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# **Health Home Care Management and the Integration of Early Intervention**

**October 27, 2017**

**NYC**

# Agenda

- Eligibility Criteria and Appropriateness
- Health Home Referral Process
- Health Home Standards of Service Delivery
- Health Home Training
- CANS-NY and Training
- Service Transition Timing and Billing
- Process and Oversight



# Health Home Eligibility Criteria and Appropriateness

# Health Home *Chronic Condition* Eligibility Criteria

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

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/docs/health\\_home\\_chronic\\_conditions.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/health_home_chronic_conditions.pdf)

- Chronic Condition Criteria is NOT population specific (e.g., being in foster care, under 21, in juvenile justice etc. does not alone/automatically make a child eligible for Health Home)
- In addition, the Medicaid member **must** be appropriate for the intensive level of care management services provided by Health Home, i.e., satisfy appropriateness criteria



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

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

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

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

### **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.)*



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# Complex Trauma – Single Qualifying Condition for Health Home

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

## Definition of Complex Trauma

- a. The term complex trauma incorporates at least:
  - i. Infants/children/or adolescents' exposure to multiple traumatic events, often of an invasive, interpersonal nature, and
  - ii. the wide-ranging, long-term impact of this exposure.
- b. Nature of the traumatic events:
  - i. often is severe and pervasive, such as abuse or profound neglect;
  - ii. usually begins early in life;
  - iii. can be disruptive of the child's development and the formation of a healthy sense of self (with self-regulatory, executive functioning, self-perceptions, etc.);
  - iv. often occur in the context of the child's relationship with a caregiver; and
  - v. can interfere with the child's ability to form a secure attachment bond, which is considered a prerequisite for healthy social-emotional functioning.
- c. Many aspects of a child's healthy physical and mental development rely on this secure attachment, a primary source of safety and stability.
- d. Wide-ranging, long-term adverse effects can include impairments in:
  - i. physiological responses and related neurodevelopment,
  - ii. emotional responses,
  - iii. cognitive processes including the ability to think, learn, and concentrate,
  - iv. impulse control and other self-regulating behavior,
  - v. self-image, and
  - vi. relationships with others.



# Process to Determine Health Home Complex Trauma Eligibility

## Completed by Non-Licensed Professional or Licensed Professional w/o access to tools

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

## Eligibility determined by Licensed Professional with access to tools

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



# Health Home Appropriateness Criteria

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

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

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



# Determining Health Home Eligibility

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



# Crosswalk of Chronic Conditions Between Health Homes and Early Intervention

To estimate how many EI children may be potentially eligible for both EI and HH CM services, a crosswalk of eligible conditions was conducted

- HH Chronic conditions currently do not include certain developmental disabilities
- Eligibility for Early Intervention includes diagnosed conditions and developmental delays (Identified ICD-10 Codes)
- Prior to CMS authorization to expand Health Homes to Serve the IDD population, there is a limited number of Chronic Conditions that meet both EI Eligibility and HH Chronic Condition Eligibility
- Currently, approximately 2,700 EI children with 50% of the children residing in NYC are estimated to be eligible – DOH will provide County data

*See appendix for a list of current EI conditions*



# Health Home Referral Process



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# Using MAPP to Refer Children to Health Home

- MAPP (Medicaid Analytics Performance Portal), a State Department of Health System, includes a Children's HH Referral Portal
- The Children's MAPP HH Referral Portal is the vehicle to record referrals (create an assignment with a referral record type), and enroll children in Health Homes
- The following entities now have access to the MAPP Children's HH Referral Portal and can make a referral
  - ✓ Managed Care Plans
  - ✓ Health Homes
  - ✓ Care Management Agencies/Voluntary Foster Care Agencies
  - ✓ LGU/SPOA
  - ✓ LDSS (In NYC, VFCA that contract with ACS will make Referrals on behalf of ACS)
- In the future, the State expects to 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.)



# MAPP Functionality



Provides online interface to the Manage Care Plans (MCP), Health Homes (HH), and Care Management agencies (CMA) to collaborate in real-time and track a member's status.

\* **NOTE:** Future plans for DOH to expand access of MAPP Referral Portal to the Local Department of Health, therefore EI providers would have access directly to the MAPP Referral portal

# Direct Communication between Health Homes and Early Intervention providers for Referrals

- ✓ Health Homes and Early Intervention Agencies are encouraged to build relationships to have direct communication with each other to make referrals and re-referrals when necessary
  - The parent, guardian and or legally authorized representatives consent is necessary when sharing information
- ✓ The Early Intervention Official (EIO) will be able to have a direct communication with Health Homes to make a referral to a Health Home when the child is not eligible for Early Intervention or transitioning from Early Intervention, once consent by the parent, guardian and or legally authorized representative is obtained
- ✓ The Health Home will have a direct communication to the County EIO to refer children that may be eligible for Early Intervention



# Health Home Care Management Standards of Service Delivery



# Overview of the Six Core Health Home Services

## 1. Comprehensive Care Management

- A comprehensive health assessment that identifies medical, mental health, chemical dependency and social service needs is developed.

## 2. Care Coordination and Health Promotion

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

## 3. Comprehensive Transitional Care

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



# Overview of the Six Health Home Core Services

## 4. Patient and Family Support

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

## 5. Referral to Community Supports

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

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

Health Home providers will make use of available HIT and access data through the regional health information organization/qualified entities to conduct these processes as feasible

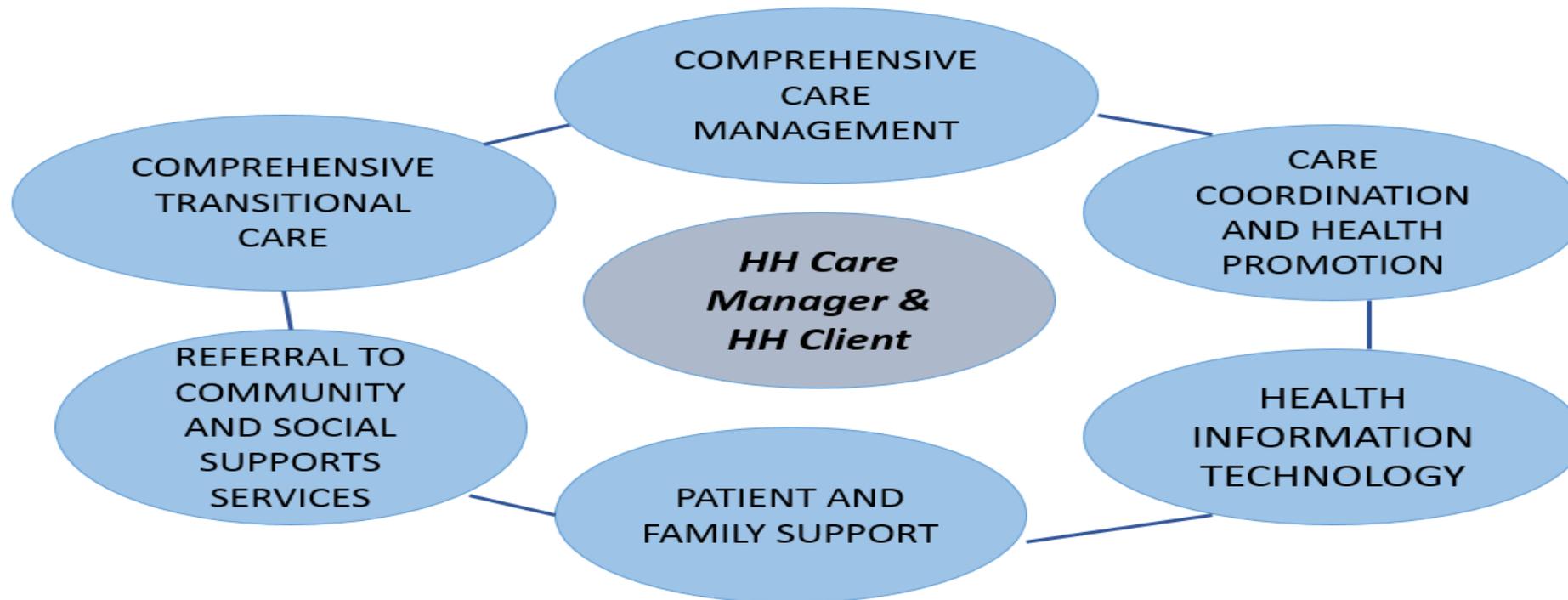
[For detailed description of each core service please see:](#)

[http://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/provider\\_qualification\\_standards.htm](http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/provider_qualification_standards.htm)



# Health Homes Serving Children 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



## Staff Qualifications Health Home Care Managers Serving Children

- 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.
- If the provider was originally a HH CMA prior to becoming an EI approved provider, then the HH CM qualifications for “*high*” caseload must be followed
- The Health Home Qualification Waiver cannot be utilized by EI providers

*(Health Home and Early Intervention qualifications are outlined in the Appendix)*



# Required Training for Health Home Care Managers and Supervisors

- ❖ Lead Health Homes are responsible for ensuring that care managers and supervisors are appropriately trained and that trainings and qualifications of care managers are appropriate and reflect the populations that care managers serve.
- ❖ Health Homes must document compliance with training requirements for Care Managers and Supervisors prior to the delivery of services and within six months of employment
- Required Training for care managers and supervisors - **Prior** to providing Health Home Care Management Services, (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
  - ✓ Review of webinars and guidance provided by State for Health Homes Serving Children

## Required Training for Health Home Care Managers and Supervisors

- Required training for care managers and supervisors within **six months** of employment or from first date care managers or supervisor provide any Health Home care management services (including outreach).
  - ✓ Engagement and Outreach (e.g., Motivational Interviewing)
  - ✓ Safety in the Community (e.g., conducting home visits, partnering with law enforcement, carrying cell phones, communication with supervisor, awareness of surroundings)
    - ✓ *Free to providers, offered by OMH and similar training being developed by OCFS*
  - ✓ Trauma Informed Care
  - ✓ Person Centered Planning
  - ✓ Cultural Competency/Awareness
  - ✓ LGBTQ Issues – serving transgender children/adolescents and working with Lesbian/Gay/Bisexual/Transgender/Questioning Families
  - ✓ Meeting Facilitation



# Overall Health Home Training

- It is the responsibility of the Lead Health Homes to provide policies and procedures surrounding all issued DOH Health Home program Standards and Policies / Procedures for their network care management agencies
- Additionally, each Lead Health Home has HIT and Billing platforms to ensure:
  - Proper documentation,
  - Compliance with Health Home requirements
  - Timely payment to providers,
  - Tracking of member services and
  - Ability to provide oversight of their network partners
- Each Lead Health Home may have different policies, procedures and oversight monitoring requirements for their Care management agencies, therefore amount and time table for training may vary
  - CMAs need to work with their Lead Health Home to determine the amount of training time will be needed



# **Child and Adolescent Needs and Strengths Assessment-NY (CANS-NY), Comprehensive Assessment and the Plan of Care**



## 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.



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

- CANS-NY tool is housed in UAS and interfaces with Medicaid Analytics Performance Portal (MAPP) to provide billing information
- The CANS-NY assessment (as modified for New York) is conducted by the Health Home care manager and 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



# CANS-NY Training

DOH continues to provide in-person one-day CANS-NY trainings – New Announcement just issued for the remainder of 2017 and beginning 2018

- If in-person training is completed, the on-line training is not required to test and get certified
- In-person training is not required but is recommended for new providers and providers that have utilized a different CANS tools for another program

On-line training is available and takes 4 to 6 hours to complete, depending on reading level. That includes reading items and watching videos, taking practice multiple choice tests and at least one practice test.

The final takes the average successful user about 45 minutes to complete

Estimate the UAS-NY course sequence for the CANS-NY Assessor to take about 3 ½ hours total

- This training is an overview of how to utilize the UAS and maneuver through the system
- These trainings are required to be completed prior to the system allowing the assessor the ability to add and or start a CANS-NY



# LearnerNation: Transfer of Course Completion

CANS-NY training completed in LearnerNation is uploaded into the UAS-NY Training Environment on Tuesday and Friday afternoons.

## Scenarios:

- If you complete your training on Monday afternoon, you will see the completed status in the UAS-NY Tuesday afternoon.
- If you complete your training on Tuesday afternoon, you will see the completed status in the UAS-NY Friday afternoon.

## For a successful transfer of completion, please make sure:

1. Your HCS User ID is recorded in the External GUID ID field, and
2. You have correctly designated NYS in the Jurisdiction field in your Learner Nation Profile Page.



# Service Transition Timing and Billing



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# Health Home Per Member Per Month Rates for Health Homes Serving Children

## 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/acuties
  - ✓ 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



# CANS-NY Assessments

- The CANS-NY must be completed every 6 months from the first day of the month it was completed
- A fee is paid for the initial CANS-NY only
- The CANS-NY will not be pre-populated with previous results
- A one-time assessment fee (\$185) per enrollment into a children's designated Health Home may be billed upon *completion of the CANS-NY*
- Once the child is enrolled in a Health Home, low acuity is billed for the child until the month in which the CANS-NY is completed and the acuity algorithm determines the appropriate rate (high, medium or low)
- Health Homes will be expected to meet best practice standards by completing the CANS-NY 30 days from the date of enrollment.
- If the CANS-NY is not completed by the end of the second month of enrollment, the Health Home/Plan will no longer be able to bill for any service until the month in which the CANS-NY is completed.



# Health Home 5 Core Billable Services

Health Home Core Billable Services that will be identified on the Children's Billing Questionnaire and MUST be documented in the member's records and care plan, when appropriate

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

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

# Billing

- If Health Home Care Management and Early Intervention Initial Service Coordination are engaged simultaneously, billing for both services can occur as EI ISC is seen as a separate, distinct and time limited service.
- When a HH CMA/OSC is assigned, Early Intervention OSC activities and Health Home services will be billed as one service under the Health Home structure of the CANS-NY acuity rate.
  - Other EI services such as OT, PT, Speech, etc. billing will remain intact according to existing EI procedures



# Transition Timing and Billing

## Health Home First Engaged:

- If the child is being served by the Health Home first, the HH CM should review the needs of the child and determine if a referral should be made to EI. Both HH and ISC can bill according to their respective procedures
  - If the child is eligible for EI, prior to the IFSP the EIOD and HH CMA should discuss who would be the appropriate provider to serve the child based upon designated HH CM/OSC list and service relationships already established (Parental choice and consent is key)

## Initial Service Coordination First Engaged:

- If the child is being served by the EI ISC first, then the EI ISC and Multidisciplinary team should determine if the child might be eligible and appropriate for HH services. If a referral will be made for HH services, it should occur at the time of the IFSP and the parental choice for an OSC.
  - There needs to be an agreed upon transition date for the child to be enrolled in a HH and assigned to a designated HH CM/OSC and for HH billing to begin



# Transition Timing and Billing - continued

## On-going Service Coordination First Engaged:

- If the child is being served by the EI OSC first and a HH referral seems appropriate, with parental choice, a designated HH CM/OSC should be assigned and HH billing will begin
- If the child will be transitioning out of EI and the OSC believes the child would be eligible and appropriate for Health Home services, a referral should be made at the time of transition planning. EI OSC billing must end prior to HH billing to begin

***Reminder: HH bills a Per Member Per Month (PMPM) that starts the first of the month***



# Process and Oversight



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# Process

- Health Home eligibility and appropriateness must be determined by HH care managers according to HH's standards and policies
- Early Intervention eligibility must be determined by the EI Initial Service Coordinator and the Multidisciplinary Evaluation team according to EI program protocols
  - Evaluations, assessments and screening from either program can be utilized to assist with eligibility determination with appropriate parental consent
- Once eligibility is determined, a discussion with the family should occur to educate and assist with program information and choice of providers.
- Providers will need to work collaboratively, to develop an enrollment plan, a warm hand-off (if needed), and to establish when billing for either or both programs will occur



# Process - continued

- The initial IFSP will be scheduled and billed for by the EI Initial Service Coordinator
  - HH CM can and should attend such meeting, if possible according to developed specific case processes
- Many of the responsibilities of the HH CM and the EI OSC are comparable to one another. As long as the appropriate attendees are invited, the purpose and outcome is properly documented according to each program requirements, the activity can be utilized to meet both program requirements
- Such as:
  - IFSP meetings, HH interdisciplinary team meetings and HH plan of care meetings
  - EI OSC meeting with the family and HH CM face to face requirement for high or medium and when needed
  - Meeting and discussions with involved providers
  - Linking the family to other resources and or services
  - Transitional planning meetings



# Oversight

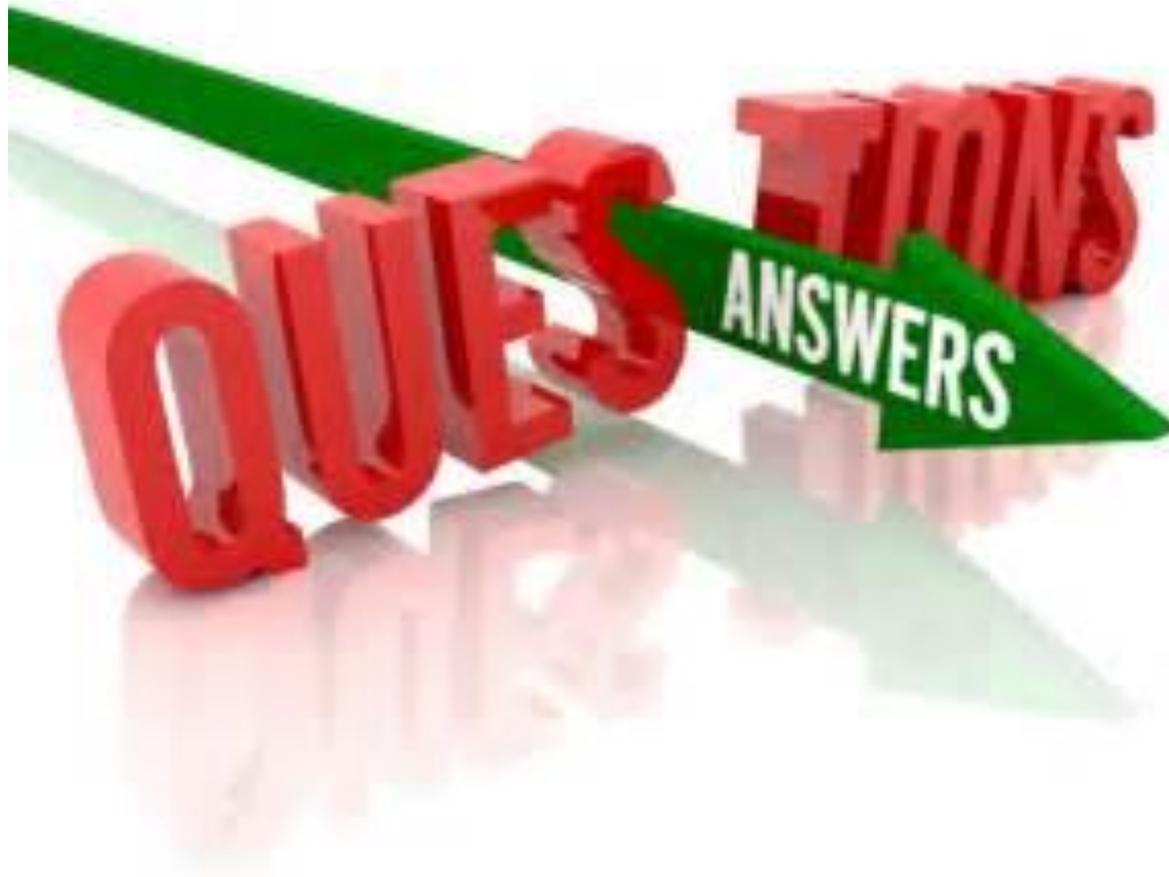
- The Lead Health Homes continue to have oversight and monitoring of their network partners and ensure compliance with all HH standards, policies and procedures
- Local municipalities and NYC EI programs continue to have oversight and monitoring of their EI providers and ensure compliance with all EI regulations, policies and procedures
  - Providers who are approved to provide HH CM/ OSC will need to comply with both oversight bodies
  - These providers will need to ensure that during an audit of their services, the HH CM/OSC provider will be able to produce exact program documentation for the specific requesting oversight body and not compromise the information of the other services area
- Lead Health Homes will be required to have policies that outlined that they have network partners that are fulfilling the role of HH CM and EI OSC and the expectation of such



# Next Steps

- Continue to educate Health Homes, Care Management Agencies and Early Intervention providers regarding Health Homes and integration of service
- Provide guidance to HHs regarding their policies for HH CM/OSC providers
- Provide informational document that outlines expectations, processes and oversight
- Assist EI providers in becoming HH CMAs
- Track enrollment of EI children within HH





# Additional Information and Support

**UAS-NY Support Desk**  
[uasny@health.ny.gov](mailto:uasny@health.ny.gov)

or

**518-408-1021, option 1**

**Monday – Friday**

**8:30 AM – 12:00 PM**

**1:00 PM – 4:00 PM**

**CANS-NY Training**

[support@CANSTraining.com](mailto:support@CANSTraining.com)

Or

[www.canstraining.com](http://www.canstraining.com) and click on  
contact us

**CANS-NY Policy**

[hhsc@health.ny.gov](mailto:hhsc@health.ny.gov)

**MAPP Customer Care Center**

[MAPP-](mailto:MAPP-)

[customercarecenter@cma.com](mailto:customercarecenter@cma.com)

Phone: 518-649-4335

**Commerce Accounts Management  
Unit (CAMU)**

**866-529-1890**



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- Stay up-to-date by signing up to receive Health Home e-mail updates
- Subscribe  
[http://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/listserv.htm](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](https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action)



# Updates, Resources, Training Schedule and Questions

Please send any questions, comments or feedback on Health Homes Serving Children to:

[hhsc@health.ny.gov](mailto: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](http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm)



# ***APPENDIX***



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



# Health Homes Serving Children

## List of Acronyms

- MAPP: Medicaid Analytics Performance Portal (Health Home Tracking System HHTS)
- MCO/MCP: Managed Care Organization / Managed Care Plan
- MRT: Medicaid Redesign Team
- MMIS #: Medicaid Management Information Systems
- NPI #: National Provider Identifier
- OASAS: Office of Alcoholism and Substance Abuse Services
- OCFS: Office of Children and Family Services
- 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



Health Home	Counties Designated to Serve Children	Designated Contact for Children's Designated Health Home
<b>Adirondack Health Institute, Inc.</b>	Clinton, Essex, Franklin, Hamilton, St. Lawrence, Warren, Washington	Emily Walter <a href="mailto:ewalter@ahihealth.org">ewalter@ahihealth.org</a> (518) 480-0111 Ext. 6  Sarah Colvin <a href="mailto:scolvin@ahihealth.org">scolvin@ahihealth.org</a>
<b>Catholic Charities of Broome County - Encompass Health Home</b>	Albany, Allegany, Broome, Cattaraugus, Chautauqua, Cayuga, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Erie, Essex, Franklin, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Warren, Washington, Wayne, Wyoming, Yates	Lori Accardi <a href="mailto:laccardi@ccbc.net">laccardi@ccbc.net</a> (607) 729-9166  Tonya Brown <a href="mailto:tbrown@ccbc.net">tbrown@ccbc.net</a> (607) 729-9166
<b>Central New York Health Home Network (CNYHHN Inc.)</b>	Albany, Rensselaer, Schenectady, Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, St. Lawrence	Jane Vail <a href="mailto:Jane.vail@cnyhealthhome.net">Jane.vail@cnyhealthhome.net</a> (315)797-9057 ext.278



Health Home	Counties Designated to Serve Children	Designated Contact for Children's Designated Health Home
<b>Children's Health Home of Western New York dba Oishei Healthy Kids</b>	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	Momba Chia <a href="mailto:mchia@kaleidahealth.org">mchia@kaleidahealth.org</a> O:716-878-7807 C:716-359-2390  Kirsten Newby <a href="mailto:knewby@kaleidahealth.org">knewby@kaleidahealth.org</a> O: 716-878-1354 C: 716-364-2380
<b>Children's Health Homes of Upstate New York, LLC (CHHUNY)</b>	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	Nicole Bryl <a href="mailto:nbryl@hhuny.org">nbryl@hhuny.org</a> O: 585-613-7644 C: 716-572-9858  Donna Fiscella <a href="mailto:dfiscella@childrenshealthhome.org">dfiscella@childrenshealthhome.org</a> O: 315-632-6195



Health Home	Counties Designated to Serve Children	Designated Contact for Children's Designated Health Home
<b>Collaborative for Children and Families</b>	Bronx, Brooklyn, Manhattan, Nassau, Queens, Staten Island, Suffolk, Westchester	<p>Jodi Saitowitz  <a href="mailto:jsaitowitz@ccfh.org">jsaitowitz@ccfh.org</a>  O: 646-459-3971  C: (917) 213-0130</p> <p>Lisa Peterson  <a href="mailto:Lpeterson@ccfh.org">Lpeterson@ccfh.org</a>  O: 646-459-3972  C: 646-799-8284</p>
<b>Community Care Management Partners, LLC (CCMP)</b>	Bronx, Brooklyn, Manhattan, Queens	<p>Phil Opatz  <a href="mailto:Phil.opatz@vnsny.org">Phil.opatz@vnsny.org</a>  O: 212-290-6467  C: 347-452-9557</p>
<b>Coordinated Behavioral Care, Inc. dba Pathways to Wellness Health Home</b>	Bronx, Brooklyn, Manhattan, Queens, Staten Island	<p>Amanda Semidey  <a href="mailto:ASemidey@cbcure.org">ASemidey@cbcure.org</a>  646-930-8835</p> <p>Janelle Chambers  <a href="mailto:JChambers@cbcure.org">JChambers@cbcure.org</a>  646-930-8851</p>



Health Home	Counties Designated to Serve Children	Designated Contact for Children's Designated Health Home
<b>Greater Rochester Health Home Network LLC</b>	Cayuga, Chemung, Livingston, Monroe, Ontario, Seneca, Steuben, Wayne, Yates, Allegany, Genesee, Orleans, Wyoming	<p>Deb Peartree  <a href="mailto:dpeartree@therihn.org">dpeartree@therihn.org</a>            (585) 737-7522</p> <p>Ann Potter  <a href="mailto:apotter@therihn.org">apotter@therihn.org</a>            (585)-350-1408</p>
<b>Hudson River HealthCare, Inc. dba Community Health Care Collaborative</b>	Columbia, Dutchess, Greene, Orange, Putnam, Rockland, Sullivan, Westchester, Nassau, Suffolk	<p>Andrea Hopkins  <a href="mailto:ahopkins@hrhcare.org">ahopkins@hrhcare.org</a>            845-803-3479</p> <p>Katie Clay  <a href="mailto:kclay@HRHCARE.ORG">kclay@HRHCARE.ORG</a>            914-734-8513</p>
<b>Institute for Family Health</b>	Ulster	<p>Michaela Frazier – Director  <a href="mailto:mifrazier@institute.org">mifrazier@institute.org</a>            O: 206-206-5200 x1360            C: 917-831-0334</p> <p>Melissa Martinez – Director  <a href="mailto:mmartinez@institue.org">mmartinez@institue.org</a>            O:845-255-2930            C:347-947-0667</p>



Health Home	Counties Designated to Serve Children	Designated Contact for Children's Designated Health Home
<b>Montefiore Medical Center dba Bronx Accountable Healthcare Network Health Home</b>	Bronx	Antonette Mentor <a href="mailto:amentor@monterfiore.org">amentor@monterfiore.org</a> 914-378-6086
<b>Niagara Falls Memorial Medical Center</b>	Niagara	Vicki Landes <a href="mailto:Vicki.landes@nfmhc.org">Vicki.landes@nfmhc.org</a> (716) 278-4147  Jennifer Mruk <a href="mailto:Jennifer.mruk@nfmhc.org">Jennifer.mruk@nfmhc.org</a> (716) 278-4647
<b>Northwell Health Home</b>	Queens, Nassau, Suffolk	Christina Alonso <a href="mailto:Calonso1@northwell.edu">Calonso1@northwell.edu</a> Office Phone: (516) 600-1128 Cellular Phone: (516) 287-6046



Health Home	Counties Designated to Serve Children	Designated Contact for Children's Designated Health Home
<b>Mount Sinai Health Home Serving Children</b>	Bronx, Brooklyn, Manhattan, Queens, Staten Island	<p>Alicia Korpi  <a href="mailto:Alicia.korpi@mountsinai.org">Alicia.korpi@mountsinai.org</a>            O:212-731-7841            C:646-856-5667</p> <p>Arhima Jacobs  <a href="mailto:Arhima.jacobs@mountsinai.org">Arhima.jacobs@mountsinai.org</a>            212-241-3257</p>
<b>St. Mary's Healthcare</b>	Fulton, Montgomery	<p>Katerina Gaylord  <a href="mailto:Katerina.gaylord@smha.org">Katerina.gaylord@smha.org</a>            518-841-3676</p> <p>Charis Gray            518-841-3896  <a href="mailto:Graycm@ascension.org">Graycm@ascension.org</a></p> <p>Sarah Eipp            518-841-3896  <a href="mailto:Sarah.Eipp@ascension.org">Sarah.Eipp@ascension.org</a></p>



# Conditions that Make a Child Eligible for the Early Intervention Program and on the Health Home Eligibility List

## ICD-10 Code

## ICD-10 Description

F43.10	Post-traumatic stress disorder, unspecified
F43.12	Post-traumatic stress disorder, chronic
P07.01	Extremely low birth weight newborn, less than 500 grams
P07.02	Extremely low birth weight newborn, 500-749 grams
P07.03	Extremely low birth weight newborn, 750-999 grams
Q05.0	Cervical spina bifida with hydrocephalus
Q05.1	Thoracic spina bifida with hydrocephalus
Q05.2	Lumbar spina bifida with hydrocephalus
Q05.3	Sacral spina bifida with hydrocephalus
Q05.4	Unspecified spina bifida with hydrocephalus
Q05.5	Cervical spina bifida without hydrocephalus
Q05.6	Thoracic spina bifida without hydrocephalus
Q05.7	Lumbar spina bifida without hydrocephalus
Q05.8	Sacral spina bifida without hydrocephalus
Q05.9	Spina bifida, unspecified
Q35.1	Cleft hard palate
Q35.3	Cleft soft palate
Q35.5	Cleft hard palate with cleft soft palate
Q35.7	Cleft uvula



## Crosswalk Conditions (cont'd)

### ICD-10 Code

Q35.9

Q36.0

Q36.1

Q36.9

Q37.0

Q37.1

Q37.2

Q37.3

Q37.4

Q37.5

Q37.8

Q37.9

### ICD-10 Description

Cleft palate, unspecified

Cleft lip, bilateral

Cleft lip, median

Cleft lip, unilateral

Cleft hard palate with bilateral cleft lip

Cleft hard palate with unilateral cleft lip

Cleft soft palate with bilateral cleft lip

Cleft soft palate with unilateral cleft lip

Cleft hard and soft palate w/ bilateral cleft lip

Cleft hard and soft palate w/ unilateral cleft lip

Unspecified cleft palate w/ bilateral cleft lip

Unspecified cleft palate w/ unilateral cleft lip



# Standards: Six Health Home Core Services

## 1. Comprehensive Care Management

Policies and procedures are in place to create, document, execute and update an individualized, patient centered plan of care for each individual.

**1a.** A comprehensive health assessment that identifies medical, mental health, chemical dependency and social service needs is developed.

**1b.** The individual's plan of care integrates the continuum of medical, behavioral health services, rehabilitative, long term care and social service needs and clearly identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager and other providers directly involved in the individual's care. **1c.** The individual (or their guardian) play a central and active role in the development and execution of their plan of care and should agree with the goals, interventions and time frames contained in the plan.

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

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

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

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

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



# Standards: Six Health Home Core Services - Continued

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



## Standards: Six Health Home Core Services - Continued

### 3. Comprehensive Transitional Care

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

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

**3c.** The health home provider utilizes HIT as feasible to facilitate interdisciplinary collaboration among all providers, the patient, family, care givers, and local supports.

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



# Standards: Six Health Home Core Services - Continued

## 4. Patient and Family Support

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



# Standards: Six Health Home Core Services - Continued

## 5. Referral to Community and Social Support Services

**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.



# Standards: Six Health Home Core Services - Continued

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

### 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, 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



## Staff Qualifications Health Home Care Managers Serving Children

- 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.

*(Those qualifications are further described in the Appendix)*

(The Health Home Qualification Waiver cannot be utilized by EI providers)



# Early Intervention EIP Service Coordinator Qualifications

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 may apply. Those qualifications are as follows:

A minimum of one of the following educational or service coordination experience credentials:

- (i) two years of experience in service coordination activities as delineated in this Subpart (voluntary or part-time experience which can be verified will be accepted on a pro rata basis); or
- (ii) one year of service coordination experience and an additional year of experience in a service setting with infants and toddlers with developmental delays or disabilities; or
- (iii) one year of service coordination experience and an Associates degree in a health or human service field; or
- (iv) a Bachelors degree in a health or human service field.

Demonstrated knowledge and understanding in the following areas:

- (i) infants and toddlers who may be eligible for early intervention services;
- (ii) State and federal laws and regulations pertaining to the Early Intervention Program;
- (iii) principles of family centered services;
- (iv) the nature and scope of services available under the Early Intervention Program and the system of payments for services in the State; and
- (v) other pertinent information.

