The Health Home Model & Practice: Roles and Responsibilities

Children's System

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Introduction

The information and dates in this presentation are accurate as of the date of this presentation or delivery of content

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Agenda

The Health Home Model & Practice — Roles and Responsibilities.

- Overview of Health Home
- Eligibility for Health Home
- Health Home Interaction
- Timeline for Health Home
- Resources
- Appendix

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Health Home Model and Practice: Roles and Responsibilities

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Background

New York State's Health Home (HH) Model was created to recognize the importance of care management, coordination and planning in order to improve the quality of care for children receiving behavioral health services.

Please note: While the focus of this presentation is on Health Homes and Behavioral Health (BH), the scope of Health Homes is not limited to BH services.

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Goals of Health Home

- Have awareness/understanding of all physical and behavioral health (mental health & substance use) services the child is receiving
- Facilitate care coordination and communication between all of a child's providers
- Ensure quality of care
- Provide person centered care
- Assist with closing key care gaps in order to help the child/family work towards optimal health outcomes

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Core Health Home Services

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

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Core Health Home Services

- **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.
- **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.
- **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

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Note on Health Home and Care Management Agencies

- Care Management services are provided through Care Management Agencies (CMAs) who are contracted with the Health Home to provide those services.
  - Lead Health Homes are contracted with multiple Care Management Agencies.
  - Health Homes may have own Health Home Care Managers but frequently Care Managers are employed by a CMA.
- In official documents (i.e. state manuals) often what the Care Managers (CMs) are doing is discussed as Health Home activities, this presentation follows that example for consistency.
  - Lead Health Home itself is most often administrative.
  - Health Home is the entity contracted with MMCPs and billing for Care Management services.

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Responsibilities of a Health Home Care Manager

- Connects child/family with providers and community supports
- Communicates with all providers that are providing services to a child as well as child's MMCP to ensure integration of services and care coordination and prevent duplication of services
- Provides transitional care and follow-up from inpatient to other settings
- Determines and documents child's Health Home and HCBS eligibility and reassesses (when needed) to confirm continued eligibility
- Creates individualized Plan of Care, engaging child and family in the process
- Conducts ongoing comprehensive care management and monitoring of Plan of Care and conversations with child and family

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Health Home Eligibility Criteria

- To be eligible for Health Home:
  - Individual must be enrolled in Medicaid, be appropriate for intensive level of care management that HH provides, AND have two or more chronic conditions or one single qualifying chronic condition:
    - Single qualifying conditions for children: HIV/AIDS, Serious Emotional Disturbance (SED) or Complex Trauma
    - 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)
- 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.

More information on Eligibility Criteria in Appendix

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Health Home Eligibility

Health Home Eligibility Criteria Compared to HCBS Eligibility Criteria Examples Include:		
Note: if the child is eligible for HCBS, the child is eligible for Health Home. If a child is eligible for Health Home, the child may or may not be eligible for HCBS	HCBS Eligible? (if Meet Target Risk and Functional Criteria)	Health Home Eligible Without HCBS Eligibility
SED: Elimination Disorders*	Yes	Yes (New)
SED: Sleep Wake Disorders*	Yes	Yes (New)
SED: Sexual Dysfunctions*	Yes	Yes (New)
SED: Medication Induced Movement Disorders*	Yes	Yes (New)
SED: Tic Disorder*	Yes	Yes (New)
SED: ADHD*	Yes	Yes (New
All other SED Health Home Conditions (see appendix for SED HH Definition)*	Yes	Yes
Medically Fragile	Yes	Yes, if have two or more HH chronic conditions or single qualifying HH condition
Complex Trauma (Health Home Definition)	Yes	Yes

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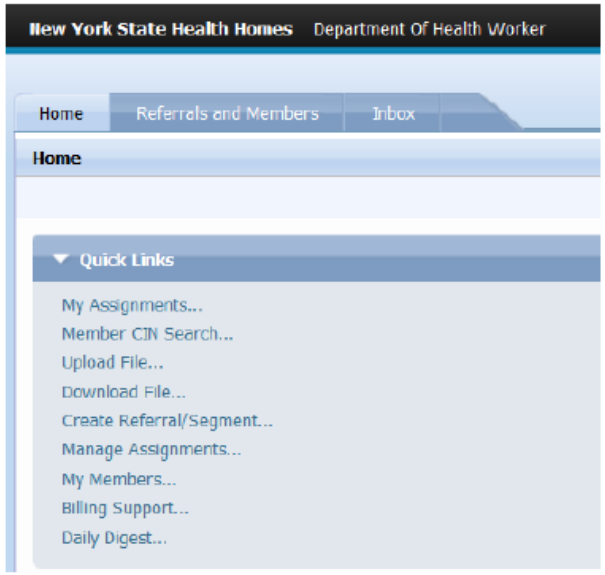
Health Home Tracking System - MAPP

Health Home Tracking System



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.

Users are able to:

- **Refer members to Health Homes**
- Upload/download member information & transactions
- Coordinate across MCPs, HHs, and CMAs using workflows & notifications
- View member's Medicaid information

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MAPP Children's Referral Portal

- MAPP Children's HH Referral Portal must be used to refer and enroll children in Health Homes
  - Children must consent to be referred to Health Home
- The following entities will have access to MAPP Children's HH Referral Portal on Day 1
  - Managed Care Plans
  - Health Home
  - Care Management Agencies
  - Voluntary Foster Care Agencies
  - LGU/SPOA
  - LDSS
- Future Phases: over time access to MAPP will expand

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RR/E Codes - Enrollment in Health Home

- The Health Home RRE Codes are A1 and A2
- For transitioning children, these codes indicate that they have been enrolled in the Health Home Program:
  - A1 in eMedNY shows the Care Management Agency's Name
  - A2 in eMedNY shows the Health Home Name
- In Epaces, the organization names appear in the "Medicaid Restricted Recipient" field and the A1/A2 appear in the "Member Exceptions" field
- A1 and A2 are compatible with all waiver codes and should appear on any member's file that has transitioned into the Health Home Program

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C-YES, Independent Entity (IE)

- If child/family decide not to enroll in a Health Home the child must be determined eligible for Aligned HCBS by the Independent Entity.
- If determined eligible, Independent Entity will manage the Plan of Care and initial coordination for the child's Home and Community Based Services.
- **After that, Medicaid Managed Care Plan will oversee continued access of child to the services in Plan of Care.**
- Independent Entity will conduct any HCBS re-eligibility determinations for Medicaid Managed Care children.
- State has determined the Independent Entity will be Maximus. This is the only Independent Entity. The Independent Entity is being referred to as **Children and Youth Evaluation Services (C-YES)**.

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Managed Care Plans and Children's Health Home

- MMCPs are required to offer contracts to at least one Children's Health Home in their service areas
- Lead Health Home will bill MMC for Care Management services
- Health Home and MMCP will communicate about child's Plan of Care and services they are receiving

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Role of Health Home in CFTSS and Aligned HCBS

- New CFTSS - Child does NOT need to be enrolled in a Health Home to access these services
- HCBS – Health Home enrollment is not mandatory
  - If the child/family chooses to enroll in a Health Home (HH), the Health Home determines HCBS eligibility and creates/manages the Plan of Care (POC)
  - If the child/family opts out of Health Home, eligibility is determined and POC must be created by C-YES, the Independent Entity (IE), to allow access to these services

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Waiver Children Transitioning to Health Home

- **<u>January 1, 2019:</u> 1915(c) waiver care coordination transitioned to Health Home Care Management**
  - Once waiver child transitioned, started billing for Health Home not care management under waiver
  - All 1915(c) waiver children transitioned to Health Home (or Independent Entity) by March 31, 2019
- **<u>Post transition (as of April 1, 2019)</u>**
  - Care manager must keep proper documentation as required for Health Home
  - For any transitioning waiver child whose annual recertification was on or after April 1, 2019, based on the recertification date under the former waiver, the new HCBS/LOC Eligibility Determination will be completed within the month annual recertification is due

More information about the transition process (January 1, 2019 – March 31, 2019) in Appendix

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HCBS and Health Home Eligibility will Expand

- **Beyond waiver** other children will be determined eligible for Aligned HCBS based on Level of Care (LOC)
  - If a child is eligible for HCBS, they are automatically also eligible for Health Home
  - Children can be eligible for Health Home (HH) but not HCBS
  - If child is no longer eligible for HCBS, they will also lose HH unless found separately HH eligible
- 3-year phase in of expansion of Level of Care (LOC) eligibility for HCBS began July 1, 2019
  - Expansion operates within limits of global spending cap
  - After LOC phase in, Level of Need (LON) expansion will begin
  - These expansions will expand enrollment in Health Home

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Resources

- **List of NYS Health Homes by County:**
  - https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_map/index.htm
- **DOH Health Home Serving Children page:**
  - https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/index.htm
- **DOH Health Home Program:**
  - hhsc@health.ny.gov
- **Subscribe to DOH Health Home listserv**
  - http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/listserv.htm

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Resources

C-YES (Independent Entity)

- Can be contacted at 1-833-333-CYES (1-833-333-2937);
- TTY: 1-888-329-1541

Resources

State Issued Guidance

- Required Steps for the Transition of 1915(c) Waiver Care Coordination to HH CM or IE:
  - https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/docs/1915c_transition_steps.pdf
- Transition to Health Home Care Management Guidance for Providers:
  - https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/docs/transition_to_hh_cm_guidance_for_providers.pdf

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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
- CFTSS: Children and Family Treatment and Support Services
- CPST: Community Psychiatric Support and Treatment
- C-YES: Child and Youth Evaluation Service
- DEAA: Data Exchange Agreement Application
- EI: Early Intervention
- eMedNY: Electronic Medicaid system of New York
- FFS: Fee For Service
- HCBS: Home and Community Based Services
- HCS: Health Commerce System
- HH: Health Home
- HHSC: Health Home Serving Children
- HHTS: Health Home Tracking System
- HIT: Health Information Technology
- IE: Independent Entity
- LDSS: Local Department of Social Services
- LGU: Local Government Unit

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Health Homes Serving Children
List of Acronyms

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

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Appendix

More Information on Health Home Eligibility Criteria and 1915c Transition to Health Home

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Serious Emotional Disturbance (SED)

- **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
- **Functional Limitations Requirements for SED Definition of Health Home** -To meet definition of SED for Health Home the child must have experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis. The functional limitations must be moderate in at least two of the following areas or severe in at least one of the following areas as determined by a licensed mental health professional:
  - Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
  - Family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
  - Social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
  - Self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
  - Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

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

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Complex Trauma – Single Qualifying Condition for Health Home

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

Definition of Complex Trauma

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

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

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

D. Wide-ranging, long-term adverse effects can include impairments in:
   I. physiological responses and related neurodevelopment,
   II. emotional responses,
   III. cognitive processes including the ability to think, learn, and concentrate,
   IV. impulse control and other self-regulating behavior,
   V. self-image,
   VI. relationships with others and
   VII. dissociation

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Health Home Appropriateness Criteria

- Individuals must meet the Chronic Condition Criteria AND be Appropriate for Health Home Care Management
- Appropriateness Criteria: Individuals meeting the Health Home eligibility criteria must be appropriate for the intensive level of care management provided by Health Homes. Assessing whether an individual is appropriate for Health Homes includes determining if the person is:
  - At risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)
  - Has inadequate social/family/housing support, or serious disruptions in family relationships;
  - Has inadequate connectivity with healthcare system;
  - Does not adhere to treatments or has difficulty managing medications;
  - Has recently been released from incarceration, placement, detention, or psychiatric hospitalization;
  - Has deficits in activities of daily living, learning or cognition issues, or
  - Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home

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Waiver Children Transitioning to Health Home

- Began January 1, 2019: 1915(c) waiver care coordination transitioned to Health Home Care Management
  - Once waiver child transitioned, started billing for Health Home not care management under waiver
  - All 1915(c) waiver children transitioned to Health Home (or Independent Entity) by March 31, 2019

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1915(c) Waiver Transition to Health Home

- All children receiving 1915(c) waiver services are eligible for Health Home
- All 1915(c) Care Managers(CM) transitioned to Health Home
  - Allows continuity of care for the children they serve

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1915(c) Waiver Transition to Health Home

- **<u>January 1 – March 31, 2019</u>**
  - Child's Care Manager (CM) described Health Home Care Management and how this interacts with HCBS
  - Child enrolled in Health Home
    - If waiver child and family did not consent to enroll in HH, referred to C-YES (Independent Entity)
      - C-YES began accepting referrals February 1, 2019
      - C-YES updated/developed HCBS Plan of Care (POC)

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1915(c) Waiver Transition to Health Home

January 1, 2019 – March 31, 2019

- Health Home required to ensure proper documentation completed
  - CANS-NY completed for the child
  - Level of Care (LOC) forms completed as was required under waivers for any transitioning child who was due for annual recertification in this time period, even if the child already transitioned to Health Home during this period
    - For any transitioning waiver child whose annual recertification was on or after April 1, 2019, based on the recertification date under the former waiver, the new HCBS/LOC Eligibility Determination will be completed within the month annual recertification is due

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1915(c) Waiver Transition to Health Home

Jan 1 – March 31, 2019 (continued)

- Waiver Plan of Care transitioned to Health Home Plan of Care and Health Home converted into comprehensive POC which crosswalked to the Children's HCBS (since waiver services transitioned to fee-for-service Children's HCBS April 1, 2019), and included any CFTSS the child was receiving
- HCBS 1915(c) waiver services continued (as appropriate) until April 1, 2019 when waiver ended. Services managed by Health Home

Post Transition

- Care manager must keep proper documentation as required for Health Home

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