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***A Series of Webinars for CAH I & II Providers on
Medicaid Redesign Activities to Improve the Delivery of
Health Care for Children***

Series #1: Overview of Health Homes Serving Children

New York State and Care at Home I & II Partnership in Implementing Medicaid Redesign Team (MRT) Initiatives for Transforming Delivery of Health Care for Children

- State's Key Partnership Goals:
 - ✓ Work with CAH I & II Providers to understand, identify and leverage opportunities to incorporate the expertise of CAH providers in caring for medically complex/fragile children (both children who are eligible for CAH I & II and medically complex children who are not) in the MRT Children's Behavioral Health and Health Design
 - ✓ Enhance the service array provided to medically complex/fragile children that are now eligible for CAH I & II Program to improve care
 - ✓ Ensure that CAH I & II Providers and the children and families they now serve smoothly (and as seamlessly as possible) transition to the new design (i.e., Health Home care management, services received today by children eligible/ enrolled in CAH I & II Program are maintained)
 - ✓ Provide CAH providers, the children and families they serve, with as much technical assistance as possible to ensure successful implementation and transition to new design (webinars, questions/answers, implementation challenges, solutions etc.)



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New York State and Care at Home I & II Partnership in Implementing Medicaid Redesign Team (MRT) Initiatives for Transforming Delivery of Health Care for Children

- With the State and CAH I & II partnership goals in mind, the State reached out directly to CAH I & II providers to inquire what we could do to be the most helpful
- Feedback, including questions received, reflected a wide divergence of knowledge by CAH I&II providers regarding Health Homes and other elements of the MRT Design for Children (e.g., new State Plan services, Home and Community Based Services, transition of CAH I & II Waivers to Health Home/Managed Care, eligibility)
- Generally, CAH I & II providers requested specific webinar(s) for CAH I & II providers with a question and answer session (note: State is willing to do in person meetings)
- Given the wide range of knowledge across the topic areas, the timeframe for finalizing the MRT Design for children, the State will present a series of Webinars for CAH I & II providers:
 - Today's Discussion: Overview of Key Elements of MRT Design, but primary focus on Health Home Serving Children (launch date December 2016) and how CAH I & II providers can become Health Home Care Managers
 - As MRT Children's Design becomes final (i.e., documents are submitted to the Center for Medicare and Medicaid (CMS, the Federal Government):
 - New State Plan Services, Home and Community Based Services, the transition of CAH I&II Waiver Program to Health Home care management and to Managed Care (where applicable)
 - These Webinars will support (not replace) other informational Webinars and trainings around Health Homes Serving Children and elements of the MRT Design for Children and provide CAH I & II providers an opportunity to ask questions about issues particularly relevant to you and the children you serve



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Agenda for Today's Presentation

- ✓ MRT Visions and Goals and Timeline
- ✓ Health Home Care Management Overview
 - Health Homes Contingently Designated to Serve Children
 - List of Health Homes by County
- ✓ How a CAH I & II Become a Health Home Care Management Agency
- ✓ Enrolling Children in Health Home
 - Eligibility and Appropriateness Criteria
 - Consent
 - Referral Portal
- ✓ Child and Adolescent Needs and Strengths Assessment-NY (CANS-NY) and Training
- ✓ Health Homes Serving Children Standards
- ✓ Future Planning for CAH I & II
- ✓ Next Steps
- ✓ Questions and Discussion



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Medicaid Redesign Team (MRT)'s Vision, Goals and Principles for Transforming the Delivery of Health Care for Children

- The Design and Implementation of Health Homes for Children is a component of the Medicaid Redesign Team's (MRT) Plan to Transform the Delivery of Health Care for children
 - MRT is a collaborative partnership among State Agencies, stakeholders, providers and advocates
- Vision and Goals for the Children's Medicaid Redesign
 - ✓ Keep children on their developmental trajectory
 - ✓ Focus on recovery and building resilience
 - ✓ Identify needs early and intervene
 - ✓ Maintain child at home with support and services
 - ✓ Maintain the child in the community in least restrictive settings
 - ✓ Prevent escalation and longer term need for higher end services
 - ✓ Maintain accountability for outcomes and quality
 - ✓ **Maintain access to services for children - “Family of One”**



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Schedule for Implementing Key Components of MRT Design for Children

What is timeline for Transferring CAH Children to Health Home?

Schedule for Implementing Key Components of MRT Design for Children

Health Homes for Children – Focus of Today’s Discussion

- Enrollment Begins for Eligible Children, OMH TCM Program Transitions to Health Home,
- ***Opportunity: CAH I & II providers may provide care management for children not enrolled in waivers***
- Six New State Plan Services for ***All Children***
- Under 1115 Waiver:
 - Transition CAH I&II, and other 1115 Waiver Programs (OMH SED, OCFS B2H) to Health Home Note: timing is coincident with timing of making expanded array of Home and Community Based Services available – cannot be accelerated to December 1, 2016
 - Expanded array of Home and Community Based Services available
 - Transition existing Behavioral Health Benefits to Managed Care
 - Transition Foster Care Children (those which are currently subject to Agency Based Medicaid Per Diem) to Managed Care
- ***Maintains Access to Services for Children that are Family of One (through deeming parental income and access to Fee-for-Service if cannot be enrolled in Managed Care)***

December 2016

Beginning in January 2017

July 2017 (NYC, Long Island and Westchester)

January 2018 (ROS)



“Family of One” and Medicaid Eligibility Questions

- The Children’s Design (i.e., the 1115 Waiver) will have the same authority to deem parental income under family of one as the current 1915(c) waivers, including CAH I & II
 - ✓ Family of one children with comprehensive insurance who are eligible because they meet HCBS criteria and their parents’ income is waived will continue to be eligible for Medicaid
 - ✓ Family of one children will receive Medicaid services through the fee-for-service delivery system if they cannot be enrolled in Managed Care such as having a comprehensive private insurance or spend down requirements (or until such time as they can be enrolled in Managed Care). This includes:
 - All Medicaid services if they meet medical necessity criteria,
 - The new array of HCBS services,
 - Health Home care management (or other similar care management if not eligible, details under development)



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Goals for Health Homes and CAH I & II, the Children and Families they Serve, and Medically Complex Children



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Goals for Care at Home Providers, the Children and Families they Serve, and Health Homes

- There are two key parts and critical goals to how Health Homes will impact providers, children and families served today by Care at Home I & II, or children that are medically complex with two or more chronic conditions
- Part one: Key and critical goal is to ensure that the expertise of CAH I & II providers are integrated and imbedded in the Health Homes Serving Children that will launch **December 2016**
 - Ensure there is 100% connectivity (BAAs/contracts – discussed later) between Health Homes serving children and CAH providers that choose to become Health Home Care Managers
 - Provides opportunity to provide Health Home care management for medically needy and other children that meet chronic condition eligibility criteria for Health Home that are not today eligible for CAH I&II
- Part two: **Beginning July 2017** – Key and critical goal is to smoothly transition children and families enrolled in CAH I & II Waiver to Health Home (beginning 2017), ensure continuity of care for care management and services for children not eligible for Managed Care and for children who become Medicaid eligible and access services through “deeming”
 - Accomplishing part one will help ensure the part two is smooth – will include working closely with CAH I&II providers to effectively and clearly communicate with families
 - As MRT Children’s Health and Behavioral Health Design becomes final more operational details will be provided in trainings and in the CAH I & II series of Webinars
- The following series of slides give overview of key elements of Health Home Serving Children Care Management Model that answer questions asked by CAH I & II providers and that would be of particular use to CAH I & II providers

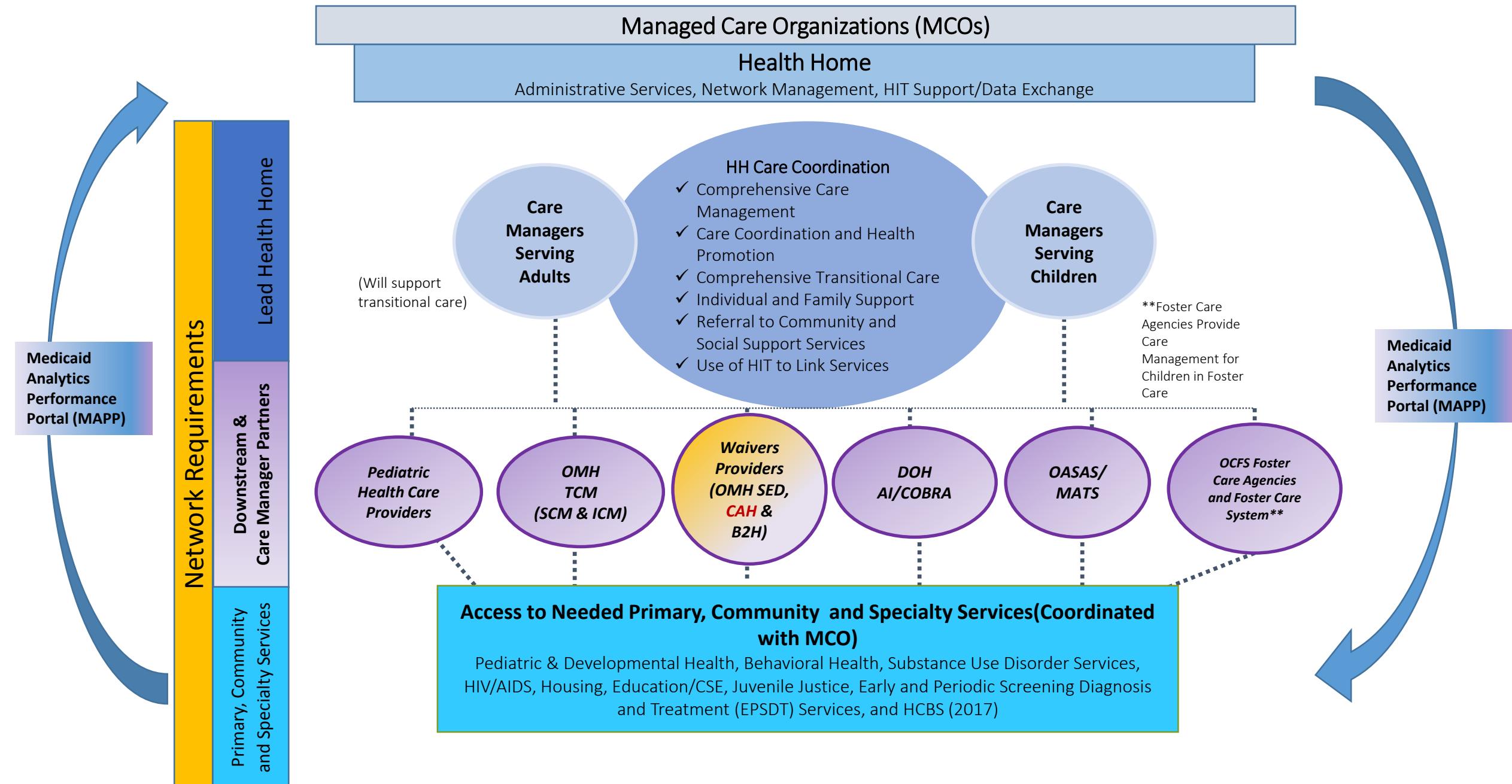


Health Home Optional Benefit that Provides Comprehensive Care Management – Integral Part of Medicaid Redesign Team Medicaid Transformation Initiatives

- Health Home is an *optional* State Plan benefit authorized under Section 2703 of the Affordable Care Act (ACA) to coordinate care for people with Medicaid who have *chronic conditions* – *there is choice*
- ***Is Health Home enrollment voluntary or mandatory ? Voluntary***
- Health Home is a Care Management model that provides:
 - Enhanced care coordination and integration of primary, acute, behavioral health (mental health and substance abuse) services, and
 - Linkages to community services and supports, housing, social services, and family services for persons with chronic conditions
- In New York State, the Health Home model has been a central feature of the Medicaid Redesign Team (MRT) initiatives for adults and children, including overall efforts to integrate behavioral and physical health and social supports and provide “Care Management for All”; transitioning the behavioral health benefit to managed care for children and adults; transitioning children’s waiver programs to Managed Care; and reducing avoidable hospitalizations under the Delivery System Reform Incentive Payment (DSRIP) Program.



New York State Health Home Model for Children



Health Homes Serving Children – *Who Are They, Primary Contact?*

- There are 32 Health Homes currently operating in New York that now serve adults
- 16 Health Homes have been contingently designated to serve children (HHSC), 13 of those currently also serve adults
 - The HHSC were contingently designated to provide them time, and the State time, to implement readiness activities – including network adequacy - care management relationships and children's providers, contracts (Administrative Services Agreements (ASAs)) with Managed care plans to provide Health Home services, billing readiness, HIT readiness
 - Health Home is a State Plan and Managed Care plan benefit – also Fee for Service (FFS)
- Who are they – Health Home Serving Children Contact
 - Website http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm
 - A list of HHSC, the counties they will be designated to serve children, and if applicable what counties they are designated to serve adults
 - A list of counties and the HHSC those children
 - Primary contact of HHSC – CAH Providers should reach out to these primary contacts to establish relationships



Health Home	Designated to Serve Children Pending the Acceptance and Implementation of Contingencies	Current Designation to Serve Adults
Adirondack Health Institute, Inc.	Clinton, Essex, Franklin, Hamilton, St. Lawrence, Warren, Washington	Clinton, Essex, Franklin, Hamilton, St. Lawrence, Warren, Washington
Catholic Charities of Broome County	Encompass Catholic Charities Children's Health Home Albany, Allegany, Broome, Cattaraugus, Chautauqua, Cayuga, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Wayne, Warren, Washington, Wyoming, Yates	Broome
Central New York Health Home Network (CNYHHN Inc.)	Albany, Rensselaer, Schenectady, Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, St. Lawrence	Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, St. Lawrence



Health Home	Designated to Serve Children Pending the Acceptance and Implementation of Contingencies	Current Designation to Serve Adults
Children's Health Homes of Upstate New York, LLC (CHHUNY)	Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming, Yates	N/A
Collaborative for Children and Families	Bronx, Brooklyn, Manhattan, Nassau, Queens, Staten Island, Suffolk, Westchester	N/A
Coordinated Behavioral Care, Inc.	Bronx, Brooklyn, Manhattan, Queens, Staten Island	Brooklyn, Manhattan, Staten Island
Community Care Management Partners, LLC (CCMP) - VNS	Bronx, Brooklyn, Manhattan, Queens, Staten Island	Bronx, Manhattan



Health Home	Designated to Serve Children Pending the Acceptance and Implementation of Contingencies	Current Designation to Serve Adults
Greater Rochester Health Home Network LLC	Cayuga, Chemung, Livingston, Monroe, Ontario, Seneca, Steuben, Wayne, Yates, Allegany, Genesee, Orleans, Wyoming	Monroe
Hudson River HealthCare, Inc. (HRHCare) and Open Door Family Medical Centers dba Hudson Valley	Columbia, Dutchess, Greene, Orange, Putnam, Rockland, Sullivan, Westchester, Nassau, Suffolk	Columbia, Dutchess, Greene, Orange, Putnam, Rockland, Nassau, Suffolk, Sullivan, Westchester
Institute for Family Health	Ulster	Ulster
Kaleida Health dba Children's Health Home of Western New York –	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	N/A
Montefiore Medical Center dba Bronx Accountable Healthcare Network Health Home	Bronx	Bronx



Health Home	Designated to Serve Children Pending the Acceptance and Implementation of Contingencies	Current Designation to Serve Adults
Mount Sinai Health Home dba St. Luke's-Roosevelt Hospital Center	Bronx, Brooklyn, Manhattan, Queens, Staten Island	Manhattan
Niagara Falls Memorial Medical Center	Niagara	Niagara
North Shore LIJ Health Home	Queens, Nassau, Suffolk	Queens, Nassau, Suffolk
St. Mary's Healthcare	Fulton, Montgomery	Fulton, Montgomery



How does a CAH I&II Provider become a Health Home Care Manager?



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Health Home and CAH I&II Linkages

- To ensure Health Homes leverages and imbeds the expertise of CAH I & II providers in providing care management for medically complex children, the State, required as part of its application to become a Health Home serving children, in Health Homes contingent designation letter, and the State's overall review of Health Homes readiness and network adequacy requirements,
 - ✓ Requiring each Health Home Serving Children to have linkage to current CAH I & II providers that want to become Health Home care managers
- If you have not already been contacted by a Health Homes that serves the service area you now or are willing serve, please use contact list discussed on slide 12 to reach out to lead Health Homes to begin discussions
 - Be prepared to explain the expertise you, as a current CAH I & II provider can bring to the Health Home – particularly in serving medically needy children
 - Provide the Health Home with information about your organization, the work you do and your performance/ successes, your relationships with families
 - Have the Health Home explain their processes for ensuring Health Homes care managers meet the standards and requirements of the Health Home program – including software expectations
 - **Will all Health Homes have same EMR?** – Not all Health Homes use the same care planning electronic records – (examples include: GSI Health and Netsmart)
- The following slides provide qualifications for Health Home care managers and helpful to know operational procedures and requirements as you work to establish relationships with lead Health Homes and become a Health Home care manager



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Health Home Serving Children Care Manager Qualifications

- ***What are the qualifications of Health Home Care Managers?***
- Staff qualifications for care managers that serve children with an acuity level of “high” as determined by the CANS-NY must have:
 - ✓ A Bachelors of Arts or Science with two years of relevant experience, or
 - ✓ A License as a Registered Nurse with two years of relevant experience, or
 - ✓ A Masters with one year of relevant experience.
 - ✓ For children enrolled in the Early Intervention Program and receiving Health Home services through a provider approved under the Early Intervention Program, the minimum qualifications for EIP service coordinators set forth in Section 69-4.4 of 10 NYCRR will apply.
- Health Homes may seek a waiver from the State for care managers that have demonstrated experience but do not meet the required criteria –*Stakeholders supported ability to seek waivers*
- The State will develop a process to review qualifications proposed under waivers submitted by Health Homes
- The staff qualifications standards are ***minimum*** requirements
 - Health Homes may establish staffing requirements that exceed these standards (e.g., to better serve the particular needs of the children the Health Home may serve)

NOTE: *Health Homes are required to ensure that care managers have the expertise required to serve particular child's needs (e.g., medically complex, serious emotional disturbance, complex trauma etc.)*



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Readiness Activities Needed to be a CMA Contracts and BAAs

To formalize your care manager Health Home relationship with Health Home after identifying the Health Home(s) your organization wants to work with the following will be needed:

- A Business Associate Agreements (BAAs) between Health Homes and care management agencies must be established
- Your Health Home may engage you in other business documents to establish Health Home care management relationship



Readiness Activities Needed to be a CMA BAAs and Sharing Protected Health Information

- Health Homes are required, by State and Federal Laws, to have Data Exchange Application Agreements with NYSDOH in order to share minimum necessary data *prior to obtaining signed informed consent*
- To facilitate outreach efforts (i.e., locating adult Medicaid members that have been identified as potentially Health Home eligible and placed on an assignment list – re: process in adult HH) the MAPP provides “minimum PHI for Medicaid members (i.e., CIN#, name, address, PHI from the last five claims and encounters)
- Although children will be enrolled in Health Homes through a referral process the minimum PHI information described above for Medicaid members that are children will be available in MAPP and may be used by Health Homes, care managers, and Plans to assist in the referral process and care planning
- To allow the limited PHI information for both children and adults to be shared prior to consent the following agreements must in place:
 - ✓ Data Exchange Application Agreements (DEAAs) between the New York State Department of Health and the lead Health Homes
 - ✓ **Business Associate Agreements (BAAs) between Health Homes and care management agencies (e.g. CAH providers)**
 - Existing Health Homes will need to enter into BAAs with any new care management agencies they contract with
 - Example BAA:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_deaa_5_25_2015.docx
 - Additional Details: See May 27, 2015 Webinar on DEAAs and BAAs
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/5_27_2015_children_webinar.pdf



Readiness Activities Needed to be a CMA

To formalize your care manager Health Home relationship with Health Home after identifying the Health Home(s) your organization wants to work with the following will needed:

- If you do not already have one, your organization will need to have a valid Medicaid Management Information Systems (MMIS ID) and National Provider Identifier (NPI #)
- Your organization will have to identify a Single Point of Contact (SPOC) to receive correspondence from DOH regarding information and steps to proceed – you will provide your Health Home with a SPOC for your agency – the Health Home will relay that information to DOH
- Obtain an organization Health Commerce System (HCS) account by identifying a HCS Director and Coordinator (if not already established) to manage the staff that will need access to the HCS
 - HCS access is required to access the Medicaid Analytics Performance Portal (MAPP) and the CANS-NY which will reside in the Uniform Assessment System (UAS-NY)
 - Then a MAPP Gatekeeper will need to be identified to help track the roles and responsibilities of staff within MAPP
- Care Managers will need to be trained and certified in the CANS-NY assessment tool



Key Roles in the Health Commerce System (HCS)

- Single Point of Contact (SPOC) – At your option can be the same person you provided to Health Home
- HCS Director
- HCS Coordinator
- MAPP Gatekeeper
- Training will also be provided see slide 27

For further information regarding roles in the Health Commerce System, please refer to MAPP/HCS Webinars at

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



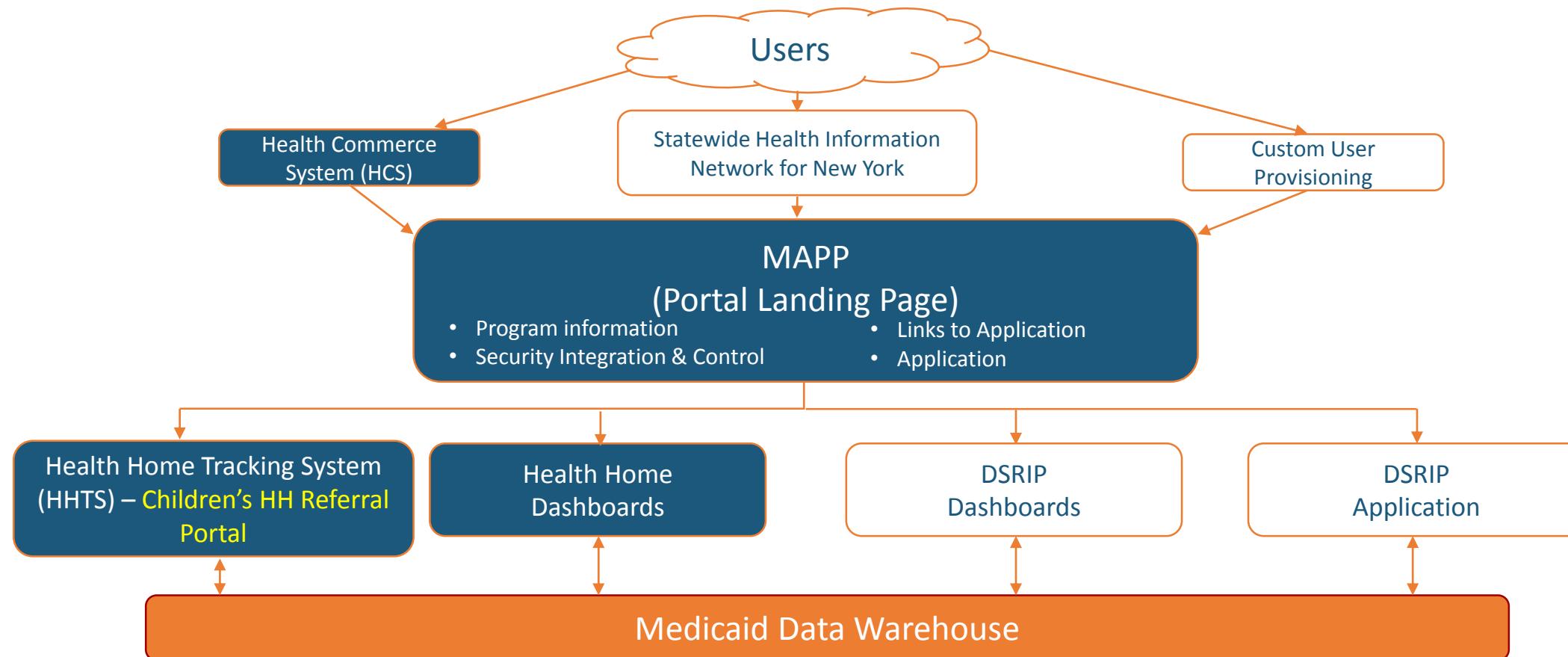
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Medicaid Analytics Performance Portal



Access to MAPP: Health Homes, CMAs, MCP, LDSS' and LGU/SPOAs

- The following entities will have access to the MAPP Children's HH Referral Portal on Day 1:
 - ✓ Managed Care Plans
 - ✓ Health Homes
 - ✓ Care Management Agencies (e.g., [Care at Home I & II](#) Providers who become [Health Home Care Managers](#))
 - ✓ LGU/SPOA
 - ✓ LDSS (In NYC, VFCA that contract with ACS will make Referrals on behalf of ACS)

Future Phases: Over time, the State will expand access to the MAPP Children's HH Referral portal by identifying and authorizing other entities that are natural points of contact in the systems of care that impact children to make referrals through the MAPP Referral portal (School Districts, county probation departments, pediatricians, emergency rooms, Early Intervention initial care coordinators, etc.)



Medicaid Analytics Performance Portal (MAPP) Functionality for Children's Home

- MAPP is being modified for Health Homes Serving Children to include:
- MAPP Children's Health Home Referral Portal for Children (under 21)
 - ✓ MAPP Referral Portal must be used to refer (create an assignment with a referral record type) and enroll children in Health Homes
 - ✓ Community Referral (by LGU/SPOA and LDSS, and eventually others) for Assignment
 - ✓ Assignment and Enrollment by Health Homes, Plans and Care Managers
- Consent Management (Consent to refer, enroll, share information/ protected services)
- Billing Information
 - ✓ CANS-NY tool will be housed in UAS-NY and will interface with Medicaid Analytics Performance Portal (MAPP)
 - ✓ Algorithm to determine High, Medium, Low will be run against completed CANS-NY and information will be transmitted to MAPP



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Access to MAPP: Health Homes, CMAs, MCP, LDSS' and LGU/SPOAs

- To access MAPP Health Home Tracking System and the UAS-NY (for CANS-NY) all Health Homes, CMAs, MCP, LGU/SPOAs, and LDSS' must acquire access to Health Commerce System (HCS)
 - ✓ Each organization (e.g., current CAH provider) must have an organizational HCS Director and Coordinator
- Training will be held for identified **HCS Directors and Coordinators** regarding the various roles and responsibilities within MAPP and the UAS-NY which will occur in October 2016
 - ✓ Once that training has occurred, organizations will then need to identify the staff who need access to MAPP and the UAS-NY and what role they should have
 - ✓ Each staff identified within the organization that will need a role in MAPP and the UAS-NY will need a HCS account prior to being able to have a role assigned to them within MAPP or the UAS-NY
- Training to specific MAPP and UAS-NY **end-users** will then be conducted
 - ✓ MAPP Training tentatively scheduled for October / November 2016
 - ✓ UAS-NY training in September / October 2016 for organizations (OMH-TCM and NYC VFCA) who can pre-populate the CANS-NY in October 2016
 - ✓ UAS-NY training for the rest of end-users will occur in October / November 2016
- All correspondence regarding HCS, MAPP and UAS-NY access and training will be sent to organization's Single Point of Contact (SPOC) – Important for organizations to be aware of who their individual SPOC is and ensure that DOH has an updated SPOC when a change is made



Enrolling Children In Health Homes

- Eligibility Criteria
- Consent
- Referral Portal



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Health Home *Chronic Condition Eligibility Criteria*

- The individual **must** be enrolled in Medicaid
- Medicaid members eligible to be enroll 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)
- *See DOH Website for list of chronic conditions

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/09-23-2014_eligibility_criteria_hh_services.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



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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.



Complex Trauma - CMS/SAMHSA Definition included in State Plan

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, and
 - vi. relationships with others.



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
- Gender Dysphoria
- Somatic Symptom and Related Disorders
- Feeding and Eating Disorders
- 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

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:

- 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.)

*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.



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Documenting Chronic Conditions Health Home Eligibility Criteria

- For eligibility chronic conditions, other than Complex Trauma, care managers are required to document eligibility for Health Home that is based on chronic conditions (e.g., DSM-V- SED, and other diagnoses of chronic conditions) by including in the care management record appropriate diagnoses made by Medicaid qualified providers that are licensed practitioners acting within their scope of practice
- For Complex Trauma, care managers are required to document eligibility for Health Home that is based upon the outlined process and tools by including them in the care management record
- Additionally, Health Home Appropriateness needs to be reviewed and documented
- NOTE: CANS-NY tool by itself does not determine HH eligibility
- NOTE: Multiple Eligibility Reasons can be chosen



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Prioritizing the Enrollment of Children in Health Homes

December 2016 Begin Date for Enrollment

- To manage initial capacity (and provide time to build up capacity) Health Homes, LDSS, LGU, Care Managers and Plans, should prioritize the enrollment of children that meet Health Home eligibility and appropriateness criteria and have the highest needs, including the following:
 - ✓ Children enrolled in OMH TCM care management programs that will convert to Health Home
 - ✓ Children on OMH Waiver waiting list (already Medicaid eligible), within 30 days of discharge from inpatient/residential/day treatment settings to participate in discharge planning, TCM waitlist; [SPOA who refers to HH]
 - ✓ Children who are on the Bridges to Health Wait list,
 - ✓ Children in licensed congregate care,
 - ✓ Children that are within 3 months of foster care discharge,
 - ✓ Children enrolled in LDSS prevention services where foster care placement is imminent,
 - ✓ Children prescribed 3 or more psychotropic medications
 - ✓ Children who are within 30 days of discharge from inpatient, residential or detox setting
 - ✓ Medically Fragile Children with multiple chronic conditions that have had recent (past 30 days) inpatient stay
 - ✓ Children who have an ER referral but are not admitted for inpatient services; or are discharged with a recommendation for community follow up;
 - ✓ Children with multiple system involvement (child welfare, criminal justice)



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Health Home Program: Types of Consent

August 17, 2016 Consent Protocol Webinar

- Consent to Refer (Verbal Consent documented in the MAPP Referral Portal)
- Health Home Consent Enrollment (Form DOH 5200) For Use with Children and Adolescents Under 18 Years of Age
- Health Home Consent Information Sharing (Form DOH 5201) For Use with Children Under 18 Years of Age
- Health Home Withdrawal of Health Home Enrollment and Information Sharing Consent (Form DOH 5202) For Use with Children Under 18 Years of Age
- Functional Assessment consent form (Must be signed to complete a CANS-NY within the UAS)
- Health Home Release of Educational Records Consent (Form DOH 5203)
- Health Home Withdrawal of Release of Educational Records (Form DOH 5204)
- Health Home Patient Information Sharing Consent form for adults (Form DOH 5055)
- Health Home Patient Information Sharing Withdrawal of Consent for adults (Form DOH 5058)



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Children's MAPP Referral Process for CAH I & II Providers who are CMA

What is the Entire Referral Process for Children Transitioning from CAH to Health Home?

- All referrals to Health Home must go through the MAPP Referral Portal
- All Health Homes, care managers, and Managed Care plans will have access to MAPP
- Care management agencies (including CAH I & II providers) that have working relationship with a child (other than a child in foster care) may directly refer and enroll a child in Health Home it is working with
 - there needs to be alignment to the member's Plan (i.e., care manager has relationship with Health Home and Plan for which the child is enrolled (if applicable) has a relationship (i.e., an Administrative Services Agreement (ASA)) with the same Health Home
 - Beginning in December 2016, CAH I & II providers that are Health Home care managers working with children that are eligible for Health Home and not enrolled in CAH I&II may make a MAPP referral as described above
- The Primary objective is preserving continuity of care and the current relationship between CAH I & II providers and the families they serve as children are transitioned from the waiver to Health Home (beginning July 2017) – including parental/legal guardian choice and consent
- State will provide listing of which Plans have Administrative Services Agreements with which Health Homes



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Children's MAPP Referral Process for CAH I & II Providers (and HH, other CMA/VFCAs for Children NOT in Foster Care)

HH or CMA/VFCA users making a referral for a child that is **NOT** in Foster Care to a Health Home will be required to provide the following information:

1. Accept Terms and Conditions [provides brief overview of Health Home program and eligibility requirements (Medicaid member and two chronic conditions, Serious Emotional Disturbance (SED), Complex Trauma, HIV/AIDS)]
2. Identify that the child is **NOT** in Foster Care
3. Affirm and indicate they have obtained consent to make the referral from the child's parent, guardian, legally authorized representative, or self (individual's 18 -21 years of age or minors that are married, pregnant, or a parent may provide consent on their own behalf)
4. Provide the Medicaid CIN # for the individual being referred
5. Identify all chronic conditions that the referrer believes make the child eligible for Health Home and appropriateness meeting Health Home eligibility



Children's MAPP Referral Process for CAH I & II Providers (and HH, other CMA/VFCAs for Children NOT in Foster Care

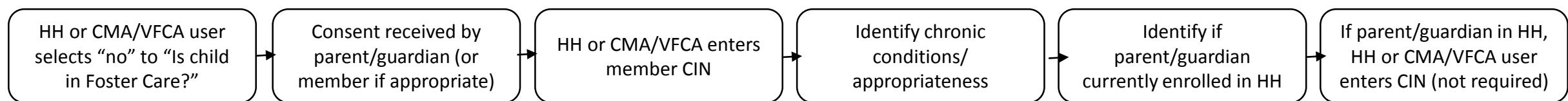
6. Indicate whether the parent/guardian is currently enrolled in a Health Home (if yes, may provide CIN number of parent/guardian)
7. Provide consenter's contact information
8. ***HH or CMA/VFCA user indicates they have been engaged and in communication with the child and wants to enroll the child in the Health Home or has already obtained consent to enroll***
9. HH or CMA/VFCA enters the child in an outreach segment (i.e., consent to enroll has not yet been obtained) or in an enrollment segment (i.e., consent to enroll in Health Home has been obtained)
 - If the HH or CMA/VFCA is not engaged and in communication with the child and will not be serving as the HH CMA, the referral will be submitted to either the Managed Care Plan for members in Managed Care, or for FFS members, the appropriate Health Home based on loyalty match
10. MCP or HH receives an assignment with a referral record type

* If the member is enrolled in a MCP, the member will be reflected in the Plan's list of Health Home assigned members

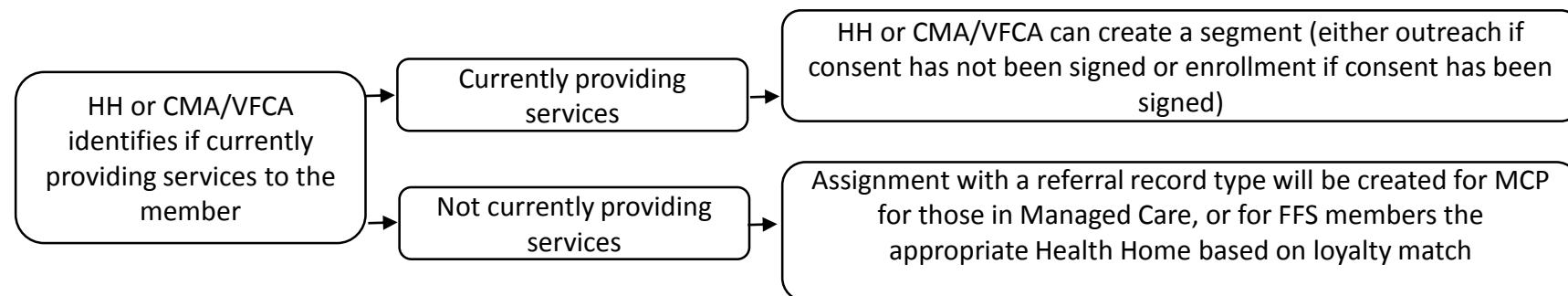


Children's MAPP Referral Process for CAH I & II Providers (and HH, other CMA/VFCAs for Children NOT in Foster Care)

Non-Foster Care Flow



Referral Received/Processed



Child and Adolescent Needs and Strengths Assessment-NY (CANS-NY) and Health Home Serving Children Per Member Per Month Rates



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CANS-NY and Health Home (CANS-NY Child and Adolescent Needs and Strengths Assessment-NY)

- CANS-NY tool will be housed in UAS and will interface with Medicaid Analytics Performance Portal (MAPP) to provide billing information
- The CANS-NY assessment (as modified for New York) will be conducted by the Health Home care manager and will be used:
 - ✓ To assist in the development of the person centered care plan
 - ✓ Determine a care management acuity, using an algorithm run against the results of a completed CANS-NY, for purpose of determining Health Home per member per month rate tier (i.e., High, Medium, Low)
 - ✓ CANS-NY by itself will not determine Health Home eligibility
 - ✓ Note: the CANS-NY will also be employed to determine HCBS eligibility with transition to managed care beginning in July 2017



CANS-NY and Health Home (CANS-NY Child and Adolescent Needs and Strengths Assessment-NY)

The CANS-NY assessment tool is:

- A multi-purpose tool to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.
- Developed from a communication perspective so as to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices.
 - Provides the care coordinator, the family, and service providers with a common language to use in the development, review, and update of the child's care plan.
- Designed to give a profile of the current functioning, needs, and strengths of the child and the child's parent(s) and/or parent substitute.
- *The CANS-NY tool was modified to include domains that better assess medically complex children*
- *Care managers may use assessment tools other than the CANS-NY to assist them in developing care plans for the child*



Required Trainings for Care Managers Conducting CANS-NY Assessments

- Care Managers, including CAH I & II providers that become Health Home Care Managers, must be trained and certified in the CANS-NY prior to directly serving children enrolled in Health Home
- CANS-NY assessments cannot be completed by a care manager that has not satisfied training and certification process)
 - ✓ Care Manager must keep their CANS-NY certification current by annual renewal
 - ✓ 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
- This summer and last summer a series of in person CANS-NY trainings, conducted by the author of the CANS-NY John Lyons, were held across the State – Recorded version of one of those sessions is available at http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/health_homes_and_children.htm
- Online training is available at <https://canstraining.com/login>
- **By what date do all Care Managers need to be trained in CANS-NY?** Care managers must be CANS-NY trained and certified prior to providing Care Management services for a Health Home and to have access to the UAS-NY to complete a CANS-NY
- **Can CAH providers pre-population CANS-NY?** Yes - As we get closer the transition of the CAH I & II 1915-c waiver population to Health Homes, guidance will be given to allow CAH I & II providers time to pre-populate CANS-NY for children they currently serve in CAH I & II (similar to guidance which has been provided to OMH TCM providers that are transitioning to Health Home December 2016)



What are the Health Home Per Member Per Month Rates for Health Homes Serving Children? What are case load requirements?

Legacy care management payments will be developed for Children's Waiver Programs (e.g., CAH I&II as well as B2H, OMH Waiver) when they transition to Health Home – will be in effect for two-year period (OMH TCM providers also have Legacy approach to their 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
Outreach	135	135
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 (see slide 53)

Note: see slide 50 for care manager to supervisor ratios



Algorithm for High, Medium and Low Health Home Serving Children Rates

- State is now finalizing programming of CANS-NY algorithms that determine Health Home rate acuity (High, Medium, Low)
- Stakeholders have requested CANS-NY Health Home rate acuity algorithms
- ***Will information on Algorithm for High, Medium, Low care management rate acuity for Health Homes be provided?***
- ***What will results of algorithm be for CAH children?***
 - Algorithms anticipated to be released in early September 2016
- State will monitor acuity determinations against supporting documentation and services included in care plan



Health Homes Serving Children Standards



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Health Homes Serving Children Standards

Will CAH providers be provided a Policy Manual for Health Homes?

- Foundation of Health Home care management model and standard is the six core services – tailored to youth-centered and family driven
- In conjunction with stakeholders, the State has developed a series of other standards and training requirements applicable to Health Homes Serving Children – next several slides will highlight key provisions
- The State is working to integrate these standards into current Health Home standards document used within Health Homes Serving Adults – One standards document

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf

- Lead Health Homes will provide their care management agencies with policies and protocols that ensure care management is delivered in a manner that is consistent with core services and standards
- The State's Health Home manual will also be updated
- The core services and standards are minimum requirements – Health Home may establish requirements that exceed those minimum requirements



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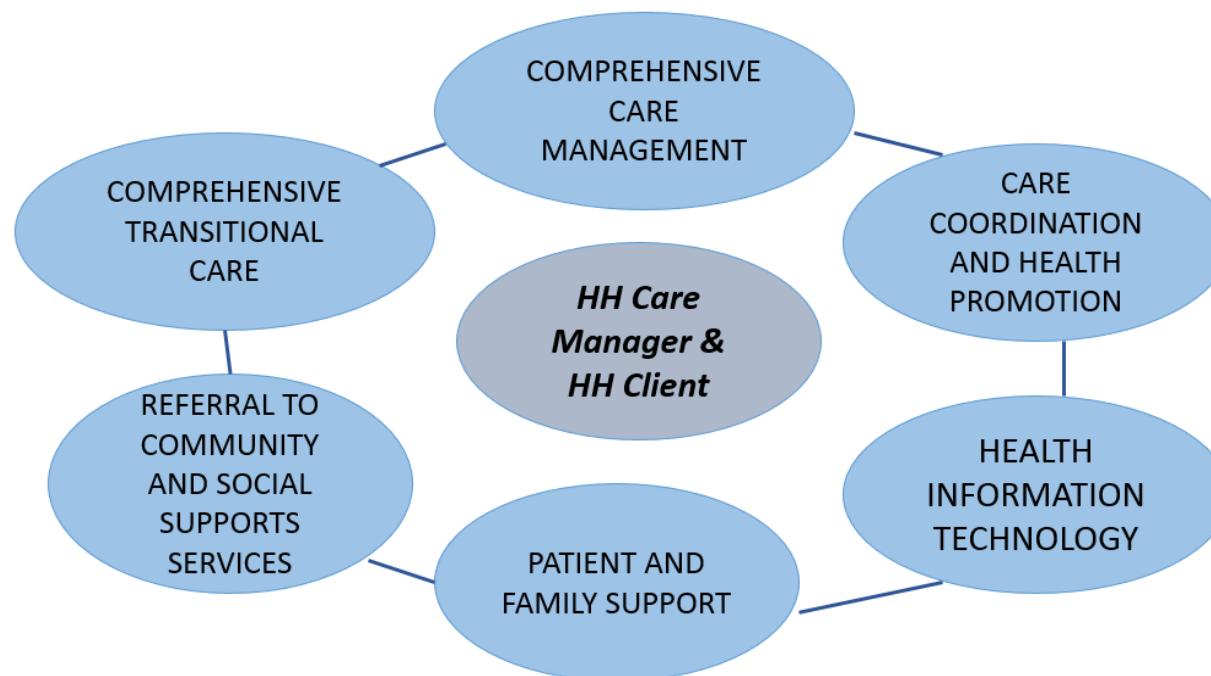
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Health Homes Serving Children Standards

Six Core Services

Health Homes Provide Six Core Care Management Functions



Health Home care management is “whole-person” and “person-centered” and integrates a care philosophy that includes both physical/behavioral health care with family and social supports

Detailed description of activities that comprise the six core services available in Standards Document and Examples are Provided in Appendix of this Webinar



Required Training for Health Home Care Managers and Supervisors

Required Training for care managers and supervisors - Prior to providing Health Home Care Management Services, (including outreach) 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 - HIPPA/CFR 42/sharing of information
- Trainings provided by State for Health Homes Serving Children

Within six months of employment

- 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 being offered by OMH and similar training 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
- Mandated Reporter Training



Supervisor to Care Management Ratio Policies and Requirements

To ensure quality supervisory oversight, State is recommending as **a best practice**, a supervisor to care manager ratio of 1:5, **however**:

- ✓ Health Homes must establish and document their supervisor to care management ratios requirements for care management agencies
- ✓ Health Homes should work with care management agencies to establish and review the workload expectations of supervisors to ensure oversight and documentation of the delivery of quality care management services (i.e., the work of supervisors must go beyond administrative functions related to personnel management).
- ✓ State's performance management activities and re-designation process will review the relationship between Health Homes supervisor to care management ratios and the quality of care management being provided



Health Home Serving Children Standards – Review of Current Standards Developed in Previous Webinars with Stakeholder Feedback

- 1) HH to ensure all Care Managers/Supervisors receive required trainings (initial and within six months, including CANS-NY)
- 2) HH to tailor delivery of services to children and ensure the Six Core Services
- 3) HH to meet staff qualifications for the Care Manager serving children
- 4) HH supervisor to Care Management ratio of CMAs
- 5) HH will ensure child's eligibility and Plan of Care are monitored/reviewed minimally quarterly and disenrollment criteria are reviewed – Supporting Documentation needs to be present within the case record
- 6) HH to ensure policies for interdisciplinary team meeting standards are in place
- 7) HH to ensure Plan of Care has the “10 Elements of Plans of Care”
- 8) HH to ensure consent and enrollment forms are completed for each child
- 9) HH care managers must provide two HH services per month for medium to high acuity children, one of which must be a face-to-face encounter with the child



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Four New Implementation Protocols for Health Home Serving Children

- 10) HH to ensure that policies/procedures are in place for care managers to contact child/family within 48 hours of discharge from an inpatient unit, residential services, detention, ED, etc. (when they are notified or become aware) – HH care managers should be involved in the discharge planning process
- 11) If during outreach (prior to enrollment), the member (if appropriate) or the parent/guardian/legally authorized representative refuses Health Home services, then the Health Home Care Manager should contact the referent (the person who made the referral – information is included in the Health Home Referral Portal) and make them aware of such refusal of Health Home services and document such prior to closing the referral.
Reminder: A minimum of verbal consent must be given by the member (if appropriate) or the parent/guardian/legally authorized representative for a HH referral to be made in the HH Referral Portal.
- 12) For children in Assertive Community Treatment (ACT) or Assisted Outpatient Treatment (AOT) (between 18-21), if eligible for Health Home, the Health Home type must be adult, not children.
- 13) Documentation within the case record and reflected within the POC needs to be present to support the CANS-NY ratings that determine HML for Health Homes.
 - o Such documentation may be school records, psychosocial assessments, child welfare records and information, etc.



CANS-NY – Reasons to Conduct Early Reassessments

- Significant events can necessitate a CANS-NY be completed earlier than the six month interval requires, i.e., an Early Reassessment
- Reasons an early CANS-NY reassessment should be completed are:
 1. Significant change in child's functioning (including increase or decrease of symptoms or new diagnosis)
 2. Service plan or treatment goals were achieved
 3. Child admitted, discharged or transferred from hospital/detox, residential placement, or foster care
 4. Child has been seriously injured or in a serious accident
 5. Child's (primary or identified) caregiver is different than on the previous CANS-NY
 6. Significant change in caregiver's capacity/situation
 7. Court request
- Health Homes will be expected to meet best practice standards by completing the Early Reassessment CANS-NY 30 days from the date of the **Documented** significant event selected above.
- There is no fee paid for re-assessments



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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)

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 conserver'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)



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Today and Tomorrow – The Future of CAH Children

Today 2016 – CAH Children	Tomorrow CAH Children 2017
Children Eligible for CAH enrolled in CAH I, II Waiver	<p>Children enrolled in CAH and other Waiver children will transition to Health Home (directly enrolled in Health Home by CAH provider that contracts with Health Home)</p> <p><i>Transition provisions will be developed and will preserve continuity of care (care manager and types of services)</i></p> <p><i>Parental Consent and Choice</i></p>
Under Waiver: Receive Case Management from CAH I and II Case Manager	<p>Will receive Care Management under Health Home Program (6 Core Services)</p> <p>CAH case managers will be transitioned to Health Home Care Managers - Preserve expertise of CAH case managers in Health Home Program</p>
Under Waiver: Children age out of CAH I and II at the age of 18	<p>Children that continue to qualify for Health Home Care management transition to adult Health Homes (i.e., they do not “age out”)</p>



Today and Tomorrow – The Future of CAH Children

Today – CAH Providers	Tomorrow CAH Providers 2017
Under Waiver: Subject to requirements outlined in 1915c Home and Community Based Waiver Agreement	Meet requirement of Health Home care management model as defined by six core services and other standards for delivering care management for children (e.g., at least one face-to-face meeting per month for children with High or Medium acuity)
Under Waiver: Pediatric Patient Review Instrument (PPRI) and Level of Care form used to determine eligibility for HCBS and plan of care needs	CANS-NY will be used to determine Health Home rate tier and eligibility for HCBS services (providers may use other assessment tools to assist in development of person centered care plan)
Under Waiver: Paid \$22.73 per 15 minute interval unit using case management rate codes 2301 or 2302, no additional fee for assessment, no concept or payment for outreach	Initially paid Legacy Payment then paid Per Member Per Month (PMPM) rate based on High, Medium, Low tier that is determined by CANS-NY algorithm and paid separate rate for assessment and outreach
Under Waiver: No central data register or system to record, review, and analyze individual and/or aggregate performance measures across network	MAPP a performance management system, that will provide tools to the HH network to track members, assist with billing information, and provide performance data dashboards, and eventually house other performance metrics



Children's Health Home Training Webinars and Presentations can be found at :
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hhsc_webinars.htm

Webinars include:

[August 24, 2016 Health Homes Serving Children Readiness Update](#)

[August 17, 2016 Consent Protocol](#)

[July 13 & 17 2016 REVISED MAPP Children's Referral Portal](#)

[June 29, 2016 Health Homes Serving Children Billing Guidance Final](#)

[April 7, 2016 Health Homes Serving Children Update: Readiness for Enrolling Children](#)

[December 16, 2015 Health Homes Serving Children Update: Readiness for Enrolling Children](#)

[April 29, 2015 Tailoring Health Home Model to Serve Children: Design and Implementation Updates](#)

[March 4, 2015 Health Home Implementation Webinar, Session #51 - Health Information Technology: Requirements for Health Homes](#)

[February 27, 2015 Commissioner's Advisory Panel - Tailoring Health Homes to Serve Children](#)

[July 9, 2015 Connecting to the Health Commerce System \(HCS\)](#)

[August 13, 2015 Overview for Care at Home I & II Providers](#)

[May 27, 2015 Data Exchange and Health Homes Serving Children: Data Exchange Application & Agreements for Health Homes Serving Children](#)



MCTAC Children's System Transformation

<http://www.ctacny.org>

[Children's SPA Service Webinar: Community Psychiatric Support and Treatment \(CPST\)](#)

[Children's SPA Service Webinar: Crisis Intervention](#)

[Children's SPA Service Webinar: Family and Peer Supports](#)

[Children's SPA Service Webinar: Other Licensed Professionals \(OLP\)](#)

[Children's SPA Service Webinar: Psychosocial Rehabilitation Services \(PSR\)](#)

[Children's System Transformation Forums](#)

[Managed Care Readiness Assessment Findings for Child-Serving Organizations Webinar](#)

[Transforming the Children's Medicaid System Webinar Series: Part I - Overview](#)

[Transforming the Children's Medicaid System Webinar Series: Part II - Who's Included and Service Walkthroughs](#)

[Transforming the Children's Medicaid System Webinar Series: Part III - Building Capacity and Preparing for Changes Ahead](#)



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Follow Up Series of Webinars

- Topics will include:
 - ✓ Follow up on Health Home implementation
 - ✓ Review of details of 1115 Waiver
 - ✓ Details on any changes to accessing current services and accessing new services
 - ✓ Details on transitioning CAH I&II Waiver
 - ✓ Topics raised by CAH I&II Providers
 - ✓ Questions (Gladly accepted ahead of time) and Answers



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Questions and Discussion



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- Subscribe
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/listserv.htm
- Health Home Bureau Mail Log (BML)
https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action



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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



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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
- 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
- HTS: Health Home Tracking System
- HIT: Health Information Technology
- LDSS: Local Department of Social Services
- LGU: Local Government Unit



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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
- OMH: Office of Mental Health
- OMH-TCM: Office of Mental Health Targeted Case Management
- PMPM: Per Member Per Month
- 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



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APPENDIX



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1. Comprehensive Care Management

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

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



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

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



2. Care Coordination and Health Promotion

- 2a.** The Health Home provider is accountable for engaging and retaining Health Home enrollees in care; coordinating and arranging for the provision of services; supporting adherence to treatment recommendations; and monitoring and evaluating a individual's needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services where appropriate through the creation of an individual plan of care.
- 2b.** The Health Home provider will assign each individual a dedicated care manager who is responsible for overall management of the individual's plan of care. The Health Home care manager is clearly identified in the individual's record. Each individual enrolled with a Health Home will have one dedicated care manager who has overall responsibility and accountability for coordinating all aspects of the individual's care. The individual cannot be enrolled in more than one care management program funded by the Medicaid program.
- 2c.** The Health Home provider must describe the relationship and communication between the dedicated care manager and the treating clinicians that assure that the care manager can discuss with clinicians on an as needed basis, changes in the individual's condition that may necessitate treatment change (i.e., written orders and/or prescriptions).
- 2d.** The health home provider must define how care will be directed when conflicting treatment is being provided.
- 2e.** The Health Home provider has policies, procedures and accountabilities (contractual agreements) to support effective collaborations between primary care, specialist and behavioral health providers, evidence-based referrals and follow-up and consultations that clearly define roles and responsibilities.
- 2f.** The Health Home provider supports continuity of care and health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers.
- 2g.** The Health Home provider supports care coordination and facilitates collaboration through the establishment of regular case review meetings, including all members of the interdisciplinary team on a schedule determined by the Health Home provider. The Health Home provider has the option of utilizing technology conferencing tools including audio, video and /or web deployed solutions when security protocols and precautions are in place to protect PHI.
- 2h.** The Health Home provider ensures 24 hours/seven days a week availability to a care manager to provide information and emergency consultation services.
- 2i.** The Health Home provider will ensure the availability of priority appointments for Health Home enrollees to medical and behavioral health care services within their Health Home provider network to avoid unnecessary, inappropriate utilization of emergency room and inpatient hospital services.
- 2j.** The Health Home provider promotes evidence based wellness and prevention by linking Health Home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self-help recovery resources, and other services based on individual needs and preferences.
- 2k.** The Health Home provider has a system to track and share information and care needs across providers and to monitor outcomes and initiate changes in care, as necessary, to address the individual's needs.



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

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



3. Comprehensive Transitional Care

- 3a.** The Health Home provider has a system in place with hospitals and residential/rehabilitation facilities in their network to provide the Health Home prompt notification of an individual's admission and/or discharge to/from an emergency room, inpatient , or residential/rehabilitation setting.
- 3b.** The Health Home provider has policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings, providers and community-based services to help ensure coordinated, safe transitions in care for individuals who require transfers in the site of care.
- 3c.** The Health Home provider utilizes HIT as feasible to facilitate interdisciplinary collaboration among all providers, the enrollee, family, care givers, and local supports.
- 3d.** The Health Home provider has a systematic follow-up protocol in place to assure timely access to follow-up care post discharge that includes at a minimum receipt of a summary care record from the discharging entity, medication reconciliation, timely scheduled appointments at recommended outpatient providers, care manager verification with outpatient provider that the individual attended the appointment, and a plan to outreach and re-engage the individual in care if the appointment was missed.



Examples of activities that constitute providing **Comprehensive Transitional Care** include:

- Follow up with hospitals/ER upon notification of child's admission and/or discharge to/from an ER, hospital/residential/rehabilitative setting.
- Facilitate discharge planning and follow up with hospitals/ER upon notification of a child's admission and/or discharge to/from ER/ hospital/residential/rehabilitative setting.
- Link child/family with community supports to ensure that needed services are provided.
- Follow up post discharge with child and family to ensure needed services are provided.
- Notify and consult with treating clinicians, including child's primary care physician, schedule timely follow up appointments, and assure that all ordered medications are in the home and at other administering sites (e.g., schools and day care), and assist with medication reconciliation.



4. Patient and Family Support

- 4a.** Enrollee's individualized plan of care reflects individual and family or caregiver preferences, education and support for self-management, self-help recovery, and other resources as appropriate.
- 4b.** Enrollee's individualized plan of care is accessible to the individual and their families or other caregivers based on the individual's preference.
- 4c.** The Health Home provider utilizes peer supports, support groups and self-care programs to increase enrollees' knowledge about their disease, engagement and self-management capabilities, and to improve adherence to prescribed treatment.
- 4d.** The Health Home provider discusses advance directives with enrollees and their families or caregivers.
- 4e.** The Health Home provider communicates and shares information with individuals and their families and other caregivers with appropriate consideration for language, literacy and cultural preferences.
- 4f.** The Health Home provider gives the individual access to plans of care and options for accessing clinical information.



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Examples of activities that constitute providing **Patient and Family Support** under the Health Home model include:

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



5. Referral to Community and Social Supports

- 5a.** The Health Home provider identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.
- 5b.** The Health Home provider has policies, procedures and accountabilities (contractual agreements) to support effective collaborations with community-based resources, which clearly define roles and responsibilities.
- 5c.** The plan of care should include community-based and other social support services as well as healthcare services that respond to the patient's needs and preferences and contribute to achieving the patient's goals.



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

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



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

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

Initial Standards

- 6a.** Health Home provider has structured information systems, policies, procedures and practices to create, document, execute, and update a plan of care for every patient.
- 6b.** Health Home provider has a systematic process to follow-up on tests, treatments, services and, and referrals which is incorporated into the patient's plan of care.
- 6c.** Health Home provider has a health record system which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers and which allows for population management and identification of gaps in care including preventive services.
- 6d.** Health Home provider makes use of available HIT and accesses data through the regional health information organization/qualified entity to conduct these processes, as feasible.

Final Standards

- 6e.** Health Home provider has structured interoperable health information technology systems, policies, procedures and practices to support the creation, documentation, execution, and ongoing management of a plan of care for every patient.
- 6f.** Health Home provider uses an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers. If the provider does not currently have such a system, they will provide a plan for when and how they will implement it.
- 6g.** Health Home provider will be required to comply with the current and future version of the Statewide Policy Guidance (http://health.ny.gov/technology/statewide_policy_guidance.htm) which includes common information policies, standards and technical approaches governing health information exchange.
- 6h.** Health Home provider commits to joining regional health information networks or qualified health IT entities for data exchange and includes a commitment to share information with all providers participating in a care plan. RHIOs/QE (Qualified Entities) provides policy and technical services required for health information exchange through the Statewide Health Information Network of New York (SHIN-NY).
- 6i.** Health Home provider supports the use of evidence based clinical decision making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance.



Children's Home and Community Based Services (HCBS)

- Comprehensive Care Coordination (for children who do not meet HH criteria)
- Habilitative Skill Building
- Caregiver/Family Supports & Services
- Respite (Crisis/Planned)
- Prevocational Services
- Community Self-Advocacy Training and Supports
- Non-Medical Transportation
- Day Habilitation
- Adaptive & Assistive Equipment
- Accessibility Modifications
- Palliative Care



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Children's HCBS Descriptions

Comprehensive Care Coordination:

Care coordination for children who do not meet HH criteria.

Habilitative Skill Building:

This service focuses on helping the child to be successful in the home, community and school by acquiring both social and environmental skills associated with his/her current developmental stage.

Caregiver/Family Supports & Services:

Family/caregiver supports and services enhance the child's ability to function as part of a family/caregiver unit and enhance the family/caregiver's ability to care for the child in the home and/or community. This service may be provided to individual children and their family/caregivers in small groups of a maximum of three HCBS-eligible children and their support networks, where the child and/or family/caregivers participate with others who are in similar situations.

Respite (Crisis/Planned):

Crisis Respite is a short-term care and intervention strategy for children and their families as a result of a child's mental health/substance use crisis event, medical crisis or trauma that creates an imminent risk for an escalation of symptoms without supports and/or a loss of functioning. It may be used when acutely challenging emotional or medical crisis occur which the child is unable to manage without intensive assistance and support.

Planned respite services provide planned short-term relief for family/caregivers that are needed to enhance the family/caregiver's ability to support the child's functional, mental health/substance use disorder and/or health care issues. The service is direct care for the child by staff trained to support the child's needs while providing relief from caregiver activities for the family/caregiver.

Prevocational Services:

Prevocational services are individually designed to prepare a youth to engage in paid work, volunteer work or career exploration. Prevocational services are not job-specific, but rather are geared toward facilitating success in any work environment for youth whose functional limitations do not permit them access to other prevocational services.

Supported Employment:

Supported employment services are individually designed to assist youth to engage in paid work or volunteer work. Supported employment services provide assistance to children/youth with severe functional challenges for the purposes of engaging in work.



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Children's HCBS Descriptions

Community Self-Advocacy Training & Supports:

Community advocacy and support improves the child's ability to gain from the community and educational experience and enables the child's environment to respond appropriately to the child's disability and/or health care issues. Community advocacy and support is intended to assist the child, family/caregiver, and community/school staff in understanding and addressing the participant's needs related to their disability(ies).

Non-Medical Transportation:

Non-medical Transportation services are offered, in addition to any medical transportation furnished under the 42 CFR 440.17(a) in the State Plan. Non-medical Transportation services are necessary, as specified by the service plan, to enable participants to meet the goals outlined in their plan of care.

Habilitation:

Habilitation services assists children with developmental disabilities with the self-help, socialization, and adaptive skills necessary for successful functioning in the home and community when other types of skill-building services are not appropriate.

Adaptive & Assistive Equipment:

This service provides technological aids and devices that can be added to the home, vehicle, or other eligible residence of the enrolled child to enable him/her to accomplish daily living tasks that are necessary to support the health, welfare, and safety of the child.

Accessibility Modifications:

This service provides internal and external physical adaptations to the home or other eligible residences of the enrolled child that are necessary to support the health, welfare, and safety of the child.

Palliative Care:

This is a set of services offered to help families deal with end-of-life related issues due to child's illness. Types of services included: Family Palliative Care Education (Training); Bereavement Therapy; Pain and Symptom Management; Expressive Therapy (Art, Music and Play); and Massage Therapy.



Children's State Plan Services

- Crisis Intervention
- Psychosocial Rehabilitation
- Community Psychiatric Support & Treatment (CPST)
- Other Licensed Practitioners
- Family Peer Support Services
- Youth Peer Support and Training



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Children's State Plan Service Descriptions

Crisis Intervention:

Crisis Intervention (CI) services are provided to all children/youth who are identified as experiencing a seriously acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved (e.g. collateral, provider, community member) to effectively resolve it.

Psychosocial Rehabilitation:

Psychosocial Rehabilitation Services (PRS) are designed to work with children and their families to implement interventions outlined on a treatment plan to compensate for or eliminate functional deficits and interpersonal and/or environmental barriers associated with a child/youth's behavioral health needs.

Community Psychiatric Support & Treatment (CPST):

CPST services are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the child's treatment plan. CPST is designed to provide community-based services to children and families who may have difficulty engaging in formal office settings, but can benefit from community based on-site rehabilitative services.

Other Licensed Practitioners:

Non-physician licensed behavioral health practitioner (NP-LBHP) who is licensed in the State to prescribe, diagnose, and/or treat individuals with the physical, mental illness-disability, substance use disorder, or functional limitations at issue, operating within the scope of practice defined in State law and in any setting permissible under State practice law. Activities would include:

- Recommending treatment that also considers trauma-informed, cultural variables and nuances.
- Developing recovery or treatment plan
- Activities within the scope of all applicable state laws and their professional license including counseling, individual, or family therapy.

Family Peer Support Services:

Family Peer Support Services (FPSS) are an array of formal and informal activities-and supports provided to families caring for/raising a child who is experiencing social, emotional, medical developmental, substance use and/or behavioral challenges in their home, school, placement, and/or community. FPSS provide a structured, strength-based relationship between a Family Peer Advocate (FPA) and the parent/family member/caregiver for the benefit of the child/youth.

Youth Peer Support and Training:

Youth support and training (YPST) services are youth formal and informal services and supports provided to youth and families raising an adolescent who are experiencing social, emotional, medical, developmental, substance use and/or behavioral challenges in their home, school, placement, and/or community centered services. These services provide the training and support necessary to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process.

