Policy Title: Health Home Serving Children Care Management Core Service Requirements and Billing Policy
Policy Number: HH0017
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Applicable to: Health Homes Serving Children (HHSC), Health Home Care Managers (HHCM), Care Management Agencies (CMA)

Purpose: This policy outlines Core Service requirements for Health Home Care Management billing, which is based upon the Child Adolescent Needs and Strengths (CANS-NY) assessment (as modified for New York) decision model acuity (levels of care management support).

CONTENTS

I. CANS-NY

The CANS-NY assessment is a multi-purpose tool used to support decision making around level of care, levels of care management support and service planning, and links the assessment process to an individualized plan of care. The CANS-NY has two assessments and decision model acuity algorithms to support the diverse needs of children/youth at different ages: one for children from birth through age five (0 through 5), to be used until the child's sixth birthday, and one for children ages six through twenty (6 through 20), to be used until the youth's 21st birthday. The decision model acuity titles changed in November 2023 to reference the levels of care management support to be provided by the care manager to meet the child/youth's level of need identified from the CANS-NY assessment, according to their age and acuity:

- 0 through 5: Low, Early Development {formerly labelled Medium}, Complex {formerly labelled High}
- 6 through 20: Standard {formerly labelled Low}, Intensive {formerly labelled Medium}, Complex {formerly labelled High}

For more information on CANS-NY, please refer to the Child Adolescent Needs and Strengths - NY (CANS-NY)
For more information on HHSC, please refer to the Medicaid Health Homes - Comprehensive Care Management (ny.gov)

II. Decision Model Acuity

The CANS-NY assessment determines the child/youth's identified levels of care management support and the core service interventions required for the Health Home to be permitted to bill for services. Children/youth receiving Health Home (HH) services have medical, behavioral, or developmental needs, functional limitations; and the child/youth's caregiver may need medical, behavioral, or social supports, or additional education to care for their child/youth. The intensity of the needs and strengths determines the child's level of care management support.

The following are the criteria for the levels of care management support:

- **Low (0 – 5)/Standard (6 – 20**) (formerly labelled Low): Default for children/youth who are deemed eligible for Health Home, but who do not meet Early Development/Intense (formerly labelled Medium) or Complex (formerly labelled High) decision model acuity thresholds via CANS-NY assessment. For children/youth who are Low/Standard acuity, the core service frequency requirements are lower, *as care management needs are less intensive and focused on maintenance and preventing escalation of needs*.

- **Early Development (0 – 5)/Intense (6 – 20)** (formerly labelled Medium): Children/youth who meet specific criteria via CANS-NY assessment who require higher levels of care from a care manager (CM). Children/youth with Early Development/Intense acuity are served with the Health Home core services more frequently, *as the needs identified require a level of action and direct service intervention to prevent escalation of a condition or crisis.*

- **Complex (0 – 5 & 6 – 20)** (formerly labelled High): Intended for children/youth who require a high level of care management and coordination. Children/youth with Complex acuity are served with the Health Home core services at a high frequency, *as the needs identified require immediate and constant action and intervention.*

- **High Fidelity Wraparound (HFW)** is an evidence-based care management approach that is intended for youth with Complex acuity who have been determined to meet additional criteria. Children/youth receiving High Fidelity Wraparound are served with Health Home core service at the required frequency for Complex acuity, plus one additional Health Home core service to meet the fidelity of the model.

III. Required Care Management Core Interventions Per Month

- **Low (0 – 5)/Standard (6 – 20):** One completed core service per month. Quarterly (or every third month), the core service must be with the member, and at the request of the member/caregiver, the member contact per quarter may be via telehealth.

- **Early Development (0 – 5)/Intense (6 – 20)**: Two completed core services per month, at least one must be in person with the member. After the first three months of Health Home enrollment (which are required to be in person services), at the request of the member/caregiver, member contact may be via telehealth instead of in person, up to six times per year.

- **Complex (0 – 5 & 6 – 20):** Three completed core services per month, at least two must be with the member. At least one member contact per month must be in-person, and at the request of the member/caregiver, one member contact per month may be via telehealth.

- **High Fidelity Wraparound (HFW)**: Four completed core services per month, including one Child and Family Team Meeting (CFTM). Each of the four core services must be contacts with the member/caregiver. Two contacts must be with the member and two contacts may be with the caregiver based upon the current needs of the member and caregiver and what is needed to support progress on the plan of care. The member and the caregiver must be in attendance at the CFTM. The CFTM counts as one contact. At least two member/caregiver contacts per month must be in person, and at the request of the member/caregiver, up to two member/caregiver contacts per month may be via telehealth.

IV. Member vs. Caregiver (Medical Consenter) Contact

This policy frequently references contact with the member. When the member is a minor, the caregiver (medical consenter) must also be present when consents or signatures of the caregiver must be obtained. If the member is able to legally self-consent due to their age or due to eligible circumstances, as outlined in the Health Home guidance available at Health Home Serving Children (HHSC) (ny.gov), the caregiver does not need to be seen, even for an

assessment or an update to the Plan of Care (POC). While not required in these situations, the care manager should encourage the member to include their identified caregiver in care management services. Contacts with the caregiver can be considered a core service, but if the member is not also present, the contact cannot be considered a member contact.

V. Use of Telehealth

Telehealth is utilized based upon the request of the member/caregiver and must be documented within the case record. Care management services may be provided via telehealth when they are not required to be provided in-person, as outlined in this policy. Telehealth should be delivered via audio-visual modalities and may be delivered via telephonic/audio only when audio-visual technology is not available. When utilizing technology conferencing tools including audio, video and/or web, the care manager must ensure security protocols and precautions are in place to safeguard the member's Protected Health Information (PHI). It is the responsibility of the care manager to assist the member/family with procurement of telehealth equipment, if needed. Care managers must also adhere to general Medicaid telehealth guidance when delivering services via telehealth, which requires that services be based on the best interest and needs of the member, not that of the provider nor for the convenience of the provider. For additional Telehealth guidance, including billing guidance, refer to NYS Medicaid Coverage of Telehealth.

VI. Interdisciplinary Team Meetings (IDT)

Interdisciplinary Team Meetings (IDT) or Interdisciplinary Team Meetings must be conducted in accordance with Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations. The IDT must be person-centered and scheduled for a time and location that is convenient for the child/youth and caregiver. The IDT can be counted as required member contact during the month in which it occurs.

Although the child/youth and caregiver must be in attendance for a IDT meeting to take place, it is not necessary that all members of the care team be in attendance. While in-person attendance is always preferable, the child/youth and caregivers/family and team members may agree to allow participation by video conferencing or phone.

The child's decision model acuity level determines the frequency of the IDT; however, an IDT can be requested at any time by the child/youth and caregiver, an IDT member, or the care manager as needed.

- **Low (0 – 5)/Standard (6 – 20):** An IDT must occur annually and when developing or updating the plan of care and when completing CANS-NY or HCBS Eligibility Determination assessments.

- **Early Development (0 – 5)/Intense (6 – 20)**: The IDT meeting must occur every six months and when developing or updating the plan of care and when completing CANS-NY or HCBS Eligibility Determination assessments.

- **Complex (0 – 5 & 6 – 20):** The IDT meeting must occur every three months and when developing or updating the plan of care and when completing CANS-NY or HCBS Eligibility Determination assessments.

- **High Fidelity Wraparound (HFW)**: The Child and Family Team Meeting (CFTM), which serves as the IDT meeting, must occur monthly, except during the first month of enrollment in HFW. Fidelity standards allow for up to 45 days for the initial CFTM as intensive engagement activities to build the team are occurring.

VII. Health Home Six Core Billable Services

The following are the Health Home six core services, descriptions, and examples of billable services provided under each one:

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. For example, 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 supporting referrals and connections to social and community services where appropriate through the creation of an individual plan of care. Additionally, care coordination and health promotion are demonstrated through on-going communication with the child/youth, caregiver, or provider regarding the member's care, health, safety, service delivery, or regarding the plan of care goals.

3. Comprehensive Transitional Care from Inpatient to Other Settings, including Appropriate Follow-Up. This may include communicating and coordinating with hospitals and residential/rehabilitation facilities regarding an individual's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting to ensure successful transition. Transitional services due to the child/youth's age and development, that may include coordinating educational, medical, and developmental services of Early Intervention, school setting, for older youth transition to an adult primary care physician, or a different system of care (OPWDD).

4. Individual and Family Support, which includes Authorized Representatives: The care manager provides patient and family or caregiver support to assist with the member's goals, or education and support for self-management or self-help recovery, in accordance with the member's individualized plan of care, as appropriate.

5. Referral to Community and Social Support Services if Relevant: 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: The care manager uses available HIT and 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 of the Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations.

VIII. Short-Term Waiver of In-Person Requirements for Members Meeting Specified Criteria

In-person meetings between the Health Home care manager and the member are required based upon CANS-NY decision model acuity, as outlined above.

Families/caregivers with Medically Fragile/Medically Complex children/youth are engaged with a multitude of providers, often in the home. In recognition, this policy permits certain exceptions to monthly in-person service requirements if the family/caregivers prefer to limit the number of individuals the child/youth come in contact with, or if they are able to successfully manage and communicate with their HHCMs without in-person meetings. Some in-person requirements may be waived for members/caregivers who meet these criteria and consent to receive services remotely.

In certain instances, the HHCM may use their discretion to initiate an in-person contact based on risk factors, life events, or potential safety issues, even though the member/family have elected to waive in-person requirements.

Short-term waivers of in-person requirements are not applicable for children/youth enrolled in the Health Home program or the Children's Waiver under the SED single qualifying condition or two Mental Health criteria

A. Criteria to Waive HHCM Monthly In-Person Requirements

Individuals who meet ALL the following criteria can elect to waive the monthly in-person care management requirements for up to six months at a time:

- The member is enrolled in the Children's Waiver under the Target Population of Medically Fragile or Developmental Disability Medically Fragile, or the member meets the definition of Medically Fragile under Public Health Law §4401, provided below:

  "Medically fragile child" means an individual who is under twenty-one years of age and has a chronic debilitating condition or conditions, who may or may not be hospitalized or institutionalized, and meets one or more of the following criteria (a) is technologically dependent for life or health sustaining functions, (b) requires a complex medication regimen or medical interventions to maintain or to improve their health status, or (c) is in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health, or development at risk. Chronic debilitating conditions include bronchopulmonary dysplasia, cerebral palsy, congenital heart disease, microcephaly, pulmonary hypertension, and muscular

dystrophy. The term "medically fragile child" shall also include traumatic brain injury, the nature of which typically requires care in a specialty care center for medically fragile children, even though the child does not have a chronic debilitating condition or also meet one of the three conditions of this subdivision. Notwithstanding the definitions set forth in this subdivision, any patient which has received prior approval from a health maintenance organization for admission to a specialty care facility for medically fragile children shall be considered a medically fragile child at least until discharge from that facility occurs.

- The member receives at least two in-person services per month in the home and is having regular contacts with two or more distinct service providers (doctors, specialists, private duty nurse, etc.) who can be successfully contacted monthly by the HHCM.

- The member has been enrolled in Health Home for at least three months.

- The member/family must consent and must complete the *Monthly Required In-Person Waiver Request Form* attesting agreement to waive the in-person visits.

- The member/family agrees to notify the HHCM upon any change in the member's condition, providers, services, functioning, or caregiver, or other significant life event. Based upon this notification, the HHCM needs to determine the next steps, which may include an in-person visit an update to the safety or crisis plan, if applicable and/or an update to the plan of care.

- The member is NOT enrolled in Health Home High-Fidelity Wraparound.

- The member is NOT enrolled in the Children's Waiver under the Serious Emotional Disturbance (SED) target population.

- The member is NOT enrolled in the Health Home program under the SED single qualifying condition or two Mental Health conditions criteria.

- An in-person care management core service with the member occurred in the month prior to the temporary in-person waiver.

B. Procedure for Requesting a Waiver of In-Person Requirements

1. Member/caregiver requests that care management be provided via telehealth.

2. The care manager determines if the member would benefit from the waiver of in-person requirements.

3. The care manager explains the criteria for the in-person waiver.

4. The care manager verifies the member meets the criteria outlined above.

5. The member/caregiver completes the *Health Home Serving Children Monthly Required In-Person Waiver Request Form* attesting their agreement and identifies how many months they would like to waive the in-person requirement, up to six months at a time.

6. The care manager retains the form and documentation of the agreement with the member/caregiver in the member's record and sends a copy to their Health Home.

7. The request is approved or denied by the Health Home in accordance with their procedures and the care manager is notified.

8. At any time, the member/caregiver can withdraw or change this request or request an in-person meeting with the care manager. The care manager must arrange for an in-person appointment, if requested.

C. Requirements During the Six-Month Waived In-Person Contacts

Six-month waived in-person contacts: Requests to waive the in-person requirement for Early Development/Intense or Complex Acuity members that meet the criteria to waive HHCM monthly in-person requirements, as listed in section VI.A above, will be approved for up to six months at a time. In lieu of the monthly in-person contacts with the member, the HHCM must continue to coordinate care and services for the member to monitor progress, ensure member engagement, must make additional provider contacts, and must make member contact via telehealth and verify and confirm the member's health and safety through telehealth appointments. The HHCM must also maintain documentation of the member's health and safety.

Monthly responsibilities during the six-month waived period: When the monthly in-person requirement is waived, the HHCM must complete the required number of contacts with the member through telehealth per decision model levels of care management support. In lieu of each in-person contact with the member (one per month for Early Development/Intense and two per month for Complex), member contact via telehealth is required and the HHCM must make successful contact with at least two of the member's providers to verify and confirm the member's care, services, health and safety, and plan of care goals.

After the six-month waived period: The HHCM is required to have a successful in-person visit with the member/caregiver after the in-person waiver period has been completed. The HHCM must review the plan of care goals and progress, services, continued HCBS and Health Home eligibility, and the safety and wellbeing of the member at the in-person visit. Upon the successful in-person visit, the member/caregiver may request the in-person requirement be waived for an additional six months.

In-Person Requirements that Cannot be Waived: The HCBS Eligibility Determination is required to be completed in-person in conjunction with the member (and caregiver, as appropriate). The annual review and update of the plan of care, comprehensive assessment, and CANS-NY is required to be completed in-person in conjunction with the

member (and caregiver, as appropriate). In-person, in-home evaluations must be conducted prior to submission of requests for environmental modifications.

IX. Billing Guidance

A. CANS-NY Assessment

The child/youth's decision model acuity level (as determined by the CANS-NY assessment) and whether the core service requirements are met, determines the rate per member per month (PMPM) that the Health Home Serving Children is reimbursed for care management. The care manager must be certified annually to conduct the CANS-NY assessment and must be the individual who enters the results of the assessment in the UAS for billing to occur properly. For more information, please refer to the Health Home Chronic Conditions and Billing Questionnaire/HML Selection Guidance).

B. General Rules

1. It is important to build a rapport with the child/youth and their caregiver to identify their needs and strengths. A minimum of one in-person meeting with the child/youth and caregiver is required to complete the CANS-NY assessment. Additional assessment meetings can occur through telehealth modality, at the request of the member/caregiver.

2. Prior to conducting the CANS-NY, it is incumbent upon the care manager to share the tool with the child/youth and caregiver as well as the identified service professionals and other supports to obtain all necessary information and documentation to complete the assessment. The care manager must obtain consent to communicate and collaborate with all involved service professionals and other supports the child/youth and caregiver identifies.

3. A one-time assessment fee ($185) may be claimed for the initial *"CANS-NY Assessment Upon Enrollment"* ***only,*** which is completed when the child/youth is first enrolled in the Health Home program. There is no fee paid for re-assessments. Health Homes **must** use the MAPP transfer process for individuals who transfer to a new care management agency or Health Home within twelve months of an assessment. An initial assessment fee cannot be billed when a member transfers to a new care management agency or Health Home. If the member is disenrolled from the Health Home program and then re-enrolls, a new assessment is required. However, only if the member has been dis-enrolled for more than 30 days prior to re-enrollment can the initial assessment fee be billed by the new HH/CMA.

4. Once the child/youth is enrolled in Health Home, the Low/Standard acuity rate may be claimed until the month in which the CANS-NY is completed (For up to 2 months). The CANS-NY decision model acuity level determines the maximum rate that can be billed thereafter.

5. If the CANS-NY is not completed by the end of the second month of enrollment, the Health Home is not permitted to bill for care management until the month in which the CANS-NY is completed in the UAS-NY.

6. The CANS-NY assessment must be completed in the UAS-NY to bill for services. A paper CANS-NY is not acceptable.

7. The CANS-NY must be completed on an annual basis except for children/youth enrolled in High Fidelity Wraparound (HFW). The CANS-NY is completed every six months for children/youth enrolled in HFW.

8. The CANS-NY must be completed by the end of the month in which the assessment is due for the Health Home to be eligible for payment of the PMPM for that month.

X. Billing Process and Examples

Each month, prior to the Health Home submitting a claim for a Health Home care management monthly payment, the care manager must complete the *Monthly Children's Billing Questionnaire* within the MAPP-HHTS, attesting to the core interventions provided.

Services provided via telehealth must include 95 or GT modifier for audio-visual telehealth and 93 or FQ for audio-only telehealth modality. Please refer to general Medicaid telehealth guidance for additional details on billing telehealth claims.

The Health Home care manager must successfully complete the number of required care management core interventions for the member's CANS' decision model acuity (including High Fidelity Wraparound) to bill the acuity rate each month.

> *Example: The member's CANS' acuity is Intense, the care manager must complete two core interventions, one being an in-person contact with the member (or a telehealth contact, as permitted). The care manager completes the Monthly Children's Billing Questionnaire attesting to the required two core interventions, including a member contact, to bill the Intense acuity rate. (Please note the MAPP HHTS will require the care manager to identify if the member contact was completed through telehealth modality).*

When a Health Home care manager is unable to complete the required number of care management core interventions associated with the member's CANS' acuity level (including High Fidelity Wraparound) in a given month, the Health Home is permitted to bill a lower acuity rate, if the required number of care management core interventions associated with the lower acuity level were completed during the month.

> *Example: The member's CANS-NY acuity is Intense and the care manager must complete two core interventions, one being an in-person member contact, as the previous two months' contacts were completed via telehealth and the in-person requirements are not waived. The care manager was unable to complete an in-person meeting with the member but met with the member via telehealth, and completed one*

core intervention through contact with the member's pediatrician. The Health Home can bill for the Standard/Low acuity rate. If the in-person requirement is waived and the care manager completed an appointment with the member via telehealth and made an additional provider contact, the Health Home can bill for the Intense acuity rate.

Example: The member's CANS-NY acuity is Intense and the care manager must complete two core interventions, one being a member contact. The care manager was unable to complete a member contact but completed two core interventions through contact with the member's pediatrician and the school. The Health Home can bill for the Low/Standard acuity rate.

Example: The member is enrolled in High Fidelity Wraparound and the care manager must complete four core services with four contacts with the member/caregiver, including one Child and Family Team Meeting (CFTM). Two contacts must be with the member and two contacts may be with the caregiver based upon the current needs of the member and caregiver and what is needed to support progress on the plan of care. The member and the caregiver must be in attendance at the CFTM. The CFTM counts as one contact. At least two member/caregiver contacts per month must be in person and, at the request of the member/caregiver, up to two of the member/caregiver contacts may be via telehealth. The care manager was only able to complete three core services by meeting with the member once in person and twice via telehealth. A CFTM did not occur during the month. The Health Home can bill for the Complex acuity rate.

If the care manager is unable to complete the required number of care management core interventions associated with the Low/Standard acuity level during the month, then billing for that month ***is not permitted***.

Example: The member's CANS-NY acuity is Intense and the in-person requirement is not waived. The care manager must complete two core interventions, one being a member in-person contact, as contact has been via telehealth for the previous two months. The care manager was unable to complete any contacts with the member and only made one successful contact with the pediatrician. No billing for this month can occur, since only one core service was provided.

The Health Home ***is not permitted*** to bill a higher rate than the member's CANS-NY acuity indicates, even if more than the required number of care management core interventions are provided during the month.

Example: The member's CANS-NY acuity is Intense, and the care manager must complete two core interventions, one being an in-person with the member. The care manager completed four successful core services within the month with two in-person contacts with the member. Billing is limited to the Intense acuity rate.

The *Monthly Children's Billing Questionnaire* within the MAPP-HHTS will verify the number of required care management core interventions needed each month, based upon the member's acuity and the billing rules outlined above.

Attachment A – Summary Core Service and In-Person Requirements for HHSC

Former Acuity Level	Age Group	CANS 2.0 Acuity Label	HHCM Rate Code	Core Service Requirement	Core Services Per Month	Member Contacts Per Month	Multi-Disciplinary Team Meeting	In-Person Requirements	Short-term In-person Waiver for Medically Fragile Members
Low	0 - 5 to	Low	1864 & 1869	One completed core services per month. At least one per quarter must be contact with the member.	2	1 per Quarter	Required annually	Assessments must be done in-person. At the member/caregiver's request, member contact may be delivered via telehealth	Not applicable
	6 - 20	Standard							
Medium	0 - 5	Early Development	1865 & 1870	Two completed core services per month. At least one per month must be contact with the member.	2	1	Required every six months	Assessments must be done in-person. During the first three months of initial Health Home enrollment, at least one member contact per month must be in-person. After the first three months of enrollment, at the request of the member/caregiver, member contact may be delivered via telehealth up to six times per year, for no more than two consecutive months.	At the member's request, if criteria are met, in-person contact can be substituted with a telehealth contact plus two additional provider contacts for six months. An in-person contact is required prior to renewing the request.
	6 - 20	Intense							

Former Acuity Level	Age Group	CANS 2.0 Acuity Label	HHCM Rate Code	Core Service Requirement	Core Services Per Month	Member Contacts Per Month	Multi-Disciplinary Team Meeting	In-Person Requirements	Short-term In-person Waiver for Medically Fragile Members
High	0 - 5	Complex	1866 & 1871	Three completed core services per month. At least two per month must be contacts with the member.	3	2	Required quarterly	Assessments must be done in-person. One of the two member contacts per month must be in-person, and at the request of the member/caregiver, one of the monthly member contacts may be delivered via telehealth.	At the member/caregiver's request, if criteria are met, in-person contact can be substituted with a telehealth contact plus two additional provider contacts for six months. An in-person contact is required prior to renewing the request.
	6 - 20	Complex							
High + HFW	6 - 20	High Fidelity Wraparound	1867	Four completed core services per month, including one Child and Family Team Meeting (CFTM). Each of the four core services must be contacts with the member/caregiver.	4, including one CFTM	2 with the member, including the CFTM, and 2 may be with the caregiver only	The Child and Family Team Meeting (CFTM), which serves as the IDT meeting, is required monthly, except during the first month of enrollment in HFW.	Assessments must be done in-person. Two of the four monthly member/caregiver contacts must be in-person, and at the request of the member/caregiver, two of the monthly member/caregiver contacts may be delivered via telehealth.	Not applicable