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Approved by:

Applicable to: Health Homes Serving Children (HHSC), Health Home Care Managers (HHCM), Care Management Agencies (CMA)

Purpose: To establish standards and clear guidance regarding Health Home person-centered Plans of Care, which will inform New York State Health Home and Care Management Agency policies and procedures.

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Definitions

Formal Supports –

Paid support system that provides formalized services based on the goals/needs and interventions/activities outlined in the Plan of Care (e.g. Home Health Aide).

High Fidelity Wraparound (HFW) –

High Fidelity Wraparound (HFW) is a research oriented, evidence-based care management approach that has been proven successful with children with Serious Emotional Disturbance (SED) who have significant mental health needs, including cross-system needs, that have led to the child/youth being admitted to or at imminent risk of long-term hospitalization or out of home placement and treatment. HFW uses a team approach to support youth and their families to meet their needs.

In-Person –

An interaction that must be conducted with both the member and Health Home care manager physically in the same location. This type of interaction cannot be done via telehealth.

Initial/Comprehensive Plan of Care –

The first Plan of Care created for a newly enrolled member that has a required timeframe for completion of fifty-six (56) calendar days from enrollment (based on the consent date or the segment start date, whichever is later). These terms can be used interchangeably.

Interventions or Supports –

The necessary activities and strategies used by the provider/service that support the member/participant's progress in accomplishing their objective(s). These terms can be used interchangeably.

Member or Participant –

The individual (both adults and children/youth) enrolled in the Health Home program. The term includes the parent, guardian, legal authorized representative of the member, as applicable. These terms can be used interchangeably.

Multidisciplinary Team (MDT)/Interdisciplinary Team (IDT)/Child & Family Team Meeting (CFTM)/Case Review Meeting/Case Conference/Care Conference/Care Team Meeting members -

Consists of the Health Home care manager, member, member supports (including parent, guardian, legally authorized representative), Medicaid Managed Care Plan (MMCP), healthcare, and service providers, collaterals and others approved by the member to ensure member needs are addressed in a comprehensive manner. The composition of a Multidisciplinary Team may vary at any point in time during the member's enrollment and from member to member. These terms can be used interchangeably.

Multidisciplinary Team (MDT)/Interdisciplinary Team (IDT)/Child & Family Team Meeting (CFTM)/Case Review Meeting/Case Conference/Care Conference/Care Team Meeting is-

A non-hierarchal group of healthcare professionals who are discipline oriented but work in parallel with one another to provide comprehensive, individualized care to the member. The focus is to support the members' needs and objectives, address any potential challenges, and increase the likelihood of successful outcomes. In addition to professionals, non-professionals and family/supports identified by the member may be part of the Multidisciplinary Team (MDT)/ Interdisciplinary Team (IDT)/Child & Family Team Meeting (CFTM)/Case Review Meeting/Case Conference/Care Conference/Care team at any point in the member's HH enrollment.

Natural Supports –

Informal, unpaid support systems as identified by the member in their case records, Comprehensive Assessment, or Plan of Care (e.g. family member).

Goals –

Identified high level desired outcome(s) for a member's specific need(s)/ concern(s) and the program/service eligibility criteria, as outlined in the Plan of Care (POC).

Objectives –

A member's specific and measurable actions that will help accomplish their goal.

Person-Centered

Person-centered planning (PCP) is a process led by the person receiving support in collaboration with chosen team members that results in the co-creation of an action plan centered around the individual's most valued priorities and wellness goals.

Plan of Care -

A roadmap to behavioral and physical health, and recovery which guides the providers and the member, their family, and other supports toward achieving the member's goals for successful outcomes. Based on a thorough assessment of the individual's strengths, preferences, barriers, and needs, the Plan of Care will define which paid and unpaid services and supports the person has approved to work with.

Significant Life Event –

Specific experiences or changes in medical and/or behavioral health or social needs that directly impact/alter the member's life.

Telehealth –

Telehealth is defined as the use of electronic information and communication technologies to deliver health care to patients at a distance. Medicaid covered services provided via telehealth include assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a Medicaid member. Telehealth is utilized based upon the request of the member/caregiver and must be documented within the case record. Care managers must also adhere to general Medicaid telehealth guidance when delivering services via telehealth, which requires that services be based on the best interest and needs of the member, not that of the provider nor for the convenience of the provider.

For additional Telehealth guidance, including billing guidance, refer to NYS Medicaid Coverage of Telehealth or the Medicaid Telehealth Policy Manual. For Health Home Serving Children, please refer to the *UPDATED Health Home Serving Children Care Management Core Service Requirements and Billing Policy #HH0017* – September 2024

I. Policy

Health Homes serving adults and children will establish and maintain policies and procedures that are based on State policy, including how and when the Plan of Care is created, implemented, updated, and distributed for all consented Health Home members. In addition, Health Homes (HH) will have clear and focused Plan of Care training requirements and maintain a quality assurance program to ensure compliance.

*This policy document, Health Home Plan of Care Policy-HH0008, supersedes all previous versions of this policy.

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 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 Care Manager core service requirements are met through providing the intervention in the Plan of Care; however, periodically, additional Health Home Care Manager services may be needed based on the member's needs at times. The member's needs should drive the intensity and frequency of Health Home Care 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 plays a central and active role in the development and execution of their Plan of Care and agrees 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 qualifying diagnosis for Health Home, such as Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), Substance Use Disorder (SUD), HIV/AIDS, Complex Trauma, Sickle Cell Disease, or chronic conditions (Health and Community Based Services needs for children/youth) and other healthcare and 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.

> **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)

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.

II. Plan of Care 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.

A. Initial Plan of Care Development

Health Homes will ensure that 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 completed 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 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 Multidisciplinary Team members and other entities for which service provision linkages may already exist or are newly made to support development of the Initial Plan of Care (see Section VII. Conducting Multidisciplinary Team Meetings). Health Home Care Managers document all involvement.
- Is signed and dated by the member (for children who are age-appropriate to

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

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 is 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 this 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).

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 Care 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 all 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 Care 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) calendar 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 is to identify goals, interventions, and resources which serve to develop a member's capacity to live independently. 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 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 as well as the party responsible for conducting the action steps. For Foster Care members, the Care Manager begins this process no less than eighteen (18) months before the member's twenty-first (21st) birthday.

IV. Home and Community Based Services (HCBS) 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 of Adult Behavioral Health and Health and Community Based Services.

Medicaid Managed Care Plans (MMCP) 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 (MMCP) authorize Frequency, Scope, and Duration as outlined in the Health and Community Based Services Plan of Care Workflow policy.

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.

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 Events include, but are 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

- 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 (for example, when a goal/goals is achieved); however, if a Plan of Care needs to be changed as a result of a member's Significant Life Event the Health Home Care Manager reviews and updates the Plan of Care accordingly. If a Significant Life Event is identified, the Health Home Care 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.

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 Health Home 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:

- 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)

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.

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 in the Guidance for Use of the Continued Eligibility for Services (CES) Too and in the DOH - Health Home Continued Eligibility for Services (CES) Tool

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 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 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).

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.

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.

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

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

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).

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 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).

VIII. Health Home Care Manager Training

Health Homes include in policies and procedures training for Health Home Care Manager staff regarding the following topics:

- Types of Plan of Cares and required timelines for completion:
    - Initial
    - High Fidelity Wraparound (HFW)
    - Annual
    - Significant Life Event

    - Other Plan of Care
- Plan of Care development and documentation requirements:
    - Goals
    - Interventions
    - Progress in reaching goals
    - Updates/changes to Plan of Care
    - Individualized person-centered care planning and how to reflect that in a Plan of Care
    - Plan of Care signature and date requirements
    - Conducting Multidisciplinary Team Meetings
    - Billing

IX. Quality Management Program

Health Homes have a person-centered Plan of Care quality assurance process in place to comply with Health Home policies and procedures as outlined in the Health Home Quality Management Program policy.

X. Use of Health Information Technology (HIT)

Health Home 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 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. 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.

Relevant Statutes and Standards

- Eligibility Requirements for Health Home Services and Continued Eligibility in the Health Home Program HH0016
- UPDATED Health Home Serving Children Care Management Core Services Requirements and Billing Policy HH0017 September 2024)
- Guidance for Use of the Continued Eligibility for Services (CES) Tool
- Access to/Sharing of Personal Health Information (Personal Health Information) and the Use of Health Home Consents HH0009

- Health Home Comprehensive Assessment Policy (Adult and Children) HH0002
- Member Disenrollment From the Health Home Program HH0007
- Health Home Notices of Determination and Fair Hearing Policy HH0004
- Health Home Standards and Requirements for Health Homes, Care Management Agencies, and Managed Care Organizations
- Health Home Enrollment and Information Sharing Consent For Use with Children Under 18 Years of Age (DOH 5201)
- Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) Segment End Date Category & Reason Codes Crosswalk and Guidance Chart
- **Plan of Care Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) Specifications Document**

  NOTE: There are two documents that together describe the structure of the Plan of Care files and describe how the files work. As these documents are updated a few times a year, follow the instructions below to access the most recent Plan of Care Specifications Documents:
  - Click on this link
    Expand the *Tracking System Updates and File Formats* section

  For the detailed Plan of Care file specifications in excel, find the most recent Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) Plan of Care File Specifications link in the **Updated File Specifications (XLSX)** column.

  For a description of how the Plan of Care file works, find the most recent Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) Specifications PDF in the **Updated File Specifications Document (PDF)** column (*see Plan of Care Files* section).