



**Department
of Health**

**Office of
Mental Health**

**Office of Alcoholism and
Substance Abuse Services**

**Office of Children
and Family Services**

Readiness Activities for the Enrollment of Early Intervention Children in the Health Homes Serving Children's Program

March 23, 2017

Agenda

- ✓ Timeline, Process and Workflow
- ✓ Options for EI Integration in Health Home
 - Notice of Interest – Due by Friday, April 28, 2017
- ✓ Readiness Survey Results
- ✓ Steps – How to become an Agency authorized to provide on-going EI service coordination
 - Application Approval
 - Network
 - On-going Service Coordinator Training
 - NYEIS: New York Early Intervention System (Data System)
- ✓ Steps - How to become a Health Home Care Management Agencies to provide care management services
 - Health Commerce System (HCS) and Uniformed Assessment System (UAS-NY)
 - HH Network process
 - Training Requirements
 - HH Care Manager Requirements



Timeline



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Status of Readiness Activities for Enrolling EI and Health Home Eligible Children in Health Home

- The Department of Health, Health Home Serving Children and the Bureau of Early Intervention have been working with Health Homes, Early Intervention providers and other stakeholders to ensure processes and systems are in place for enrolling children in Health Homes, including the role of the Health Home assuming the ongoing care coordination role for children in Early Intervention
- Several webinars and presentations have been conducted to educate providers regarding the workflow and other requirements related to enrolling children ***that are eligible for Early Intervention and also meet Health Home eligibility criteria in Health Home***
- As of early March, there were outstanding readiness activities and EI stakeholders requested more time complete such activities
 - Health Homes have not demonstrated network adequacy
 - Only a small percentage of Early Intervention agency have a BAA (Business Associate Agreement) with a lead Health Home to provide Health Home care management and ongoing service coordination services in the counties they have been designated to provide Health Home services
 - Health Homes, Care Management Agencies and Early Intervention agencies have not been crossed trained in Health Home systems and program requirements and EI systems and program requirements



Process for Designating HHs to Serve EI Eligible Children

- Those agencies that are interested in providing Health Home Care Management services and Early Intervention On-going Service Coordination services OR that will enter into a subcontracting relationship to provide Care Management Services to children who are eligible for both EI and HH CM services, will need to complete a Notice of Interest by Friday, April 28, 2017 to DOH
- Agencies will be required to include in their Notice of Interest the Health Homes they intend to work with (i.e., enter to into BA) and if they intend to be a direct or subcontracted HH provider
- DOH will forward the list of agencies to Health Homes – Agencies are encouraged to reach out independently and begin this work asap
 - The Notice of Interest will be sent out to via the DOH listserv, to those who registered for this webinar and will be posted to the DOH Health Home Serving Children website
 - Post April 28, 2017 there will be open enrollment for agencies that decide to provide these services at a later time
- The DOH, Health Home Serving Children and Bureau of Early Intervention will work with Health Home to assess network adequacy of those agencies who have completed the Notice of Interest



Process for Designating HHs to Serve EI Eligible Children

- Lead Health Home will be required to demonstrate agencies have met the provisions of the Readiness Tool and that they have taken the necessary steps to be prepared and trained to serve children who are eligible for both EI and HH CM services
 - The Readiness tool will be sent out to via the DOH listserv, to those who registered for this webinar and will be posted to the DOH Health Home Serving Children website
- DOH will then designate Health Homes that are ready to enroll EI
- Lead HH will be required to ensure they have network adequacy by county of agencies to serve as the Health Home Care Manager and Early Intervention On-going Service Coordinator
 - As required by the Health Home application - Network Adequacy includes relationships with EI service providers of Speech, Physical and Occupational Therapist, etc. in the HH network partner list
- As described in the next section of the Webinar, DOH anticipates that readiness activities and process completed this Summer - with anticipated begin enroll date by those Health Homes that meet readiness criteria of September 1, 2017



Process and Workflow



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Direct Communication between Health Homes and Early Intervention

- ✓ Health Homes and Early Intervention Agencies will be 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 representative consent is necessary when sharing information beyond a referral
- ✓ 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 verbal 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



Phase 1 – December 2016 to August 31, 2017

- HH CMAs, Early Intervention Officials and Early Intervention Service Coordinators continue to build relationships
- Children in EI that are transitioning out of EI and may be potentially eligible for HH



Process for Health Homes between December 2016 – August 31, 2017

- Health Homes Designated to Serve Children **began enrollment of children December 2016**
- ***Enrollment of Children in Early Intervention that may also be eligible for Health Home***
 - Children who are now receiving Early Intervention Service are not being enrolled in Health Home Services at this time
 - When children ages 0-3 years old are referred to a Health Home or are enrolled in a Health home, the HH CM should evaluate whether the child is potentially eligible for EI services (please refer to the EI presentation for more information)

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/12_13_2016_ei_info_for_hhcm_agencies.pdf



Process for Health Home Between December 2016 – August 31, 2017

- If the HH CM believes the child is potentially eligible for EI services, the HH CM must discuss with the family and parent about Early Intervention services and the benefits of EI Services:
 - Early Intervention expertise being utilized
 - Evaluation and Service Coordination Services
 - Direct link and relationship with EI service agency
- The HH CM should explain to the family and parent, should the child be found ineligible for Early Intervention services, then Early Intervention Official (EIO) / NYC 311 can refer the child back to the Health Home CMA if the parent chooses
- If the family and parent would like a referral to Early Intervention, then the HH CM needs to contact the appropriate County Early Intervention Official (EIO) / NYC 311 to make referral to EI
- The HH CM will close out HH outreach/enrollment segment in MAPP HHTS for the child



Process for Early Intervention agencies between December 2016-August 31, 2017

- Children in EI with an Individualized Family Service Plan (IFSP) will stay in Early Intervention receiving On-going Service Coordination (OSC) until such time the child transitions out of EI (age out or no longer eligible)
- For EI children who will be transitioning out of EI during this time period, the OSC should assess if they believe the child might be eligible and appropriate for Health Home Care Management Services (please refer to the HH presentation to assist)

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/11_15_2016_hhsc_presentation.pdf

Please note: If it is determine during EI Initial Service Coordination that the child is not eligible for Early Intervention Services, the ISC should also follow the following steps



Process for Early Intervention agencies between December 2016-August 2017

- The OSC will discuss with family possible referral to HH as part of the child's EI transition plan, if the OSC believes the child is potentially eligible and appropriate for HH services,
- The OSC must discuss with the family and parent what is a HH, the role of the HH and their interest to be enrolled
- If the family and parent is interested in a referral to the HH, the OSC will obtain verbal consent to make a referral for the Health Home Program
- The EIO and or OSC will contact the Health Home to make a referral for Health Home Services
- Prior to HH enrollment the OSC, HH CM, child's family, and IFSP team must meet to discuss child's IFSP and transition to a HH Plan of Care
- The OSC and HH CM will agree on the transition date for the child to be enrolled in a HH and billed by the HH CMA (HH bills a Per Member Per Month (PMPM) that starts the first of the month)



Child Who Does Not Meet Eligibility for Early Intervention

- EI Multidisciplinary Evaluation (determines child NOT EI eligible)
- The EI Multidisciplinary team and or Initial Service Coordinator (ISC) believes the child is still eligible and appropriate for HH services
- The Initial Service Coordinator (ISC) will discuss with the family and parent their interest in a referral to the HH, the ISC will obtain verbal consent to make a referral for the Health Home Program
- The EIO and or ISC will communicate to the Health Home that the child does not meet EI eligibility and the parent wishes to be referred to the HH program
- Initial Service Coordinator, Early Intervention Official and HH Case Management Agency collaboratively work together (warm handoff to Health Home)
- Health Home Referral and Outreach/Enrollment Steps



Phase 2 - September 1, 2017

Anticipated begin date (pending completion of readiness activities) for enrolling children who are eligible for both EI and HH CM



Three Options for Providing HH CM to EI Eligibles

- ✓ Health Home Care Management agencies can also become an Early Intervention Ongoing Service Coordination agency
 - HH CMA would need to be approved by DOH Bureau of Early Intervention as a Early Intervention provider for ongoing service coordination and meet all EI standards and requirements
- ✓ Early Intervention Agencies who provide Service Coordination (Initial and or Ongoing) can also become a Health Home Care Management Agency
 - Service Coordination agencies would need to meet HH Care Management Agency (CMA) standards and requirements
 - Service Coordination who become HH CMAs need to affiliate with a lead Health Home and be in their network
- ✓ Early Intervention service coordination agencies could sub-contract with a Health Home or HH Care Management Agency
 - Would need to establish clear roles, responsibilities and integration of service delivery to limit confusion to the family
 - Would need to establish a payment arrangement, as both entities cannot bill for service coordination (i.e., Medicaid Target Case Management)



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



Early Intervention referral to Health Home during ISC

Scenario A (ISC): Initial Service Coordinator (ISC) refers child for Health Home services

- ✓ ISC and Evaluation team will assess whether they believe the child meets HH eligibility criteria and appropriateness during their Multidisciplinary Evaluation
 - If the team believes the child is eligible for HH, the EI ISC will:
 - Discuss with the family and parent what is a HH, the role of the HH and their interest to enroll
 1. If the EI ISC agency also is cross trained to provide EI OSC and HH CM services, then EI ISC will talk with their EI OSC-HH CM staff to make a referral through the Medicaid Analytics Performance Portal (MAPP) for Health Home services, the EI OSC–HH CM will be able to maintain the referral **OR**
 2. If the EI ISC agency has a sub-contract with a HH CMA, the EIO and or ISC will contact the sub-contracted HH CMA to make a referral for HH services **OR**
 3. The EI ISC agency will select a HH CMA that is cross trained as an EI OSC, then the EIO and or ISC will contact this HH provider to make a referral for HH services

Please Note: In all above instances, alignment with the child’s managed care plan must occur

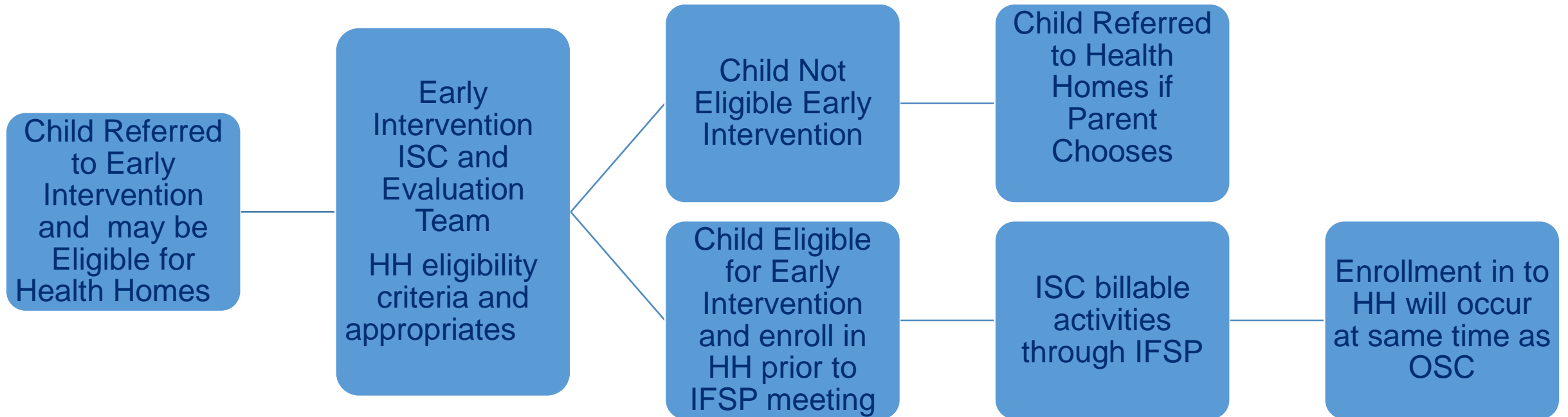
Early Intervention referral to HH during ISC

Scenario A (ISC): Initial Service Coordinator (ISC) refers child for Health Home services

- The referral for Health Home services will ideally occur during the initial IFSP development within a 45 day timeline
 - The EI ISC may bill for ISC services and IFSP activities prior to HH enrollment
- Parental consent for Health Home services must be obtained by EI OSC-HH CM provider prior to child's enrollment into Health Home
 - The enrollment into HH will occur at the same time as EI ongoing service coordination would begin

REFERRAL TO EARLY INTERVENTION - MAY BE ELIGIBLE FOR HEALTH HOMES

Scenario A (ISC):



Early Intervention referral to Health Home during OSC

Scenario B (OSC): EI Ongoing Service Coordinator (OSC) refers child for Health Home services

- ✓ Through periodic reviews and assessments of the child, the IFSP team may believe the child meets HH eligibility criteria and appropriateness
 - Discuss with the family and parent what is a HH, the role of the HH and their interest to enroll
 1. If the EI OSC agency who also is cross trained to provide EI OSC and HH CM services, then EI OSC will make a referral through the Medicaid Analytics Performance Portal (MAPP) for Health Home services and keep servicing the family for both HH CM and EI OSC. Once child is enrolled in Health Home, the EI OSC will end billing for EI services coordination and begin billing for Health Home Care Management services based on acuity **OR**
 2. If the EI OSC agency is not crossed trained to also provide HH CM service but has a sub-contract with a HH CMA, the EIO and or OSC will contact the sub-contracted HH CMA to make a referral for Health Home services, **OR**
 3. If the EI OSC agency is not crossed trained to also provide HH CM nor has a subcontract then the EIO and or OSC will select a HH CMA that is cross trained as an EI OSC to make a referral for Health Home services

Please Note: In all above instances, alignment with the child's managed care plan must occur



Early Intervention referral to HH during OSC

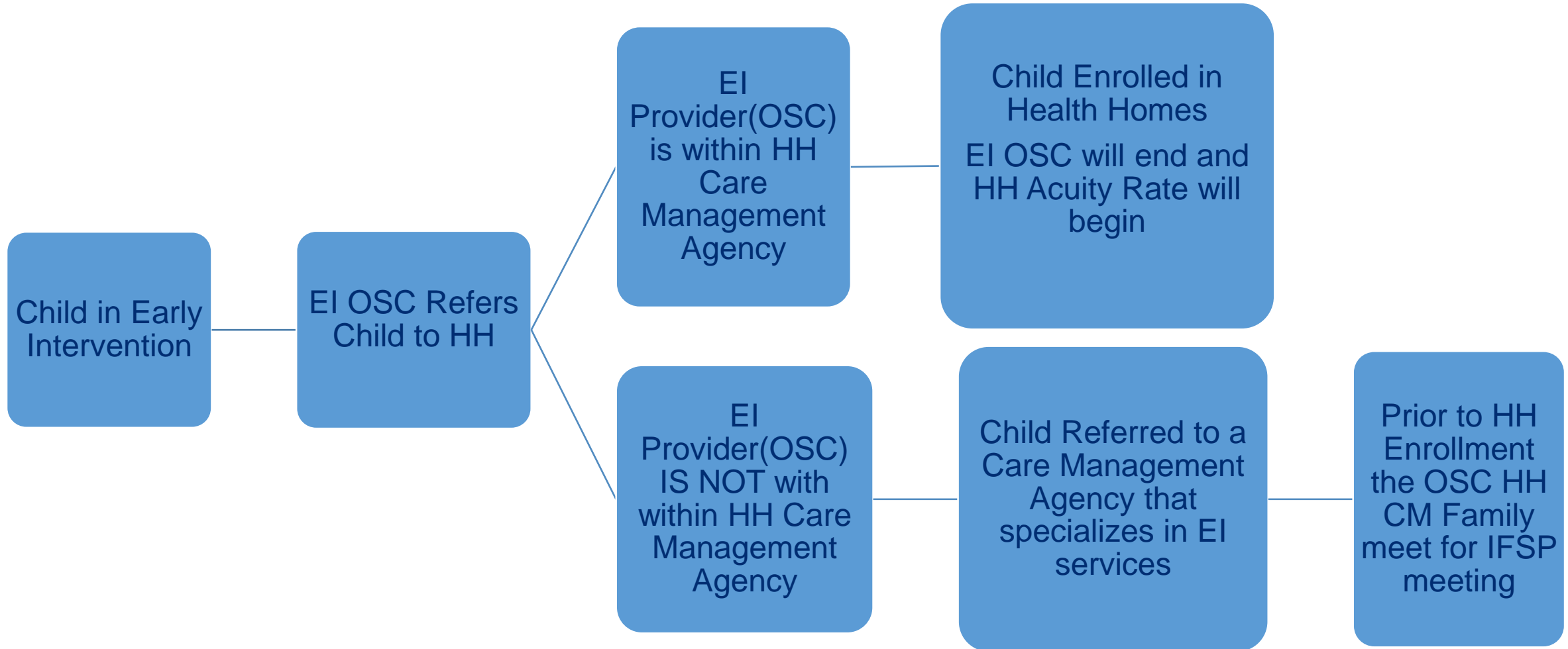
Other than option 1 (Where the child continues to have the same EI OSC)

- The family should be informed of the various agencies that have been cross trained to provide both services of EI OSC and HH CM and work collaboratively with the current EI OSC agency
 - An IFSP meeting must be scheduled with the current EI OSC, the EIO, child's family, IFSP team and the new HH CMA that will be providing both HH CM and EI OSC, to discuss transition to the new HH CMA as well as discuss the child's EI IFSP and HH Plan of Care (warm handoff to the HH CM – EI OSC)
 - Additionally, an agreement on the transition date for billing purposes will be determined
- Once the child is enrolled in Health Home, the EI OSC will end billing for EI service coordination and the new HH CMA will begin billing for HH Care Management services based on acuity
- This scenario includes those children who initially do not want to be referred to HH but later choose to join



CHILD EARLY INTERVENTION - MAY BE ELIGIBLE FOR HEALTH HOMES

Scenario B (OSC):



Children Enrolled in Health Home Prior to Being Enrolled in EI

- DOH is currently developing work flows and reviewing systems to allow an initial service coordinator to bill for EI initial service coordination services for a child that is concurrently enrolled in Health Home
- This will leverage the expertise of the distinct and separate roles of the Initial Service Coordinator and Ongoing Service Coordination and ensure continuity of care for Health Home care management services and the Health Home care plan
- It will be the responsibility of the Health Home to ensure there is a properly qualified individual to fulfill the role of the Ongoing Service Coordinator – ideally the existing Health Home care manager



Subcontract Arrangements

Early Intervention service coordination agencies (county or agency) could subcontract with a Health Home or HH Care Management Agency

- Need to enter into a Business Associate Agreement
- Need to establish clear roles, responsibilities and integration of service delivery to limit confusion to the family
- Need to establish a payment arrangement, as both entities cannot bill for service coordination (i.e., Medicaid Target Case Management)



SURVEY RESULTS



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Survey Results

148 Total Responses

Early Intervention Service Coordination Providers

Early Intervention Municipalities (Early Intervention Officials)

HH Case Management Agencies (CMAs)

Health Homes



Survey Results- EI Providers

Of those who responded to these questions

- 31% of agencies had not been adequately informed on what a Health Home Serving Children is and the array of services provided
- 49% of agencies did not have a clear understanding of the Health Home Serving Children eligibility requirements and appropriateness criteria
- 37% agencies were not aware of the roles and responsibilities of a Health Homes Care Manager (CMA)



Survey Results- EI Providers

Of those who responded to these questions

- 49% of EI agency were interested in also becoming a Health Home Care Management Agency (CMA)
- 45% of EI agencies where interested in subcontracting with a Health Home or Health Home Care Management Agency (CMA)
- 73% of EI agencies did not have a Business Associate Agreement (BAA) with a Health Home
 - DOH has the list of EI providers that already have a BAA with a HHSC



Survey Results- HHSC & CMAs

Of those who responded to these questions

- 76% of Health Homes/CMAs were adequately informed on what an Early Intervention Program is and the array of services provided
- 73% of Health Homes/CMAs have a clear understanding of the Early Intervention program eligibility requirements
- 70% of Health Homes/CMAs are aware of the roles and responsibilities of an EI Ongoing Service Coordinator



Survey Results- HHSC & CMAs

Of those who responded to these questions

- 64% of Health Homes/CMAs are interested in being cross-trained as an Early Intervention Program
- 67% of Health Homes/CMAs have not yet had a discussion with an Early Intervention Program regarding integration within Health Homes
- 62% of Health Homes/CMAs are interested in subcontracting with an Early Intervention Provider



Survey Results

- ❑ Many EI, HH and CMA providers indicated that they were interested in being cross trained and receptive to a subcontracting relationship

- ❑ Relationships and BAAs between HHs and EI providers needs to be a priority as many do not have a BAA relationship
 - List of Health Homes, the counties designed to serve in and contact information

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

- ❑ Small percentage of EI agency staff (county or provider agency) started or completed the Child and Adolescent Needs and Strengths Assessment of New York Certification training (CANS-NY)

- ❑ Small percentage of EI agency (county or provider agency) have a Medicaid Analytics Performance Portal (MAPP HHTS) Gatekeeper

- ❑ High percentage of agencies have a valid Medicaid Management Information Systems (MMIS ID#) and have a Health Commerce System (HCS) account, with an identified HCS Director and Coordinator



Continued Need for Capacity, Training and Relationship Building

- Connection between EI SC Agencies, HHs and CMAs
 - Business Associate Agreements (BAA)

- Enrollment of HH CMA as an EI SC Provider Agencies

- Cross Training for both EI SC and HH CMAs needed
 - Specific CANS-NY and UAS-NY training for EI SC providers
 - Specific NYEIS training for HH CMAs

- Network Capacity evaluation will be necessary



Steps to Become an Early Intervention Agency



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Steps for Health Home CMAs to be Prepared to Conduct EI Service Coordination

How do Health Home CMAs become a EI Service Coordination Agency?

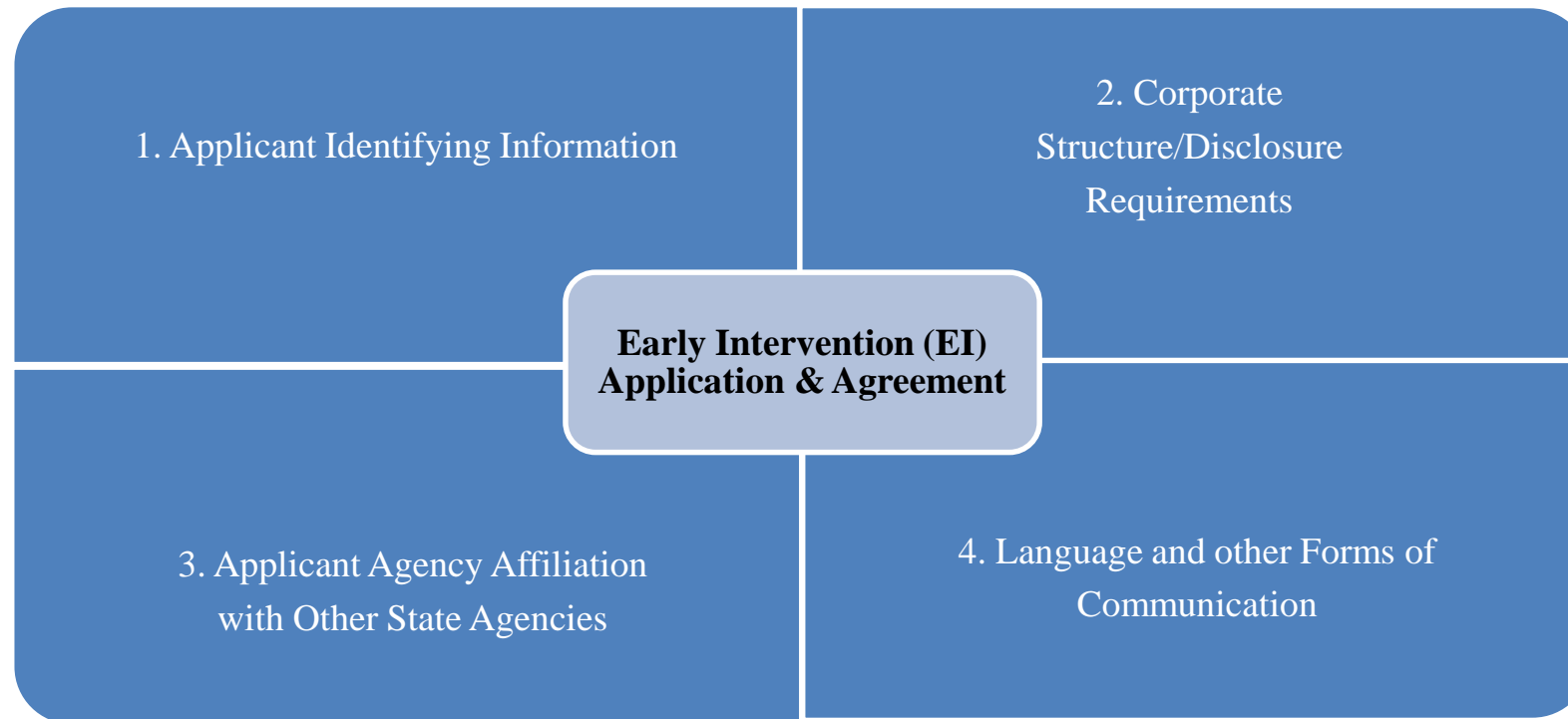
What EI cross training needs to take place for Health Home CMAs?

What needs to be know about the EI New York Early Intervention System (NYEIS-data system)?



How do HH CMAs become a EI Service Coordination Agency?

All HH CMAs providing early intervention (EI) case management must become an approved EI agency provider and in an EI agreement with the NYS Department of Health. The application for approval is simplified for HH CMAs. There are four basic parts to the application. All HH CMAs that have an approved application as a EI agency provider will have a provider agreement which will outline responsibilities for EI service coordination services.



STEP 1: EI Application Process

What do we mean by Identifying Information?

<i>AGENCY NAME</i>	NPI# _____	<i>Federal Employer Identification Number</i> / / - / / / / / / /			
<i>d/b/a (where applicable)</i>					
<i>Mailing Address (Street)</i>					
<i>City</i>	<i>County</i>	<i>State</i>	<i>Zip</i>	<i>Telephone # ()</i>	
<i>Fax # ()</i>					
<i>Office Address (location of files and records)</i>					
<i>E-mail Address</i>					



STEP 2: EI Application Process

What do we mean by Corporate Structure and Disclosure Requirements?

A. Type of Ownership

Check the box that indicates the Type of Ownership of the applicant. If the applicable, attach a certified copy of the Assumed Name Certificate (d/b/a). Where certified copies are required, such documents can be obtained by the issuing agency, either the New York State Department of State, Division of Corporations, 41 State Street, Albany, New York 12231 or the county clerk's office in which the business is located.



STEP 3: EI Application Process

What do we mean by Agency Affiliations?

- 1) **New York State Department of Health** No Yes
- Article 28 PHL Diagnostic and Treatment Center # _____
 - Article 28 PHL Hospital Based Outpatient Clinic # _____
 - Article 36 CHHA (Certified Home Health Agency) # _____
 - Article 36 LHCSA (Licensed Home Care Service Agency) # _____
 - Approved Medicaid Provider # _____
- (If more than one Medicaid Provider number, provide all numbers.)
- 2) **State Education Department** No Yes
- Section 4410 Education Law # _____
 - BOCES/School District # _____
 - VESID # _____
- 3) **Office of Mental Retardation and Developmental Disabilities** No Yes
- Article 16 OMRDD Clinics # _____
 - Comprehensive Medicaid Case Management # _____
- 4) **Office of Mental Health** No Yes
- Article 31 MHL Clinics # _____
- 5) **Office of Alcohol and Substance Abuse Services** No Yes
- Article 22 Service Provider # _____



STEP 4: EI Application Process

Why are languages required?

C. Languages and Other Forms of Communication

Indicate the languages (other than English) and other forms of communication that can be used by agency staff that provide early intervention services.

Provision

Spanish
 Russian
 Chinese Mandarin
 Arabic
 Haitian Creole
 Hebrew
 Bengali
 French
 Vietnamese
 Sign Language
 Yiddish
 Urdu
 Other (Specify)

Service Coordination

Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No



How do Health Home Care Management Agencies become a EI Service Coordination Agency?

What do we need to do, so we can be listed as a HH CMA who is available to also provide early intervention (EI) service coordination?

CMA's who are currently an approved Early Intervention (EI) Agency Provider

- Update to current approval needed
- Please contact the Bureau of Early Intervention via email provider@health.ny.gov
- Request to add HH care management to your existing approval

CMA's who are not currently an approved Early Intervention (EI) Agency Provider

- EI Application and agreement needed
- Please contact the Bureau of Early Intervention via email provider@health.ny.gov or call 518-473-7016 (press 1)
- Request an application for approval to provide EI/HH care management

All CMA's who seek to provide care management to EI children

- Provide copy of Business Associate Agreements (BAA) with lead Health Homes
- Identify catchment area/counties served
- Must be in good standing with NYS Medicaid
- May request more information via email or by calling EI Provider Approval Unit at 518-473-7016 (press 1)



What is a Provider Agreement?

New York State Department of Health
Bureau of Early Intervention

Early Intervention Provider Agreement

This Provider Agreement is entered into by and between the New York State Department of Health (hereinafter referred to as the “Department”), and

<NYS Provider ID/State ID> _____ (hereinafter referred to as the “Provider”). Provider acknowledges that this agreement is made by and between the Department and Provider, as Provider is currently organized and constituted or presented. The Department reserves the right to terminate this agreement should the Provider reorganize or otherwise substantially change the character of its corporate or other business structure or presentation.

Purpose of Agreement

The purpose of this Agreement is to set forth the terms and conditions for participation in the Early Intervention Program (EIP) and to establish the obligations, expectations and relationship between the Department, municipalities within the State and the Provider.

Providers intending to receive service authorizations for early intervention services directly from a Municipality and payment from the Municipality for such services rendered must complete and comply with the attached **Appendix 1- Payee Provider Agreement/Service Authorizations and Payment**. Appendix 1 sets forth the terms and conditions for such authorizations and payment.



What is a Provider Agreement?

- A9. The Provider shall be reasonably available to the parent in a manner that does not limit service access to daytime and/or weekday hours and does not limit access to a specific location. The Provider shall ensure that accessibility for service coordination are available to families in non-traditional schedules and through a variety of methods and locations. Provider shall be responsible for informing families of changes to their contact number, email address, and the specific times and places of their accessibility.
- A10. Provider shall communicate with the family about the purpose of Early Intervention, provide all information to the family in the family's dominant language or other mode of communication unless clearly not feasible to do so, and shall ensure that the family has received or has access to the current version of The Early Intervention Program: A Parent's Guide, the parent's handbook that provides information about the program upon referral to the EI Program.
- A11. Provider shall describe the rationale for services in natural environments. Provider shall describe each step of the IFSP process, including its purpose, and what service delivery might look like.
- A12. Provider shall collaboratively balance listening to the family with sharing information and shall use open-ended questions that encourage the family to share their thoughts and concerns. Provider shall discover family preferences for sharing and receiving information as well as the family's teaching and learning strategies they prefer to use with their child.
- A13. Provider shall review with the EI family the EIP procedural safeguards/due process rights upon initial contact with the family and whenever the family may disagree with an eligibility decision or with the early intervention official/designee decision regarding services for their child/family.



What is a Provider Agreement?

Signatory must be legally authorized to enter into an Agreement on behalf of the Provider.

I have read and understand my obligations as stated in this Agreement. Yes

My request includes the terms outlined in Appendix 1 (check one):

Yes

No

In Witness Whereof, the parties hereto have executed* this Agreement as of the latest date written below.

Provider Name

Agency Name/Individual Provider Name	
NYS Provider ID/State ID	

By

First Name	M.I.	Last Name
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Address

Street Address			Apartment/Floor
City	State	Zip Code (9 digit) https://tools.usps.com/go/ZipLookup	County (if in NY)
E-mail Address		NPI	

Service Catchment Area(s): Circle all counties/municipalities for which you are available to provide services.

Albany
Allegany
Broome
Cattaraugus

Fulton
Genesee
Greene
Hamilton

Orange
Orleans
Oswego
Otsego

Tioga
Tompkins
Ulster
Warren



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How long does the approval and agreement process take?

- ❖ An application can be completed in less than one hour.
- ❖ The Department's approval of the application will take 2-3 weeks.

Cross-Training for HH CMAs regarding Early Intervention Service Coordination

Mandated Training for all EI Service Coordinators

- Introductory Service Coordination Training
- NYEIS Access and Training

Other Training/Knowledge that EI Service Coordinators should have

- Individualized Family Service Plan
- Advanced Service Coordination: Transition
- EI Program Records
- Advanced Service Coordination- Working with Families
- Introduction to EI Evaluation, Assessment, and Eligibility Determination



Where do I find out information of EI Training?

Link to SDOH EI website

https://www.health.ny.gov/community/infants_children/early_intervention/training.htm

Link to current EI Training Contractor site

<https://www.eilearningnetwork.com/>



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Available Upcoming EI Trainings

Introductory Service Coordination- Mandated for all EI Service Coordinators:
3/28/17, 9 AM- 4 PM in Westchester

Advanced Service Coordination: Transition
3/24/17, 9AM-12:30 PM in Newburgh

Program Records
3/27/17, 9 AM- 2 PM in Saratoga Springs

Advanced Service Coordination: Working with Families
3/29/17, 9 AM-12:30PM in Orangeburg



New- EI Web-based Training

- Training Contractor to be identified soon
- Information on new training schedule will be posted on SDOH EI website
https://www.health.ny.gov/community/infants_children/early_intervention/training.htm
- No in-person training



New York Early Intervention System (NYEIS) Data System

- NYEIS is the Curam-based application used by all municipalities and EIP providers to manage their EIP work.
- NYEIS is a centralized, Web-based system that electronically manages EIP administrative tasks (referral, evaluation, IFSP, service authorizations) and provides for information exchanges.
- The system is designed to support EIP's service delivery, administration, and management activities at both the local and state levels.
- A EI SC must have access to Home Commerce System (HCS) and NYEIS



Health Commerce System (HCS) ID Requests for EI

It is anticipated that many HH CMAs will have HCS accounts for access to MAPPs.

- HH CMAs without HCS access should follow their procedure in order to obtain an HCS account
- HH CMAs with HCS IDs already can follow the NYEIS User Account Requests steps

Agencies who were previously approved in EI should not have to take any action to obtain an HCS or NYEIS user account unless they have not done so already.

HH CMAs that becomes a newly approved EIP Provider Agency need to follow the steps to request an HCS IDs

- Approved EI Provider Agency must first designate up to 3 HCS Director(s) and 3 HCS Coordinator(s) to establish new HCS accounts
 - Agency must send an e-mail to beinyeishcsacct@health.ny.gov to request instructions and documents needed to designate their HCS Agency Director(s) & Coordinator(s)
 - Agency will receive instructions and a spreadsheet from BEI to designate their HCS Directors and Coordinators
 - Once the spreadsheet is returned, the information will be entered via an on-line process, initiating the HCS Director and HCS Coordinator designations and requesting an associated HCS account for each person.
 - Agency will receive communication from HCS when the accounts have been established
 - The designated HCS Directors and HCS Coordinators, now having an HCS account, will be able to request HCS accounts for Agency employees and contractors who do not have a health professions license issued by the State Education Department via an online HCS account application process.



NYEIS User Account Requests

- Request a NYEIS user account, send an e-mail to beinyeishcsacct@health.ny.gov
- Agency staff have received their HCS IDs
- Request NYEIS account instructions
 - Instructions and a spreadsheet will be provided detailing information needed for a NYEIS user account such as
 - Name, HCS ID, Phone Number, E-mail Address
 - Agency Name and EI Provider State ID
 - If the user is a partner/affiliate, this would be the name of the partner/affiliate agency if they do not already have a NYEIS accounts
 - Level of Access needed such as:
 - Agency-level/administrator role (this role will allow the HH provider to manage partners/affiliates and employees in NYEIS, assignment of EI providers via service authorizations).
 - Service coordination role (management of IFSPs, management of transition process, management of insurance information for the child, case closure)
- Completed Spreadsheets will be sent to BEI, NYEIS accounts will be created, and HH CMAs will be notified.



NYEIS Available Training and Resources

Available training material and resources that will assist new NYEIS users.

NYEIS Provider Training recorded webinars that can be found at:

http://www.health.ny.gov/community/infants_children/early_intervention/system/training/provider_webinars.htm.

Suggested order of viewing trainings:

- **Provider - Refresher Getting Started, Referral, Case Management Webinar** (2 Hrs, 18 mins) OR **NYEIS Ask the Trainer Provider Session - Getting Started** (1 Hr, 10 mins)
- **NYEIS Targeted Provider Training Webinar - Case Management** (2 Hrs)
- **NYEIS Targeted Provider Training Webinar - IFSPs and Service Authorizations** (2 Hrs, 21 Mins)
- **NYEIS Targeted Agency Provider Training Webinar - Provider Management** (1 Hr, 38 Mins)
- **Third Party Insurance Information** (1 Hr, 10 Mins)



NYEIS Available Training and Resources

Users can access NYEIS documents, including the user manual, targeted resources, templates for data changes/feature requests and electronic claiming materials on the HCS.

To access these documents, please follow these instructions:

- Log into HCS
- Select the **My Content** button on the Top Menu Bar of the HCS Portal page, then select **Documents by Group**
- Click on the link for your appropriate group from the My Groups section (e.g., LHD)
 - If you do not see your Group in the drop down, click the View All Document Groups link.
- Select the green '+' next to your group
- Select the "Family and Community Health" link
- Select the "Early Intervention" link
- Select the "NYEIS" link. Click on 'Add to Fav' at the end of this displayed path to more easily access the NYEIS Document Group from HCS Home.
 - If you have added the NYEIS folder to your favorites in HCS, this folder will now be available from your HCS homepage under "My Favorites"



NYEIS Available Training and Resources

- It is suggested that HH CMAs users become familiar at a minimum with the following units of the User Manual and resources:
 - Unit 1: Getting Started
 - Unit 4: Case Management
 - Unit 6: Individualized Family Service Plan and Service Authorizations
 - Unit 9: Provider Management
 - Provider Management, Case Management, NYEIS IFSP and Service Authorizations (SAs), and Third-Party Insurance targeted resources

Users will also have access to the NYEIS helpdesk to assist with general NYEIS questions. They can be reached at nyeis@cma.com or 518-640-8390.



How to Become a Health Home Care Management Agency



Department
of Health

Office of
Mental Health

Office of Alcoholism and
Substance Abuse Services

Office of Children
and Family Services

“To Do” List for Entities Seeking to Become a Health Home Care Management Agency

- Obtain NPI number (**Note: all approved EI agencies have an NPI # and can utilize this NPI # to become a HH CMA**)
- Obtain MMIS Provider ID (**Note: process can take up to 90 days**)
 - NPI number is required to obtain an MMIS provider ID
 - The MMIS provider ID will provide you access to eMedNY and is required to access the Health Commerce System (HCS) and for full access to Medicaid Analytics Performance Portal (MAPP) to perform Health Home Care Management functions
- Information about how to apply for NPI and MMIS provider IDs is posted at NYS DOH eMedNY website at <https://www.emedny.org/info/ProviderEnrollment/index.aspx>
- Notify DOH of current or new MMIS Provider ID using DOH EI Tracker (DOH will provide tracker template*)
- Notify DOH of Single Point Of Contact (SPOC) using DOH EI Tracker*
 - ** (Your SPOC will be the single point of communication between DOH and your EI agency. The SPOC will ensure all applications, contracts and required trainings are completed for your agency)**
- Complete CANS-NY training and certification at: www.canstraining.com
- Access UAS-NY – (CANS-NY is housed in the UAS-NY system) at: uasny@health.ny.gov or 518-408-1021
- Complete Business Associate Agreement w/ a lead HHSC



“To Do” List for Entities Seeking to Become a Health Home Care Management Agency

- ❑ Submit completed BAAs to the DOH Privacy Office for approval: Doh.sm.medicaid.data.exchange@health.ny.gov
- ❑ Submit **Health Commerce System (HCS)** Director and Coordinator account request form to DOH: HHSC@health.ny.gov

– **Note:**

- i. DOH will send the HCS account request form to your EI SPOC
- ii. SPOC will return the completed HCS account request form to DOH
- iii. DOH will submit the completed HCS request form on your behalf
- iv. Once submitted, your SPOC will receive an automated message to complete the printable HCS application
- v. It is incumbent upon your organization to complete the printable HCS application and submit to the Commerce Accounts Management Unit (CAMU)

**** Entities must submit a new HCS application to CAMU in order to add Health Home CMA services to your organization’s existing HCS account**

- ❑ Once HCS Coordinator account is activated for the “**Health Home CMA**” *Org Type*, the HCS Coordinator will establish HCS User Accounts for respective staff
- ❑ Select a Gatekeeper for your organization and submit to MAPP Customer Care for access to the Medicaid Analytics Performance Portal (MAPP) at, MAPP-customercenter@cma.com



Timely Completion of “To Do” List Items

- Please be sure to read all application materials and related correspondence **carefully**.

**** Errors in submission of time sensitive application materials will delay implementation process for your agency by 1 month or more.**

- ✓ Submit ALL requested materials to the respective entity by the established deadline
- ✓ Promptly inform DOH of a change(s) in SPOC information
- ✓ Monitor your SPAM or Junk folder regularly, as time sensitive correspondence or program updates may be redirected by your security system
- ✓ When in doubt, contact the DOH Health Home Serving Children Team at:
HHSC@health.ny.gov or 518-473-5569



Overview of Health Commerce System for the Health Home Program



Department
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and Family Services

HCS Organization Types

- ✓ Governmental Entity
- ✓ Licensure or Certification
- ✓ State Approval
- ✓ Program Specific



HCS Select Applications

Health Commerce System Applications

[View Help](#)

Browse by **A B C D E F G H I J K L M N O P Q R S T U V W X Y Z** [View All](#)

Application Name	Acronym	Profile	Restricted
Access and Update your own account information		i	
Adult Cystic Fibrosis Assistance Program	ACFAP	i	Yes
Advantage Dual Eligible Managed Care		i	Yes
AIDS Contract/Program Performance Upload		i	
Asbestos Training Verification		i	

Medicaid Analytics
Performance Portal
(MAPP)

Uniform Assessment
System for New York
(UAS-NY for CANS-NY)

UAS Community Mental
Health Assessment
(Adults)

DSRIP

Health
Home

Assessments

LMS
(Training)

Community Mental
Health Assessment

HCS Organization Types

CACFP Center Sponsors	CACFP Home Sponsors	CHP Lead Org
Canadian Organizations	Child Foster Care Agency	Children Camps
City Government	Clinical Laboratory	Clinical Labs - Limited
Clinical Labs - Other	Clinical Labs - VA/Mil	Commercial
County Agency	County DOH	County DSS
County OEM	DATC (ext clinic)	DATC (opcert)
DATC (pfi)	Dental Practices	Dentist, Restricted Dental Faculty Practices
Dentist, Restricted Dental Faculty as organization	Dentists as organizations	EMS Course Sponsor
EMS Program Agencies	EMS Services	Early Intervention Provider
Educational	Emergency Services other than EMS	Emergency Volunteers - County
Environmental Lab	FAN Clinic	Fire Departments
Fire Districts	Food Services	Funeral Directors
Government	HSA	Health Care Associations - Adult Care
Health Care Associations - Home Care	Health Care Associations - Hospital	Health Care Associations - Nursing Home
Health Care Associations - Other	Health Home CMA	Health Home Program
Home Health Agency	Hospice	Hospital (ext clinic)
Hospital (opcert)	Hospital (pfi)	Hospital (school-based ext clinic)
Individual Practitioners	Industry Group	LHCSA
Liability Insurer	Local Law Enforcement	MDs as organizations
Managed Care	Managed LTCP	Medical Practice
Midwife Practices	Midwives as organizations	Military Installations
Multi-County Coordinated Applications	NORMET Volunteers	NY Exchange Insurers
NYS Attorney General	NYS Board	NYS CFA
NYS OASAS	NYS OCFS	NYS OMH
NYS OPWDD	NYS OTDA	NYSDOH AIDS Institute

MMIS Id is used to create Health Home and Health Home Care Management Agency HCS Organization Accounts



Health Home Care Management Agency Organization Set Up

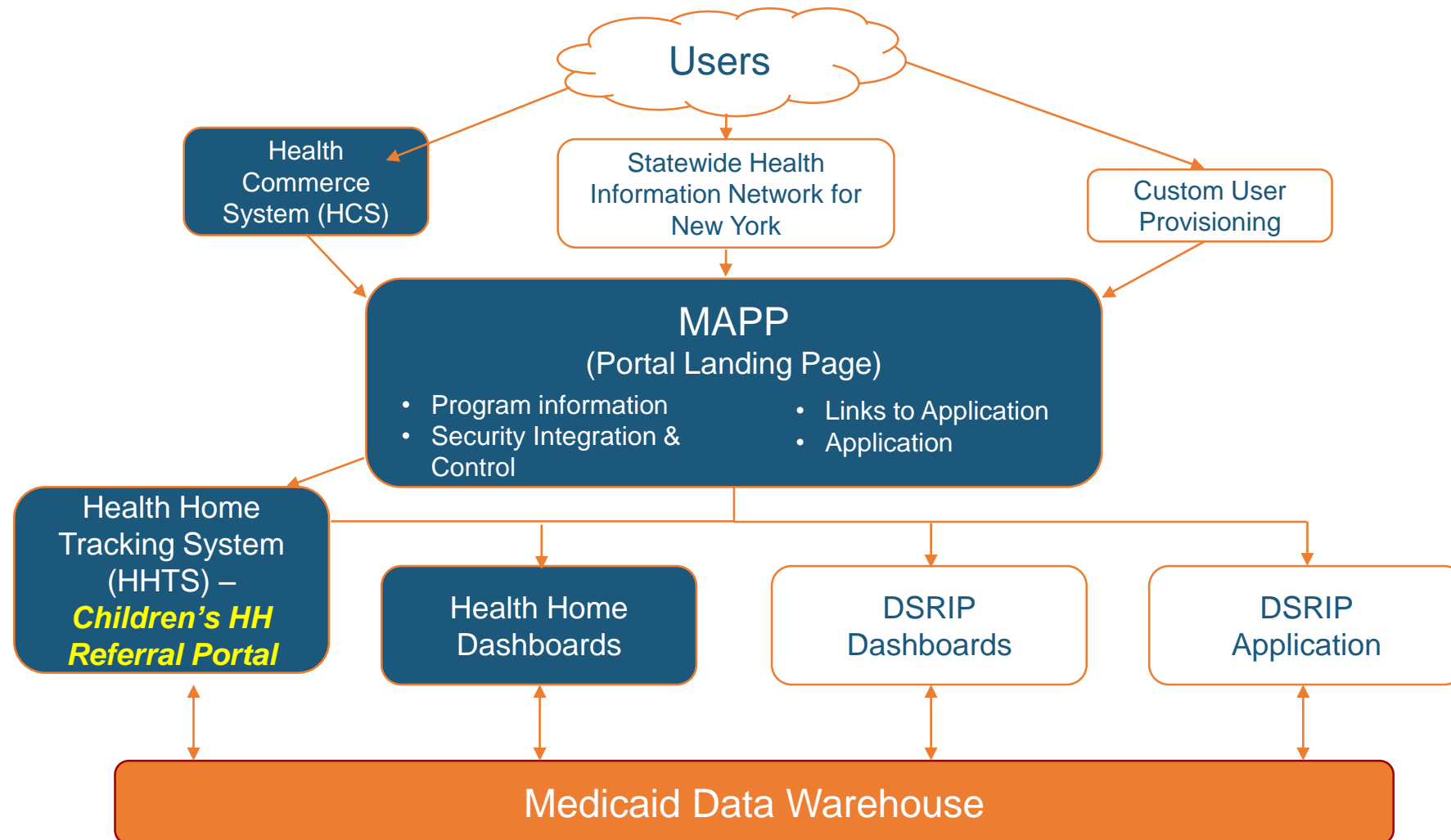
- Health Home Care Management Agency will designate an HCS Director and HCS Coordinator.
- Health Home Care Management Agency will identify staff that will require access to the MAPP and the required role.
- Once the HCS Coordinator account is activated, the HCS Coordinator will establish HCS User Accounts for respective staff.
- MAPP Gatekeeper will receive instructions on assigning MAPP roles to staff.



Overview of the MAPP Health Home Tracking System (HHTS)



Medicaid Analytics Performance Portal (MAPP)



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.



MAPP Functionality

Users are able to:

- **Refer members to Health Homes**
- Identification Assigning eligible individuals to Health Homes, Referrals of potential members (for adults, different process for children – today’s Webinar)
- Outreach of Care Management Agencies (CMA) and Health Homes to potential members
- Enrolling an individual into a Health Home once outreach is complete
- Billing Support (Members’ MCO, HH, and CMA and Diagnosis information)
- Transfer of individuals between Health Homes
- Ability to check on member’s connection to Health Home
- Member Batch lookup and export
- Dashboards to assist Care Managers, Plans and Health Homes to manage performance, identify and evaluate best practices



SUMMARY

- EI providers need a Health Commerce System (HCS) Director and Coordinator for both MAPP and UAS-NY
 - If your agency already has a HCS Director and Coordinator for EI, they can be the same people for Health Home
 - The Director or Coordinator will be responsible to assign roles and responsibilities to staff within the UAS-NY for the CANS-NY
- EI Providers need to identify a Single Point of Contact (SPOC) in which all Health Home communication will go to
 - This can be a same or different person as your HCS Director or Coordinator
- EI Providers need to identify a MAPP and UAS-NY Gatekeeper who will be the first to be trained and will assign the roles within both systems to agency staff
 - Again this can be a same or different people then listed above



Health Home Serving Children

Other Requirements



Health Home Six Core Services

- ✓ Application for Serving Children in Health Homes, State Plan requirements, and current Health Home State standards, and signed contingency letters, currently specify in detail requirements for delivering Health Home care management
- ✓ Health Home policies and procedures must be documented, and reflect and adhere to these minimum requirements
- ✓ Health Homes applying to serve children were required to demonstrate how these core requirements would be tailored to meet the needs of children and families
- ✓ **The Appendix** includes detail list of each of the many requirements for meeting each of the core services – below is a high level summary

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 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.

Six Core Services of Health Home - Continued

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.

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, to comply with the initial standards and final standards as required

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



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)



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
- *Stakeholder feedback generally supportive of training requirements as proposed:*
- 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



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



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



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*



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



Questions and Discussion



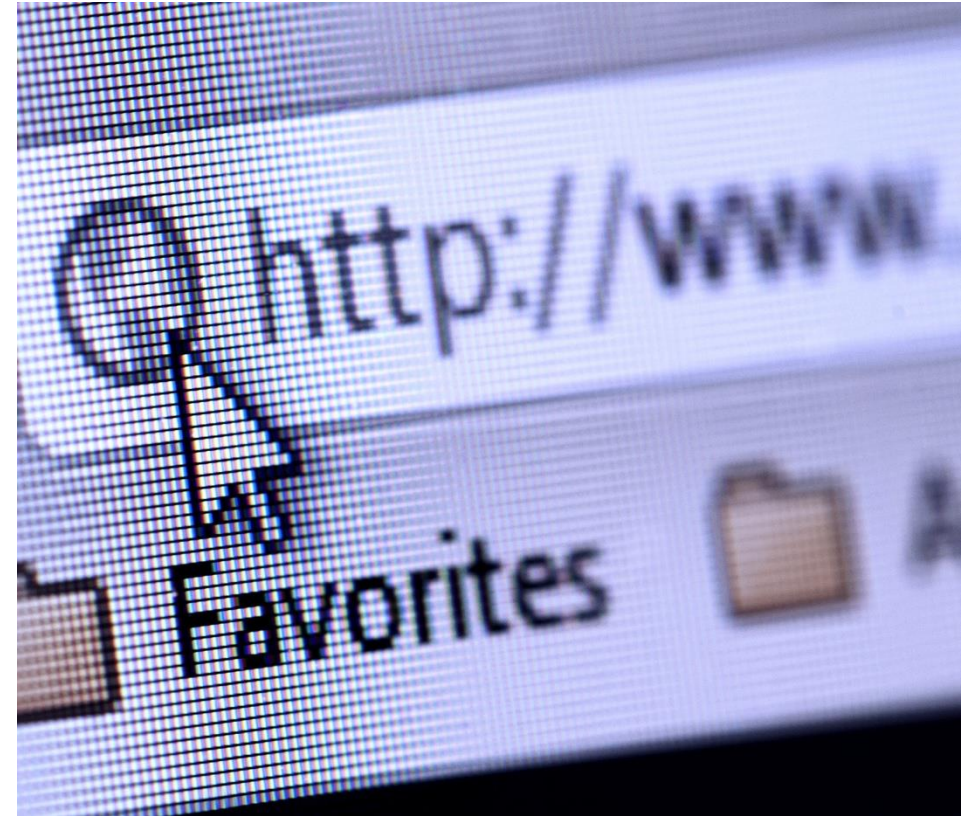
Subscribe to the HH Listserv

- 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
- Health Home Bureau Mail Log (BML)
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 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



APPENDIX



Department
of Health

Office of
Mental Health

Office of Alcoholism and
Substance Abuse Services

Office of Children
and Family Services

Health Home Eligibility Criteria and Appropriateness and MAPP Referral Portal (Medicaid Analytics Performance Portal)



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)
- 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



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 – 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.



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)



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.



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



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

