



Health Home Standards and Requirements for Health Homes, Care Management Agencies, and Managed Care Organizations UPDATED May 1, 2022

Introduction: The purpose of this guidance document is to explain and clarify the roles and responsibilities of Lead Health Homes, downstream Care Management agencies and Managed Care Organizations (MCOs) for the provision of Health Home services; and for Managed Care members, the Medicaid Managed Care benefit package care management services to enrollees as required by the Medicaid Managed Care Contract.

Please note: The outlined Standards and Requirements apply to both the Health Homes Serving Children and Adults, unless otherwise specified. Section F specifically outlines Standards and Requirements for the Health Home Serving Children's program as of the noted date above.

A. State Plan Standards and Requirements for Health Homes

As specified in the State Plan, Health Homes are required to provide the following six Health Home Core Services. Health Homes must have policies and procedures in place to ensure care management services meet the following requirements.

1. Comprehensive Care Management

Lead Health Home must have planning, and policies and procedures in place to ensure care managers create, document, execute and update an individualized, person-centered plan of care for everyone.

1a. A comprehensive health assessment that identifies medical, behavioral health (mental health and substance use) and social service needs is developed.

1b. The individual's plan of care integrates the continuum of medical, behavioral health services, rehabilitative, long term care and social service needs and clearly identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager and other providers directly involved in the individual's care.

1c. The individual (or their guardian) play a central and active role in the development and execution of their plan of care and should agree with the goals, interventions and time frames contained in the plan.

1d. The individual's plan of care clearly identifies primary, specialty, behavioral health and community networks and supports that address their needs.

1e. The individual's plan of care clearly identifies family members and other supports involved in the individual's care. Family and other supports are included in the plan and execution of care as requested by the individual.

1f. The individual's plan of care clearly identifies goals and timeframes for improving the individual's health and health care status and the interventions that will produce this effect.



1g. The individual's plan of care must include outreach and engagement activities that will support engaging individuals in their care and promoting continuity of care.

1h. The individual's plan of care includes periodic reassessment of the individual needs and clearly identifies the individual's progress in meeting goals and changes in the plan of care based on changes in patient's need.

2. Care Coordination and Health Promotion

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

2b. The Health Home provider will assign each individual a dedicated care manager who is responsible for overall management of the individual's plan of care. The Health Home care manager is clearly identified in the individual's record. Each individual enrolled with a Health Home will have one dedicated care manager who has overall responsibility and accountability for coordinating all aspects of the individual's care. The individual cannot be enrolled in more than one care management program funded by the Medicaid program. **2c.** The Health Home provider must describe the relationship and communication between the dedicated care manager and the treating clinicians that assure that the care manager can discuss with clinicians on an as needed basis, changes in the individual's condition that may necessitate treatment change (i.e., written orders and/or prescriptions). **2d.** The health home provider must define how care will be directed when conflicting treatment is being provided.

2e. The Health Home provider has policies, procedures and accountabilities (contractual agreements) to support effective collaborations between primary care, specialist and behavioral health providers, evidence-based referrals and follow-up and consultations that clearly define roles and responsibilities.

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

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

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

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



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

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

3. Comprehensive Transitional Care

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

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

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

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

4. Enrollee and Family Support

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

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

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

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

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

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

5. Referral to Community and Social Supports

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

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

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

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

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

Initial Standards

6a. Health Home provider has structured information systems, policies, procedures and practices to create, document, execute, and update a plan of care for every patient. **6b.** Health Home provider has a systematic process to follow-up on tests, treatments, services and, and referrals which is incorporated into the patient's plan of care. **6c.** Health Home provider has a health record system which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers and which allows for population management and identification of gaps in care including preventive services.

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

Final Standards

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

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

6g. Health Home provider will be required to comply with the current and future version of the Statewide Policy Guidance

(http://health.ny.gov/technology/statewide_policy_guidance.htm) which includes common information policies, standards and technical approaches governing health information exchange.

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

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

B. Additional Health Home Standards and Requirements

In addition to the core services established above, Health Homes must have policies and procedures in place to satisfy each of the requirements below. Health Homes shall ensure compliance by their subcontracted care management providers with applicable policies and procedures or require such providers to establish additional policies and procedures to ensure compliance with these requirements.

1. Lead Health Homes must identify a single point of contact and establish communication protocols with Managed Care Organizations (MCOs).
 - a) Health Homes must use information and performance data, including outreach and enrollment data, dashboards and other data made available through Medicaid Analytic Performance Portal (MAPP), and hold periodic meetings with care managers and MCOs to evaluate and improve performance.
 - b) Health Homes should ensure care managers have access to other pertinent administrative data that may not be available in MAPP to inform real time decision making regarding outreach and engagement efforts.
 - c) The Health Home should have an identified point of contact and clear processes for community referrals (*inclusive of individuals/providers who do not have access to the Children's Health Home Referral Portal*) including (but not limited to) from Local Government Units/Single Point of Access (LGUs/SPOA), Local Department of Social Services (LDSS), inpatient settings, forensic releases, pediatricians, and community providers to coordinate timely linkage to a care manager, with special consideration for individuals receiving Assisted Outpatient Treatment (AOT), and other specific populations as described in this document.
2. Health Homes must have policies and procedures in place for responding when critical events occur, including when a member 1) has presented at a hospital ER/ED and was not admitted 2) is admitted to inpatient hospital or 3) when the member is



in crisis and presents at a location that provides additional opportunities to outreach, connect to services, and engage the member. Such policies and procedures must incorporate information that will become available through MAPP referral portal and MAPP alerts.

3. Health Home care management providers must contact enrollees within 48 hours of discharge from an inpatient unit, ER, hospital, residential, detention, etc. (when they are notified or become aware of the admission), or sooner if clinically indicated, to facilitate the care transition. Health Home care managers shall engage in the discharge planning process, including the review of upcoming appointment dates and times, medication reconciliation, and potential obstacles to attending follow-up visits and adhering to recommended treatment plan.
4. When Health Home care management providers are notified or become aware of an enrollee's admission to a detox facility they must attempt to make a face-to-face contact 1) during the stay of an enrollee that has been admitted to a detox facility and 2) within 24 hours of discharge from a detox facility to ensure that the enrollee is aware of follow-up appointments and to provide supports for getting to appointments.
5. As a best practice, *Health Homes Serving Adults* should communicate with care management providers to assess their capacity to accept new referrals prior to sending them assignments. Such communication will help ensure that the care management providers will be able to act promptly in their efforts to locate and enroll prospective members. As a best practice, after receipt of a referral from a Health Home, Health Home care management providers should begin outreach immediately.

For *Health Homes Serving Adults*, if the Health Home sends an assignment list during the 1st to the 15th of the month, outreach should begin immediately. If Health Home sends an assignment list on the 16th of the month or later outreach can begin immediately but may be initiated the following month to take advantage of the full month of outreach, but no later than the 5th business day of the following month. Health Homes shall require documentation from Health Home care management providers regarding any failure of the care management provider to commence outreach activities within these timeframes. Such documentation shall state the reasons for not meeting such timeframes and shall propose a corrective action plan.

Health Homes shall thereafter report such deficiencies and corrective action plans to the MCO and the State.

6. Health Home care management providers must assign care managers to enrollees based upon care manager experience and defined member characteristics including, but not limited to, acuity, presence of co-occurring or co-morbid Serious Mental



7. Illness (SMI) or Serious Emotional Disturbance (SED), Substance Use Disorder (SUD) or co-occurring medical co-morbid conditions, and patterns of acute service use.
8. Health Homes must submit plans of care, for review and approval by the enrollee's MCO as required in developed procedures and workflows. The approved plan of care is reassessed at least annually, and more frequently when warranted by a significant change in the member's medical and/or behavioral health condition. Such reassessment shall document the member's progress in meeting his or her goals from prior plans of care and shall be documented in the member's record.
9. The plan of care should be developed by experienced and qualified individuals. Lead Health Homes are responsible for ensuring that care managers and supervisors are appropriately trained and that trainings and qualifications of care managers are appropriate and reflect the populations that care managers serve. *(See Section F for HHSC care manager and supervisor training requirements and qualifications)*
10. The Health Home and MCO must establish clear lines of responsibility to ensure services are not duplicated.
11. For all individuals enrolled in a *Health Home Serving Adults*, the plan of care must include the following specific elements: *(See Section F for HHSC POC elements)*
 - The individual's stated **Goal(s)** related to treatment, wellness and recovery (1e);
 - The individual's **Preferences and Strengths** related to treatment, wellness and recovery goals;
 - **Functional Needs** related to treatment, wellness and recovery goals (1e);
 - **Key Community Networks and Supports both formal and informal that address identified needs;**
 - Description of planned **Care Management Interventions;**
 - The individual's **Signature** documenting agreement with the plan of care; and
 - Documentation of participation by all **Key Providers** in the development of the plan of care.
 - Medicaid State Plan and Non-Medicaid services identified to meet individual's needs must be person-centered, comprehensive and integrated to include physical, behavioral health, community, and social supports as stated under Section A.1; 1.d.

The Plan of Care elements are the minimum standards required for Plans of Care. Health Homes may expand the required plan of care elements.
11. Health Homes that provide care management and direct services must ensure that the provider providing care management is not the same as the provider providing direct care services and that these individuals are under different supervisory structures.

12. Health Home care managers are restricted from assessing a person for whom they have financial interest or other existing relationship that would present conflict of interest.
13. Enrollees shall be provided with a choice of providers from among all the MCO's network providers of a particular service. Health Homes shall document the enrollee's selection in the plan of care.
14. Health Homes must submit claims to MCOs within 120 days after the date of service to be valid, however, there is nothing to preclude the MCOs and the Health Homes from agreeing to other terms which are more favorable to the Health Home.
15. Health Homes must provide access to and information regarding training opportunities that include:
 - a) Marketing Health Home care management services;
 - b) Typical care management needs of populations with multiple co-morbidities;
 - c) Evidence-based methods for increasing engagement including Motivational Interviewing, Recovery-Oriented Practices, Person-centered Planning, role and benefits of Certified Peer Specialists/Peer Advocates and Wellness Recovery Action Plans;
 - d) Outreach and engagement strategies for members who are disengaged from care or have difficulty adhering to treatment recommendations including individuals with histories of homelessness, criminal justice involvement, first-episode psychosis and transition-age youth;
 - e) The availability and range of services that would be beneficial to Health Home members (e.g., Home and Community Based Services for HARP members and Assisted Outpatient Treatment); and
 - f) Training on any State required assessment tools.

(Health Home Serving Children has several additional required trainings outlined in Section F of this document)

16. Health Homes must have policies and procedures in place to ensure consistent use of any State required eligibility and assessment tools to ensure high inter-rater reliability standards.
17. When an MCO elects to request assistance from the member's Health Home care management provider to carry out its responsibilities to provide notice of enrollee rights under Section 13.6 of the Medicaid Managed Care Contract for Adults, the MCO shall provide the member's Health Home care manager with information about the means employed to contact the member, including the dates of attempted contact, the outcome of the attempted contact (i.e. mail returned undeliverable, telephone service disconnected), and the address(es) and/or telephone number(s) used to contact the member, if available.



18. Health Homes shall undertake the following engagement efforts for members lost to follow-up (lost to service). Please see the revised HH policy - Continuity of Care and Re-engagement for Enrolled Health Home Members #HH0006 and the FAQs at https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/greater6.htm

C. Additional Health Home Standards and Requirements for Specialty Mental Health Care Management Agencies (SMH CMA) serving Health Home Plus Adult enrollees with Serious Mental Illness (HH+ SMI), including Assisted Outpatient Treatment (AOT) enrollees:

Specialty Mental Health Care Management Agencies serving the HH+SMI population will have unique program guidelines and its own rate code. Please refer to the OMH website for program and billing guidance. (All AOT enrollees must be enrolled in a Health Home Serving Adults. Young adults that are on AOT who are in a Health Home Serving Children must be transferred to a Health Home Serving Adults with the appropriate AOT providers.)

Effective March 8, 2021, only CMAs designated by the NYS OMH as Specialty Mental Health Care Management Agencies (MH CMAs) will be eligible to enroll newly referred individuals meeting HH+ SMI eligibility criteria. Only Specialty MH CMAs currently authorized by the State, LGU and lead Health Home(s) will have the ability to accept referrals, serve and bill HH+ for individuals on AOT.

Health Home Plus (HH+) is an intensive Health Home Care Management (HHCM) service established for defined populations with Serious Mental Illness (SMI) who are enrolled in a Health Home (HH) serving adults.

HHs must have Specialty MH CMA capacity in their network to ensure HH+ services will be available for adults with SMI and who meet certain indicators for high need, such as risk for disengagement from care and/or poor outcomes (e.g., multiple hospitalizations, incarceration, and homelessness), as outlined in HH+ SMI program guidance issued by the State.

In the case where a HH member becomes HH+ SMI eligible while enrolled with a non-Specialty MH CMA, lead Health Homes shall ensure care managers are informing HH+ eligible members of their option to transfer to a Specialty MH CMA, and ensuring access to HH+ services, as appropriate.

HH+ individuals shall receive a level of service consistent with program requirements outlined in the HH+ SMI guidance:

https://omh.ny.gov/omhweb/adults/health_homes/hh-plus-high-need-smi-guidance.pdf

Additional program requirements for Individuals on AOT

1. Individuals receiving court ordered AOT will be assigned to a CMA with behavioral health expertise or otherwise qualified to serve HH+ individuals, through the Local Governmental Unit's (LGU) AOT process.
2. Individuals on AOT court orders must receive Health Home Plus services. Upon enrollment:
 - a) The Health Home care management provider must inform the Health Home when the recipient has been placed on court ordered AOT or when the court order has expired or has not been renewed (information provided in MAPP can be used to satisfy this requirement);
 - b) The Health Home must inform the MCO of the member's AOT status (information provided in MAPP can be used to satisfy this requirement).
3. Health Home care management providers working with court ordered AOT individuals must adhere to all Health Home Plus SMI Guidance issued by the State including:
 - a) Provide face-to-face contact at least four times per month
 - b) Work with the LGU's AOT coordinator as per local policy;
 - c) Comply with the court order and all statutory reporting requirements under Kendra's Law
 - d) Have a caseload ratio no greater than 1:20
 - e) Meet the minimum staff qualification standards and complete program requirements listed in Health Home Plus guidance available at: https://www.omh.ny.gov/omhweb/adults/health_homes/hhp-final.pdf
4. Health Home care managers must complete and submit all AOT reporting requirements to the Office of Mental Health (OMH) as required by AOT legislation and as currently reported in the OMH CAIRS (Child and Adult Integrated Reporting System).
5. Each Health Home must assure capacity to serve individuals receiving AOT. Individuals receiving AOT can be served by designated Specialty MH Care Management Agencies authorized by the State, the LGU and the lead Health Home.

D. Additional Health Home Serving Adults Standards and Requirements Related to the Provision of Home and Community Based Services to HARP Enrollees and HARP-eligible HIV SNP Enrollees.

1. Health Home care managers will perform Home and Community Based Services (HCBS) Eligibility Assessments to determine if HARP members are eligible for Home and Community Based Services.



For more information on the administration of and billing for the BH HCBS assessments please click on the link below:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/community_mental_health_assessments_billing_guidance.htm

2. As a best practice, Health Home care managers shall complete NYS Eligibility Assessment (brief interRAI) to determine HCBS eligibility within 10 days, but not longer than 21 days of an individual's assignment to the care management provider. As a best practice the entire assessment process, including both the brief and full assessment, should be completed within 30 days of the individual's enrollment in a State designated Health Home or other State-designated entity, but in no case, shall such process be completed more than 90 days after such enrollment unless such timeframe is extended by the State as necessary for a limited period to manage the large number of assessments anticipated during the initial HARP enrollment period.
3. Health Home care managers will perform HCBS reassessments at least annually and when there is a significant change in status for HARP members receiving HCBS such as hospitalization and loss of housing.
4. Health Home care managers that perform HCBS assessments or reassessments must meet the following qualifications:
 - a) A Master's degree in one of the qualifying fields and one (1) year of Experience; OR
 - b) A Bachelor's degree in one of the qualifying fields and two (2) years of Experience; OR
 - c) A Credentialed Alcoholism and Substance Abuse Counselor (CASAC) and two (2) years of Experience; OR
 - d) A Bachelor's degree or higher in ANY field with either: three (3) years of Experience, or two (2) years of experience as a Health Home care manager serving the SMI or SED population.

Experience must consist of:

- i. Providing direct services to people with Serious Mental Illness, developmental disabilities, alcoholism or substance abuse, and/or children with SED; OR
- ii. Linking individuals with Serious Mental Illness, children with SED, developmental disabilities, and/or alcoholism or substance abuse to a broad range of services essential to successful living in a community setting (e.g. medical, psychiatric, social, educational, legal, housing and financial services).

AND

Training and Supervision:

- a) Specific mandated training for the designated NYS Community Mental Health Assessment (community mental health suite of the interRAI) tool, the array of



- b) services and supports available, and the person-centered service planning process.
- c) Training in assessment of individuals whose condition may trigger a need for HCBS and other supports, and an ongoing knowledge of current best practices to improve health and quality of life.
- d) Supervision from someone meeting any one of the following:
 - i. Licensed level healthcare professional with prior experience in a behavioral health setting; OR
 - ii. Master's level professional with two (2) years prior supervisory experience in a behavioral health setting.

The State may waive such qualifications on a selected basis and under circumstances it deems appropriate which may include care manager capacity issues.

- 5. For individuals enrolled in a HARP, the plan of care must include the following additional specific elements:
 - a) Documentation of results of the Home and Community Based Services (HCBS) Eligibility Screen (e.g., Not Eligible, Eligible for Tier 1 HCBS only, Eligible for Tier 1 and Tier 2 HCBS);
 - b) For individuals eligible to receive HCBS, a Summary of the NYS Community Mental Health Assessment; and
 - c) For individuals eligible to receive HCBS, Recommended HCBS that target the Individual's identified goals, preferences, and needs.

For information on the BH HCBS plan of care approval process and timeframes please click on the link below:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hcbs_poc_workflow.pdf

- 6. Health Homes must prepare plans of care for HARP members receiving HCBS that meet the requirements established by the Centers for Medicare and Medicaid (CMS). *For more information on the CMS requirements for the BH HCBS POC and the Person Centered Planning Process please click on the links below:*
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hcbs_poc_fed_rules_regs.pdf
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hcbs_fed_person_centered_planning_process.pdf

- 7. A plan of care for HCBS is not required in instances where an enrollee:
 - a) is determined to be ineligible for HCBS; or
 - b) declines HCBS offered through the assessment process
- 8. For HARP Members that Opt-out of Health Home Services, but elect to receive HCBS, Health Homes may contract with MCOs to conduct NYS Eligibility Assessment and NYS Community Mental Health Assessment and to develop HCBS plans of care for

members that opt out of Health Home care management services. The HCBS plans of care must still be developed in accordance with HCBS plan of care requirements.

E. Additional Health Home Standards and Requirements for Health Homes Serving Adult Home Class Members Pursuant to a Stipulated Order and Settlement (RESERVED)

F. Additional Health Home Standards and Requirements for Health Homes Serving Children (HHSC)

Health Homes Serving Children must have policies and procedures in place to satisfy the outlined standards below and any policies and procedures developed by the Department.

Health Homes Serving Children must ensure their subcontracted care management providers are in compliance with policies and procedures or require those providers to create policies and procedures that confirm their compliance with the following standards and the Department's policies and procedures.

1. Determining Chronic Condition Eligibility and Appropriateness Criteria for Health Homes

The following Eligibility Requirements: Identifying Potential Members for Health Home Services:

- (1) process,
- (2) list of chronic conditions and
- (3) appropriateness criteria can be found:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/health_home_chronic_conditions.pdf

Chronic Condition Criteria is NOT population specific (e.g., being in foster care, under 21, in juvenile justice etc. does not alone/automatically make a child eligible for Health Home).

A. Complex Trauma Determination Process

Complex Trauma has been approved as a single qualifying condition for eligibility in Health Homes Serving Children. There is a DOH approved process to determine Complex Trauma and eligible tools as well as documents required for Complex Trauma eligibility.

Need Identified by Non-Licensed Professional or Licensed Professional without access to tools

- Complete the Complex Trauma Exposure Screen
- Referral Cover Sheet
- Other family and child history and information obtained
- If positive for Complex Trauma (on Exposure Screen) –Referral can be made for HH

Eligibility determined by Licensed Professional with access to tools

- Complex Trauma Exposure Assessment Form
- Functional Impairment Assessment through the completion of the appropriate identified NCTSN guideline list of domain assessment tools
- Complex Trauma Eligibility Determination Form
- Other family and child history and information obtained
- If positive Determination of Complex Trauma –Referral can be made for HH and Child is Eligible for Health Home under Complex Trauma single qualifying condition.

Licensed Professionals who may administer the Department of Health Complex Trauma Exposure Assessment, Functional Impairment Assessment(s) and Complex Trauma Eligibility Determination include:

- Licensed Masters Social Worker, LMSW
- Licensed Clinical Social Worker, LCSW
- Licensed Psychologist
- Licensed Psychiatrist
- Licensed Psychiatric Nurse Practitioner, LNPP,
- Licensed Marriage and Family Therapist, LMFT,
- Licensed Mental Health Counselor, LMHC
- Pediatrician/Family Medicine Physician or Internist *with specialization in Behavioral Health*

B. Verification of HHSC eligibility and appropriateness

Health Home appropriateness means that an individual requires the intense level of Health Home Care Management Services. Health Homes Serving Children aim to establish care management services for high need children who do not have the social and family support needed to manage their chronic condition. Children appropriate for Health Homes may have challenges such as lack of access to medical services or non-compliance with treatment. As a result, the child may be at risk for adverse events such as an inpatient hospitalization.

1. In order to be considered eligible for Health Home services, the individual must meet both **eligibility** and **appropriateness** criteria. Health Homes must ensure that both eligibility criteria and appropriateness criteria are documented in the

individual's care management record. Eligibility and appropriateness must be verified **prior** to HHSC enrollment.

2. Following verbal or written verification of the child's eligibility and appropriateness for HHSC services, a child can be enrolled in the Health Home program. For example: if a therapist tells a care manager that a child is both eligible and appropriate for HHSC services, the care manager must document in the child's record the information that the therapist provides (diagnosis for eligibility, details of the child's appropriateness for HHSC services). It is incumbent upon the HHCM to later gather documentation that confirms that at the time of enrollment, the child was both eligible and appropriate for HHSC services.
3. Appropriateness for Health Home must be continuously monitored and evaluated. HHSC care managers must document Chronic Conditions for Health Home eligibility criteria as well as an individual's appropriateness for Health Homes for enrollment.
4. No less than quarterly, care managers must actively **review** and **document** in the case record the child's eligibility, appropriateness and the need for this level of care management services. Reviews should evaluate and consider condition/stability of the child and eligibility criteria for which they entered Health Homes.
5. The Department has developed eligibility and appropriateness forms that can be utilized by Health Home care managers to document quarterly eligibility and appropriateness.
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/docs/hhsc_initial_and_quarterly_eligibility_and_appropriateness_documentation.pdf
 - a. For eligibility chronic conditions, other than Complex Trauma, care managers are required to document eligibility for Health Home that is based on chronic conditions (e.g., DSM-V- SED, and other diagnoses of chronic conditions) by including in the care management record appropriate diagnoses made by Medicaid qualified providers that are licensed practitioners acting within their scope of practice
 - b. For HIV/AIDS, documentation from a medical or social work provider indicating HIV status, date of diagnosis, most recent viral load count and most recent CD4 count must be documented in the care management record.
 - c. For Complex Trauma, care managers are required to document eligibility for HHSC that is based upon the outlined process and tools by including them in the care management record.



2. Obtaining and Utilizing the various Types of Consent

It is imperative that the Health Homes and Care Management Agencies train care managers surrounding how to work with a family regarding consent and the implications of obtaining proper consent as well as any clinical issues when obtaining consent. Health Home Care Managers who are responsible for obtaining consent, must be knowledgeable of the specific federal and New York State legal protections for minors related to minor consent. In addition, the Health Home Care Manager must be mindful of who is the responsible party able to provide consent, i.e., the parent, guardian, legally authorized representative or in some cases, the child/adolescent. Additionally, there are instances where both the parent, guardian, legally authorized representative and the child/adolescent must provide consent.

- Verbal consent is required to make a referral to Health Home Serving Children in the MAPP Referral Portal. Consent is required to enroll children and share protected health information in HHSC. The State has developed required consent forms; they are posted and available on the DOH Health Home website and are translated in multiple languages at:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/consent_forms-templates.htm

B. Health Home Serving Children Program: Types of Consent

1. Consent to Refer (Verbal Consent documented in the MAPP Referral Portal)
2. Health Home Consent Frequently Asked Questions (FAQ) for use with Children and Adolescents Under 18 Years of Age
3. Health Home Enrollment and Information Sharing Consent (Form DOH 5201) For Use with Children Under 18 Years of Age
4. Health Home Release of Educational Records Consent (Form DOH 5203)
5. Health Home Withdrawal of Release of Educational Records (Form DOH 5204)
6. Health Home Patient Information Sharing Consent form for adults (Form DOH 5055)

Health Homes Serving Children: Consent Document Guidance regarding the proper utilization of the HHSC consent forms can be found at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/consent_forms-templates.htm

C. General Consent Rules

1. The Children's Health Home program is for children and adolescents under the age of 21. **All Children must go through the MAPP Children's HH Referral Portal to be referred and then enrolled into the Children's Health Home Program.**



2. Children and adolescents who are parents, pregnant, married or are 18 years or older, are legally able to consent for their own enrollment into a Children's Health Home. They must do this by completing the Health Home Patient Information Sharing Consent form (DOH 5055). Children and adolescents completing the DOH 5055 form do not need a parent, guardian or legally authorized representative to be present to enroll in a Health Home.
3. Legally authorized representative for the purpose of sharing health information is defined as, "a person or agency authorized by state, tribal, military or other applicable law, court order or consent to act on behalf of a person for the release of medical information".
4. For children in foster care the legally authorized representative is the Local Department of Social Services (LDSS) in rest of State and the Voluntary Foster Care Agency (VFCA) who has placement of the child and an agency under contract with the Administration for Children's Services (ACS) to provide foster care in NYC.
5. To ensure that children in Foster Care who are found eligible and would benefit from Health Home services, have access to such service, the following process to obtain consent for children in foster care must be followed:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/hhsc_consent_for_children.htm

3. Outreach, Engagement to Enrollment

Consent to refer must be obtained in order to refer an individual who appears to be eligible and appropriate for Health Home services. An outreach segment can begin at this time.

During the outreach segment, the HH CM works with the member/parent/guardian/legally authorized representative to verify eligibility for Health Home Services and obtain consent to enroll, as well as other consents i.e. Functional Assessment Consent, Consent to Share information, etc.

A. Communication with the Referral Source

1. To ensure that individuals that make referrals of children to Health Home care management are informed of the outcome and disposition of their referral, care

managers are required to contact the referral source provided in Referral Portal, **within 48 hours** or as soon as practical, to identify themselves as the care manager and their care management agency.

2. This communication will provide the care manager the opportunity to obtain important information about the child and family, and if appropriate, discuss possibly including the individual in the interdisciplinary team.
3. For referrals that come from LGU/SPOAs, will provide the care manager with the opportunity to discuss county-specific services and other ways the LGU/SPOAs can assist the care manager in developing comprehensive care plan for the child.
4. Involved professionals, inclusive of the referral source (if appropriate) with the referred child/adolescent should be involved in the inter-disciplinary team meetings.
5. If a family refuses to consent to enroll, the outreach segment should be terminated, and any **referring entity must be notified** that the family declined services and they can be re-refer at a later time. Documentation of such prior to closing the referral (outreach segment) is needed.
6. Once eligibility has been determined, the enrollment consent should be signed and the child/adolescent should be enrolled in HHSC program with an enrollment segment. Enrollment consent should not be obtained until the child/adolescent is known to be eligible for HH CM services.

B. Progressive Outreach

1. After a referral is made and a HHCM is assigned, the HHCM should work diligently, according to the HH Outreach policy, to contact the family, educate them regarding the HH program and care management services, and determine if the child/adolescent is eligible to be enrolled in the program.
2. If the HH CM is unable to locate or enroll the child/adolescent initially, then progressive outreach with a core service is needed to bill for outreach.
3. **Active and meaningful** outreach would include direct communications (face to face, electronic or by telephone) with the member (if appropriate, with appropriate consent) or their parent/guardian/legally authorized representative (with appropriate provisions to ensure patient privacy is protected).
4. There should be evidence that outreach efforts are progressive and are escalated as appropriate with the expected outcome of enrollment. All outreach efforts **MUST** be documented in the member's record.

5. If the member/parent/guardian/legally authorized representative indicates that they do not want the HH service, then the outreach segment should be closed immediately, proper documentation in the member's record and proper notification to the referral source should occur.

4. Pending Assignments

The State expects the MCOs, HHs and CMAs to review daily the Medicaid Analytics Performance Portal and that assignment with an outreach or enrollment segment is initiated within 3 business days.

A. Referral Process:

The members or parent/guardian/legally authorized representative choice of assignment to a specific Health Home and or Care Management Agency must be paramount in the assignment process.

1. Referring a child/adolescent with a Managed Care Plan (MCO)
 - If a referred child/adolescent has a Managed Care Plan (MCO), the referral through the MAPP Referral Portal will be sent to the MCO assignment file. The MCO will have up to 3 business days to assign the referral to a Lead Health Home.
 - The Lead Health Home then has up to 3 business days to assign the referral to a Health Home Care Management Agencies (CMA) for a care manager to be assigned.
 - Once a CMA is assigned, the care manager should be assigned no more than **within 24 hours**.
2. Referring a child/adolescent Fee for Service (FFS)
 - If a referred child/adolescent does not have a Managed Care Plan (MCO) and is therefore FFS, the referral through the MAPP Referral Portal will be sent to a Lead Health Home assignment file. The Lead Health Home is determined by the Health Home which has a number of providers involved with the referred child/adolescent (past or present) on their (Lead HH) network providers list. The assigned Lead Health Home will have up to 3 business days to assign the referral to a Health Home Care Management Agencies (CMA) for a care manager to be assigned.
 - Once a CMA is assigned, the care manager should be assigned no more than **within 24 hours**.



3. Referring a child in Foster Care

- The Health Home model for children recognizes that children in Foster Care are in the care and custody of Local Department of Social Services (LDSS) in Rest of State and the Administration for Children Services (ACS) in New York City. New York City ACS delegates its care role to the Voluntary Foster Care Agency (VFCA).
- Only a LDSS (in Rest of State) or NYC VFCA can make a Health Home referral for a child in foster care.
- The Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) was built for the LDSS (NYC VFCA) to refer children in foster care and directly link to a VFCA who is also a Health Home Care Management Agency.
- Since the LDSS for children in foster care selects and directly assigns the CMA (which is a VFCA HH CMA) without the referral first going to the MCO or Lead Health Home, these pending assignments will not be known to the Lead Health Home until such time that the CMA assigns a CM and a MAPP segment of outreach or enrollment is created for a Health Home connection to be made.
- Therefore, CMAs (VFCAs) need to work with LDSS to request if they are making an assignment to ensure that the HH CMA is aware of the referral for the HH program.
- Daily monitoring of the MAPP Referral assignment file and assigning care managers within 24 hours as required, will prevent a delay in an assignment of a child/adolescent in foster care.
- Should a LDSS want to make a Health Home referral for a child/adolescent in foster care but would like to assign a non-VFCA care management agency, then the outlined posted process should be followed:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_home/s/hh_children/guidance/hh_referral_of_foster_care_child_to_non-vfca.htm

5. Staff Qualifications, Training Requirements and Supervision for Health Homes Serving Children Care Managers

A. Staff Qualifications

The New York State Department of Health (DOH) has outlined in the Health Home Serving Children Standards that care managers must meet staff qualifications.

These qualifications are the **minimum** standard and apply to all care managers serving children with an acuity level of **“high”** as determined by the CANS-NY.

1. Staff qualifications for 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.

2. Health Homes may seek a waiver from the State for care managers that have demonstrated experience but do not meet the required criteria. The process can be found at the following:
 - https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/guidance/hhcm_staff_qualification_waiver_guidance.htm
 - https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hhcm_staff_qualification_waiver_form.pdf
3. Health Homes may establish staffing requirements that exceed these standards (e.g., to better serve the particular needs of the children the Health Home may serve)

B. Health Home Care Manager and Supervisor Training

In addition to staff qualifications, care managers and supervisors are required to complete trainings outlined below. Health Homes must have policies and procedures surrounding required trainings and how such monitoring will occur to ensure completion of such requirements. Lead Health Homes may require additional trainings as they see necessary to deliver quality care management services.

1. Prior to providing Health Home care management services, to children or families, the following required training must be completed:
 - 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
 - Mandated Reporter training - [New York State Mandated Reporter Resource Center - Training Course](#)



- Consent – HIPAA/CFR 42/sharing of information
- Trainings provided by the State for Health Homes Serving Children (or by the Lead Health Home)

It is incumbent upon the lead Health Home to ensure that their subcontracted care management providers are aware of State issued guidance, trainings, webinars and standards. Health Homes can use DOH webinars to inform their training of care managers. Training, Webinars and Presentations provided by DOH can be found at the link below:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/webinars/index.htm

2. The following training for care managers and supervisors is required to be completed within **six months** of employment or from the first date care managers or supervisors provide any Health Home care management services:
 - 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)
 - Trauma Informed Care
 - Person Centered Planning
 - Cultural Competency/Awareness
 - LGBTQ Issues – serving transgender children/adolescents and working with Lesbian/Gay/Bisexual/Transgender/Questioning Families
 - Meeting Facilitation
3. For Health Homes Serving Children, the care managers and supervisor completing the CANS-NY must be trained and certified in the CANS-NY on an annual basis.
4. Health Homes must document compliance with training requirements for care managers and supervisors prior to the delivery of services and within six months of employment.

C. Supervisor to Care Management Ratios, Caseload Ratios

1. Health Homes Serving Children must establish supervisor to care management ratios. As a best practice, care management agencies should have a supervisor to care manager ratio of 1:5. This is the recommendation by DOH. Health Homes must establish and document their supervisor to care manager ratio requirements for care management agencies.
2. Health Homes should work with care management agencies to establish and review the workload expectations of supervisors to ensure oversight and documentation of the delivery of quality care management services (i.e., the

- work of supervisors must go beyond administrative functions related to personnel management).
3. The “Rate Build” assumes case load assumptions of High: 1:12, Medium 1:20 and Low 1:40. Case load assumptions were developed only for the rate build and are **NOT** mandated caseloads. Health Homes must have policies and procedures that outline the HH’s expected allowable caseload ratio and how caseloads will be monitored across the HH’s care management network. Health Homes and HH CMAs need to manage caseload ratios to ensure quality of services provided to children.
 4. Goal of keeping case load ratios as low as practicable and to provide Health Homes and care managers flexibility in assigning children with various levels of needs/acuties
 - Care managers providing services to “high” acuity children (as determined by the CANS-NY Health Home billing algorithm) are required to keep their caseload mix predominantly to children of the High acuity level.
 - Care managers providing services to “medium” and “high” acuity children (as determined by the CANS-NY Health Home billing algorithm) will be required to provide two Health Home services per month, **one of which must be a face-to-face encounter with the child.**
 5. Health Homes Serving Children will have policies and procedures outlining what an acceptable caseload size is based upon acuity, as well as have performance management oversight of CMAs caseload sizes of their care managers.

The State’s performance management activities and re-designation process will review the relationship between Health Homes’ supervisor to care management ratios, caseload and the quality of care management being provided and determine if it is impacting performance. Additionally, reviews will include the relationship between the frequency of services provided by the care manager as related to the member’s needs to assess the quality of care management being provided.

6. Child Adolescent Needs Strengths (CANS-NY)

A. CANS-NY Standards

The CANS-NY assessment tool is a multi-purpose tool to support decision making, including level of care, acuity and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. Developed from a communication perspective to facilitate the linkage between the assessment process and the design of individualized service plans. Provides the care coordinator, the family, and service providers with a common language to use in the development, review, and update of the child’s care plan. Designed to give a profile of the current

functioning, needs, and strengths of the child and the child's parent(s) and/or parent substitute.

CANS-NY tool is housed in Uniformed Assessment System (UAS) and interfaces with Medicaid Analytics Performance Portal (MAPP) to provide billing information for Health Home care coordination. The CANS-NY assessment (as modified for New York) is conducted by the Health Home care managers to determine a care management acuity, using an algorithm run against the results of a completed CANS-NY, for purpose of determining Health Home per member per month rate (i.e., High, Medium, Low).

CANS-NY by itself will not determine Health Home eligibility. Additionally, the CANS-NY will also be employed to determine HCBS eligibility with transition to managed care.

1. The CANS-NY is completed best practice within 30-days of enrollment in a Health Home.
2. The CANS-NY must be completed every 6 months from the first day of the month it was completed, unless one of the following significant life event occurs that requires the CANS-NY to be completed prior to 6 months:
 - Significant change in child's functioning (including increase or decrease of symptoms or new diagnosis)
 - Service plan or treatment goals were achieved
 - Child admitted, discharged or transferred from hospital/detox, residential placement, or foster care
 - Child has been seriously injured or in a serious accident
 - Child's (primary or identified) caregiver is different than on the previous CANS-NY
 - Significant change in caregiver's capacity/situation
 - Court request

Health Homes will be expected to meet best practice standards by completing the Early Reassessment CANS-NY 30 days from the date of the Documented significant event selected above.

3. Upon completion of the CANS-NY assessments tools (ages 0-5 and ages 6-21) and algorithm will be run for the purpose of determining the Health Home Per Member, Per Month (PMPM) fee for children under 21. The Health Home PMPM for children, i.e., referred to as High, Medium, or Low (HML) Health Home care management acuity is a measure of the level of care management required to serve a child in the Health Home program.
4. Health Homes and care management agencies must ensure the Plan of Care and case records for members served include supporting documentation for

elements required by the standards for Health Home plans of care, the CANS-NY assessment and the Health Home PMPM care management acuity. Children that do not meet the High or Medium algorithm will be assigned Low Health Home care management acuity.

5. The DOH has provided examples of supporting documentation that can be obtained from professionals and providers, including those that assist with completing the CANS-NY. More Information on supporting documentation and the acuity algorithms can be found at the link below:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/supporting_docs.htm
6. Where providers may not be able provide documentation of a situation, then well documented case notes from discussions the care manager has with relevant involved professionals, providers and family members may be acceptable.
7. The CANS-NY does not determine Health Home eligibility.
8. The CANS-NY will assist in the development of the person-centered Plan of Care.

B. CANS-NY and Billing Process

1. A one-time assessment fee (\$185) per enrollment is paid for the initial “*CANS-NY Assessment Upon Enrollment*” **only**, that is completed when the member is first enrolled in the Health Home program
2. The CANS-NY will not be pre-populated with previous results
3. Once the child is enrolled in a Health Home, low acuity is billed for the child until the month in which the CANS-NY is completed and the acuity algorithm determines the appropriate rate (high, medium or low).
4. If the CANS-NY is not completed by the end of the second month of enrollment, the Health Home/Plan will no longer be able to bill for any service until the month in which the CANS-NY is completed in the UAS-NY.
5. There is no fee paid for re-assessments
6. The CANS-NY assessment must be completed in the UAS-NY in order to bill for services and a paper CANS-NY is not acceptable
7. If the CANS-NY assessment determines medium or high acuity for the member, then two required core services each month, one of the core services be a face to

face contact with the member. Partial billing cannot be done if only one core services was completed.

7. Other Practice Standards

Outlined below are standards for practice of Health Home Serving Children Care Managers.

A. Assignment and Discharge Follow-up

1. Health Home care management providers must assign care managers to members based upon care manager and care management agency experience and defined member characteristics including, but not limited to, acuity, presence of co-occurring or co-morbid Serious Mental Illness (SMI), serious emotional disturbance (SED), Substance Use Disorder (SUD), Complex Trauma, co-occurring medical co-morbid conditions, and patterns of acute service use or specific to children.
2. Health Homes to ensure that policies/procedures are in place for care managers to contact child/family within 48 hours of discharge from an inpatient unit, residential services, detention, ED, etc. (when they are notified or become aware) Health Home care managers should be involved in the discharge planning process, including:
 - review of upcoming appointments
 - medication reconciliation
 - potential obstacles to attending follow up visits
 - adhering to treatment planFor Health Home Serving Children, this face to face contact can count for the required one face to face contact for medium and high acuity children

B. Interdisciplinary Team Meetings

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

1. An interdisciplinary team meeting must occur:
 - a) during completion of the initial full CANS-NY and during subsequent CANS-NY updates to develop the plan of care
 - b) as frequently as needed and determined by the Health Home Care Manager
 - c) at the request of the Health Home Care Manager, and/or the child/parent/guardian/ legally authorized representative (including the LDSS), based upon new information from another provider (e.g., primary care physician).

2. A team meeting must be person-centered focused and scheduled to accommodate the child and parent/guardian/medical consenters' attendance.
3. Every possible effort should be made by the Health Home Care Manager to have the parent/guardian/legally authorized representative for the child attend the team meeting.
4. The parent/guardian/legally authorized representative for the child should be an active member of the interdisciplinary team and a contributor to the plan of care.
5. The plan of care and other decisions should not be completed without the input of the parent/guardian/legally authorized representative for the child.
6. The Health Home interdisciplinary meeting can account for other required meetings in various systems, if the appropriate attendees are invited and the meeting purpose and outcome is documented.
7. The Health Home Care Manager must invite the following persons to the interdisciplinary plan of care team meetings:
 - Parent/guardian/legally authorized representative for the child
 - The child/adolescent (if appropriate)
 - Service providers for the child, including medical providers and those from other child serving systems (e.g., education)

Others **recommended** to be invited to attend team meetings:

- Family members and other caregivers
 - Representative of Local Department of Social Services (LDSS), Local Government Units (mental health) or Department of Juvenile Justice and Opportunities for Youth (DJJOY), or its designee for children in foster care
 - Representative from the voluntary case planning agency for children in foster care
 - Anyone the child or parent/guardian/legally authorized representative wishes to have participate
- *If an invitee from the list cannot attend then a phone conference and or a summary report can be given, to ensure everyone's information and input is gathered.*
- *The interdisciplinary team meeting and other care team/multidisciplinary team meetings can count for the HHSC meetings or other program required meetings if the appropriate and necessary professionals are invited (i.e. Early Intervention IFSP meeting).*

C. Comprehensive Assessment

The CANS-NY assessment does not replace the need for the Comprehensive Assessment. The comprehensive assessment is required and should be developed in conjunction with the ratings of the CANS-NY.

Please see the DOH policy and appendix C for HHSC guidance:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/comprehensive_assessment_policy.pdf

1. A comprehensive health assessment that identifies medical, behavioral health (mental health and substance use) and social services is required.
2. The information collected must result in a fully integrated comprehensive plan of care.
3. The Health Home comprehensive assessment will identify service needs currently being addressed; service and resource needs requiring referral; gaps in care and barriers to service access; and the member's strengths, goals, and resources available to enhance care coordination efforts and empower individual choice and decision making.
4. The care manager will assess for risk factors that will include but not limited to HIV/AIDS; harm to self or others; persistent use of substances impacting wellness; food and/or housing instabilities.
5. The initial comprehensive assessment must be completed concurrently with an initial plan of care within 60 days of enrollment. An assessment may be completed over the course of several days; at least one of these encounters during the initial assessment period will be face to face.
6. An annual reassessment of each member is required. If the member experiences a significant change in medical and/or behavioral health or social needs before the annual review, a comprehensive assessment is not necessary. However, the care manager should perform an abbreviated evaluation of the member's current status including rescreening for risk factors; it should then be reviewed and signed by a supervisor.
7. Any changes in the member's goals or service needs should be reflected in the POC and trigger a case review with a supervisor or applicable members of the care team. Such significant changes to the member's condition and/or POC should be reflected later in the annual reassessment.

D. Plan of Care

1. Health Homes care managers must develop an initial comprehensive Plan of Care (POC) within 60 days of member enrollment. The POC of must relate directly from the needs and strengths identified by the completed CANS-NY and comprehensive assessment.
2. Since the CANS-NY reassessment is on a 6-month basis, care managers shall ensure that the plan of care is updated accordingly to any changes within the CANS-NY reassessment or if there is an early CANS-NY reassessment. Such reassessment shall document the member's progress in meeting his or her goals from prior plans of care and shall be documented in the member's record.
3. The HHSC has a minimum requirement template of 10 Elements to be included in all POC for children.
 - The child's Emergency Contact and disaster plan for fire, health, safety issues, natural disaster, other public emergency.
 - The child's History and Risk Factors related to services and treatment, wellbeing and recovery.
 - The child's Functional Needs related to services and treatment, well-being and recovery.
 - The child's and caregivers' identified Strengths and Preferences related to services and treatment, well-being and recovery.
 - Medicaid State Plan and Non-Medicaid services identified to meet child's needs –must be person-centered, comprehensive and integrated to include Physical, Behavioral Community and Social Supports. Plan must also document the indication of choice of (a) Service Provider, (B) Reason for the Service and (C) Intended Goals.
 - Key Informal Community Supports. This would include any supports in place for the child/family that address identified needs (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).
 - Description of planned Care Management Interventions (including Services Care Management, Referral, Access, Engagement, Follow Up, and Service Coordination) and Timeframes.



- 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)
- Documentation of participation by inter-disciplinary team (all Key Providers) in the development of the plan of care.
- The child/adolescent and or parent/guardian/legally authorized representative'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).

The Plan of Care elements are the minimum standards required for Plans of Care. Health Homes may expand the required plan of care elements.

There may be other POC requirements established by CMS for POCs that include Children's Home and Community Based Services (HCBS) that will become available as part of the transition of the behavioral health benefit to Managed Care for Children.

E. Monitoring Appropriateness for Health Homes and Disenrollment

1. If the child no longer needs the intense level of care management services provided by the Health Home, discharge planning will begin when **one or more** of the following exists:
 - The chronic conditions(s) that made the child eligible for Health Homes are being managed and or maintained
 - All parties concur the child has met the goals of his/her plan of care and is stable enough to no longer require the services of a Health Home Care Manager
 - The child has service and support needs that can be met by family/guardian and services without the intensive level of Health Home care management
 - The child/guardian/legally authorized representative and family are no longer interested in Health Home services
 - The child no longer meets the eligibility criteria for Health Home (i.e., does not meet the chronic condition eligibility criteria)
 - A child that does meet the criteria but is stable/no longer needs intensive level of Health Home services can be and should be discharged
 - The child is no longer eligible for Medicaid (Health Home may continue to work with the member that is in and out of Medicaid but may not bill while member is not enrolled. Health Home 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
 - Individuals who are 18 years of age, parents, pregnant, and/or married, and who are otherwise capable of consenting, may exercise independent choice to disenrollment
2. The CANS-NY can assist with the development of the plan of care, however it does not determine when a child is discharged from a Health Home (e.g., a child with a CANS-NY medium acuity can be discharged from a Health Home).

F. Health Home Network / CMA Providers

1. Health Homes should have connection to the Local District of Social Service (LDSS), NYC Administration of Children, Local Government Unit (LGU), County of Single Point of Access (SPOA) who are access points to the Children MAPP Referral Portal.
2. For children in ACT or AOT (between 18-21), if eligible for Health Home, the Health Home type must be adult and the CMA must be an ACT provider. For children in AOT (between 18-21), if eligible for Health Home, the Health Home type must be adult in order to meet the HH plus requirements.
3. The Health Home provider ensures 24 hours/seven days a week availability to a care manager to provide information and emergency consultation services.
4. The Health Home provider will ensure the availability of priority appointments for Health Home enrollees to medical and behavioral health care services within their Health Home provider network partner list to avoid unnecessary, inappropriate utilization of emergency room and inpatient hospital services.
5. The Health Home provider has a system to track and share child/adolescent information and care needs across providers and to monitor patient outcomes and initiate changes in care, as necessary, to address patient need

G. Health Home 5 Core Billable Services

Health Home billable services are predicated from the Health Home required Core Services (listed in section A) and will be identified on the Children’s Billing Questionnaire and MUST be documented in the member’s records and care plan, when appropriate:

1. Comprehensive care management;

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



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

2. Care coordination and health promotion;

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

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

3. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;

Examples of activities that constitute providing Comprehensive Transitional Care:

- Follow up with hospitals/ER upon notification of child's admission and/or discharge to/from an ER, hospital/ residential/rehabilitative setting.
- Facilitate discharge planning and follow up with hospitals/ER upon notification of a child's admission and/or discharge to/from ER/ hospital/residential/rehabilitative setting.
- Link child/family with community supports to ensure that needed services are provided.
- Follow up post discharge with child and family to ensure needed services are provided.



- Notify and consult with treating clinicians, including child's primary care physician, schedule timely follow up appointments, and assure that all ordered medications are in the home and at other administering sites (e.g., schools and day care), and assist with medication reconciliation.

4. Individual and family support, which includes authorized representatives; *Examples of activities that constitute providing Patient and Family Support:*

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

5. Referral to community and social support services if relevant

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

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

Health Homes and Care Management Agencies must be aware of an additional standards and policies and procedures issued by the Department of Health, Health Home program and ensure that HHs and CMAs policy and procedure manuals are updated accordingly. Additionally, that relevant training for care managers occur for new and updated standards, policies and procedures of the program.

G. Standards and Requirements for MCOs Related to the Provision of Health Home Care Management Services (Unless otherwise noted, the following apply to HHs serving adults and children)

1. MCOs must provide data to Health Homes and/or care management agencies to assist in outreach and engagement efforts, subject to any required agreements for sharing Medicaid Confidential Data in accordance with HIPAA and other state requirements regarding confidentiality.
2. MCOs must include information in the Health Home Welcome Letter that encourages potentially eligible members to enroll in a Health Home by including a brief summary of the services and benefits provided by the Health Home.



3. MCOs must continue periodic education to eligible members until member enrolls in a Health Home. This includes identifying opportunities for Health Homes to reengage in outreach (e.g., appearance at emergency room or inpatient hospitalization) and reassigning the member to a Health Home.
4. MCOs must inform their provider network about Health Homes and how they can benefit eligible members.
5. After enrollment in the Health Home, MCOs must share current claims data and demographic information, including information received from New York Medicaid Choice, with Health Homes, and must enter the most recent demographic information in MAPP, in accordance with HIPAA and state confidentiality requirements.
 - a. MCOs must share information and performance data, including claims and encounter data, billing (or lack thereof) for monthly Health Home services, outreach and enrollment data, dashboards and other data made available through MAPP and hold periodic meetings with Health Homes and care managers to evaluate and improve Health Home performance.
6. MCOs must identify a single point of contact and establish communication protocols with Health Homes' single point of contact.
7. MCOs must have policies and procedures in place to inform and assist Health Homes in responding when critical events occur, including when a member 1) has presented at a hospital ER/ED and was not admitted 2) is admitted to inpatient hospital or 3) is in crisis and presents at a location that provides additional opportunities to outreach to a member. Such policies and procedures must incorporate information that will become available through MAPP referral portal and MAPP alerts. MCOs will be involved in the discharge planning process and make timely determinations on any requests for authorization (if applicable).
8. MCOs must have policies and procedures in place that provide for timely and effective communications between the MCO and the Member's care management provider when the Member receives services at an emergency room, Comprehensive Psychiatric Emergency Program, Crisis Respite, residential addiction program or inpatient setting, and to ensure that the Member is safely transitioned to the Member's subsequent setting when such services are no longer necessary. Such policies and procedures shall require that Members have timely access to follow-up care post-discharge and that the Member's plan of care is updated as necessary.
9. MCOs must include a sufficient number of Health Homes in their network to serve all eligible Health Home members.
10. *For Health Home Serving Adults*, MCOs may use their own data in evaluating Department of Health (DOH) recommendations for Health Home assignments that are based on loyalty data.
11. *For Health Home Serving Adults*, MCOs must assign the adult DOH list-identified or MCO-identified members to the Health Home as soon as possible, but no longer than 45 business days from the date the member first appears on the DOH list so long as the Health Home has capacity to serve the member.



- a. MCOs that do not meet this target must provide a report to the State identifying reasons for not meeting such and remedial actions to make improvements.
12. MCOs must assign community referrals (provider-identified) for adult and children as well as MAPP Children's Referral Portal referrals as soon as possible, but no longer than 3 business days from the date the referral is assigned within MAPP to the MCO.
13. MCOs must submit claims for Health Home reimbursement to the State no less frequently than once every 14 days and make payment to the Health Home within 14 days of receipt of payment from the State.
14. *For Health Home Serving Adults*, MCO's will work with Assertive Community Treatment (ACT) programs and work with the local Single Point of Access (SPOA) agency to manage capacity and utilization of its members.
15. The MCO is responsible for verifying Health Home eligibility for all members (this may be delegated by the MCO to the Health Home).
16. MCOs will review plans of care for consistency with assessment results and known member health needs, and make coverage and medical necessity determinations for services included in plans of care within timeframes established in the Medicaid Managed Care Model Contract.
17. MCOs will retain responsibility for reviewing member complaints and appeals and making timely determinations related to disputes regarding eligibility for Health Home services, the provision of Health Home services, the development of plans of care, the provision or arranging of services identified in the plan of care, and requests to transfer to another Health Home.
18. MCOs and Health Homes must establish clear lines of responsibility to ensure services are not duplicated.
19. MCOs shall require that Health Homes ensure that members have access to care management 24 hours per day, seven days per week for information, emergency consultation services and response in the community, if necessary.
20. MCOs will ensure that Health Homes offer members the choice of providers that include providers not part of the Health Home.
21. Upon prior notice to the Health Home, in a form and manner prescribed by the Agreement between the MCO and the Health Home, the MCO may transfer a Member to another state-designated Health Home upon request of the Member, if the Member relocates or transfers to a Primary Care Provider affiliated with another Health Home, or if the Member's Health Home loses its Health Home Designation for any reason or if another state-designated Health Home has successfully engaged the enrollee and the enrollee has consented to enrollment.
22. When a member, parent/guardian or legally authorized representative requests to be transferred to another Health Home, the MCO shall timely transfer the Member to another Health Home, if available. The MCO shall ensure that the Health Home transfers the Member within a reasonable timeframe, but no later than 30 days. When a Member requests assignment of a new care manager, MCO will forward the request to the Health Home and follow up with the Health Home until the reassignment is completed.



23. The MCO shall transfer a member to another Health Home, if available, if the Health Home is not:
- Effectively providing or managing Health Home Services to the member • Achieving quality goals
 - Adhering to the MCO's protocols or
 - Meeting the member's needs, as determined by the MCO after consultation with the Member and/or the parent/guardian/legally authorized representative and the Health Home.
24. A MCO may not transfer a Member of a Health Home to another Health Home without consulting the member, parent/guardian or legally authorized representative, unless one of the criteria in paragraph 23 is the cause of the transfer.
25. If the MCO must transfer or deactivate a Member's enrollment in a Health Home and there is no other Health Home in the MCO's network or service area, the MCO shall immediately assume responsibility for providing care management, care coordination and execution of the Member's plan of care.
26. When a member is transferred or reassigned, or where a member is deactivated from enrollment in a Health Home, or in any other case where another entity assumes the care management responsibilities for a member, the MCO shall require through the Health Home Agreement that the Health Home cooperate with the entity assuming such responsibilities and transfer all relevant records and materials necessary for the continuation of care management services.
27. MCO shall monitor the performance of the Health Home and the Health Home service providers using the appropriate financial, programmatic and oversight tools and measures. All such tools and measures used shall be shared with the Health Homes to facilitate and foster proactive ongoing continuous improvement efforts in a form and manner prescribed by Agreements between the MCO and the Health Homes.
28. MCO shall not terminate the Agreement with a Health Home before:
- MCO notifies the Health Home of any deficiencies and works with the Health Home to develop a remedial plan for addressing such deficiencies AND
 - notifying the State of any deficiency, attempted remediation, and termination.
29. The MCO shall support the State in building capacity in Health Homes by identifying Health Homes best suited for managing members with SMI, SED, identified Complex Trauma or functionally limiting SUD.
30. MCOs shall oversee and ensure that the Health Home undertakes engagement efforts for members lost to follow-up care pursuant to Section G (7 & 8) above.
31. **For HARP Members that opt out of Health Homes Serving Adults but elect to receive HCBS:**
- a. MCOs must contract with eligible providers to conduct the NYS Community Mental Health Assessment and develop the HCBS plan of care. The MCO may contract with a Health Home or other entity designated by the State for this purpose to conduct the initial NYS Eligibility Assessment and NYS Community Mental Health Assessment and to develop or make necessary revisions to a HCBS plan of care that meets the requirements of Centers for Medicare and Medicaid (CMS). The MCO will reimburse the Health Home or other State-designated entity no less than the rate

established by the State for assessments and development of plans of care for HCBS.

- b. The MCO shall ensure the assessment process is completed through its subcontracts with State-designated entities, within 90 days of the Member's declination to enroll in a Health Home. Such timeframe may be extended by the DOH as necessary for a limited period to manage the large number of assessments anticipated during the initial HARP enrollment period.
- c. The MCO is responsible for providing care coordination for the implementation of the Member's plan of care. The MCO will be responsible for monitoring the implementation of the HCBS plan of care in accordance with HCBS and Medicaid Managed Care Model Contract requirements for care management of members in receipt of HARP and HCBS services. This includes ensuring the member has access to services that are included in the plan of care; periodic updating of the plan of care; and arranging for NYS Community Mental Health Assessment re-assessment at least annually.