



## **Standards and Requirements for Health Homes and Care Managers and Managed Care Plans**

### **A. Current Standards and Requirements for Health Homes**

**As required by the State Plan,** Health Homes are required to provide the following six the 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**

Health Home must have planning and policies and procedures in place to ensure care managers create, document, execute and update an individualized, patient centered plan of care for each individual.

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

#### **2. Care Coordination and Health Promotion**



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

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

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

**2d.** The health home provider must define how patient care will be directed when conflicting treatment is being provided.

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

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

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

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

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

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



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

### 3. Comprehensive Transitional Care

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

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

**3c.** The health home provider utilizes HIT as feasible to facilitate interdisciplinary collaboration among all providers, the patient, 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 patient attended the appointment, and a plan to outreach and re-engage the patient in care if the appointment was missed.

### 4. Patient and Family Support

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

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

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

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

**4e.** The 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 patient access to care plans and options for accessing clinical information.

### 5. Referral to Community and Social Supports



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

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

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

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

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

#### **Initial Standards**

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

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

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

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

#### **Final Standards**

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

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



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**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](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.

**In addition to the core standards and requirements established above Health Homes must have policies and procedures in place to satisfy the following standards:**

1. Health Homes must identify a single point of contact and establish communication protocols with MCOs.
  - Health Homes must use information and performance data, including outreach and enrollment data, dashboards and other data made available through MAPP, and hold periodic meetings with care managers and MCOs to evaluate and improve performance.
  - 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.
  - The Health Home should have an identified point of contact for community referrals including (but not limited to) those from LGU's, inpatient settings, forensic releases, and community providers to coordinate timely linkage to a care manager, with special consideration for the Health Home Plus populations.
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 to a member. Such policies and procedures must incorporate information that will become available through MAPP referral portal and MAPP alerts.
3. Health Homes must contact members within 48 hours of discharge from an inpatient unit (when they are notified or become aware of the admission), or sooner if clinically indicated, to facilitate the care transition. Health Homes care managers should become engaged 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 treatment plan.
4. Health Homes must attempt to make a face-to-face contact 1) during the stay of member that has been admitted to a detox facility and 2) within 24 hours of





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- discharge to ensure that the member is aware of follow-up appointments and to provide supports for getting to appointments.
5. Health Homes must assign individuals to Health Home care managers within xx? business days from the day the Plan makes an assignment to the Health Home.
  6. Health Home care managers must begin outreach within xx? business days after receipt of referral from a HH.
    - Health Homes must provide a report to its care managers, the Plans and the State identifying reasons for not meeting such timeframes for making assignments and remedial actions to make improvements.
  7. Health Homes must assign care managers to members based upon care manager experience and defined member characteristics including, but not limited to, acuity, presence of co-occurring SMI/SUD or co-morbid conditions, and patterns of acute service use.
  8. Health Homes must submit plans of care, for review and approval by the member's MCO.
  9. For all individuals enrolled in a Health Home, the plan of care must include the following specific 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**;
    - Description of planned **Care Coordination Interventions and Time Frames**;
    - 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.
  10. Health Homes that provide case management and direct services, must ensure that the individual providing case management is not the same as the individual providing direct care services and that these individuals are under different supervisory structures
  11. 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
  12. Health Homes will provide a choice of at least 2 providers for services in plan of care
  13. On or before xx, Health Homes must certify they have processes in place to make payments to all downstream care managers (legacy and non-legacy providers) within xx days of receipt of payment from the Plan
  14. Health Home must provide access to and information regarding training opportunities that include:
    - Typical care coordination needs of populations with multiple co-morbidities;



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- Evidence-based methods for increasing engagement including Motivational Interviewing, recovery-oriented practices, person-centered planning, role and benefits of certified peer specialists and Wellness Recovery Action Plans;
- Outreach and engagement strategies for members who are disengaged from care or have difficulty adhering to treatment recommendations including individuals with history of homelessness and criminal justice involvement;
- 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 AOT)
- InterRAI training to conduct assessments for HARP members

### Health Home Standards for Assisted Outpatient Treatment (AOT) enrollees:

15. The Health Home will assign individuals to Health Home care managers within two business from the day the Plan makes an assignment to the Health Home.
16. The Health Home care manager will begin outreach within two business days after receipt of referral from a Health Home.
17. Individuals AOT court orders must receive Health Home Plus services. Upon enrollment:
  - The Health Home care manager 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;
  - The Health Home must inform the Managed Care Plan of the member's AOT status – information provided in MAPP can be used to satisfy this requirement
18. Health Home care managers working with court ordered AOT individuals must adhere to all Health Home Plus AOT Guidance issued by the state including :
  - Provide face-to-face contact at least once a week;
  - Work with the LGU's AOT coordinator as per local policy;
  - Comply with all statutory reporting requirements under Kendra's Law
  - Have a caseload ratio no greater than 1:12 (i.e. 8.5% of a full-time Health Home care manager's available care management time if the caseload also includes non-Health Home Plus members.
  - Meet the minimum qualification standards listed in Health Home Plus guidance available at: [http://www.omh.ny.gov/omhweb/adults/health\\_homes/hhp-final.pdf](http://www.omh.ny.gov/omhweb/adults/health_homes/hhp-final.pdf)
19. Health Home care managers working with court ordered AOT individuals must have the following qualifications:



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- Education: Bachelor's degree in a listed field (see guidance); OR NYS teacher's certificate for which a bachelor's degree is required; OR NYS licensure and registration as a Registered Nurse and a bachelor's degree.
  - Experience: Four years of experience either: Providing direct services to mentally disabled members; OR Linking mentally disabled members to a broad range of services essential to successfully living in a community setting (e.g., medical, psychiatric, social, educational, legal, housing, and financial services). A master's degree in a listed field (see guidance) may be substituted for two years of experience.
20. Health Home care managers must complete all AOT reporting requirement to the Office of Mental Health as required by AOT legislation and as currently reported in the OMH CAIRS system.

*For Other Health Home Plus Enrollees OMH State Psychiatric Center discharges and Central New York Psychiatric Center discharges as well as their satellite clinics*

21. Health Home care managers providing Health Home Plus services to other than AOT members, must adhere to all Health Home Plus guidance issued by the State including:
- Have a caseload ratio no greater than 1:12 (i.e. 8.5% of a full-time Health Home care manager's available care management time if the caseload also includes non-Health Home Plus members.
  - Meet the minimum qualification standards listed in Health Home Plus guidance available at: [http://www.omh.ny.gov/omhweb/adults/health\\_homes/hhp-final.pdf](http://www.omh.ny.gov/omhweb/adults/health_homes/hhp-final.pdf) regarding:
  - Education: Bachelor's degree in a listed field (see guidance); OR NYS teacher's certificate for which a bachelor's degree is required; OR NYS licensure and registration as a Registered Nurse and a bachelor's degree.
  - Experience: Four years of experience either: Providing direct services to mentally disabled members; OR Linking mentally disabled members to a broad range of services essential to successfully living in a community setting (e.g., medical, psychiatric, social, educational, legal, housing, and financial services). A master's degree in a listed field (see guidance) may be substituted for two years of experience.

*For HARP Members:*

22. Health Home care managers will perform InterRAI assessments to determine if HARP members are eligible for Home and Community Based Services
23. Health Home care managers shall complete brief InterRAI assessments to determine HCBS eligibility within xx days and full InterRAI assessment within xx days





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24. 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.
25. Health Home care managers that perform HCBS assessments or reassessments must meet the following qualifications:

Education:

- A bachelor's degree in any of the following: child & family studies, community mental health, counseling, education, nursing, occupational therapy, physical therapy, psychology, recreation, recreation therapy, rehabilitation, social work, sociology, or speech and hearing; OR
- NYS licensure and current registration as a Registered Nurse and a bachelor's degree; OR
- A Bachelor's level education or higher in any field with five years of experience working directly with persons with behavioral health diagnoses; OR
- A Credentialed Alcoholism and Substance Abuse Counselor (CASAC).

Experience:

- Two years experience (a Master's degree in a related field may substitute for one year's experience) either:
  - Providing direct services to persons diagnosed with mental disabilities, developmental disabilities, alcoholism or substance abuse; OR
  - Linking persons who have been diagnosed with mental disabilities, developmental disabilities, alcoholism or substance abuse to a broad range of services essential to successfully living in a community setting.

Training and Supervision:

- Specific training for the designated assessment tool(s), the array of services and supports available, and the client-centered service planning process. Training in assessment of individuals whose condition may trigger a need for HCBS and supports, and an ongoing knowledge of current best practices to improve health and quality of life.
- Mandated training on the interRAI Community Mental Health Assessment tool and additional required training
- Must have supervision from a Master's level clinician

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

For individuals enrolled in a HARP, the plan of care must include the following additional specific elements: see #40 and HCBS document

26. For individuals enrolled in a HARP, the plan of care must include the following additional specific elements:

- 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);



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- For individuals eligible to receive HCBS, a **Summary of the interRAI Functional Needs Full Assessment**; and
  - For individuals eligible to receive HCBS, **Recommended HCBS** that target the individual's identified goals, preferences, and needs.
27. Health Homes must prepare plans of care for HARP members receiving HCBS services that meet the requirements established by the Centers for Medicare and Medicaid (CMS) see attached document under development

*For HARP Members that Opt Out of Health Home and Elect to Receive HCBS Services*

28. Health Homes may contract with MCOs to conduct InterRAI assessment and develop HCBS plans of care for members that opt out of Health Home care management services.
29. HCBS care plans must be developed in accordance with HCBS plan of care requirements.

### Standards and Requirements for Plans

30. MCOs must include information in the Welcome Letter that encourages potentially eligible members to enroll in a Health Home, ideally prior to Health Home outreach. If the MCOS has assigned the member to a Health Home, the Welcome Letter shall also include the name, address, and contact information of the Health Home; a brief summary of the services and benefits provided by the Health Home; and a copy of the Health Home Patient Information Sharing Consent Form and completion instructions.
31. MCOs must help educate their members on the benefits of Health Home, continuing periodic education until person enrolls in Health Home.
32. MCOs must inform their provider network about Health Homes and the how they can benefit eligible members.
33. MCOs must share current claims data and demographic information, including information received from New York Medicaid choice, with Health Homes, and must enter such more recent demographic information in MAPP.
34. MCOs must identify a single point of contact and establish communication protocols with Health Homes' single point of contact
- a. MCOs must use information and performance data, including claims and encounter data, billings (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 performance.
35. 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



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- 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 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).
36. MCOs may use its own data in evaluating Department of Health recommendations for Health Home assignments that are based on loyalty data.
  37. MCOs must include a sufficient number of Health Homes in their network to serve all eligible Health Home members.
  38. MCOs must assign DOH list identified, plan identified or individuals identified by another provider (e.g. local government unit, behavioral health service provider) to HHs within xx business days.
  39. MCOs that do not meet these targets must provide a report to its Health Homes, and the State identifying reasons for not meeting such and remedial actions to make improvements
  40. MCOs must make payments to Health Homes within xxxxxxxxx  
MCO's will work with Assertive Community Treatment (ACT) programs and work with local Single Point of Access (SPOA) agency to manage capacity and utilization of its member
  41. The MCO is responsible for verifying Health Home eligibility for all Plan members (this may be delegated by the Plan to the Health Home)
  42. MCOs will review plans of care for consistency with assessment results and known member health needs, and make a coverage and medical necessity determination within timeframes established in the Medicaid Managed Care Model Contract. For services included in the plan of care, MCOs will review requests for prior authorization (where applicable) in a timely manner and in accordance with the plan of care.
  43. MCOs will retain responsibility for reviewing member complaints and appeals and making timely determinations related to disputes regarding eligibility for Health Home services, processes for development of plan of care, services identified in the plan of care; and requests to transfer to another Health Home.

### For HARP Enrollees that Opt Out of Health Homes But Elect to Receive HCBS Services

44. The preferred approach is for the Plan to contract with HH to conduct InterRAI assessment and develop HCBS plan of care. The MCO may contract with a Health Home (not as a Health Home care manager but as a contracted entity) or other entity to conduct initial and InterRAI assessments and to r develop or make necessary



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revisions to a Plan of Care for HCBS services that meets the requirements of Centers for Medicare and Medicaid (CMS).

45. The Plan 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 enrollees in receipt of HARP and HCBS services; which includes ensuring the member accesses services included the plan of care; periodic updating of the care plan as a member's needs change; and arrangement for InterRAI re-assessment at least annually.
46. The MCO must continue to work with the member to encourage Health Home enrollment and must monitor claims and encounter data of the member and look for opportunities (critical times e.g., appearance at emergency room or inpatient hospitalization) when it may make sense to have the Health Home outreach again to the member.

*For Assisted Outpatient Treatment (AOT) Enrollees:*

47. For all individuals on Assisted Outpatient Treatment (AOT) status, discharged from Central New York Psychiatric Center and its satellite's discharges, State Psychiatric Center discharges, and Inpatient detoxification discharges the MCO will assign DOH list identified, plan identified or individuals identified by another provider (e.g. local government unit, behavioral health service provider) to a Health Homes within two business days.
48. MCOs that do not meet these targets must provide a report to its Health Homes, and the State identifying reasons for not meeting such and remedial actions to make improvements
49. MCO's will examine utilization management of the Assertive Community Treatment (ACT) program and work with local Single Point of Access (SPOA) agency to manage capacity and utilization of this intensive outreach program.