Guide to Edits Included in Policies Relating to Plan of Care (Plan of Care)

Summary: As of December 2024, the Health Home Plan of Care Policy HH0008 now reflect revised language (indicated by text in red) alongside prior language (indicated by text crossed out text in black). This update supersedes the previous policy and guidance issued July 2019 and reflects an implementation date of **January 1, 2025.**

Document	New Page and Section	Update Made	Update Specifications Language may be completely new or partially reused from earlier policies. Reference "Former Location of Information" column.	Former Page and Section
Health Home Plan of Care Policy	**N/A**	Three new sections have been added: *Contents*, *Definitions*, and *Relevant Statues and Standards*	**Refer to policy document to view new sections.**	**New addition to the Plan of care Policy**
	Pages 4-5, I. Policy	Section title has been updated and language has been updated and revised to further outline a Plan of Care.	**A. Overview of a Health Home Plan of Care** The Plan of Care is integral to the Health Home model, goals and services that are provided. The Health Home Plan of Care is a comprehensive, individualized, and person-centered living document that changes over time depending on the member's needs. It should be used as an active tool to guide day-to-day care management work and support the required collaboration among providers and others approved by the member and listed in the Plan of Care and, on the member's Health Home consent (e.g., care team, Medicaid Managed Care Plan (MMCP), family/supports, etc.) to monitor member progress towards goals. Minimally, Health Home Case Manager core service requirements are met through providing the intervention in the Plan of Care; however, periodically, additional Health Home Case Manager services may be needed based on the member's needs at that time. The member's needs should drive the intensity and frequency of Health Home Case Manager services. Changes in member's needs, goals, preferences, and interventions should be confirmed with the member and documented in the Plan of Care. The member ~~(or their parent/guardian/legally authorized representative)~~ plays a central and active role in the development and execution of their Plan of Care and agree with the identified needs, goals, interventions, and time frames contained in the Plan of Care. The Health Home Plan of Care contains assessed needs, goals, and objectives that support the member's desire to address their qualifying diagnosis for Health Home, such as Serious Mental Illness, Serious Emotional Disturbance, Substance Use Disorder, HIV/AIDS, Complex Trauma, Sickle Cell Disease, or chronic conditions (Health and Community Based Services (HCBS) needs for Children/Youth) and other healthcare and	**1- Elements of a Health Home Plan of Care**

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			social needs, as the member deems necessary. Needs and goals outlined by members of the Multidisciplinary Team (MDT) will also be incorporated and they are involved in the development process (please refer to section VII. Conducting Multidisciplinary Team Meetings) of the Plan of Care. The Plan of Care is written in plain language and in a manner that is accessible to individuals with disabilities and persons with limited English proficiency and should reflect the cultural considerations of the member. ~~Person-centered service planning guidelines may apply for some populations*.~~ ~~For additional guidance on person centered service planning: https://www.health.ny.gov/health_care/medicaid/redesign/cfco/docs/2018-12-19_pcsp_guidelines.pdf~~ **NOTE:** For children, the Child Adolescent Needs and Strengths – NY (CANS-NY) assessment identifies the strengths and needs of the member to assist with the development of a person-centered Plan of Care. A member may defer addressing an identified "need" as long as the member is actively working on another need outlined in the Plan of Care. The Health Home Care Manager documents this decision and periodically revisits consideration of the deferred "need." If the member continued to express unwillingness/inability to work on any Plan of Care goal/s, the Health Home Care Manager discusses this with the member to evaluate whether continued enrollment is appropriate. Minimally, during core service delivery to the member, the Health Home Care Manager conducts an intervention or activity listed in the member's Plan of Care that supports the member's progress towards their goal/s. Periodically the member may require additional Health Home Care Manager services due to an unpredicted life event (e.g., Emergency Department visit, inpatient stay, incarceration, etc.) that is not reflected in the member's Plan of Care. Such Health Home Care Manager services should be provided but should not replace activity/s driving progress on care plan goals unless the member is unwilling/unable to work on a Plan of Care goal/s that month. **NOTE:** For youth enrolled in High Fidelity Wraparound (HFW), planning is an ongoing and intensive team-based process central to the High Fidelity Wraparound (HFW) model. The Plan of Care is continually refined to reprioritize needs to promote positive outcomes for the youth and family and to support them toward transition. For this reason, the Plan of Care is reviewed as part of the monthly Child and Family Team Meeting (CFTM). (Please refer to the UPDATED Health Home Serving Children Care Management Core Services Requirements and Billing Policy HH0017 September 2024)	

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			The requirements for completing the Plan of Care (POC) during the Initial, Annual, or upon the occurrence of a Significant Life Event can be found below in their respective sections. Failure to complete all steps outlined may lead to billing blocks.	
	Pages 6, II. Plan of Care Development Timeline	New section/language has been included to clarify the timelines and intervals for reviewing/updating the Plan of Care.	**II. Plan of Care (POC) Development Timeline** Certain timelines and requirements are attached to developing, completing, and updating the Plan of Care. These are established in this section. The Plan of Care is updated when there are significant changes to the goals, interventions, services, etc. for the member. Unless otherwise specified within this policy document, Health Homes ensure that at each required interval for reviewing and updating the Plan of Care e.g. Initial, Annual, Significant Life Event, and Other, the Plan of Care is digitally uploaded into the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS). Exceptions to this requirement can be found in the "Significant Life Events" and in the "Other Considerations for Plan of Care Review" sections. The process of digitally uploading Plans of Care to the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) creates an avenue for Medicaid Managed Care Plans (MMCP) and other entities, such as State Agency Partners (SAP), to readily access the documents on demand, easily downloading Plans of Care either as a PDF or CSV file. Health Homes, Medicaid Managed Care Plans (MMCP), State Agency Partners (SAP), etc. are encouraged to use the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) as their mechanism of choice for sharing the Plan of Care.	**New Material**
	Pages 6-7, II. Plan of Care Development Timeline	New section/language has been included to outline the development of an initial Plan of Care.	**A. Initial Plan of Care Development** Health Homes will ensure that ~~individualized, person-centered POC is created~~ an Initial Plan of Care is completed concurrently with the Health Home Comprehensive Assessment for all new consented Health Home members, regardless of age (adult/child).[1] The Initial Plan of Care is in compliance with the required information outlined in the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) Specification Document to be properly uploaded to Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS). ~~The Health Home care manager will be the single point of contact for the member's care coordination and~~	**New and revised language to the Plan of care Policy**

[1] Prior to September 7, 2024, the fifty-six (56) calendar day timeline was sixty (60) calendar days/two (2) months).

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			~~will take full responsibility for the overall management of the member's Plan of Care.~~ **The Initial Plan of Care is a planning process that:** • Includes member's need/s associated with Appropriateness Codes and Criteria if they have not yet been completely resolved at the time the Initial Plan of Care is signed. • Includes review and input from team members and other entities for which service provision linkages may already exist or have been newly made to support development of the Initial Plan of Care (see section VII. Conducting Multidisciplinary Team Meetings) • Is signed and dated by the member (for children who are age-appropriate to understand and contribute to their Plan of Care) and/or representative (if one exists). For children who are age-appropriate to understand and contribute to their Plan of Care and refuse to sign, this must be documented in the case record and the Parent, Guardian or Legally Authorized Representative signature is sufficient. • Is digitally uploaded into the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) within the fifty-six (56) calendar day period. Further information related to the Plan of Care in the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) can be found at link; and, • Is provided to the member and the member's family and significant others (Parent, Guardian, Legally Authorized Representative), offered to the Multidisciplinary Team members, and made accessible via Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) to Medicaid Managed Care Plans (MMCP) and other entities, such as State Agency Partners (SAP). **Note Regarding High Fidelity Wraparound (HFW):** There is an exception to the fifty-six (56) calendar day timeline for youth enrolled in High Fidelity Wraparound (HFW). The High Fidelity Wraparound (HFW) model requires an initial Plan of Care within forty-five (45 days) of High Fidelity Wraparound (HFW) case assignment. (refer to the Definition section for Initial Plan of Care related to fifty-six (56) calendar day requirement). Health Home Care Managers document the involvement of the Multidisciplinary Team members in the creation and updating of the Plan of Care (Refer to Section VII. Conducting Multidisciplinary Team Meetings).	

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			To be considered a complete the Initial Plan of Care, all requirements outlined in the Medicaid Analytics Performance Portal Specification Document be completed in the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS). [1] Prior to September 7, 2024, the fifty-six (56) calendar day timeline was sixty (60) calendar days/two (2) months).	
	Pages 7-8, **III. Goals and Interventions**	Updated section title/language has been included to outline the role of goals and interventions in the Plan of Care.	**III. Goals and Interventions** Care Managers ensure that at least one of the member's goals, or a member's identified high level desired outcome for an identified need are identified during the Initial Appropriateness determination (refer to Eligibility Requirements for Health Home Services and Continued Eligibility in the Health Home Program HH0016). An associated intervention or support that will be used by the provider/service to assist the member in accomplishing their goals, should be identified, as well. This intervention should also include any activities or strategies that will be used by the Health Home Case Manager to assist the member in accomplishing their goals. This would include planned Care Management interventions (e.g., Services Care Management, Referral, Access, Engagement, Follow Up, and Service Coordination) and Timelines. The Initial Plan of Care should be completed by the Health Home Care Manager and include relevant Goals and Interventions identified by the member and Multidisciplinary Team. If the need(s) associated with Initial Appropriateness was completely addressed and resolved at the time the Initial Plan of Care is signed, it does not have to be included in the Initial Plan of Care. However, evidence of encounters and Health Home Case Manager activities conducted toward meeting the goal of the member's initial need(s) are documented in the member's record within the fifty-six (56) day period regardless of whether it was met or is still in progress. The ***Health Home Serving Children's Program requires additional considerations to be integrated into*** a member's Initial Plan of Care. For youth who are age fourteen (14) or older, the Care Manager identifies goals developing a member's capacity to live independently, and the interventions and ~~available~~ resources for youth ~~over~~ age fourteen (14) or older. A Care Manager identifies transitional goals and services for transitioning youth who will be aging out of children's services and moving to adult services. This includes assisting the member in planning for transition to other services and/or programs as physically disabled participants reach their seventeenth 17th birthday and generating a Transition Plan that identifies the action steps needed to connect with services each youth needs in adulthood and the party responsible for conducting the action steps. For Foster	**2-** **All plans of care must include the following:**

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			Care members, the Care Manager begins this process eighteen months prior to reaching the enrolled member's twenty- first (21st) birthday.	
	Pages 8-9, IV. Home and Community Based Services within the Plan of Care	New section/language to clarify the additional requirements for Home and Community Based Services within the Plan of Care.	**IV. Home and Community Based Services within the Plan of Care** For members who are eligible and/or enrolled in Health and Community Based Services, it is necessary for the Plan of Care to include Health and Community Based Services identified and/or chosen by the member to help them attain their goals. Once the Health and Community Based Services provider has met with the member and it is agreed that the service(s) will address the member's needs, the Health and Community Based Services provider will determine Frequency, Scope, and Duration for each individual Health and Community Based Services. The care manager will ensure the approved Frequency, Scope, and Duration for the Health and Community Based Services is then identified on the Health Home Plan of Care. Additionally, Health and Community Based Services complies with all Health and Community Based Services Final Rule requirements, including participant choice in the service(s) provided and the setting where the service(s) is provided. The Plan of Care identifies the setting in which the member resides and if it is a community-based setting, if the member wants to reside in the setting/address, and if the member has choice where they reside based upon their identified risk factors. For Health Homes Serving Children, these items are identified *only* for members who can self-consent. Health and Community Based Services cannot be provided in a prohibited setting. Please visit the Health and Community Based Services Final Rule webpage for further information regarding appropriate settings and other requirements. For ***Health Home Serving Adults*** **serving members enrolled in Health and Recovery Plans (HARP)**, please see Adult BH Health and Community Based Services Workflow Guidance for additional information regarding eligibility assessment, level of service determination, and referral requirements applicable to the coordination Adult Behavioral Health and Health and Community Based Services. Medicaid Managed Care Plans download the ***digitized*** Plan of Care of Health and Community Based Services members for their records. For Children's Health and Community Based Services, Medicaid Managed Care Plans will authorize Frequency, Scope, and Duration as outlined in the Health and Community Based Services Plan of Care Workflow policy.	**New addition to the Plan of care Policy**

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	Page 9, **V. Reviewing and Updating the Plan of Care**	New section/language has been included to provide guidance for the annual Plan of Care review.	**V. Reviewing and Updating the Plan of Care** **A. Annual Plan of Care Review** The Health Home Care Manager continually monitors the Plan of Care ensuring progress toward goals and updating the Plan of Care, as necessary. The Plan of Care is reviewed and updated annually for all Health Home members. ***For children***, the Plan of Care is reviewed and updated and is informed by the annual Comprehensive Reassessment and a Child Adolescent Needs and Strengths – NY (CANS-NY) assessment. ***For adults***, the Plan of Care is reviewed and updated concurrently with the annual Comprehensive Reassessment. ***For children/youth enrolled in High Fidelity Wraparound (HFW)***, the Plan of Care is reviewed and updated as part of the monthly Child and Family Team Meetings (CFTMs). At minimum, the Plan of Care is updated every three months to reflect the intensive nature of High-Fidelity Wraparound (HFW) implementation. The Plan of Care is informed by the underlying needs prioritized by the youth and family, the Child Adolescent Needs and Strengths – NY (CANS-NY) assessment (completed every six (6) months in High Fidelity Wraparound (HFW) and, the annual Comprehensive Reassessment. (Please refer to the UPDATED Health Home Serving Children Care Management Core Services Requirements and Billing Policy HH0017 September 2024) The Annual Plan of Care is signed and dated by the member and/or representative (if one exists). It is then ***digitally uploaded*** into the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) for continued billing to occur. For more information on the Plan of Care in the Medicaid Analytics Performance Portal, please reference this guide.	**New addition to the Plan of care Policy**
	Pages 9-10, **V. Reviewing and Updating the Plan of Care**	New sub-section and language has been included to provide to clarify what constitutes a Significant Life Event and the review process.	**B. Significant Life Event Plan of Care Review** Significant Life Events include specific experiences or changes in medical and/or behavioral health or social needs that directly impact/alter the member's life. Examples of Significant Life Event include, but not limited to: • Significant change in member's functioning or condition (including increase or decrease of symptoms or new diagnosis) • Member admitted, discharged or transferred from hospital/detox, residential placement, arrest/detention/incarceration, or foster care	**2-** **All plans of care must include the following:**

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			• Member's been seriously injured or has medical/behavioral health event a major • Change in the member's caregiver (for children/youth, primary or other identified) guardian, legally authorized representative • Significant change in caregiver's capacity/situation • Court request or order e.g., Assisted Outpatient Treatment (AOT) • Change in information or diagnosis, more information obtained Not all Significant Life Events will require the Plan of Care to be changed; however, if a Plan of Care needs to be changed as a result of a member's Significant Life Event the Health Home Case Manager reviews and updates the Plan of Care accordingly. If a Significant Life Event is identified, The Health Home Case Manager evaluates the member's current status, including rescreening for risk factors as discussed in the Health Home Comprehensive Assessment Policy (Adult and Children) #HH0002. The Plan of Care is then signed and dated by the member and/or representative (if one exists), showing the member's involvement and approval of the changes in the Plan of Care. Applicable members of the Multidisciplinary Team are notified of the changes to the Plan of Care for Significant Life Events and provided access to the updated Plan of Care. After completing all necessary updates to the Plan of Care as a result of a Significant Life Event and obtaining member/member representative's signature, the Plan of Care ***is digitally uploaded*** into the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS). For more information on the Plan of Care in the Medicaid Analytics Performance Portal, please reference this guide.	
	Page 10-11, V. Reviewing and Updating the Plan of Care	New sub-section and language has been included to clarify additional scenarios that could constitute an update to the Plan of Care of the fifty-six (56) calendar day, Annual, or Significant Life Event review.	**C. Other Considerations for Plan of Care Review** Changes may be needed to the Plan of Care that are outside of the Initial, Annual, or Significant Life Event review, such as when a member changes providers, member supports and services, or when a Plan of Care goal is met. The Health Home Care Manager **ensures** these types of changes to the member's Plan of Care are approved by the member and communicated to appropriate providers and others. The Health Home Care Manager documents the changes and the member's approval in the member's record (e.g., progress notes) and include these changes in discussion during the next Plan of Care review. For these changes, a new member signature is not required on the HH Plan of Care. However, the updated HH Plan of Care is digitally uploaded into the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS), for the following changes:	**New addition to the Plan of care Policy**

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			• When Adult Behavioral Health, Health and Community Based Services provider changes are made to the Plan of Care • When Adult Behavioral Health, Health and Community Based Services service changes are made to the Plan of Care • When Health Home Care Manager (Adult and Children) service changes are made to the Plan of Care • When a Plan of Care goal is met (Important: this is different from Meeting all Plan of Care goals as identified in the Significant Life Event section above)	
	Page 11, V. Reviewing and Updating the Plan of Care	New section/language to explain that the member's Client Identification Number (CIN) should be reviewed monthly alongside the steps to take if the number has changed.	**D. When the Member's Client Identification Number (CIN) Changes** When conducting monthly checks to confirm a member's Medicaid status, the Care Management Agency/Health Home Care Manager will be able to identify when the current Client Identification Number is no longer active. When this occurs, the Health Home Care Manager follows up with the member to determine whether their Medicaid has ended completely or if the member's Medicaid is active under a new Client Identification Number. When Medicaid is active under a new Client Identification Number, the Care Management Agency/Health Home Care Manager enters the new Client Identification Number into the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS). The current Plan of Care in Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) will ***not*** automatically transfer from the current Client Identification Number to the new Client Identification Number. While completion of a new Plan of Care is not required, the current Plan of Care is copied and uploaded into the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) under the new Client Identification Number by the Care Management Agency/Health Home Care Manager within fifty-six (56) calendar days to ensure the most current version is accessible in the system.	**New addition to the Plan of care Policy**
	Page 11, V. Reviewing and Updating the Plan of Care	New sub-section and language has been added clarify that a new risk factor identified by a member's Continued Eligibility for Services (CES) Tool outcomes will need require a Plan of Care update.	**E. Continued Eligibility for Services (CES) Tool Outcomes and Updating the Plan of Care – ADULTS only** Upon completion of the Continued Eligibility for Services (CES), the final recommendation, Continued Services, or Disenrollment, is documented in the member's record. If a risk factor is identified that is not addressed in the current Plan of Care, the Plan of Care is updated to include this new information. Further information related to completion of the Continued Eligibility for Services (CES) Tool can be found here along with the DOH - Health Home Continued Eligibility for Services (CES) Tool	**New addition to the Plan of care Policy**

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	Pages 11-13, VI. Obtaining Member Signature(s)	A new section/language has been added to explain the process of obtaining member, types of acceptable signatures, and a member's signature being verification of agreement with the Plan of Care.	**VI. Obtaining Member Signature(s)** Member signature on the Plan of Care verifies the member's involvement in the development of and agreement with the contents of the Plan of Care. If the member agrees with the Plan of Care but for some reason cannot sign, the Health Home Care Manager documents in the member's record the details of the communication with the member and reason why signature could not be obtained. The Health Home Care Manager would write "member unable to sign" on the signature line with the date. If the member expresses reservations about signing the Plan of Care, the Health Home Care Manager explores the source of the concern and works with the member to amend the Plan of Care so it meets their approval. The member then signs the Plan of Care to demonstrate that approval. If the member continues to refuse to sign the Plan of Care, and the Health Home Care Manager is unable to amend it such that the member will sign, then the Health Home Care Manager is to explain to the member the significance of the Plan of Care as the foundation summarizing the scope of the work the Health Home Care Manager and the member will engage in together for the benefit of the member. The Health Home Care Manager is to further explain that without an agreed-upon Plan of Care, as demonstrated by the member's signature, a member cannot remain in the Health Home program. The reasons and discussion held with the member is documented in the case record. If after discussion with the member, they are still not willing or able to agree to a Plan of Care and/or sign a Plan of Care, the Health Home Care Manager engages with their supervisor to explore other options before proceeding to disenrollment procedures. The Health Home Care Manager or supervisor is to document all efforts made. If after all reasonable efforts to develop a Plan of Care the member is still unwilling to sign, the program may proceed towards disenrollment. For additional information and guidance for the member disenrollment process, refer to the Member Disenrollment From the Health Home Program HH0007 policy to include the issuance of the Notice of Determination for Disenrollment in the New York State Health Home Program (DOH 5235). Signature and date are required for the following: • Initial Plan of Care • Annual Plan of Care • Significant Life Event Contingent upon the member's consent and upon request, the Plan of Care is then to be provided by the Care Manager to the member and the member's family and significant	**New addition to the Plan of care Policy**

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			others (Parent, Guardian, Legally Authorized Representative). The Plan of Care is also offered to the member's Multidisciplinary Team members and made accessible via Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) to the Medicaid Managed Care Plan (MMCP) and other entities, such as State Agency Partners (SAP). Signatures on the Plan of Care can be obtained by the Care Manager through wet (ink on paper) or electronic means**.** The practice of obtaining member signature via electronic means is acceptable as long as Health Homes and Care Management Agencies are in compliance with all applicable New York State and Federal laws. For more information refer to the Electronic Signatures and Records Act. **NOTE:** Refer to sections above for Initial, Annual, Quarterly High Fidelity (HFW), Significant Life Event and Other Plan of Care regarding requirement for digitally uploading the Plan of Care into Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS).	
	Page 13, **VI. Obtaining Member Signature(s)**	A new-sub section/language has been added to explain that an Assisted Outpatient Treatment (AOT) order supersede a member's refusal to sign.	**For Health Home Members Under Court-Ordered Assisted Outpatient Treatment (AOT)** If a member with an active Assisted Outpatient Treatment (AOT) order refuses to sign a Plan of Care (POC), the court order on file will supersede the refusal and care management services will continue. The Health Home Care Manager (HHCM) documents the refusal in the member's record but **does not** proceed with disenrollment. The Health Home Care Manager (HHCM) writes "AOT order" on the signature line with the date.	**New addition to the Plan of care Policy**
	Page 13-14, **VI. Obtaining Member Signature(s)**	A new sub-section has been added to further clarify for members under the age of eighteen (18) and cannot self-consent.	**For Children/Youth Who Are Under The Age Of Eighteen (18)** The Plan of Care is developed by the Health Home Care Manager with the child/youth's Parent, Guardian or Legally Authorized Representative. Children and youth who are capable of understanding the plan of care and meaningfully participate in their care management services are to be involved in the development of their Plan of Care[2]. This includes education about the purpose of the Plan of Care, their preferences related to their goals and the requirement that they demonstrate their agreement with the plan by signing the Plan of Care.	**New addition to the Plan of care Policy**

[2] Health Home Consent Frequently Asked Questions (FAQ) For Use with Children Under 18 Years of Age.

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			If the child/youth is unwilling/unable to sign their Plan of Care, then the signature of the Parent/Guardian/Legally Authorized Representative is appropriate to proceed with service planning under the developed Plan of Care. The Health Home Care Manager is to document the reason why the child/youth could or did not participate and/or sign the Plan of Care. The Health Home Care Manager continues to approach the child/youth in the future to ensure they are involved in the development and updating of their Plan of Care and to obtain signature, as outlined below in this policy. **NOTE:** For Health Homes serving children, under Section 2 on the DOH-5201 Consent Form: Health Home Consent Information Sharing For Use with Children and Adolescents Under eighteen (18) years of Age, there are special implications for the comprehensive assessment and Plan of Care. If a minor/adolescent is between ten (10) and eighteen (18) years of age and has elected to not share health information with a parent, guardian, or legally authorized representative (as indicated in Section 2 of Department of DOH- 5201), the care manager completes a separate section/page of the Plan of Care with only the minor/adolescent and not with the parent, guardian, or legally authorized representative present. The care manager will only obtain the minor/adolescent's signature for this section/page of the Plan of Care, which serves to show the child's agreement with the contents of the separate Plan of Care. This separate section/page of the Plan of Care should not be given to the parent, guardian, or legally authorized representative and should be stored separately from the rest of the Plan of Care that the parent, guardian, or legally authorized representative has access to. If the child has elected to share health with a parent, guardian, or legally authorized representative (as indicated in Section 2 of DOH-5201), the care manager would not need to fill out a separate section/page of the Plan of Care. The Plan of Care would be signed by the minor/adolescent and the parent, guardian, or legally authorized representative. Minors/adolescents who are in the exception categories (minor/adolescent who is pregnant, parent, married, or eighteen (18) years and older) are able to self-consent into Health Homes, and therefore would be allowed to sign their Plan of Care without a parent/guardian/legally authorization representative and would not need a separate section/page of the Plan of Care. (refer to the Access to/Sharing of Personal Health Information (Personal Health Information) and the Use of Health Home Consents #HH0009 policy). [2]Health Home Consent Frequently Asked Questions (FAQ) For Use with Children Under 18 Years of Age.	

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	Pages 14-15, VII. Conducting Multidisciplinary Team Meetings	A new section/language has been added to further explain the role and members of a Multidisciplinary Team alongside the process to conduct Multidisciplinary Team Meetings.	**VII. Conducting Multidisciplinary Team Meetings** The Health Home Care Manager will be the single point of contact for the member's care coordination and will have responsibility for the overall management of the member's Plan of Care. The Health Home Care Manager facilitates collaboration with the member's Multidisciplinary Team (see definition on page 2). Multidisciplinary Team Meetings are conducted in accordance with Health Home Standards and Requirements for Health Homes, Care Management Agencies, and Managed Care Organizations. The Multidisciplinary Team Meeting is person-centered and scheduled for a time and location that is convenient for the member and caregiver. The needs and goals of the member outlined on the Plan of Care are to be discussed with the members of the Multidisciplinary Team. During this meeting, additional needs or goals may be identified by members of the team. The Health Home Care Manager will review the providers' input and incorporate the new goal(s) or need(s) into the Plan of Care. A Multidisciplinary Team Meeting is conducted to develop the Initial Plan of Care, to include those healthcare and service providers already identified as serving the member. It is understood that not all necessary providers and/or service supports may be lined-up during the first fifty-six (56) calendar days of enrollment and therefore would not be available to be a part of the Multidisciplinary Team Meeting. The Health Home Care Manager continues to work with the member to include all necessary providers and supports at future Multidisciplinary Team Meetings to ensure member needs are fully addressed. If there is a Significant Life Event with the member that requires a change(s) in the Plan of Care, the Health Home Care Manager should consider having a Multidisciplinary Team Meeting and/or contacting relevant involved providers. A Multidisciplinary Team Meeting is held annually when the Plan of Care is reviewed. Additionally, a Multidisciplinary Team Meeting can occur at the request of the member, other Multidisciplinary Team members or, if the Health Home Care Manager thinks it would be helpful due to the events that are occurring in the member's life. **NOTE:** For Health Home Serving Children, see the UPDATED Health Home Serving Children Care Management Core Services Requirements and Billing Policy HH0017 September 2024) Should a provider(s) not be able to attend a Multidisciplinary Team Meeting in-person, the Health Home Care Manager 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 member Personal Health Information. Scheduling availability of Multidisciplinary Team members should not prevent the Health Home Care Manager from timely completion of the Plan of Care. The Health Home Care	**2- All plans of care must include the following:**

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			Manager should connect with Multidisciplinary Team members as a full group to obtain input and documentation needed to complete the Plan of Care. However, in instances when this cannot be accomplished, the Health Home Care Manager can facilitate smaller group contacts or have direct contact with single providers/others to obtain needed information from all Multidisciplinary Team members. For those Multidisciplinary Team members unable to participate at all, the Health Home Care Manager documents in the member's record an attempt(s) made to obtain information/update from those providers and update the Plan of Care accordingly for information received. If an invitee from the Multidisciplinary Team is unable to/does not attend, a phone conference and/or summary report can be given to ensure necessary information is provided for feedback and input. The Care Manager documents the Multidisciplinary Team Meeting in the member's record. A properly documented Multidisciplinary Team Meeting fulfills program requirements even when not all members of the Multidisciplinary Team who are invited to attend actually attend. Health Homes will ensure Care Management Agencies have a process in place to guarantee the Plan of Care is provided to the member and the member's family and significant others (Parent, Guardian, Legally Authorized Representative), and offered to the member's Multidisciplinary Team members, and made accessible via Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) to the Medicaid Managed Care Plans (MMCP) and other entities, such as State Agency Partners (SAP).	

	**Page 15-16,
	VIII. Health Home Care Manager Training**
		Section title has been revised and new language has been to clarify training topics.	**VIII. Health Home Care Manager Training**
			
			Health Homes include in policies and procedures training for Health Home Case Manager staff regarding the following topics:
			
			• Types of Plan of Cares and required timelines for completion:
			  o Initial
			  o High Fidelity Wraparound (HFW)
			  o Annual
			  o Significant Life Event
			  o Other Plan of Care
			• Plan of Care development and documentation requirements:
			  o Goals
			  o Interventions
			  o Progress in reaching goals
			  o Updates/changes to Plan of Care
			  o Individualized person-centered care planning and how to reflect that in a Plan of Care
				For all children's plans of care:

Document	New Page and Section	Update Made	Update Specifications Language may be completely new or partially reused from earlier policies. Reference "Former Location of Information" column.	Former Page and Section
			o Plan of Care signature and date requirements o Conducting Multidisciplinary Team Meetings o Billing	
	Pages 16, **X. Use of Health Information Technology (HIT)**	New language has been included to explain the option to utilize technology conferencing tools and the inclusion in policy to digitally upload the Plan of Cares into the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS).	**X. Use of Health Information Technology (HIT)** Health Homes have a structured, interoperable health information technology (HIT) system, policies, procedures, and practices to support the creation, documentation, execution, and ongoing management of a Plan of Care for every member. Health Home Case Manager 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 member Personal Health Information. The Health Home will use an electronic health record system that qualifies under the Meaningful Use provisions of the Health Information Technology for Economic and Clinical Health Act, which allows the member's health information and Plan of Care to be accessible to care team. Additionally, policies include the process for Plan of Cares to be digitally uploaded into the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) and monitoring adherence to timelines.	**3 and 4-** **For all children's plans of care:**

Updates made related to the 10 Elements of a Plan of Care (reference the Updates to the Previous 10 Elements of a Plan of Care document)				
Document	**New Page and Section**	**Update Made**	**Update Specifications** Language may be completely new or partially reused from earlier policies. Reference "Former Location of Information" column.	**Former Page and Section**
Health Home Plan of Care Policy		Language referencing the "10 elements" has been removed {Separate chart provided regarding the location of each of the 10 elements where required, as part of the updated Plan of Care policy or elsewhere}	~~Children's Health Home has 10 required elements of Plan of Care as outlined in the "Health Home Standards and Requirements for Health Homes, Care Management Agencies, and Managed Care Organizations" https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf~~ ~~Subsequently, when working with the member and their family, the children's Plan of Care should reflect that the "Health Home Comprehensive Assessment Policy" appendix C: "Required Components of the Health Home Comprehensive Assessment (Children)" have been reviewed and obtained as part of the development of the Plan of Care. https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/comprehensive_assessment_policy.pdf~~	**2**
			• ~~emergency contact and disaster plan for fire, health, safety issues, natural disaster, or other public emergency;~~ • ~~other service plans as appropriate, such as Early Intervention Individual Service Plan and foster care Family Assessment Services Plan, which should be reviewed by the care team and appropriate items incorporated as needed;~~	**2**

List of existing policies related to the Health Homes Plan of Care Policy that will be updated:

- HCBS Plan of Care Workflow Policy
- Health Home Comprehensive Assessment Policy
- Health Home Standards and Requirements for Health Homes, Care Management Agencies, and Managed Care Organizations
- Transfer Referral Process Between the Children and Youth Evaluation Services (C-YES) and Health Home Serving Children (Health HomeSC)

Appendix:

General language updates to all policies will be made based on the updated language in the **Health Homes Plan of Care Policy** as follows:

- "Adverse event" will be changed to "Significant live event"
- "Needs, goals, and preferences" will change to "needs, goals, preferences, and interventions"