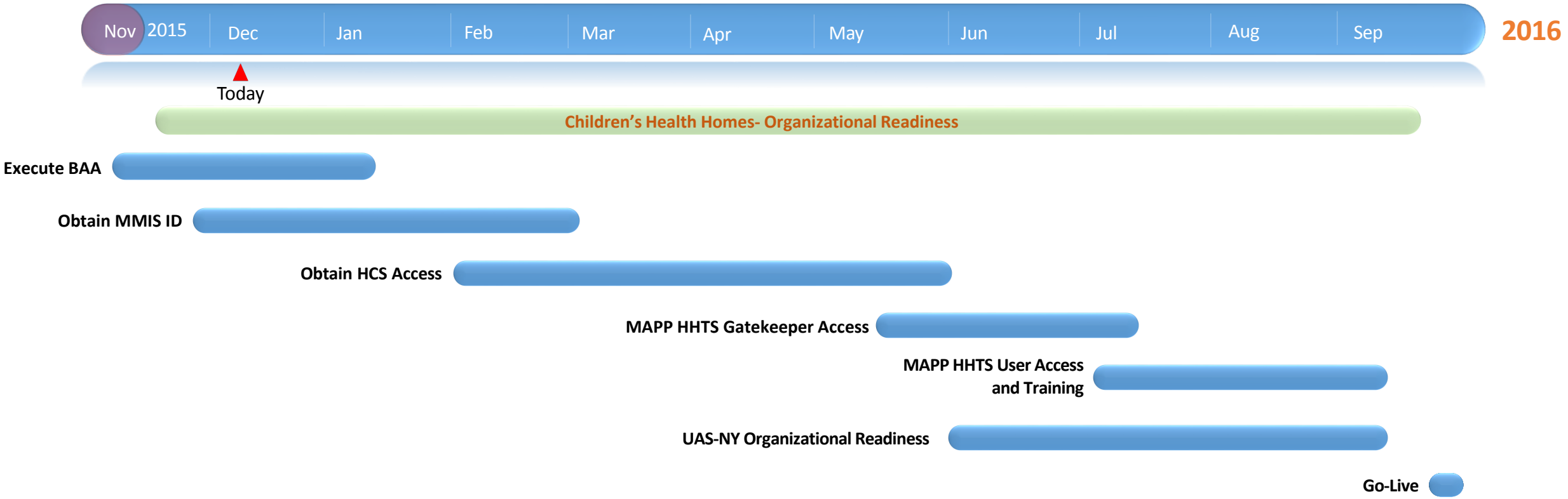
NOTE: Many Voluntary Foster Care Agencies may not have, and will need to obtain, an MMIS Provider ID.

Access to Medicaid Analytics Performance Portal (MAPP)

LGUs/SPOAs and LDSS

- LGUs/SPOAs and LDSS will have access to MAPP to refer children that, in their best judgement, may be eligible for Health Home (*see Prioritizing the Enrollment of Children later in this Webinar*)
- DOH has been working from a list of single points of contacts (SPOC) identified by LGUs/SPOAs and LDSS to provide LGUs/SPOAs and LDSS access to HCS and MAPP
- DOH will be communicating with LGUs/SPOAs and LDSS with instructions on how to access HCS and MAPP

Anticipated MAPP HHTS User Access and Training Timeline



CANS-NY Training

- In-Person CANS-NY Trainings for the Health Home program were held for individuals, supervisors, and trainers
  - July 29, 30 – Albany
  - August 20, 21 – Rochester-Hillside
  - August 25, 26 – NYC-OASAS
  - September 22, 23 – NYC- OASAS
- State expects to provide additional in-person trainings
- As a part of the in-person training sessions approximately 350 individuals were certified in CANS-NY
- A Video Recording of Albany training will be posted to the CANS website shortly
- Online CANS-NY training and certification is available to all care managers and can be accessed at the CANS website www.canstraining.com
  - On-line training website will be organized by Sub-Jurisdictions to clearly delineate which training pertains to each entity (i.e. OMH HCBS Waiver and SPOA, OCFS B2H Waivers , Health Home Care Managers for Children Enrolled in Health Homes)

CANS-NY Technical Assistance “Institute”

- Request For Proposal (RFP)
- Awardee(s) to be selected to assist with CANS-NY implementation and ongoing operationalization within care management
- State’s goals to provide:
  - Intensive technical assistance in consistent use of the CANS-NY tool
  - Support and mentoring in actively using the information on the CANS-NY tool for person-centered planning and outcome monitoring
  - Supervisory instruction in best practices to support staff in using the CANS-NY tool

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Status of CMS Approval of State Plan Amendment for Health Home and Health Home Eligibility Criteria

December 16, 2015

Health Home State Plan Amendment

- State has had several discussion with CMS and SAMHSA that began in the Fall of Last Year
- SPA has the following primary elements
    - Use of modified CANS-NY Assessment: will be used to determine Health Home rate (High, Medium, Low structure) and help develop plan of care (eventually will also be used for HCBS eligibility)
    - Referral, rather than assignment list, process for enrollment (MAPP)
    - Conversion of OMH TCM providers to Health Home, Rate Reconciliation Process
    - Approach for Health Home Care Manager to also serve children enrolled in Early Intervention (HH care manager fulfills the ongoing service coordinator role in the EI model)
    - Modifications to Health Home eligibility criteria for children: Complex Trauma as single qualifying conditions for Health Home eligibility
- CMS and SAMHSA very supportive of ***complex trauma*** as chronic condition and overall children's Health Home design
- Working with CMS to continue to be on track to receive approval by year end, ASAP

Health Home State Plan Amendment – Early Intervention

- CMS has indicated our proposed approach for having the Health Home Care Manager serve as the Ongoing Service Coordinator for children enrolled in both Health Homes and the Early Intervention Program is acceptable to CMS
  - ✓ See the April 29, 2015 Webinar for Additional Information
  - ✓ The State has been providing the Early Intervention Coordinating Council periodic updates of the Design and Implementation of Health Homes for Children – last update was on December 3, 2015
  - ✓ The State has also been meeting with representatives from New York State Association of County Health Officials (NYSACHO) on linkages between HH and Early Intervention – last meeting was on August 6, 2015.
- Next steps:
  - State to provide training to Health Homes, Care Managers and Early Intervention Coordinators:
    - About each program – Health Homes and Early Intervention
    - Roles of Health Homes and Early Intervention Coordinators (Initial and Ongoing) for Children, including Early Intervention Administrative requirements for Health Home care managers who will fulfill the role of ongoing service coordinators
  - Receive stakeholder input on roles and process
  - Early Intervention children will not be prioritized for Health Home enrollment until procedures are finalized and training is complete

Update OMH TCM Conversion to HH

- SPA also includes CMS review of OMH TCM Rate Reconciliation Process (Legacy Rates compared to HML for Children) for OMH TCM providers transitioning to Health Homes
- OMH and DOH have held several webinars for OMH TCM Providers regarding the transition of OMH TCM to Health Homes
  - June 8, 2015: Transitioning Office of Mental Health Targeted Case Management Program Serving Children to Health Homes
  - August 25, 2015: OMH TCM Serving Children Transition to Health Homes- Legacy Rates
  - September 16, 2015: Transitioning OMH TCM Serving Children to Health Home: Legacy Slot and Rates Q&A
- DOH and OMH will be scheduling additional webinars with OMH TCM program to ensure smooth transition to Health Home

General Reminders – Health Home Eligibility Criteria

- Health Home Eligibility is chronic condition based
  - Children must have two or more chronic conditions or a single qualifying criteria as authorized under the Health Home program in New York
    - The HH eligibility criteria is not population based – for example, children in Foster Care do not automatically qualify for Health Homes, they must meet the chronic condition eligibility criteria to qualify
  - Children must also be “appropriate” for Health Home, i.e., they must need the higher level, intensive care management provided by the Children’s Health Home model
- Following slides will review and provide updates on Health Home Eligibility Criteria

Current Health Home Eligibility Criteria and Proposal to Modify Health Home Eligibility Criteria (SPA Modifications in ***Bold***)

Person 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) / Serious Emotional Disturbance (SED) – SED definition has been part of the Health Home for children design
  - ✓ ***Complex Trauma (pending CMS approval)***

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)
- ✓ Obesity BMI >25 ***(BMI at or above 25 for adults, and at or above 85th percentile for children)***
- ✓ *Other chronic conditions (see DOH website for list of chronic conditions) http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/09-23-2014_eligibility_criteria_hh_services.pdf*

Complex Trauma Definition – CMS/SAMHSA Definition

- As part or our discussions with CMS around amending the SPA to include trauma as a single qualifying condition CMS, in conjunction with SAMHSA has:
  - Provided a definition of complex trauma, which has been included in the SPA now under review for formal approval by CMS
  - Requested State develop procedures/approach for documenting and determining if individuals meet the complex trauma definition

Complex Trauma - CMS/SAMHSA Definition

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

1. Definition of Complex Trauma

a. The term complex trauma incorporates at least:
   i. Infants/children/or adolescents' exposure to multiple traumatic events, often of an invasive, interpersonal nature, and
   ii. the wide-ranging, long-term impact of this exposure.

b. Nature of the traumatic events:
   i. often is severe and pervasive, such as abuse or profound neglect;
   ii. usually begins early in life;
   iii. can be disruptive of the child's development and the formation of a healthy sense of self (with self-regulatory, executive functioning, self-perceptions, etc.);
   iv. often occur in the context of the child's relationship with a caregiver; and
   v. can interfere with the child's ability to form a secure attachment bond, which is considered a prerequisite for healthy social-emotional functioning.

c. Many aspects of a child's healthy physical and mental development rely on this secure attachment, a primary source of safety and stability.

d. Wide-ranging, long-term adverse effects can include impairments in:
   i. physiological responses and related neurodevelopment,
   ii. emotional responses,
   iii. cognitive processes including the ability to think, learn, and concentrate,
   iv. impulse control and other self-regulating behavior,
   v. self-image, and
   vi. relationships with others.

Documenting Chronic Conditions and Complex Trauma – *Proposal* for Stakeholder Consideration

- Care managers should document eligibility for Health Home that is based on chronic conditions (e.g., DSM-V, and other diagnoses of chronic conditions (see page 33 for website address of chronic condition list) by including the care management record appropriate diagnoses made by Medicaid qualified providers that are licensed practitioners acting within their scope of practice
- In documenting complex trauma eligibility criteria, care managers may document determinations made by the practitioners defined above, or professionals that are trained in trauma (e.g., professionals that have completed OCFS Common Core Curriculum (Common Core teaches individuals to to *identify abuse/ maltreatment, intervene to stop it, prevent it, and support children and family members to begin healing from the effects of it).*
  - Practitioners or "professionals" may use any of the tools identified by the National Child Traumatic Stress Network http://www.nctsn.org/content/standardized-measures-assess-complex-trauma to support their determination

Modifications to the Definition of Serious Emotional Disturbance

- SED definition – must have at least one of the qualifying DSM-V diagnoses and meet the SED functional limitation criteria

- ***Added*** ADHD for children who are:
  - currently taking psychotropic medication, AND
  - have utilized any of the following services in the past three years:
    - Psych inpatient
    - Residential Treatment Facility
    - Day treatment
    - Community residence
    - HCBS Waiver
    - Targeted Case Management
  - AND meet the functional limitation criteria (see next page)

- Removed gender dysphoria from list of DSM-V conditions
  - Gender dysphoria is not considered a single qualifying condition for SED in HH
  - Young children self-identify as transgender, but are not SED

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

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

- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma- and Stressor-Related Disorders
- Dissociative Disorders
- Somatic Symptom and Related Disorders
- Feeding and Eating Disorders
- Disruptive, Impulse-Control, and Conduct Disorders
- Personality Disorders
- Paraphilic Disorders
- ADHD with the following criteria:
  - are currently taking psychotropic medication, AND
  - have utilized any of the following services in the past three years:
    - Psych inpatient
    - Residential Treatment Facility
    - Day treatment
    - Community residence
    - HCBS Waiver
    - Targeted Case Management

Functional Limitations Requirements for SED Definition of Health Home

To meet definition of SED for Health Home the child must have experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis

- 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).

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

NOTE: Gender Dysphoria has been removed as a single qualifying Chronic Condition

Health Home Appropriateness Criteria

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

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

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

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Review of Current Standards

Discussion of Proposed Standards

for Health Homes Serving Children

December 16, 2015

Reminder: Current Qualifications and Standards for Health Home Care Managers Serving Children

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

Proposals for Waivers of Care Manager Qualifications and Supervisor to Care Management Ratio

- Care Manager Qualifications:
  - *Proposal: Provide an opportunity for the Health Homes to seek waivers for care managers that have demonstrated experience but do not meet the criteria provided above*
- Supervisor to Care Manager Ratio
  - In determining staff and supervisor operations, providers should review the workload expectations of supervisors to enable the provision of quality oversight of health home care management services, documentation and quality assurance related delivery of care management (not merely human resource administrative functions related to personnel management).
  - *Proposal: Establish supervisor to care manager ratio (e.g., 1:5)*

Required and *Proposed* Training for Care Managers and Supervisors

- Current Required Training - Prior to providing Health Home Care Management Services, including Outreach to children or families
  - ✓ CANS-NY training and certification annually
  - ✓ Supervisors must be CANS-NY certified and must achieve at least a score of 80% or higher on exam
  - ✓ Care Managers must be CANS-NY certified and must achieve at least a score of 70% or higher on exam
  - *Proposal to add: Mandated Reporter training*
    - http://nysmandatedreporter.org/TrainingCourses.aspx – 2 hour training is available at no cost
- *Proposal to Add: Training for care managers and supervisors within six months of employment or from first date care managers or supervisor provide any Health Home care management service including outreach*
  - ✓ *Engagement and Outreach (e.g., Motivational Interviewing)*
  - ✓ *Safety in the Community (e.g., conducting home visits, partnering with law enforcement, carrying cell phones, communication with supervisor, awareness of surroundings)*
    - ✓ *Free to providers, offered by OMH and similar training being developed by OCFS*
  - ✓ *Trauma Informed Care*
  - ✓ *Person Centered Planning*
  - ✓ *Cultural Competency/Awareness*
  - ✓ *LGBTQ Issues – serving transgender children/adolescents and working with Lesbian/Gay/Transgender Families*
  - ✓ *Meeting Facilitation*

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

- Proposal is consistent with meeting the six core Health Home services
- Proposal: For all children enrolled in a Health Home, the plan of care must include the following specific elements:
  1) The child's Emergency Contact and disaster plan for fire, health, safety issues, natural disaster, other public emergency.
  2) The child's History and Risk Factors as identified in the CANS-NY related to services and treatment, well-being and recovery.
  3) The child's Functional Needs as identified in the CANS-NY related to services and treatment, well-being and recovery.
  4) The child's and caregivers' Strengths and Preferences as identified in the CANS-NY related to services and treatment, well-being and recovery.
  5) Medicaid State Plan services identified to meet needs, and should be comprehensive to include Physical, Behavioral Community and Social Supports, and Non-Medicaid services, including the indication of choice of (a) Service Provider, (B) Reason for the Service and (C) Intended Goals.

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

6) Key Informal Community Supports. This would include any supports in place for the child/family that address identified needs (e.g., IEP, 504 Plan, housing program).Ex. Family's neighbor is available for support as needed and is aware of child/family's needs, but is not assigned a specific task to reach a goal.
7) Description of planned Care Management Interventions (including Services Care Management, Referral, Access, Engagement, Follow Up, and Service Coordination) and Time Frames.
8) The child's Transition Plan including circumstances/services needed to transition from Health Home Care Management as needed (e.g., education, living situation, employment, community functioning, hospital, treatment facility, foster care)
9) Documentation of participation by all Key Providers in the development of the plan of care.
10) The Child's Medical consenter's Signature documenting agreement with the plan of care. (referencing *DOH 5201* Health Home Consent/Information Sharing/For Use with Children Under 18 Years of Age)

Plan of Care Requirements for Home and Community Based Services (2017)

- As part of the Children's Behavioral Health and Health Transition to Managed Care that State will be working with CMS to authorize under an 1115 Amendment an array of Home and Community Based Services (see Appendix) that will be available in 2017
- It is anticipated that there will be children that meet the Health Home eligibility criteria and will be eligible for HCBS services (Level of care, level of need criteria under development)
- The CANS-NY (performed by HH care managers) will be used to determine if children are eligible for HCBS services
- CMS requires that individuals receiving HCBS services have a person-centered care plan that meets certain requirements and follows a person-centered care planning process (documents provided in context of Adult Behavioral Health Transition)
  - http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hcbs_poc_fed_rules_regs.pdf
  - http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hcbs_fed_person_centered_planning_process.pdf
- For the Adult Behavioral Health Transition that includes HCBS services for members enrolled in HARP Plan, the State has developed HCBS Plan of Care Template that meets the CMS requirements
  - http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hcbs_poc_template.pdf
- State will be working to tailor, where necessary, the documents for children, while still ensuring they meet CMS requirements
- Health Homes should familiarize themselves with these documents, State will work collaboratively with stakeholders to tailor

Proposed Requirements for Care Plan Meetings

- Team members are defined as those individuals/providers indicated on page 3 of the Health Home consent (note care managers should be mindful it is likely the list of those involved in the child's care will change over time).
- In order to ensure quality care coordination is integrated across all systems, team input and/or meetings are important for planning and monitoring progress on the plan of care.
- *Proposal*: It is the role and responsibility of the care manager to establish and organize Plan of Care Interdisciplinary Meetings and Interdisciplinary team meetings must occur as follows:
  - First interdisciplinary team meeting must occur during completion of the initial full CANS-NY to develop plan of care
  - All other required team meetings as frequently as needed and determined by the Health Home care manager, but no less than at least every six months and in coordination with required CANS updates
  - At the request of the Health Home Care Manager, and/or the child/medical consenter (including the LDSS), based upon new information from another provider (e.g., primary care physician).

Proposed Team Meeting and Attendance Requirements

- The following chart details the proposed requirements for participation in team meetings

Must attend	Must be invited and expected to attend	May be invited and may attend
○ Health Home Care Manager ○ Medical Consenter for the child	○ Service providers of the child, including medical providers and those from other child serving systems (e.g., education) ○ Representative from the Health Home Care Management Agency beyond the child's Health Home Care Manager ○ Family members and caregivers ○ Representative from the LDSS or DJJOY for children in foster care ○ Representative from the voluntary case planning agency if the child is in foster care	○ The child ○ Anyone the child/family or medical consenter wishes to have participate

Proposed Criteria for Discharge/Disenrollment from a Children's Health Home

- Appropriateness for Health Home must be continuously monitored and evaluated
- No less than quarterly, care managers must actively assess and document in the care plan the child needs require the intense level of care management services provided by a Health Home.
- Assessments should evaluate and consider condition/stability of the child and eligibility criteria:
  - ✓ The child no longer meets the intensity of the level of care management services provided by the Health Home because of one or more of the following reasons:
    - ✓ All parties concur the child has met the goals of his/her Plan and is stable enough to no longer require the services of a Health Home care manager/ management
    - ✓ Has service and support needs that can be met by single agency/system without the intensive level of HH care management
  - ✓ If the family (on behalf of the child) is refusing to cooperate;
  - ✓ Choice: Whether the child/guardian providing consent and family no longer wants to receive care management through the Health Home;
  - ✓ The child no longer meets the eligibility criteria for Health Home (i.e., does not meet the chronic condition criteria_
  - ✓ The child is no longer eligible for Medicaid (Health Home may continue to work with member that is in and out of Medicaid but may not bill while member is not enrolled – may retroactively bill for services provided in prior 90 days if later deemed eligible and enrolled)
  - ✓ The child has moved out of New York State

Children in Enrolled in Health Home and Placed in Institutional Level of Care

- When a child is admitted to institutional level of care including hospitalization, and psychiatric inpatient facility, the child's Health Home status may be "pended" – will be feature of MAPP
  - ✓ In the month of admission and/or discharge, Health Homes services can be billed at the active care management rate, provided at least one of the Health Home core services is provided. Care management services must be provided for the purposes of discharge planning and must be translated into the patient care management plan. The care manager must share the member's care plan and coordinate with all of the member's providers to make sure that all needed services are in place to ensure a safe, timely discharge. The care management agency must keep the member actively engaged during the process.

Section 3.7 Payment for Health Home Members During an Extended Inpatient Stay in the HH Provider Manual

Other Standards to Consider???

NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services

Prioritizing the Enrollment of Children in Health Home

December 16, 2015

Prioritizing the Enrollment of Children in Health Homes
September 2016 Begin Date for Enrollment

- To manage initial capacity (and provide time to build up capacity) Health Homes, LDSS, LGU, Care Managers and Plans, should prioritize the enrollment of children that meet Health Home eligibility and appropriateness criteria and have the highest needs, including the following:
  - ✓ Children enrolled in OMH TCM care management programs that will convert to Health Home
  - ✓ Children on OMH Waiver waiting list (already Medicaid eligible), within 30 days of discharge from inpatient/residential/day treatment settings to participate in discharge planning, TCM waitlist; [SPOA who refers to HH]
  - ✓ Children who are on the Bridges to Health Wait list,
  - ✓ Children in licensed congregate care,
  - ✓ Children that are within 3 months of foster care discharge,
  - ✓ Children enrolled in LDSS prevention services where foster care placement is imminent,
  - ✓ Children prescribed 3 or more psychotropic medications
  - ✓ Children who are within 30 days of discharge from inpatient, residential or detox setting
  - ✓ Medically Fragile Children with multiple chronic conditions that have had recent (past 30 days) inpatient stay
  - ✓ Children who have an ER referral but are not admitted for inpatient services; or are discharged with a recommendation for community follow up;
  - ✓ Children with multiple system involvement (child welfare, criminal justice)

NEW YORK STATE | Department of Health | Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office of Children and Family Services

Health Home Consent Forms for Children Finalized

December 16, 2015

Children's Health Home Consent Forms

- There are *five* forms developed for children (under 18 years of age) and one FAQ
- Based upon stakeholder comments, minor modifications and clarification will be made. The State expects the forms to be finalized by January, 2016.
- http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children_forms.htm

1. (**Required**) *DOH 5200* Health Home Consent/Enrollment/For Use with Children Under 18 Years of Age
2. (**Required**) *DOH 5201* Health Home Consent/Information Sharing/For Use with Children Under 18 Years of Age
3. *DOH 5202* Health Home Consent/Withdrawal of Health Home Enrollment and Information Sharing Consent Form/ For Use with Children Under 18 Years
4. *DOH 5203* Health Home Consent/Information Sharing/Release of Educational Records
5. *DOH 5204* Health Home Consent/ Withdrawal of Release of Educational Records Health
6. Home Consent: Frequently Asked Questions

Requirements for Consent

- Consent to enroll children (under 21) in Health Home is required (self consent where permitted, or parent/ guardian)
- Within MAPP, the care manager must identify the relationship of the person who provided consent to enroll the child in Health Home (i.e., parent, guardian, legally authorized representative, member/self)
    - ✓ If the member was referred through the MAPP referral portal, the system will prepopulate the relationship with what was selected in the MAPP referral portal consent to refer.
- A new consent to enroll is required when:
    - The member changes Health Homes.
        - ✓ If the HH provider ID changes but the HH name remains the same, new consent is not required.
        - ✓ If the HH provider ID does not change, but the HH Program name changes, a new consent is required.
    - The member dis-enrolls and re-enrolls.

Requirements for Consent

- The member changes from a VFCA to a non-VFCA or when the member changes from a non-VFCA to a VFCA (foster care to non-foster care and non-foster care to foster care) to recognize change in guardianship.

- The member turns 18 years old, only if he/she did not previously consent for him/herself

- The individual gets married, becomes pregnant or becomes a parent.

  ✓ Individuals who are parents, pregnant, and/or married, and who are otherwise capable of consenting, should use the Health Home Patient Information Sharing Consent form (DOH 5055)

Stakeholder Feedback on Proposed Standards – Next Webinar

- On or before January 15, 2016 send questions, comments and feedback via email to: hhsc@health.ny.gov and enter “Stakeholder Feedback for Proposed Standards” in subject line of email

- Please include feedback and suggested topics or questions you would like addressed in future Webinars

- Next Webinar HHSC: February 9, 2016 1:00 – 3:00 pm

APPENDIX

Acronym Glossary

- **CD-HHCS** : Contingently Designated Health Homes Serving Children
- **ASA**: Administrative Service Agreements
- **MCOs**: Managed Care Organizations
- **CMAs**: Care Management Agencies
- **MCP**: Managed Care Plan
- **MAPP**: Medicaid Analytics Performance Portal
- **CANS**: Children and Adolescents Needs and Strengths
- **HCS**: Health Commerce System
- **BAA**: Business Associate Agreement
- **CM**: Care Manager
- **HHTS**: Health Home Tracking System
- **SPA**: State Plan Amendment
- **OMH TCM**: Office of Mental Health Targeted Case Management
- **NYSACHO**: New York State Association of County Health Officials
- **EI**: Early Intervention
- **SMI**: Serious Mental Illness
- **SED**: Serious Emotional Disturbance
- **SAMHSA**: Substance Abuse and Mental Health Services Administration
- **OCFS**: Office of Children and Families

Acronym Glossary (cont'd)

- **LDSS**: Local Department of Social Services
- **LGU**: Local Government Unit
- **VFCA**: Voluntary Foster Care Agency
- **SPOA**: Single Point of Accountability

MAPP Phase I Functionality

Phase 1 of the MAPP Health Home Tracking System (HHTS) will provide users with the following functionality that is not in the current Health Home Tracking System:

- ✓Care Management Agencies will have access to the MAPP HHTS.
- ✓Actions within MAPP can be performed individually or in bulk through online screen entry or through file transfer.
- ✓The creation, acceptance and rejection of assignments made from the Managed Care Plan to the Health Home to the Care Management Agency will be tracked in MAPP HHTS.
- ✓New concept of “accepting” of assignments, transfers, and referrals by all users and of Health Home “accepting” assignment, outreach, and enrollment submitted by Care Management Agencies
- ✓Allow seamless “warm” transfer of enrolled Health Home members between health homes
- ✓Uses status types and new end date reason codes for members in Assignment, Outreach, and Enrollment to better track members in outreach hiatus, incarcerated and lapsed Medicaid eligibility

Early Intervention EIP Service Coordinator Qualifications

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

Children's HCBS Services

- Care Coordination (for children who do not meet HH criteria)
- Habilitative Skill Building
- Family/Caregiver Supports & Services
- Crisis Respite
- Planned Respite
- Prevocational Services
- Supported Employment
- Community Advocacy & Support
- Non-Medical Transportation
- Day Habilitation
- Adaptive & Assistive Equipment
- Accessibility Modifications
- Palliative Care

Trainings – Health Homes Serving Children

NEW YORK STATE

Services News Government Local

Department of Health
Information for a Healthy New York

A-Z

Medicaid Health Homes

- Medicaid Health Homes Page
- Medicaid Home
- Assessment and Quality Metrics - HH-CMART
- Contact information and Network Partner Lists for Designated Health Homes
- Email NYS Health Homes Program
- Forms & Templates
- Health Homes and Children
- Health Homes and the Criminal Justice Population
- Health Home Funding Opportunities
- Health Home Medicaid Updates, Policy and Provider Manual
- Health Home Work Groups, Learning Collaborative and Webinars
- Health Information Technology (HIT)
- Housing and Health Homes
- Managed Care
- Medicaid Analytics Performance Portal (MAPP)
- Administrative Requirements for Health Homes
- Member Assignment, Tracking System, Billing and Rates
- New York State Health Home Requirements
- NYS Implementation of Health Homes

You are Here: Home Page > Health Homes and Children > Children's Health Home Training Webinars and Presentations

Children's Health Home Training Webinars and Presentations

- August 24th Webinar: OMH TCM Serving Children Transition to Health Homes-Legacy Rates (PDF, 1MB)
- August 13, 2015 Overview for Care at Home I & II Providers (PDF, 1MB)
- July 9, 2015 MAPP Children's Health Home Webinar (PDF, 1MB)
- July 9, 2015 MAPP Children's Health Home Webinar (Recording)
- June 24, 2015 Health Homes Designated to Serve Children - Next Steps (PDF, 1MB)
- June 24, 2015 Health Homes Designated to Serve Children - Next Steps (WMV, 63MB)
- June 8, 2015 Transitioning Office of Mental Health Targeted Case Management Program Serving Children to Health Homes (PDF, 2MB)
- June 8, 2015 Transitioning Office of Mental Health Targeted Case Management Program Serving Children to Health Homes (Webinar Recording)
- May 27, 2015 Data Exchange and Health Homes Serving Children: Data Exchange Application & Agreements for Health Homes Serving Children (PDF, 292KB)
- May 27, 2015 Data Exchange and Health Homes Serving Children: Data Exchange Application & Agreements for Health Homes Serving Children (WMV, 63MB)
  - NYS Department of Health Data Exchange Application & Agreement Document (DOCX, 638KB)
- May 18, 2015 Health Home Serving Children: Consent Policy and Procedures (PDF, 128KB)
- May 18, 2015 Health Home Serving Children: Consent Policy and Procedures (WMV, 90MB)
- May 11, 2015 Referral and Health Home Assignment Process for Children- Example "Use Cases" (PDF, 1MB)
- May 11, 2015 Referral and Health Home Assignment Process for Children- Example "Use Cases" (WMV, 89MB)
- April 29, 2015 Tailoring Health Home Model to Serve Children: Design and Implementation Updates (PDF, 1MB)
- April 29, 2015 Tailoring Health Home Model to Serve Children: Design and Implementation Updates (WMV, 126MB)
- April 6, 2015 Conference of Local Mental Hygiene Directors – Overview of Design of Health Home Model for Children (PDF, 1MB)
- March 4, 2015 Health Home Implementation Webinar, Session #51 - Health Information Technology: Requirements for Health Homes (PDF, 1MB)
- March 4, 2015 Health Home Implementation Webinar, Session #51 - Health Information Technology: Requirements for Health Homes (WMV, 51MB)
- February 27, 2015 Commissioner's Advisory Panel - Tailoring Health Homes to Serve Children (PDF, 1MB)
- November 5, 2014 - Overview of Final Health Home Application to Serve Children and Other Design Updates (PDF 985KB)

Subscribe to the HH Listserv

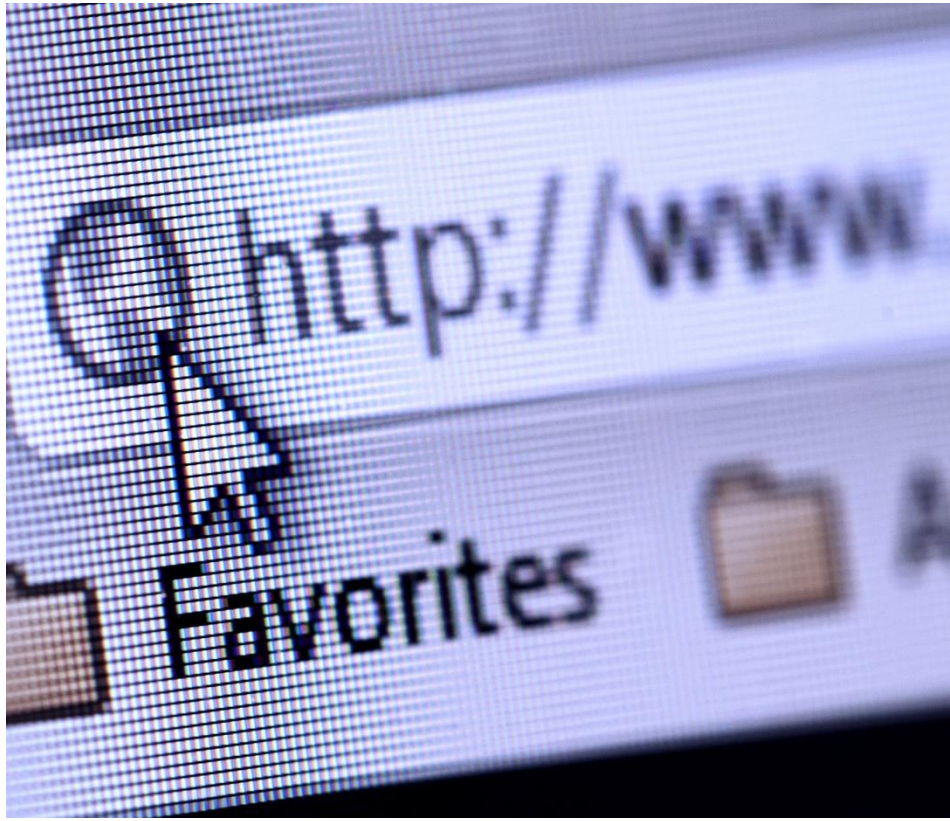
- Stay up-to-date by signing up to receive Health Home e-mail updates

- Subscribe
  http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/listserv.htm

- Health Home Bureau Mail Log (BML)
  https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action

Updates, Resources, Training Schedule and Questions

- Stay current by visiting our website: http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm



Questions?