Preparing for the Transition of 1915(c) Waiver Care Coordination to Health Home Care Management Under the Children's Medicaid Transformation

Transition and Readiness Training to Ensure Smooth Transition

UPDATED January 11, 2019

Overview of Today's Training

- Welcome and Introductions
- The Children's Medicaid Transformation and Today's Training
- Provider and Staff Readiness and Training
- Verification that ALL 1915c Children Transition
- Transition Steps
  - Health Home
  - The Independent Entity for HH opt-out
  - New waiver eligible child
- Medicaid Managed Care Plan Involvement
- Billing during the Transition
- Determining Health Home Eligibility

The Children's Medicaid Transformation and the Transition to Health Home Care Management

Transitioning care management now provided under the current six 1915(c) children's waivers (3 B2H, 2 CAH and OMH SED Waiver) to Health Homes is a key element of the Children's Medicaid Transformation which, ***pending the receipt of required Center for Medicaid/Medicare Services (CMS) approvals,*** *is currently scheduled to be implemented throughout 2019.* ***Key elements of the Children's Transformation include:***

- ✓ New Children and Family Treatment and Support Services (CFTSS) (e.g., OLP, CPST, PSR) - Beginning January 2019
- ✓ ***Transition of 1915(c) care management to comprehensive, person-centered Health Home care management - Beginning January 2019 – Focus of Today's Training***
- ✓ The transition to a new array of HCBS services under a new 1915(c) Children's Waiver which will consolidate the current six waivers into one waiver with single array of services, breakdown silos and provide children and families consistency (April 1, 2019)
- ✓ Prepare for and transition children in the new 1915(c) Children's Waiver to Managed Care (July 1, 2019, except children in foster care will remain fee for service) ***The foster care population will transition to Health Home**
- ✓ Transition Fee-for-Service Voluntary Foster Care Population to Managed Care (July 2019)

Draft, Preliminary Timeline Subject to CMS Timely Approvals	**Preliminary Draft Date**
Transition to Health Home Begins for the six current 1915c waiver OMH SED, DOH Care at Home (CAH) I/II, OPWDD Care at Home, OCFS Bridges to Health (B2H) SED, OCFS B2H Medically Fragile, OCFS B2H DD *<u>**The foster care population will transition to Health Home**</u>	***January 1, 2019 through March 31, 2019***
Implement three of Six New State Plan Services* (Other Licensed Practitioner, Psychosocial Rehabilitation, Community Psychiatric Treatment and Supports) *Children and Family Treatment and Support Services (CFTSS)	January 1, 2019
Consolidated 1915(c) Children's Waiver with the new array of HCBS	April 1, 2019
Three year phase in of Level of Care (LOC) Criteria for HCBS	July 1, 2019
Children's Waiver and Behavioral Health Benefits to Managed Care, remove exemption and exclusion for consolidated 1915(c) Children's Waiver from Managed Care	July 1, 2019
Foster Care Fee-for-Service Population to Managed Care	July 1, 2019
Implement Family Peer Supports – Children and Family Treatment and Support Service (CFTSS)	July 1, 2019
Implement Remaining New State Plan Services - Youth Peer Support and Training and Crisis Intervention	January 1, 2020

Reminder: Goals of Children's Medicaid System Transformation

- ✓Maintain child at home with support and services
- ✓Maintain the child in the community in least restrictive settings
- ✓Keep children on their developmental trajectory
- ✓Identify needs early and intervene
- ✓Focus on recovery and building resilience
- ✓Prevent escalation and longer need for higher end services
- ✓Maintain accountability for improved outcomes and delivery of quality care

Primary, Most Important Goal of Transition

Ensure that the Transition is Seamless for Children and their Families

- ✓ Continuity of Care of Providers and Services
- ✓ Well informed children, families, providers
- ✓ Access to the State for information and assistance
- ✓ Partnership with providers, plans and stakeholders to make transition seamless

Ensuring a Smooth Transition

- Today's Training session is going to focus on working with you all to ensure the transition from current 1915(c) waiver care management to Health Home is as seamless as possible for the children and families you serve today, and for you, as providers who will implement and guide the transition
- The transition to Health Home is a key element of the Children's Transformation and to ensuring the other elements of the Transformation are implemented as smoothly as possible
- A critical part of ensuring a smooth transition will be communication/messaging and collaboration between the State and Health Homes, waiver providers/care managers, and Plans to coordinate readiness and implementation activities, including the timing of, and messaging to, children and families

Ensuring a Smooth Transition

- The State has made significant and rapid process over the past four months in working to secure CMS approvals
- The State meets weekly with CMS to work towards obtaining all the necessary approvals to implement the Children's Medicaid Transformation, including the approvals to transition children to Health Home on January 1, 2019
- ***The State will keep in close contact with all of you regarding the timing of CMS approvals – as well as the timing for messaging and communicating with families to avoid confusion around any impact of the timing of CMS approvals may have on the implementation schedule and timeframes***

Beginning Trainings Now will Help Ensure Readiness and Smooth Transition

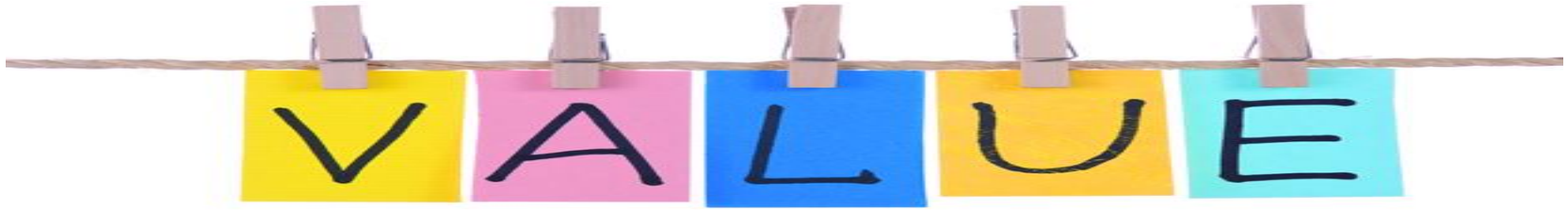
- Along side the State's work with CMS to obtain approvals, it is critically important the State work now – including today's in-person training, with Health Homes, transitioning waiver providers/care managers and Plans to begin readiness trainings to ensure everyone is prepared to implement the steps necessary to smoothly and seamlessly transition children from waiver care management to Health Home care management - and implement the remaining elements of the design
- At the close of these 15 in-person training sessions across the State, the State plans to continue to work with current 1915c providers hear your feedback and address readiness concerns or issues that come to light during the training sessions
- We look forward to today's training session and are enthusiastic about working with you to implement the Children's Medicaid Redesign!

Goals of Today's In-person Trainings

- Provide direct information to transitioning staff and supervisors, lead HHs, and Plans that will guide children and families and implement the transition
- Provide specifics steps and actions required to ensure a smooth and seamless transition for children and families now served under the current six waivers
- Answer questions and provide support –both today, and throughout the implementation, to transitioning providers, Health Homes and Plans
- Get your feedback – learn as we go, and where necessary tailor our process to proactively address issues that may arise

Continuity of Care

- Waiver Care Management Under the following Waivers will Transition to Health Home
  - OMH SED 1915(c) waiver (NY.0296)
  - DOH Care at Home (CAH) I/II 1915(c) waiver (NY.4125)
  - OPWDD Care at Home 1915(c) waiver (NY.40176)
  - OCFS Bridges to Health (B2H) SED 1915(c) waiver (NY.0469)
  - OCFS B2H Medically Fragile 1915(c) waiver (NY.0471)
  - OCFS B2H DD 1915(c) waiver (NY.0470)
- To preserve the expertise of existing 1915c waiver providers in the Children's Transformation and in Health Homes, all existing 1915(c) waiver Care Managers/Agencies providing care management under the six Waivers will transition to Health Homes
- ***Current 1915(c) Transitioning Children that will transition to Health Home care management will transition with their current care manager/agency (by choice and with consent)***
- This linkage between care managers and children and families will preserve care manager relationships with the child and their family, continuity of care and help ensure a seamless transition



Key Provisions Related to the Transition to Health Home and the January 1, 2019 to March 31, 2019 Transition Period

- Transitioning Children are children who are ***currently enrolled*** in one of the six current 1915(c) waivers (3 B2H, 2CAH, OMH SED). Enrolled means:
  - Level of Care Home and Community Based Services (HCBS) Determination
  - Plan of Care
  - Receiving HCBS service
- Transitioning Children will transition from current waiver care management to Health Home care management. ***To begin*** enrollment in Health Home, all that is needed is consent. There is no need to make a separate Health Home eligibility determination. Children that decline Health Home care management will work and transition to the Independent Entity.

Key Provisions Related to the Transition to Health Home and the January 1, 2019 to March 31, 2019 Transition Period

This is a change:

- Level of Care (LOC) forms must be completed as currently required under existing waivers for any transitioning child who is due for annual recertification between January 2019 through March 31,2019, even if the child has already transitioned to Health Home during this period.
- For any transitioning waiver child whose annual recertification is on or after April 1, 2019, based on the recertification date under the former waiver, the new HCBS/LOC Eligibility Determination will be completed within the month of the due annual recertification.

Key Provisions Related to the Transition to Health Home

- Upon enrollment of a transitioning child into Health Home, current 1915(c) waiver providers who are now Health Home care managers serving a transitioning child, they have enrolled in Health Home will bill Health Home care management rates.
- Current 1915(c) care management rates and Health Home care management rates may not be billed at the same time, i.e., duplicate billing is not permitted
- During the Jan – March 2019 period, all other requirements and rules applicable to the current six 1915(c) waivers will remain in effect, including eligibility requirements, slots and current HCBS services available under each respective waiver
- On April 1, 2019 (with CMS approvals) Transitioning Children will automatically be transition to new consolidated 1915(c) Children's Waiver and will have access to the newly aligned array of HCBS authorized under that new waiver

Connecting Children and Families to Services

- Children who are eligible for HCBS are required to have care management and a care plan for their HCBS services
- ***Children who are eligible for HCBS are eligible for Health Home***
- ***Children who are Health Home eligible are NOT automatically eligible for HCBS***
- ***Children who are no longer eligible for HCBS will also lose HH care management unless they are found HH eligible and appropriate***
- When a child is HCBS eligible, they are eligible for ALL HCBS array

Provider and Staff Readiness and Training

Provider and Staff Readiness

- DOH Health Home Children's team continue to work with 1915(c) providers to ensure readiness
- As of today, almost all 1915(c) waiver provider **agencies** are connected to the required systems, including MAPP-HHTS and UAS, and have relationships (BAAs) with Health Homes. ***However, please note agencies must also ensure individual staff transitioning are also properly connected and have access to systems***
    - Many of the OMH and OCFS waiver agencies are already Health Home care management agencies, so there was limited connectivity work needed to be completed for the agencies, however, individual staff, supervisors, etc. need to be properly connected to systems
- All staff transitioning MUST have HCS accounts associated with the Health Home program. Staff may have HCS accounts associated to other program codes, however, this is not sufficient. Those HCS accounts do not, and cannot be used to gain the required connections necessary for the Health Home program

Provider and Staff Readiness - continued

MAPP HHTS

- The Agency's assigned Gate Keeper will receive an email for training on MAPP roles
- The Gate Keeper will assign staff roles within MAPP – this will give access to the MAPP Referral Portal
- Staff will then receive an email regarding on-line MAPP HHTS training – you can begin training now

Provider and Staff Readiness - continued

UAS-NY

- The designated HCS Coordinators can assign staff roles within the UAS-NY
- It is important that agencies and HCS Coordinators understand the various roles with the UAS and determine which staff receive what role
- When staff have an active HCS account and an assigned a role within the UAS-NY, staff can open the application and begin training
  - **CANS-NY 15 – Administrative Support Staff,** supports the provider level assessors and supervisors. Limited access. Cannot add assessment data to record.
  - **CANS-NY 40 – CANS-NY Assessor,** must have CANS-NY Certification to conduct assessments
  - **CANS-NY 50 – CANS-NY Assessor Supervisor,** individuals that have the supervisory or managerial purview over the assessor teams
  - **CANS-NY 60 – CANS-NY Assessor READ (ONLY),** assessors who have lapsed CANS-NY Certification, can review their assessments but cannot edit or add assessment
  - **CANS-NY 70 – Managed Care Plan**, role for the managed care plans

❖ *Individuals can be assigned multiple roles but SHOULD NOT be assign all roles*

Uniform Assessment System – UAS-NY

- The Uniform Assessment System (UAS) is the electronic platform that houses the CANS-NY assessment tool and the HCBS Eligibility Determination
- CANS-NY tool in the UAS interfaces with Medicaid Analytics Performance Portal (MAPP) to provide billing information for Health Home billing of the per member per month (PMPM) acuity
- To be able to enter and complete a CANS-NY within the UAS, HH care managers and staff must have a specific role identified within the UAS and complete the required training for that identified role
- Estimate that the UAS-NY course sequence for the CANS-NY Assessor to take about 3 ½ hours total
  - This training is an overview of how to utilize the UAS and maneuver through the system
  - These trainings are required to be completed prior to the system allowing the assessor the ability to add and/or start a CANS-NY

❖ Additional on-line UAS training will be required regarding the HCBS Eligibility Determination prior to April 2019

CANS-NY Training

DOH continues to provide in-person one-day CANS-NY trainings – Announcements continue to be issued regarding new 2018 scheduled trainings :

- If in-person training is completed, the on-line training is not required. User can go directly to the test for certification
- In-person one-day training will **now be required** for all 1915c transitioning care manager and supervisory staff by the end of the year 2018 https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/new_requirement_to_attend_inperson_cans-ny_training.pdf
    - *If you have already completed an in-person CANS-NY for Health Home this will meet this requirement*
- Additionally, supervisor in-person trainings are available to teach skills for supervisors to be able to assist their staff in completing the CANS-NY

On-line training is available and takes 4 to 6 hours to complete, for those that need to recertify. That includes reading items and watching videos, taking practice multiple choice tests and at least one certification test. The final takes the average successful user about 45 minutes to complete

Overall Health Home Training

- It is the responsibility of the Lead Health Homes to provide policies and procedures regarding all issued DOH Health Home program Standards and Policies / Procedures for their network care management agencies

- Additionally, each Lead Health Home has Health Information Technology (HIT) and Billing platforms to ensure:
  - Proper documentation,
  - Compliance with Health Home requirements
  - Timely payment to providers,
  - Tracking of member services and
  - Ability to provide oversight of their network partners

- ***Lead Health Homes need to develop a training plan for 2019 for the 1915c waiver staff moving into Health Home***
  - Each Lead Health Home may have different policies, procedures and oversight monitoring requirements for their care management agencies, therefore the amount and time table for training may vary
  - CMAs need to work with their Lead Health Home to determine the amount of training time that will be needed

Required Training for Health Home Care Managers and Supervisors

- ❖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.
- ❖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

- Required Training for care managers and supervisors - **Prior** to providing Health Home Care Management Services, to children or families'
  - ✓CANS-NY training and certification annually
    - ◆ Supervisors must be CANS-NY certified and must achieve at least a score of 80% or higher on exam
    - ◆ Care Managers must be CANS-NY certified and must achieve at least a score of 70% or higher on exam
  - ✓Mandated Reporter training - http://nysmandatedreporter.org/TrainingCourses.aspx – 2 hour training is available at no cost
  - ✓Consent - HIPAA/CFR 42/sharing of information

Required Training for Health Home Care Managers and Supervisors

- Required training for care managers and supervisors within **six months** of employment or from 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)
    - ✓ *Free to providers, offered by OMH and similar training being developed by OCFS*
  - ✓ Trauma Informed Care
  - ✓ Person Centered Planning
  - ✓ Cultural Competency/Awareness
  - ✓ LGBTQ Issues – serving transgender children/adolescents and working with Lesbian/Gay/Bisexual/Transgender/Questioning Families
  - ✓ Meeting Facilitation

Please Note: Trainings provided by your agency may meet requirements such as HIPPA training. Please check with your lead Health Home

Verification that ALL 1915c Children Transition

1915c Providers Support

- Each 1915c provider has been connected to a DOH HH team liaison
- DOH liaisons are your link for any questions or issues related to HH and the transition
- DOH liaison will be talking with your agency to ensure that your agency and all appropriate staff are properly connected to systems and Health Homes
- Beginning in January 2019 and throughout the transition period, DOH will have regularly scheduled TA calls for transitioning providers – schedule forthcoming
- Additional Q & A webinar will be scheduled on specific topics
- Should providers have other ideas that would be helpful in assisting staff to prepare for the transition, please contact your liaison.

Verification and Tracking Transition Children

- Prior to the transition, a report will be run broken down by provider and waiver children that have been billed for by existing 1915c waiver providers
- This report will be cross referenced by the DOH liaison team and their contact with waiver providers
- On a weekly basis throughout the transition period, tracking of children transitioning to HH care management will occur through the UAS, MAPP HHTS and the required Independent Entity (IE) report, as well as by discussion with providers
- Transitioning providers must report to their DOH liaison any child that opts-out of Health Home
- Providers must report any new child that is determined waiver eligible during the transition months to their DOH liaison
- DOH will track of all transitioning waiver children by their CIN # to ensure that all children transition properly
- Current 1915c waiver slots levels will be maintained during the transition months

Transition Steps

1. Explain Transition
   - Inform Families
   - Official Notification to Families
   - Explain Health Home care management
   - Opt-out and the Independent Entity (IE)
2. Planning for Transition
   - Transition and timeline
   - HCBS Eligibility
   - Case load planning
3. Transition to HH or IE
   - Consent, Referral and Enrollment in HH
   - Independent Entity (IE) Process
4. Plan of Care Transition
5. Medicaid Managed Care Plan (MMCP) Involvement
6. New waiver eligible child

Step 1 –
Explaining the Transition

Transition Step – Inform Families

- It is important to explain to current waiver families of the changes that will be occurring in 2019. This will assist families:
  - To have the necessary information to make an informed decision regarding continued services and enrollment in Health Home care management services
  - Limit anxiety by ensuring that there will be no changes to service access, no gap in services, or change in care
  - Continuity of Care - Continuation of connection with same staff/agency

- To support waiver staff ability to discuss changes with families, a number of tools have been created:
  - Talking points for waiver staff to explain transition
  - Medicaid Managed Care Plan (MMCP) Brochure
  - MMCP Continuity of Care Desk Aid
  - Care Manager FAQ
  - Health Home Brochure
  - UAS-NY CANS-NY Reference Sheet
  - HH care manager Roles and Responsibilities
  - HH care manager Core Service Billing
  - *What other materials or information may be helpful to you?*

Transition Step – Notification to Families

- Children and families will receive required notifications and other information about the changes that will occur to will implement the Children's Medicaid Transformation
- The State is in the process of developing draft notifications that will be shared with 1915(c) waiver providers and Health Homes
- Waiver providers and Health Homes will be notified in advance of the distribution of the letters to the families. Current 1915(c) waiver providers may be called upon to help distribute letters to families to ensure every family receives the appropriate and timely notifications
- The State will be working closely with CMS to coordinate the issuance of letters to families and will ensure providers are notified of the timeframes for distributing notifications

Transition Step – Notification to Families

- Correspondence to families will include:
  - Notice regarding the transition to Health Home Care Management Services
  - Notice that their current 1915(c) waiver is closing (March 31, 2019, under current timeline and pending CMS approvals) and they will be transitioned to the new 1915(c) Children's Waiver
  - The transition to Managed Care and choosing a Plan
- The child/family should have time to discuss the changes that are occurring, be able to ask questions and to determine how they want to move forward. Multiple visits/discussion with the family may have to occur

Transition Step – Education about Health Home

Children who are eligible for Home and Community Based Services (HCBS) are required to have care management and a care plan for their HCBS

- Medicaid Health Home Care Management serves children with complex behavioral health needs
- Health Homes provides comprehensive care management that focuses on the medical, behavioral, and social service needs of the child with an emphasis on health promotion and overall well-being – 360 degree approach
- Health Home is an optional Medicaid benefit, therefore participation/enrollment are voluntary
- Health Home care management is a cross-system approach to ensure a child receives care management regardless of the door they enter – health, behavioral health, community and social supports, specialty services etc.
- Managed Care Plans, Lead Health Homes and Care Management Agencies will work together to ensure quality services and outcomes for children

Transition Step – Opt-out of Health Home

Families have the right to elect not to transition to Health Home care management for Home and Community Based Services coordination

- If a family chooses to opt-out of HH care management, they still need care management and a plan of care in order to access HCBS
- The Independent Entity (Maximus) will develop a plan of care for children who opt-out of Health Home care management

Therefore, families must be educated about the difference between the Health Home care management and the Independent Entity before they make the selection

Transition Step – Independent Entity (IE)

The role of the Independent Entity (IE):

- Will have a presence regionally and Statewide number
- Will provide care coordination and a plan of care ***only*** for HCBS, not comprehensive care management like in HHCM
- Make referrals to HCBS for the child
- Maintain the HCBS plan of care and make referrals for children who are Fee-for-Service (FFS)
- If the child is enrolled with a Managed Care Plan (MCP), the MCP will manage the HCBS plan of care once the child is enrolled in MC
- The IE will conduct HCBS eligibility and HCBS re-eligibility determinations if the child is enrolled with MC

Please note: Other non-HCBS child needs and/or services will have to be obtained and managed by the family and/or other service providers and community resources

Step 2 –
Planning for Transition

Transition Step – Transition Timeline

Subject to CMS approvals, from January 1, 2019 until March 31, 2019, all children currently receiving waiver services must transition to HH care management or to the Independent Entity to maintain HCBS - This only applies to children currently enrolled in/receiving waiver services and not for children on a waitlist

Any child not transitioned by March 31, 2019, will have to seek new HCBS eligibility under the process provided for under the new consolidated 1915(c) Children's Waiver, which is subject to CMS approvals, will take effect April 1, 2019

After March 31, 2019, providers may not bill for the current HCBS services now provided under the six 1915(c) waivers

Transition Step – HCBS Eligibility

This is a change from Trainings:

- Level of Care (LOC) forms must be completed as currently required under existing waivers for any transitioning child who is due for annual recertification between January 2019 through March 31,2019, even if the child has already transitioned to Health Home during this period.
- For any transitioning waiver child whose annual recertification is on or after April 1, 2019, based on the recertification date under the former waiver, the new HCBS/LOC Eligibility Determination will be completed within the month of the due annual recertification.

Example:

1. Child A's current waiver annual eligibility re-determination is due in February, Child A transitions to Health Home in February during the transition period, the current 1915c waiver Level of Care will be need to be completed to maintain waiver eligibility
2. Child B's annual eligibility re-determination is due in May, Child B transitions to Health Home any time during January – March, the new HCBS/LOC Eligibility Determination will need to be completed in the month of May to maintain waiver eligibility

* **Please Note:** HCBS eligibility is for one-year, unless the child is placed at a higher level of care, including but not limited to: hospitalization, incarceration, residentially placed, nursing home. If placed at a higher level of care, an eligibility re-determination will be needed

Transition Step – Caseload Planning

When planning current waiver caseload to Health Home care management, the following considerations should be made:

1. Stagger the number of children on a caseload that transition to Health Home care management between January – March 2019 for management which will stagger HCBS re-determination due date and transitional billing. Transitions can occur on or close to scheduled Service Plan Review dates for ease of coordination and readiness of the child and family.

   Example: Current waiver caseload of 20, transition 7 children in January 2019, transition 7 children February 2019 and transition 6 children in March 2019

Continued Step – Caseload Planning

2. If a child on a current waiver annual eligibility is due during the months of January through March, then those children should be transitioned in the corresponding month of the transition period

   Example: Waiver child's last eligibility re-determination was February 2018, then transition to Health Home should occur in the month of January 2019

3. If the child/family decides to transition to the Independent Entity, that transition can be initiated beginning **February 2019**

Transition Step – Transition Timeline

Any new child determined ***eligible and enrolled*** for an existing 1915c waiver ***between March 8, 2019 through March 31, 2019*** without a plan of care and/or in receipt of HCBS, will be considered a transitioning child if the following is met:

- ❑ DOH capacity management team is notified and the child is recorded as a transition child
- ❑ Waiver LOC eligibility is documented in the child's case record
- ❑ Processes to develop the plan of care and referrals to HCBS providers have begun
- ❑ The child/family has consented to HH care management and a referral and enrollment has occurred in the MAPP system **or**
- ❑ The child/family has opted-out of HH care management to the IE

Once the above is determined, pursue step 3 outline to transition the child to HH or the IE

Step 3 –
Processes to Transition to Health Home or the Independent Entity

After educating the child/family on the transition, explain the differences between HH CM and IE and determine the month the child will transition, follow the ***required*** transition processes described in subsequent slides:

Transition Step – Process to Transition to HH

1. The child/family confirms their understanding of the transition and determine they will transition to Health Home care management
2. Health Home consents are reviewed and signed by the appropriate individual(s)
   - *Children's form 5200 for HH enrollment and 5201 to share information* is for individuals who cannot self-consent for themselves and need a parent, guardian or legally authorized representative to consent
     - *FAQ* is reviewed with the child/family, the FAQ should be left with the family after review and documentation that the FAQ was reviewed is completed on the DOH form 5200
     - *DOH form 5201 Sharing of Information*, has a section 2 which must be completed by the child/youth without a parent, guardian or legally authorized representative present

Continued Step – Process to Transition to HH

- *Adult form 5055 for HH enrollment and to share information,* is for individuals who are 18-21 years of age or under the age of 18 and who are also parents, pregnant, and/or married, are legally able to consent to their own Health Home enrollment and consent to share their own protected health information
- *Functional Assessment Consent form 5230,* is required to enter PHI in the UAS for CANS-NY
- *Release of Educational Records form 5203,* is required for all individuals still attending an educational setting and ability to self-consent or not differs from the HH rules

❖ ***Consent can be signed prior to January 2019. The date the consent is signed, is the date on the consent with a notation indicating the effective date of January – March 31, 2019.***

➢ *Consent to share information need to be updated when there is change in services on the Plan of Care, when adding or discontinuing services*

Consent forms can be located on the DOH website at:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/consent_forms-templates.htm

Consent guidance, information how to complete and utilize consents can be located DOH website:

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

Continued Step – Process to Transition to HH

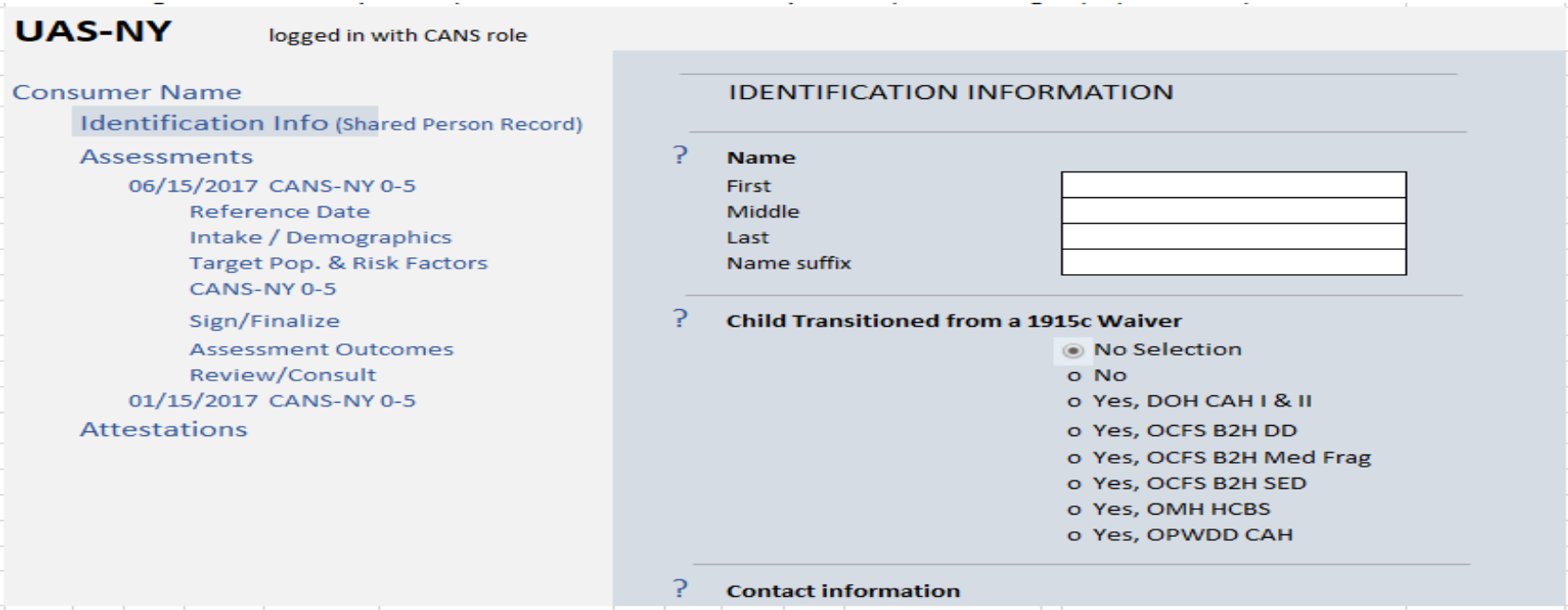
3. Health Home Referral and Enrollment with the MAPP system
   - All children must be entered into the MAPP HHTS Children's Referral Portal
   - To keep the child with your same waiver agency – answer YES to the following question: *"Have you been engaged and in communication with the child and want to outreach, or consent to enroll in the Health Home"*
   - The child (member) must be placed in an enrollment segment, as all transitioning children will automatically transition to HH enrollment
   - **No outreach segments are allowed**
     - ❖ If there is difficulty reaching your waiver family for transition, please contact your DOH liaison who will be tracking all transitioning children from your agency
   - Enrollment in HH needs to occur prior to beginning the CANS-NY

✓ **Please note:** For children in foster care, only a LDSS (Local District of Social Services) or a Voluntary Foster Care Agency can make a HH referral

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

Continued Step – Process to Transition to HH

4. Completion of the CANS-NY with a signature and finalized date
   - Within the CANS-NY "Intake Demographic" section a Transitional Question **MUST** be answered for all transitioning children

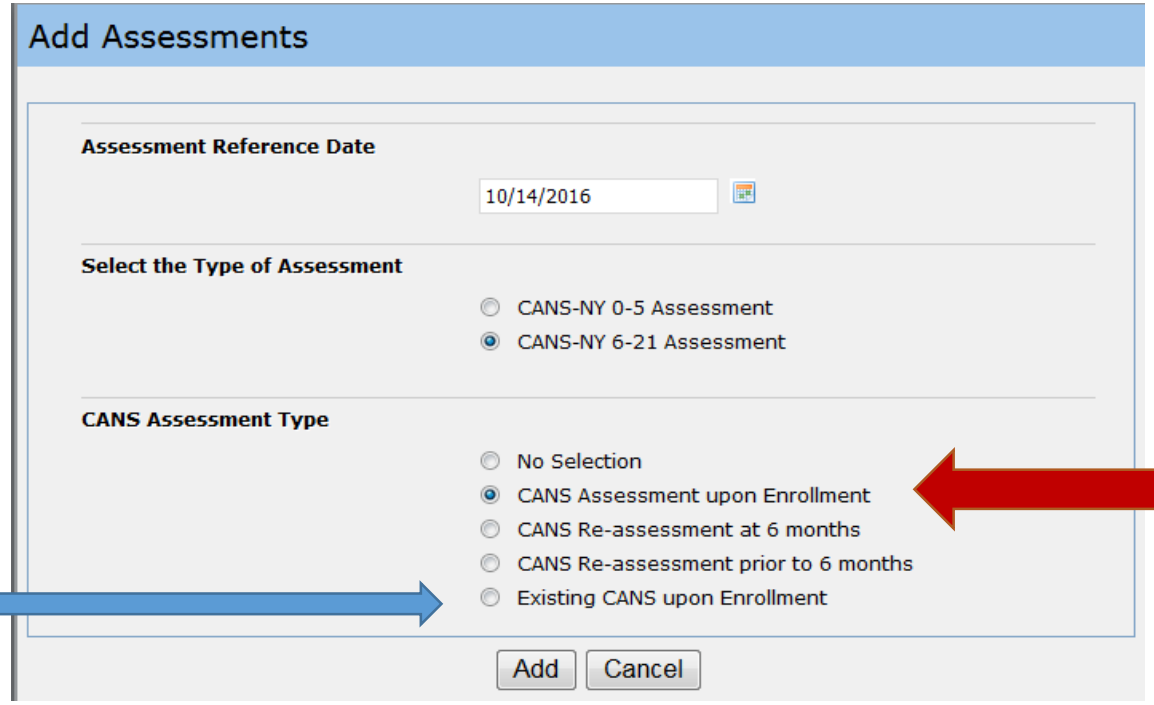


- ***Completion of a signed and finalized CANS-NY with a completed Transitional Question that identifies which waiver the child transitioned from, <u>triggers</u> the one-year HCBS Eligibility***

Continued Step – Process to Transition to HH

It is essential when completing the CANS-NY within the UAS, that the correct Assessment Type is chosen and the link to the correct Health Home in which the child has been enrolled. Both have billing implications.

This is ***NOT*** for transitioning providers



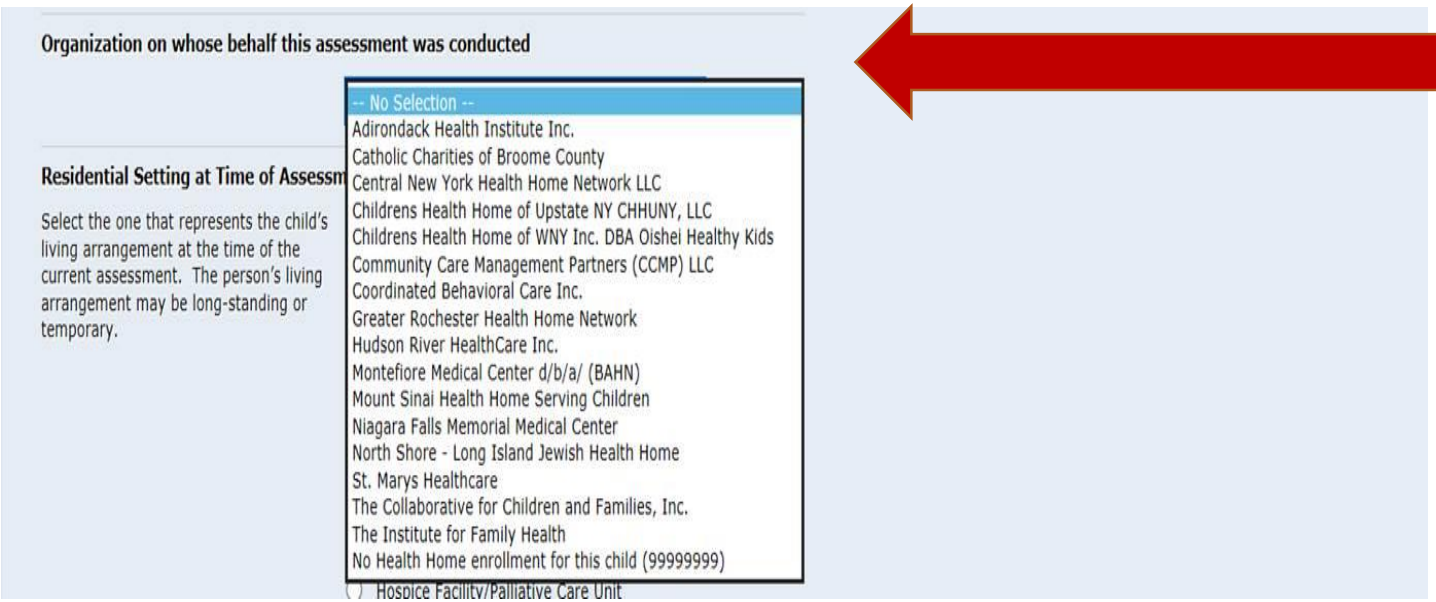
Initial CANS-NY for Health Home Enrollment

First time enrollment in the Health Home program – the choice of *CANS Assessment Upon Enrollment* triggers a one-time only CANS Assessment fee of $185. Other assessments types are for specific purposes and are not connected to billing

Continued Step – Process to Transition to HH

Choosing the Health Home in which the child is enrolled is crucial as the UAS transmits data to MAPP HHTS for billing of L/M/H. If the Health Home choice is not correct, billing cannot occur and may not be able to be corrected to recoup monthly billing. The *"Organization on whose behalf this assessment was conduct"* **is the Health Home the child is enrolled with**

Therefore, the following guidance had been issued to ensure errors are corrected in a timely manner for billing. **Guidance – Mandatory Process for Monitoring CANS-NY Errors**
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/docs/guidance_mandatory_process_monitoring_cans_ny_errors.pdf



This is Health Home the child is enrolled with – this is **NOT** your agency

Continued Step – Process to Transition to HH

5. Development/Transition of the Plan of Care (POC) – outlined in the next step

All other HH requirements such as the completion of a HH comprehensive assessment are not immediately needed during the transition period

- The focus between January – March 2019 is properly transitioning all current and newly eligible and enrolled waiver children
- However a strategy must be developed to ensure compliance with HH standards regarding the member's HH care record
- At the six month re-assessment CANS-NY or earlier than six month re-assessment CANS-NY (due to a significant life change in the child's life), all the requirements of the HH program should be met and the member's record updated:
  - Comprehensive Assessment
  - Documentation of Interdisciplinary Team Meeting
  - Update of the POC
- Transitioning children's files will be audited by the State to ensure proper transition and that current HH requirements are met

Transition Step – Process to Transition to the IE

1. Beginning February 1, 2019, the IE will begin accepting referrals for transitioning children who opt out of Health Home

2. The child/family confirms their understanding of the transition, the difference between HH care management and Independent Entity care coordination roles, and opt-out of Health Home by completing the Health Home Opt-out form (DOH-5059)

Continued Step – Process to Transition to the IE

3. A completed IE Referral Packet MUST be ***Sent and Accepted*** by the IE through the HCS. A complete IE Referral Packet includes all of the following:
   - IE Referral form
   - Health Home Opt-out form (DOH-5059)
   - Agency consent form to share information with the Independent Entity
   - HCBS eligibility assessments *- Change*
     - ❑ If a child's LOC recertification is due during the transition period, than the current waiver provider will complete eligibility and include it for the IE
     - ❑ If a child's LOC recertification is due on or after May 1, 2019, than the new HCBS/LOC eligibility Determination will be completed by the IE
   - Historical clinical, treatment and service information
   - Current Plan of Care identifying involved providers and services, cross walked to new service names (as outlined in the upcoming plan of care slides)

4. The Care Manager will receive a response from the IE through HCS, either accepting the referral or declining with a reason or a request for additional information

5. The IE will assist with tracking children's transition and one-year HCBS eligibility as the IE does not have the trigger as HHCM will

Please note: The current waiver providers will NOT conduct a new CANS-NY for HH opt outs

Step 4 –
Plan of Care Conversion

Transition Step – Plan of Care

During January 1, 2019 through March 31, 2019, the current 1915c waiver Plan of Care will transition to Health Home Plan of Care

For purposes of Continuity of Care, it is anticipated current service providers continue to provide the services they do under the current 1915c waiver and provide Home and Community Based Services (HCBS) and the Child and Family Treatment and Support Service (CFTSS)

Should current providers under 1915c waiver not become designated to provide those services after April 1, 2019, then when the POC is converted and updated for the transition period, new providers referrals will have to occur

When a child is HCBS eligible, they are eligible for ALL HCBS array

Transition Step – Transition to HH Plan of Care

Children/families who will transition to Health Home care management will need their Plan of Care converted and updated into the Health Home comprehensive POC

- Review the current Plan of Care with the child/family and add any new services requested
- Update the POC to crosswalk to the new HCBS service name and service description
- Update the target dates for goals and objectives
- If new services have been added, then referrals to new providers will occur and documented in the POC
- The new HH POC will be reviewed with the child/family, their care team and signatures will need to be obtained to have a completed transitioned POC
- The transitioning POC should not be held up due to lack of information or verification processes required by the lead HH.
  - Current waiver care plans can be converted to ensure a smooth transition and then updated appropriately at a later date (six month CANS-NY re-assessment), as current waiver care plans should have the minimal requirements
  - As an example, waiver care plan may not have all medical, behavioral health, community, and social supports identified

Transition Step – Preparing the Plan of Care to Transition to the IE

Children/families who opt-out of Health Home will transition to the Independent Entity beginning February 2019. Prior to completing and sending the IE referral packet, the transitioning waiver provider will:

- Review the current Plan of Care with the child/family and add any new services requested
- Update the POC to crosswalk to the new HCBS service name and service description
- Update the target dates for goals and objectives
- Complete the IE referral packet to include the most up-to-date Plan of Care

Once the IE referral is accepted:

- If services are added, then the IE will make referrals to new providers and document them in the POC
- The IE will review updates to the HCBS POC with the child/family and obtain signatures; the child's care team will also be given the opportunity to sign the POC

Transition Step – Plan of Care Services Crosswalk

Child Transitioning from CAH I/II Wavier to HCBS

CAH I/II Waiver

Case Management	Health Home
Palliative Care – Family Education	Care giver Family Supports and Services
Palliative Care – Bereavement	Palliative Care: Bereavement Services
Palliative Care – Massage Therapy	Palliative Care: Massage Therapy
Palliative Care – Expressive Therapy	Palliative Care: Expressive Therapy
NEW SERVICE ADDED	Palliative Care: Pain & Symptom Management
Home and Vehicle Modifications	Environmental Modifications
Home and Vehicle Modifications	Vehicle Modifications

Continue Step – Plan of Care Services Crosswalk

Child Transitioning from OCFS B2H Waiver to HCBS

OCFS B2H Waiver		
	Health Care Integration →	Health Home Care Management
	Crisis & Planned Respite →	Respite: Crisis and Planned
	Prevocational Services →	Prevocational Services
	Family Caregiver Support Services →	Caregiver/Family Support & Services
	Supported Employment →	Supported Employment
	Special Needs Community Advocacy and Support (SNCAS) →	Community Self Advocacy Training and Support
	Day Habilitation →	Community Habilitation
	Day Habilitation →	Day Habilitation

Continue Step – Plan of Care Services Crosswalk

Child Transitioning from OCFS B2H Waiver to HCBS

OCFS B2H Waiver	
Adaptive and Assistive Equipment	Adaptive and Assistive Equipment
Accessibility Modifications	Vehicle Modifications
	Environmental Modifications

Children and Family Treatment Support and Services

OCFS B2H Waiver

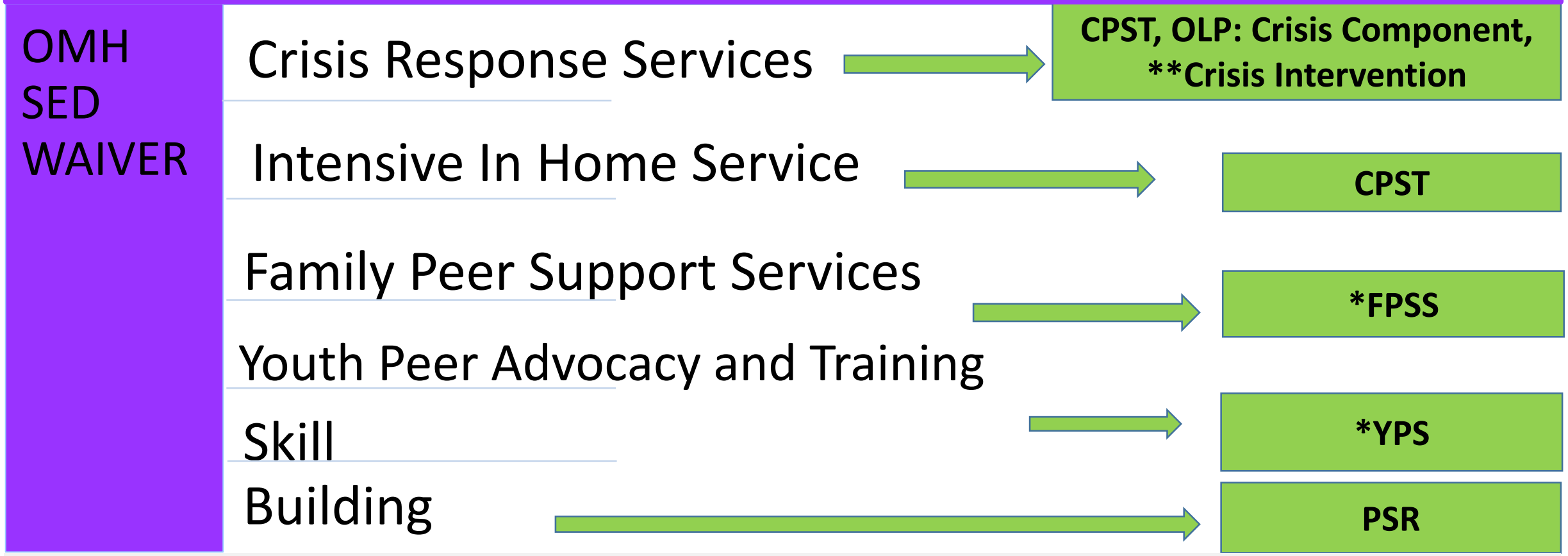
Crisis Avoidance, Management & Training	CPST
Immediate Crisis Response Services	CPST, OLP: Crisis Component, **Crisis Intervention
Skill Building	PSR

*From 4/1/2019 through 6/30/2019 Family Peer Support Services will be authorized under the 1115 for ALL children who are HCBS eligible. From 4/1/2019-12/31/2019 Youth Peer Supports will be authorized under the 1115 for all children who are HCBS eligible. Both services will be provided by designated providers identified with the interagency designation team and delivered consistent with the service descriptions and staff/provider qualifications outlined in the CFTSS provider manual found here:
https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/updated_spa_manual.pdf
**Crisis Intervention as defined in the CFTSS provider manual expands the qualifications, requirements and description of services beyond what today's waiver provides. Crisis Intervention as described in the CFTSS manual is scheduled for implementation on 1/1/2020.

Child Transitioning from OMH Waiver to HCBS

OMH SED WAIVER		
Individualized Care Coordination	→	Health Home
Respite Services	→	Respite: Crisis and Planned
Prevocational Services	→	Prevocational Services
Supported Employment	→	Supported Employment

Child Transitioning from OMH Waiver to CFTSS Services



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**Crisis Intervention as defined in the CFTSS provider manual expands the qualifications, requirements and description of services beyond what today's waiver provides. Crisis Intervention as described in the CFTSS manual is scheduled for implementation on 1/1/2020.

Child Transitioning from OPWDD Waiver to HCBS

OPWDD CAH WAIVER	
Case Management →	Health Home
Respite →	Respite: Crisis and Planned
Assistive Technology Adaptive Devices →	Adaptive and Assistive Equipment
Environmental Modifications (Home Accessibility) →	Vehicle Modifications Environmental Modifications

Step 5 –

Role of the Medicaid Managed Care Plan (MMCP), During the Transition

Transition of 1915(c) Waiver Children to Medicaid Managed Care

The Timeline below is subject to CMS approvals – State will work closely to keep plans and providers apprised of any impact CMS approvals may have on family notifications and other activities included in the timeline below

A number of activities will need to occur once a family has chosen a MMCP by the Health Home care manager or the Independent Entity

Activity - Subject to CMS Approval
Families receive informational letter regarding Children's System Transformation
The Enrollment Broker sends intent to assign letter
The Enrollment Broker sends its first reminder letter
MMCP member services begin accepting calls about HCBS
Plans will send children and families the benefit change letter for HCBS
The Enrollment Broker sends its second reminder letter
The State informs children and families of waiver closure
The Enrollment Broker sends an Auto Assignment confirmation letter
Earliest enrollment effective date

Transition Step – Role of the MMCP During the Transition

Families will receive information to select a Medicaid Managed Care Plan (MMCP) during the transition months

The waiver provider now HH CMs will work with children and families to know when MMCP information and selection letters are issued to support and help as needed

The HH CM or the IE, need to be aware of the family's MMCP selection and enrollment and they should check emedny before every appointment and before making referrals to confirm plan enrollment

For HH care management:

- Once MMCP enrollment has occurred, the HH CM will update the consent form with the family to include the MMCP as part of the care team and the ability to share information (Per HH Consent Policy)
- The HHCM will send the converted and updated POC to the MMCP
- The HHCM will notify all care team and providers of the MMCP involvement

For the IE:

- The IE will notify the family that the MMCP will manage the POC and explain the role of the IE and MMCP
- The IE will send the converted and updated POC to the MMCP

Please note: Once the Plan is known, the POC must be sent to the MMCP and not wait until April 2019

Medicaid Managed Care Plans

Medicaid Managed Care Plans are within counties and or regionally located

There must be alignment between the child's plan, the HH care management agency and Health Home

Additionally, Home and Community Based Services (HCBS) and Children and Families Treatment and Support Service (CFTSS) direct service providers must have contracts with the MMCP of the child to provide services

It is important during the transition and thereafter that current providers working with children remain consistent whenever possible

Direct service providers must have contracts with MMCP to continue to provide services. Otherwise a single case agreement will be needed for the specific child to maintain with a provider who does not have a contract with the child's Plan.

Step 6 –

New Waiver Eligible Child Post January 1, 2019

Transition Step – Newly Eligible Waiver Children

Any child can be referred for waiver services during the transition months of January 1, 2019 through March 31, 2019 to access current waiver services

The existing 1915c waiver eligibility processes established by the following waivers, will continue until March 31, 2019

- OMH SED 1915(c) waiver (NY.0296)
- DOH Care at Home (CAH) I/II 1915(c) waiver (NY.4125)
- OPWDD Care at Home 1915(c) waiver (NY.40176)
- OCFS Bridges to Health (B2H) SED 1915(c) waiver (NY.0469)
- OCFS B2H Medically Fragile 1915(c) waiver (NY.0471)
- OCFS B2H DD 1915(c) waiver (NY.0470)

Existing waiver slot capacity per the above list waivers will be maintained throughout the transition months

Any new child determined ***eligible and enrolled*** for an existing 1915c waiver ***between March 8, 2019 through March 31, 2019*** without a plan of care and or receipt of HCBS, will be considered a transition child if the following is met as outlined in previous slide 41

Service Transition Timing and Billing

Health Home Serving Children Per Member Per Month Rates

Per Member Per Month HH Care Management Rates for Children under 21 (non-Legacy Providers)		
Acuity for Determining PMPM (CANS-NY Algorithm*)	Upstate	Downstate
High	$750	$799
Medium	450	479
Low	225	240
Assessment**	185	185

*"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 case loads)***

- 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/acuities
  - ✓Care managers serving "high" acuity children keep case load sizes predominantly to children of High acuity level
  - ✓Two Health Home services provided each month, one of which must be face-to-face contact for children of Medium or High acuity

** One time assessment fee – CANS-NY is required to be updated every six months, unless significant event in child's life occurs

Billing During the Transition

Beginning January 1, 2019 (with CMS approval), current 1915(c) waiver providers will be authorized to bill Health Home rates. Billing will be dependent upon if the child that is being served has transitioned to Health Home care management or not

Billing is on a PMPM basis, therefore the month the child is transitioned by being enrolled to Health Home care management, is the month Health Home billing will begin and previous 1915c care management billing will end, ***as only one service can be billed and no duplicate billing can occur***

1. For children who have yet to transition to Health Home care management, providers will continue to bill current waiver rates, if existing waiver rules and regulations surrounding billing are met

2. For children who opt-out of Health Home care management, the provider will discontinue billing once the IE has given notification of acceptance of the IE referral packet

Billing During the Transition - Continued

3. For children who have transitioned to Health Home care management, billing will be based upon the CANS-NY L/M/H acuity
   - ❑ Children will be directly enrolled in HH, without the need for separate HH eligibility needing to be determine – children will not be put in outreach

Examples:

- Child A is currently enrolled in the OMH waiver. Child A transitions and is enrolled in Health Home care management in February 2019. Billing for Child A will occur as outlined below when all requirements for billing have occurred:
  - January 2019 – current 1915c waiver care management rates will be billed
  - February 2019 – Health Home acuity will be billed (low rate if CANS-NY was not completed)
  - March 2019 – Health Home acuity will be billed

Please Note: Any 1915c waiver enrolled child not transitioned by March 31, 2019 will have to seek new HCBS eligibility through the new process and provider(s) will not be allowed to bill for services provided after March 31, 2019

Billing – Transitional Rate

Beginning January 1, 2019 (with CMS approval) for current OMH HCBS and OCFS B2H providers, there will be a transitional rate in addition to Health Home acuity billing, to transition those providers from current 1915(c) waiver care management rates to Health Home rates over a two year period

For children who are transitioning from OCFS B2H or OMH HCBS waiver program, once the child is transitioned to HH care management ***and*** the HH requirements are met for billing, HH acuity billing will occur concurrently with the transitional rate with separate rate codes

The transitional rate will be identified by the allowable number of transitional rates “slots” by individual provider - providers will be notified in early January 2019 the number of allotted transitional rates

A separate webinar will be held on Health Home billing for waiver providers

Draft Transitional Rates:
https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/childrens_hh_transition_rates.pdf

CANS-NY Assessments

For children that transition to Health Home, a Health Home CANS-NY within the UAS is needed. Those children who opt-out of Health Home do not need a Health Home CANS-NY conducted

- The CANS-NY will not be pre-populated with previous results
- A one-time assessment fee ($185) per enrollment for the initial CANS-NY into a children's designated Health Home may be billed upon *completion of the* CANS-NY
- It is the expectation that the CANS-NY will be completed within the month the child is transitioned during the transitional period
- The CANS-NY must be completed every 6 months from the first day of the month it was completed

Note: Providers should not assume that all transitioning waiver children will be high acuity

Health Home 5 Core Billable Services

Health Home Core Billable Services that 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;
2. Care coordination and health promotion;
3. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
4. Individual and family support, which includes authorized representatives; and
5. Referral to community and social support services if relevant

Children with CANS-NY high or medium acuity must receive two Health Home services per month, one of which must be a face to face contact

The Importance of Determining Health Home Eligibility and Appropriateness

Connecting Children and Families to Services

- Children who are eligible for HCBS are required to have care management and a care plan for their HCBS services
- ***Children who are eligible for HCBS are eligible for Health Home***
- ***Children who are Health Home eligible are NOT automatically eligible for HCBS***
- ***Children who are no longer eligible for HCBS will also lose HH care management unless they are found HH eligible and appropriate***
- It is important that transitioning providers determine within the first year of the transition if the transitioning child is separately eligible for Health Home care management, so if the child loses HCBS LOC then the child can step down to HH and remain with their care manager
- After April 1, 2019, new children will be determined HH and HCBS eligible simultaneously

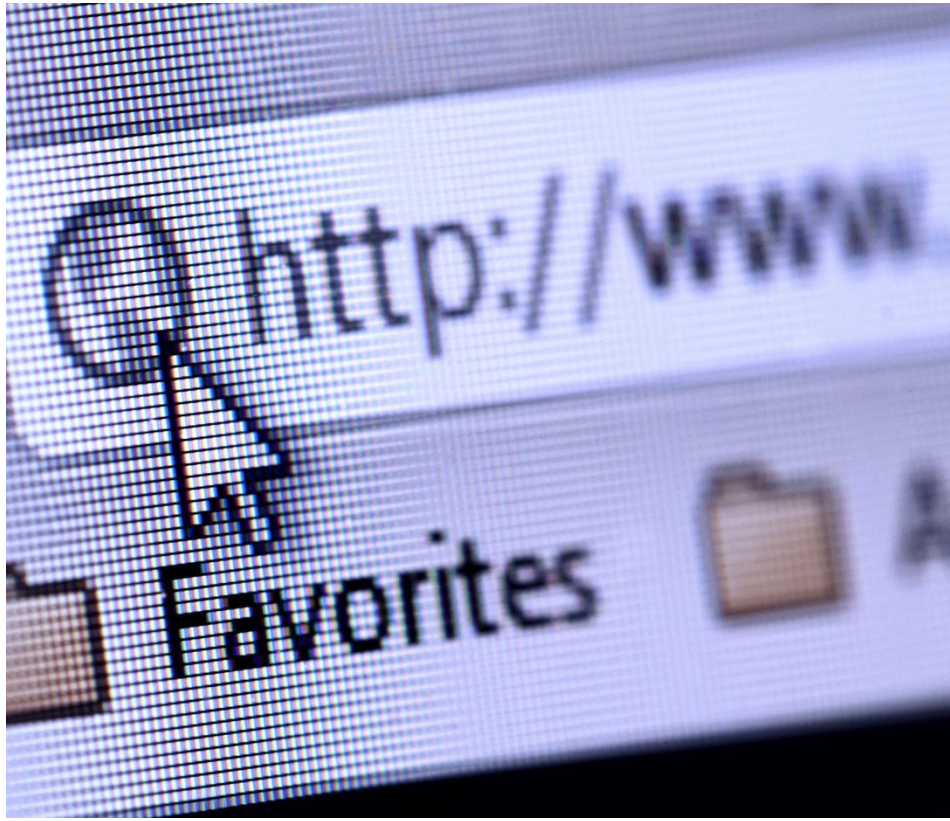
Please refer to the Appendix for Health Home Eligibility and Appropriateness criteria and information

Q
&
A

Updates, Resources, Training Schedule and Questions

- Please send any questions, comments or feedback on Health Homes Serving Children to: hhsc@health.ny.gov or contact the Health Home Program at the Department of Health at 518.473.5569
- Stay current by visiting our website: http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm
- Subscribe to the HH Listserv

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



Health Homes Serving Children
List of Acronyms

- ACS: NYC Administration of Children Services
- AI: AIDS Institute
- ALP: Assisted Living Program
- ASA: Administrative Service Agreement
- BAA: Business Associate Agreement
- BHO: Behavioral Health Organization
- CAH: Care at Home
- CBO: Community Based Organizations
- CMA: Care Management Agency
- CFTSS: Children and Family Treatment and Support Services
- CPST: Community Psychiatric Support and Treatment
- DEAA: Data Exchange Agreement Application
- EI: Early Intervention
- Emedny: Electronic Medicaid system of New York
- FFS: Fee For Service
- HCBS: Home and Community Based Services
- HCS: Health Commerce System
- HH: Health Home
- HHSC: Health Home Serving Children
- HHTS: Health Home Tracking System
- HIT: Health Information Technology
- IE: Independent Entity
- LDSS: Local Department of Social Services
- LGU: Local Government Unit

Health Homes Serving Children
List of Acronyms

- MAPP: Medicaid Analytics Performance Portal (Health Home Tracking System HHTS)
- MCO/MCP: Managed Care Organization / Managed Care Plan
- MRT: Medicaid Redesign Team
- MMIS #: Medicaid Management Information Systems
- NPI #: National Provider Identifier
- OASAS: Office of Alcoholism and Substance Abuse Services
- OCFS: Office of Children and Family Services
- OLP: Other Licensed Practitioner
- OMH: Office of Mental Health
- OMH-TCM: Office of Mental Health Targeted Case Management
- OPWDD: Office of People with Developmental Disabilities
- PMPM: Per Member Per Month
- PSR: Psychosocial Rehabilitation
- SED: Serious Emotional Disturbance
- SMI: Serious Mental Illness
- SPA: State Plan Amendment
- SPOA: Single Point of Access
- SPOC: Single Point of Contact
- TCM: Targeted Case Management
- UAS-NY: Uniformed Assessment System
- VFCA: Voluntary Foster Care Agency

Appendix

Health Home *Chronic Condition* Eligibility Criteria

- The individual **must** be enrolled in Medicaid
- Medicaid members eligible to be *Enrolled* in a Health Home **must** have:
  - Two or more chronic conditions (e.g., Substance Use Disorder, Asthma, Diabetes*) **OR**
  - One single qualifying chronic condition:
    - ✓ HIV/AIDS or
    - ✓ Serious Mental Illness (SMI) (Adults) or
    - ✓ Serious Emotional Disturbance (SED) or Complex Trauma (Children)

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)
- In addition, the Medicaid member **must** be appropriate for the intensive level of care management services provided by Health Home, i.e., satisfy appropriateness criteria

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

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

- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma- and Stressor-Related Disorders
- Dissociative Disorders
- Somatic Symptom and Related Disorders
- Feeding and Eating Disorders
- Gender Dysphoria
- Disruptive, Impulse-Control, and Conduct Disorders
- Personality Disorders
- Paraphilic Disorders
- ADHD for children who have utilized any of the following services in the past three years:
    - Psychiatric inpatient
    - Residential Treatment Facility
    - Day treatment
    - Community residence
    - Mental Health HCBS & OCFS B2H Waiver
    - OMH Targeted Case Management

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

SED Definition for Health Home - Continued

Functional Limitations Requirements for SED Definition of Health Home

To meet definition of SED for Health Home the child must have experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis. The functional limitations must be **moderate in at least two** of the following areas or **severe in at least one** of the following areas as determined by a licensed mental health professional :

- Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
- Family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
- Social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
- Self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
- Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

❖*Note: the DSM categories include in the definition of SED used to determine Health Home eligibility is different than the SED definition used to determine eligibility for other Medicaid services (e.g., OMH clinic, inpatient, etc.)*

Complex Trauma – Single Qualifying Condition for Health Home

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

Definition of Complex Trauma

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

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

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

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

Process to Determine Health Home Complex Trauma Eligibility

Completed by Non-Licensed Professional or Licensed Professional w/o 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

Health Home Appropriateness Criteria

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

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

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

Determining Health Home Eligibility

- The Health Home care manager is responsible for documenting and verifying children meet the eligibility criteria, e.g., work with health care professionals to determine and document eligibility conditions
- The State has developed a set of forms and procedures for determining if a child has complex trauma (i.e., meets the Health Home definition of complex trauma)

Overview of the Six Core Health Home Services

1. Comprehensive Care Management
   - A comprehensive health assessment that identifies medical, mental health, chemical dependency and social service needs is developed.
2. Care Coordination and Health Promotion
   - The Health Home provider is accountable for engaging and retaining Health Home members 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.
3. Comprehensive Transitional Care
   - 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.

Overview of the Six Health Home Core Services

4. Patient and Family Support
   - 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.

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

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

For detailed description of each core service please see: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/provider_qualification_standards.htm

Health Home 5 Core Billable Services

Health Home Core Billable Services that 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;
2. Care coordination and health promotion;
3. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
4. Individual and family support, which includes authorized representatives; and
5. Referral to community and social support services if relevant

Children with CANS-NY high or medium acuity must also have a monthly core service of a face to face contact

Quarterly Review Documenting Continued Need for Health Home Services

- No less than quarterly, care managers must actively review and document in the plan of care, the child's continued need for Health Home Care Management services
- Quarterly reviews should evaluate and consider condition/stability of the child and eligibility criteria for which they entered Health Homes:
  - 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 condition(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 and is stable enough to no longer require the services of a Health Home care management,

    ✓Has service and support needs that can be met by family/guardian and services without the intensive level of HH care management
  - The Care Manager can and should review if the child needs the intense level of care management provided by a Health Home regardless of the acuity used to determine HH PMPM rate (High, Medium, Low)
  - 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)

Health Home Interdisciplinary Team Meeting

The Health Home provider supports care coordination and facilitates collaboration through the establishment of regular case review meetings,

- An interdisciplinary team meeting must occur:
  - during completion of the initial full CANS-NY and during subsequent CANS-NY updates to develop the plan of care
  - as frequently as needed and determined by the Health Home Care Manager
  - at the request of the Health Home Care Manager, and/or the child/parent/guardian/medical consenter (including the LDSS), based upon new information from another provider (e.g., primary care physician).
- A team meeting must be person-centered focused and scheduled to accommodate the child and parent/guardian/legally authorized representative's attendance.
- The plan of care and other decisions should not be completed without the input of the parent/guardian/legally authorized representative's for the child.
- *The Health Home interdisciplinary meeting can account for other required meetings in various systems, as long as the appropriate attendees are invited and the meeting purpose and outcome is documented.*

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

1. The child's Emergency Contact and disaster plan for fire, health, safety issues, natural disaster, other public emergency

2. The child's History and Risk Factors related to services and treatment, well-being and recovery.

3. The child's Functional Needs related to services and treatment, well-being and recovery.

4. The child's and caregivers' identified Strengths and Preferences related to services and treatment, well-being and recovery.

5. 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.

6. 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).

7. Description of planned Care Management Interventions (including Services Care Management, Referral, Access, Engagement, Follow Up, and Service Coordination) and Timeframes.

8. The child's Transition Plan including circumstances/services needed to transition from Health Home Care Management as needed (e.g., education, living situation, employment, community functioning, hospital, treatment facility, foster care).

9. Documentation of participation by inter-disciplinary team (all Key Providers) in the development of the plan of care.

10. The Child's Medical consenter's Signature documenting agreement with the plan of care. (Referencing DOH 5201 Health Home Consent/Information Sharing/For Use with Children Under 18 Years of Age)