

Draft Health Home Application to Serve Children

June 30, 2014



DRAFT 6.30.14 Health Home Application to Serve Children

Introduction

The New York State Department of Health and its State Agency partners (the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services, and the Office of Children and Family Services, hereafter referred to as “the State”) is seeking Applications from designated Health Homes and other Medicaid providers to provide care management to children with Medicaid who have complex physical and/or behavioral health conditions under the New York State Health Home model as tailored to serve the unique needs of children. While children are currently eligible for Health Home enrollment, it has been the intent of the State to work with existing Health Homes and other providers to tailor New York State’s Health Home model (e.g., the expansion of network and, eligibility requirements, the delivery of the core Health Home services) to better serve children and to recognize the important differences in the approach to care management and planning for children and adults. The State anticipates it will begin to actively enroll children in Health Homes on January 1, 2015.

The State is releasing this Application in draft to provide Health Homes, Medicaid providers, children’s advocates and other stakeholders the opportunity to review and comment on the requirements for tailoring the Health Home model to better serve children (e.g., eligibility criteria and, network requirements, the delivery of the six core Health Home services to serve children), as well as other policy issues under consideration. In addition, the State intends for the information contained in this draft Application, including the State’s vision for serving children in Health Homes, to assist and encourage designated Health Homes, health care providers, community based and human service providers, and care managers with expertise in serving children to now engage in collaborations and network discussions that will be the foundation for serving children in Health Homes.

Important Dates for Review and Submission of Health Home Applications to Serve Children

Activity	Anticipated Due Dates
Draft Health Home Application to Serve Children Released	June 30, 2014
Due Date to Submit Comments on Draft Health Home Application to Serve Children	July 30, 2014
Due Date to Submit Letter of Interest	July 30, 2014
Final Health Home Application to Serve Children Released	August 29, 2014
Due Date to Submit Health Home Application to Serve Children	September 30, 2014
Review and Approval of Health Home Applications to Serve Children by the State	October 1, 2014 to November 15, 2014
Begin Enrolling Children in Health Homes Phase-In based on Application Approvals and Network Readiness	January 2015
Behavioral Health Services and other Children’s Populations Transition to Managed Care http://www.health.ny.gov/health_care/medicaid/redesign/care_management_for_all.htm	January 2016

Background Information and the Application

This document is divided into two parts:

Part I: Background and Policy Information for Serving Children in Health Homes, and

Part II: Health Home Application to Serve Children

Part I includes background and policy information for providers that may be interested in submitting an Application to serve children in Health Homes. Information included in this section includes principles and provider expectations for serving children in Health Homes, proposed expanded Health Home eligibility criteria, systems of care that impact children, the status of other programmatic information including Health Home rates, and quality measures.

Part II is the Health Home Application to Serve Children. Please see Part II for instructions.

Submission of Comments on Draft Application

Providers and stakeholders may submit comments on both Part I and Part II of the Application. To facilitate the review of comments and to seek stakeholder input on this Health Home Application to Serve Children, comments must be submitted on the attached form (see Attachment A) and emailed to hhsc@health.ny.gov on or before **July 30, 2014**.

Letter of Interest

Health Homes and other providers that may be interested in submitting a Health Home Application to Serve Children are encouraged to complete and submit the attached Letter of Interest (see Attachment B) on or before **July 30, 2014**.

The submission of a Letter of Interest is optional and not binding. Failure to submit a Letter of Interest does not preclude entities from submitting an Application on September 30, 2014. To facilitate discussions between potential Applicants, network partners and care managers, the Letters of Interest will be posted to the Department of Health, Health Home website.

The Application includes the following Attachments.

Application Attachments	
Attachment A	Form for Submitting Comments to Draft Application
Attachment B	Form to Submit a Letter of Interest
Attachment C	New York State Health Home Model for Children
Attachment D	Draft List of Providers with Expertise Serving Children

Part I

Background and Policy Information for Serving Children in Health Homes

Principles for Health Homes Serving Children

Applications to serve children in Health Homes must reflect the following principles and demonstrate the ability to implement and adhere to such principles. The principles were developed by the State in consultation with stakeholders.

- Ensure care coordination networks provide comprehensive, integrated physical and behavioral health care that recognizes the unique needs of children and their families.
- Provide care coordination and planning that is family-and-youth driven, and supports a system of care that builds upon the strengths of the child and family/caregiver.
- Ensure care coordinators are trained in working with families and children with unique, complex health needs.
- Ensure continuity of care and comprehensive transitional care from service to service and across systems (education, foster care, juvenile justice, child to adult).
- Incorporate a child/family specific assent/consent process that recognizes the legal right of a child to seek specific care without parental/guardian consent.
- Track clinical and functional outcomes using standardized tools that are validated for the screening and assessing of children.
- Adopt child-specific and nationally recognized measures to monitor quality and outcomes.
- Ensure smooth transition from current care management programs to Health Home, including transition plan for care management payments.

Attachment C provides a diagram of the State’s vision for tailoring the Health Home model to serve children. As explained in more detail throughout the remaining sections of this Application, the model reflects the expansion of care management network requirements to include health care providers, community support services, and care managers with expertise in serving the unique and diverse needs of children who will be eligible for Health Home and their families.

As used throughout this Application and in the context of Health Home, “family” is defined as the primary care-giving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive or self-created unit of people residing together, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren). Persons within this unit share bonds, culture, practices and a significant relationship. Birth parents, siblings and others (relatives, grandparents, guardians, foster parents) with significant attachment to the individual living outside the home are included in the definition of family.

The State’s vision for serving children in Health Home is family and child/youth driven, where the expertise of the family/caregiver is considered primary and decisions regarding goal priorities are set by the family/caregiver. Delivering family and child/youth driven

care management requires a unique skill set on the part of Health Homes and care managers, recognizing that it is not just the identified child but the entire family/caregiver unit that is engaged in the service planning and delivery process.

Importantly, the model establishes the need to connect and partner with the multiple systems that serve children (including foster care, juvenile justice and educational systems). Effectively delivering Health Home care management services to children will require knowledge of and capability to coordinate and work simultaneously as a team with multiple systems and providers. Care managers will need to be knowledgeable of child serving systems and how to advocate/plan for service access with the child's developmental needs in mind. A high level of flexibility is needed in order to make service or plan of care changes as children grow and develop.

In addition to demonstrating an adequate network of children's providers and connectivity to the children's systems of care, applicants will be required to recognize and demonstrate the ability to tailor the way in which the Health Home core services are delivered to children and their families.

Regional Approach to Health Homes Serving Children

The goal of the State is to designate qualified Applicants to ensure access and services for all Health Home eligible children in New York State. Currently there are 49 designated Health Homes (34 unique entities) serving every county of the State. For more information about New York's designated Health Homes and the counties they serve please see

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_contacts.htm. The State envisions Health Homes serving children will operate across regions (i.e., serve areas or regions that may be broader or different than the county-based regions served by existing Health Homes). This approach recognizes that the delivery system of care for children can often be a mix of county and regional based providers and services.

Who May Submit a Health Home Application to Serve Children

Current Health Homes may apply to tailor and expand their Network to better serve children. While this is the preferred approach because it leverages the existing infrastructure of Health Homes and provides the "built-in" care management capacity to transition children to adult care management, the State will accept and review Applications from Medicaid providers that intend to build a network of predominantly children's providers to primarily serve children. As described in more detail throughout this Application, Health Home Applicants will be required to meet the infrastructure standards and qualifications and deliver the core Health Home services as described in the State Plan (a copy of the State Plan can be reviewed at http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/spa13-18.pdf) and will be required to demonstrate their ability to tailor the State Plan requirements to serve the unique needs of children.

The Application process to tailor the Health Home model to serve children is not intended to disrupt the continuity or provision of Health Home services that are currently provided

to children (i.e., there is nothing to preclude any existing Health Home from providing care management to children that meets their needs). However, Health Homes that currently serve children will be expected to comply with the service delivery and other requirements contained in the Final Application.

Application Review Process

Applications will be reviewed by a multi-agency team including staff from State and Local Agencies, including DOH, DOH AI (AIDS Institute) OCFS, OMH, OASAS and NYC DOHMH. In reviewing Applications, the review team will consider (among other things) the comprehensiveness of the Health Home's Application, including the required multi-system components of the provider network, the inclusion of care managers with the experience to serve children, and the demonstrated ability to tailor the delivery of the six core services to the needs of children, and overall access to children's Health Home services.

Health Home Eligibility Requirements

The State intends to expand the current Health Home eligibility criteria to serve those children most in need of the intensive care management provided by the Health Home program. Based upon discussions with stakeholders and to the extent possible, it is the policy goal of the State to ensure that the condition-based eligibility criteria for Health Homes would make children in foster care, medically fragile children with complex health conditions, children currently receiving intensive care management under the State's waiver programs (e.g., OCFS Bridges to Health, and OMH HCBS Waiver, DOH Care at Home) and other case management programs (e.g., OMH Children's Targeted Case Management Programs) eligible for Health Home.

The State and stakeholders have identified this subset of children as those which have experienced traumatic and adverse childhood events, have or are at risk for developing chronic physical and behavioral health conditions, and/or developmental delays as a group of children which will significantly benefit from the comprehensive care management services provided by the Health Home model. Further, it is expected that the person-centered care planning and family-based Health Home model, as tailored to serve children, will result in improved health outcomes, reduce health care costs, and the prevention of adverse health outcomes in a child's later and adult years (i.e., development of other chronic physical conditions, depression and anxiety, self-harming behaviors and other psychiatric disorders).

Current Health Home Eligibility Requirements

Under the current eligibility criteria for Health Homes, an individual must be enrolled in Medicaid and have two chronic conditions or one single qualifying condition of HIV/AIDS or serious mental illness (SMI).

Chronic conditions (from the following major categories of 3M™ Clinical Risk Groups (CRGs)) include: Alcohol and Substance Abuse, Mental Health Condition, Cardiovascular Disease (e.g., Hypertension), Metabolic Disease (e.g., Diabetes), Respiratory Disease (e.g., Asthma), and Obesity BMI >25, and other chronic conditions.

Medicaid members that do not have the single conditions of SMI or HIV/AIDS must have at least two chronic conditions to be eligible for Health Home. For additional information regarding the major categories and the associated CRG categories of chronic and behavioral and medical conditions listed below, please see the State Plan outlining Health Home eligibility requirements at:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/spa13-18.pdf

In addition, individuals meeting the Health Home eligibility criteria must be appropriate for Health Home care management, including being at risk for an adverse event (e.g., death, disability, inpatient or nursing home admission); inadequate social/family/housing support; inadequate connectivity with healthcare system; non-adherence to treatments or difficulty managing medications; recent release from incarceration or psychiatric hospitalization; deficits in activities of daily living; or learning or cognition issues.

Serious Emotional Disturbance

As noted above, serious mental illness (SMI) is currently a single qualifying condition for Health Home. Under the Affordable Care Act and the current State Plan for Health Homes, SMI is interpreted to include both children with a Serious Emotional Disturbance (SED) and adults with SMI. Thus, SED is already a single qualifying condition for Health Home and additional approvals are not required to make this a single qualifying condition for Health Home. The single qualifying condition, SED, for Health Home is proposed to be defined as follows:

Serious Emotional Disturbance (SED): A child or adolescent that has a designated mental illness diagnosis according to the most current DSM of Mental Disorders AND has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. The functional limitations must be moderate in at least 2 of the following areas or severe in at least one of the following areas:

- ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
- family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
- social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
- self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
- ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

Based upon discussions with stakeholders, and other information about medically fragile children with complex health conditions (see the February 2013 Medically Fragile Work Group Report for more information)

[http://www.health.ny.gov/health_care/medicaid/redesign/docs/2013-01-](http://www.health.ny.gov/health_care/medicaid/redesign/docs/2013-01-24_final_mfc_wrkgrp_rpt.pdf)

[24_final_mfc_wrkgrp_rpt.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/docs/2013-01-24_final_mfc_wrkgrp_rpt.pdf), the State believes that children with complex medical conditions (as defined in the Work Group Report) generally have at least **two** chronic debilitating conditions that make an individual eligible for the Health Home program under the current eligibility criteria.

Expanding Health Home Eligibility Requirements to Better Serve Children

To achieve the policy goal described above of ensuring children who are most in need of intensive care management are eligible for Health Homes and consistent with the CMS requirements for developing condition-based eligibility criteria for Health Homes, the State, in consultation with stakeholders, proposes to expand the Health Home eligibility criteria to include “trauma and at risk for another chronic condition.”

Trauma and at risk for another chronic condition

Trauma refers to exposure to a negative event or events that produce distress in a person, either physically, psychologically, or both. Complex trauma has been variously described as “exposure to multiple or prolonged traumatic [negative] events” (Department of Health and Human Services July 11, 2013 State Director letter) <http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf>, or to both the exposure to multiple events AND the long-term impacts of this exposure (National Child Traumatic Stress Network). <http://www.nctsnet.org/trauma-types/complex-trauma>

Trauma and complex trauma includes exposure to the distressing event(s) only, with the understanding that complex trauma exposure in childhood has been shown to impair brain development and the ability to learn and develop social and emotional skills during childhood, consequently increasing the risks of developing serious or chronic diseases in adolescence and adulthood. Children who have experienced trauma and who are not old enough to have experienced long-term impacts are uniquely vulnerable.

Childhood exposure to child maltreatment, including emotional abuse and neglect, exposure to violence, sexual and physical abuse are often traumatic events that continue to be distressing for children even after the maltreatment has ceased, with negative physical, behavioral, and/or psychological effects on the children. Since child maltreatment occurs in the context of the child’s relationship with a caregiver, the child’s ability to form secure attachment bonds, sense of safety and stability are disrupted. Without timely and effective intervention, a growing body of research shows that “a child’s experience of these events [simultaneous or sequential maltreatment] can create wide-ranging and lasting adverse effects on developmental functioning, and physical, social, emotional or spiritual well-being” (Department of Health and Human Services July 11, 2013 State Director letter).

Trauma is defined as exposure to a single severely distressing event, or multiple or chronic or prolonged traumatic events as a child or adolescent, which is often invasive and interpersonal in nature. Trauma includes complex trauma exposure which involves the

simultaneous or sequential occurrence of child maltreatment, including psychological maltreatment, neglect, exposure to violence and physical and sexual abuse.

A child or adolescent who has experienced trauma would be defined to be at risk for another chronic condition if they have one or more functional limitations that interferes with their ability to function in family, school, or community activities, or they have been placed outside the home. Functional limitations are defined as difficulties that substantially interfere with or limit the child in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills, or for a child who experienced trauma due to child maltreatment, a functional limitation is defined as a serious disruption in family relationships necessary for normal childhood growth and development.

The proposed expansion of the Health Home eligibility criteria to include “Trauma and at risk for another Chronic Condition” is subject to State Plan approval by the Centers for Medicare and Medicaid Services (CMS). Adding trauma to the Health Home eligibility criteria is consistent with the Department of Health and Human Services July 11, 2013 State Director letter which similarly defines trauma and references Health Homes as an option for delivering services to children and youth who have experienced complex trauma. <http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf>

In addition to amending the Health Home eligibility criteria as described above, the State is augmenting the Health Home appropriateness criteria described above to include whether a child and the family/caregiver are concurrently eligible or enrolled in Health Home.

Summary of Health Home Eligibility Criteria if Proposed Criteria Approved by CMS

If the proposed expansion to the current Health Home eligibility criteria of “trauma and at risk for another condition” is approved by CMS, the new eligibility criteria for the Health Home program would be as follows:

Eligibility Criteria

Person must be enrolled in Medicaid and have:

- ✓ At least two chronic conditions or
- ✓ One single qualifying condition of
 - HIV/AIDS or
 - Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED)
- ✓ Trauma at risk for another chronic condition
 - At risk is defined as one or more functional impairments or an out of home placement

Appropriateness Criteria

Individuals meeting the Health Home eligibility criteria must be appropriate for Health Home care management, including being:

- ✓ at risk for an adverse event (e.g., death, disability, inpatient or nursing home admission or out of home placement);

- ✓ inadequate social/family/housing support; or serious disruptions in family relationships;
- ✓ inadequate connectivity with healthcare system;
- ✓ non-adherence to treatments or difficulty managing medications;
- ✓ recent release from incarceration or psychiatric hospitalization;
- ✓ deficits in activities of daily living; learning or cognition issues; and
- ✓ concurrent eligibility or enrollment of a child and the family/caregiver in Health Home.

Chronic Conditions include:

- Alcohol and Substance Abuse
- Mental Health Condition
- Cardiovascular Disease (e.g., Hypertension)
- Metabolic Disease (e.g., Diabetes)
- Respiratory Disease (e.g., Asthma)
- Obesity BMI >25
- Other chronic Conditions

Transitioning Existing Care Management Programs for Children to Health Home

The OMH Children’s Targeted Case Management (TCM) Programs (Intensive Case Management, Supportive Case Management, and Blended Case Management) are expected to begin to convert to Health Home in January 2015. Similar to the approach used to transition Adult OMH TCM Programs to Health Home, OMH and DOH will work over the coming months to provide information to facilitate a smooth transition to Health Home.

The care coordination services under the Children’s 1915(c) HCBS Waiver programs i.e., the OCFS Bridges to Health Programs (for SED, MFC, and DD), OMH HCBS Waiver, and DOH CAH I and II, will begin to convert to Health Home on January 1, 2016. This date is coincident with the date the children’s behavioral health benefit, other children’s populations, and the proposed HCBS services described elsewhere in this Application move into Medicaid Managed Care. The State will be working to develop a detailed plan to transition and phase-in children enrolled in Waivers to Health Homes and managed care.

As discussed earlier in this Application, Children receiving services from the Office of People with Developmental Disabilities (OPWDD), including children in the Care at Home III, IV, and VI Waivers will not be prioritized at this time for enrollment into Health Home. The State will continue to work with OPWDD on the transition to “Care Management for All,” for the OPWDD population, including developing a timeframe for the enrollment of both children and adults in Health Homes.

However, Waiver agencies and care managers are strongly encouraged to bring their care management expertise to Health Homes in 2015 by working now to join the networks of the Health Homes and to provide Health Home care management services to non-waiver children that will be enrolled in Health Homes beginning January 1, 2015.

New York State Systems of Care and Programs that Impact Children

Applicants will be required to demonstrate that their Health Home has established partnerships with the various systems that involve children, including the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services, and the Office of Children and Family Services, Child Welfare, Local Departments of Social Services (LDSS), Local Government Units (LGU), Single Point of Access (SPOA), Voluntary Foster Care Agencies, juvenile justice system, pediatric HIV/AIDS providers and the education system.

Health Homes working with youth who are between the ages of 18-21 years will also need to be familiar with the various services and supports available for Transition Age Youth (TAY). The TAY population has special vocational, educational, employment and housing needs. Connecting and transitioning this population to needed adult services and resources is critical for their success and stability in the community.

New York State Child Welfare System

The New York State Child Welfare System is supervised by the Office of Children and Family Services (OCFS) and locally operated by LDSS. The Family Court Act transfers the care and custody of children to the Commissioner of the LDSS through Article 3 for Juvenile Delinquents; Article 7 Persons In Need of Supervision (PINS); Article 10 (abuse and neglect); Article 10-C (destitute child), Social Services Law (SSL) section 358-a (surrendering of a child for adoption); or SSL section 384-b (deceased parents).

LDSS are responsible for custody of children, placement decisions, medical consent, the facilitation of Medicaid eligibility, enrollment of children in Managed Care Plans, and working with Family Courts in relation to determining a permanency plan for each child.

Foster Care

Children in foster care in New York State are categorically eligible for Medicaid until age 26. (Note: effective January 1, 2014, the Affordable Care Act extended Medicaid coverage through the age of 26 for youth who were in foster care at the age of 18 and in receipt of Medicaid). New York State regulations require the LDSS and voluntary agencies arrange and coordinate the health care of children in foster care.

In the Fall of 2013, there were approximately 20,000 children in foster care (with roughly 30,000 passing through the foster care system each year). LDSS contract with 87 Voluntary Foster Care Agencies across New York State for the placement of and services for approximately 16,500 children in foster care. The remaining children in foster care (approximately 3,500) are placed in foster homes licensed by the LDSS. Children in foster care may be placed in certified foster boarding homes (i.e., with a foster family in the community) licensed by the LDSS, or in the Voluntary Agencies or placed in Congregate Care. Congregate Care is group foster care placements operated primarily by Voluntary Agencies with size limits [Group Homes: less than 12 beds; Group Residences (12-24 beds); and Institutions (i.e., Residential Treatment Centers having 25+beds)].

- ✓ The median length of stay in foster care is approximately 12 months;

- ✓ The average length of stay in foster care in New York State is 290 days, while in New York City it is 334 days;
- ✓ Children under the age of one at admission have the longest length of stay (median length of stay 629 days);
- ✓ Youth between the ages of 13 and 17 at admission have the shortest length of stay (median lengths of stay is 257 days);
- ✓ Approximately 15 percent of children exit the system and re-enter it again.

Health Home Care Management for Children in Foster Care

Health Homes that submit Applications to serve children must contract with Voluntary Foster Care Agencies to provide the care management for children in foster care. It is expected that contracts between Voluntary Foster Care Agencies and Health Homes will make it the responsibility of the Voluntary Foster Care agency to ensure that the requirements and delivery of Health Home care management by its Voluntary Foster Care Agency care manager comply with statutory and regulatory mandates for health care oversight for children in Foster Care. Please see “Working Together Health Care Services for Children in Foster Care” at:

http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp

In addition, the contract between the Voluntary Foster Care Agency Health Home care manager and the Health Home will need to establish that the Voluntary Foster Care Agency care manager will provide all the Health Home care management services required to be provided under the Health Home Program. Health Home payments made to the Voluntary Foster Care Agency for Health Home services are limited to payment for care management services and are not for other non-Health Home services the care manager may provide as an employee of the Foster Care Agency.

If individual Voluntary Foster Care Agencies choose not to provide the care management for children under their care and custody, Health Homes will contract with a downstream care management provider to provide a care manager in its network.

Health Homes and Voluntary Foster Care Agencies may also agree to contract to provide care management for Health Home children who are not placed in foster care or were formerly placed in foster care. In addition, Health Homes and the Voluntary Foster Care Agencies will be required to establish agreements to ensure transitional arrangements are in place for children who transition in and out of foster care that consider continuity of care and the best interests of the child and family.

The DOH and OCFS will work closely with Health Homes and care managers to provide information, guidance and training regarding the programmatic, regulatory and statutory requirements associated with providing Health Home care management to children placed in foster care.

Services under the Federal Individuals with Disabilities Education Act (IDEA)

Early Intervention Program for Infants and Toddlers with Disabilities

The Department of Health is the State agency responsible for the Early Intervention Program (EIP). Children are eligible for the EI Program if they are under three years old and have a disability or developmental delay. A disability means that a child has a diagnosed physical or mental condition with a high probability of resulting in developmental delay (such as Down syndrome, autism spectrum disorders, cerebral palsy, vision or hearing impairment). A developmental delay means that a child has a developmental delay in one or more of the following areas of development: physical development (growth, gross and fine motor abilities), cognitive development (learning and thinking), communication development, social-emotional development or adaptive development. To be eligible for the EIP based on developmental delay, the child's developmental delay must meet criteria established in 10 NYCRR Section 69-4.23.

The EIP offers therapeutic and support service(s) such as: family education and counseling, home visits, and parent support groups; special instruction; speech pathology and audiology; occupational therapy; physical therapy; psychological services; nursing services; nutrition services; social work services; vision services; and assistive technology devices and services.

Service coordination (targeted case management) services are a federally-required component of the EIP. All children and families participating in the EIP must have a service coordinator responsible for coordinating services across agency lines; and, serving as the single point of contact in helping parents to obtain the services and assistance they need (10 NYCRR Section 69-4.6(a)).

There are two types of service coordinators in the EIP – initial and ongoing service coordinators. Early Intervention Program regulations at 10 NYCRR section 69-4.6 contain the standards for initial and ongoing service coordinators in the EIP and 10 NYCRR section 69-4.8 contains specific information about the responsibilities of EIP initial service coordinators. The initial service coordinator is assigned to the family by the municipal agency responsible for administering the EIP upon referral to the EIP, and their responsibilities include explaining the EIP to the family and facilitating the evaluation process to determine the child's eligibility for the EIP, and, if eligible, facilitating the development of an Individualized Family Service Program (IFSP) that includes outcomes for the child and family and reflects the family's priorities, concerns and resources.

The ongoing service coordinator is selected by the family and may or may not be the same agency or individual as the initial service coordinator. The ongoing service coordinator is responsible for implementing the child's IFSP and all service coordination activities articulated in 10 NYCRR Section 69-4.6.

A child must exit the EIP and transition to other services by his or her third birthday, unless the child is eligible for preschool special education services under section 4410 of the Education Law. Children found eligible for services under section 4410 of the

Education Law may remain in the EIP up to age 3 years 8 months, depending on the child's third birthday. The service coordinator is responsible for facilitating the child's transition from the EIP to preschool special education and/or other early childhood services.

It is anticipated that a subset of infants and toddlers eligible for the EIP also will be eligible for Health Home. The Health Home care management and EI service coordination roles and responsibilities for children eligible for both Health Home and EI will need to be determined. Options for defining Health Home and EI roles need to ensure that roles are clearly defined, duplicate Medicaid payments are not made for the same service, and there is no confusion (either from the Health Home or EI care provider, the family, or education system) about care management responsibilities. The State is considering an approach where the initial service coordination role would be performed by the EI service coordinator and the ongoing service coordination function would be performed by the Health Home care manager. This approach would facilitate initial enrollment in the EI program and ensure that role resides with coordinators that currently have a full breadth and understanding of the EI program, while also allowing the Health Home care manager to fully integrate ongoing EI services into the overall care management plan (i.e., a plan that includes more than EI services) for the child.

Service coordination is an integral component of the EIP. Health Home care managers serving children enrolled in the Early Intervention Program will be required to adhere to all federal and state law and regulations pertaining to the delivery of EI service coordination.

The State Agency Partners will work closely with the DOH EI Team to provide information, guidance and training to the EI service coordinators and Health Home care managers regarding the programmatic requirements of the Health Home program and the EI program, the roles of the Health Home care manager and the EI initial service coordinator, and procedures regarding the transition between roles. It is anticipated that there will be paths for existing EI service coordinators to become Health Home care managers, and for Health Home care managers to obtain necessary DOH approval to provide ongoing EI service coordination.

General Education and Special Education

As discussed above, children of preschool age (three to five years) with special needs receive special education services through an Individualized Education Program (IEP). Children between the ages of five and 21 years participate in the education system, either in general education or with services and supports designed to meet special needs, for example, through a Section 504 plan or through an Individualized Education Program (IEP).

Medicaid eligible children participating in general education or special education who meet the eligibility requirements of the Health Home program, and their families, can

benefit from the comprehensive care management services available through the Health Home program.

To operationalize this, education and training will be necessary for care managers - to understand the special education process - and for State Education Department (SED) staff (special education policy staff, regional associates, and others) and Directors of Special Education at the school district levels to understand the care management services offered under the Health Home Program.

Specifically, Health Home Program care managers would need to become familiar with the special education process, including the role and responsibility of the multidisciplinary team that accepts referrals to the special education system, the Committee on Preschool Education in the case of preschoolers or the Committee on Special Education for children ages 5-21 years. In New York City, there may also be interface with the School Based Support Team.

In addition, the Health Home care manager would need an understanding of the special education system process for evaluation of students with special needs and development of IEPs that include recommendations for special education programs and services required by a student with a disability to succeed in the school environment. Health Home care coordinators would need to be familiar with relevant federal and State educational requirements for serving students with disabilities and the types of placements that may be available for such students, including recognizing when students require a referral for consideration of a modification in their educational program.

Finally, under the Medicaid State Plan, Medicaid reimbursement is available for certain services provided to Medicaid eligible preschool and school age children receiving IEP services. This program is known as the Preschool/School Supportive Health Services Program (collectively, "SSHSP"). It is possible that some children who meet the Health Home eligibility criteria may also be receiving SSHSP services. Medicaid-reimbursable services under New York's SSHSP, for children with disabilities who are eligible for Medicaid, include:

- Physical therapy services
- Occupational therapy services
- Speech therapy services
- Psychological evaluations
- Psychological counseling
- Skilled nursing services
- Medical evaluations
- Medical specialist evaluations
- Audiological evaluations
- Special transportation services

The State will work with SED to provide training for SED staff and Health Homes.

The State will also be working with EI and SSHP to discuss ways in which those programs can help identify children eligible for Health Home and facilitate the Health Home referral process.

OASAS Treatment System

The OASAS (Alcohol/Substance Abuse) Treatment system serves over 200,000 people a year with 29,000 of those being under the age of 21. These youth and young adults are served in a variety of settings: outpatient, inpatient rehabilitation, short and long term residential, as well as detoxification programs. Many of them have co-occurring mental health and/or physical health issues. Additionally, many have histories of physical/emotional trauma, family conflict or dysfunction, educational issues and involvement with the juvenile/criminal justice systems.

OASAS services focus on discontinuing substance/alcohol use, stabilization of crisis, adopting healthy lifestyles and choices, and successful integration with family and community. Participation in OASAS treatment programs is, by regulation, voluntary.

Youth 12 – 21 years of age can access the following types of services:

OASAS Residential/Inpatient Services

Chemical Dependence Residential Rehabilitation Services for Youth (RRSY)

The RRSY program is designed specifically to serve chemically dependent youth and typically provide stabilization, rehabilitation and re-integration services to youth the age of 21. RRSY services are medically driven and Medicaid funded.

Chemical Dependence Residential Services

Chemical dependence residential service provides an array of services for persons suffering from chemical dependence. This service is currently not a Medicaid funded service. However, OASAS is currently in the process of submitting a State Plan Amendment that will make the clinical portions of these services eligible for Medicaid.

Chemical Dependence Inpatient Services

These are traditional medically driven inpatient programs. There are a limited number of youth over the age of 16 who are treated in these programs each year.

OASAS Outpatient Services

Chemical Dependence Outpatient and Opioid Treatment Programs

Chemical Dependence Outpatient programs treat individuals with substance use disorders and /or co-occurring mental health disorders and their family member and/or significant others. There are no specific standards for youth programs, however, there are a number of programs that use evidenced based practices for youth and many only serve youth.

Other OASAS Services

Chemical Dependence Withdrawal and Stabilization Services

Chemical dependence withdrawal and stabilization services are designed to provide a range of service options, that are the most effective and appropriate level of care, to persons who are intoxicated or incapacitated by their use of alcohol and/or substance. The primary purpose of any chemical dependence withdrawal and stabilization service is the management and treatment of alcohol and/or substance withdrawal, as well as disorders associated with alcohol and/or substance use, resulting in a referral to continued care. Certified providers of chemical dependence withdrawal and stabilization services can be authorized to provide one or more of the following: medically managed withdrawal and stabilization services; medically supervised inpatient withdrawal and stabilization services; medically supervised outpatient withdrawal and stabilization services; and/or medically monitored withdrawal and stabilization services. Currently, there are a limited number of these programs that serve youth.

HIV/AIDS Services

Health Homes and Care Management providers working with children and adolescents who have been exposed to or infected with HIV need to be aware of treatment guidelines (<http://www.hivguidelines.org>) in the care and treatment of these youth. Keeping them engaged in care and treatment is essential to their continued health and ability to prevent the spread of infection. In addition, the transition to adult HIV services is critical to the young adult's ongoing stability.

Juvenile Justice System

Children eligible for Health Home may also be or may have been engaged with the juvenile justice system. Youth in New York State come into contact with the juvenile justice system in many ways. Some may be arrested or issued appearance tickets for breaking the law or some for the commission of "status" offenses (activities such as breaking curfew, drinking, driving under the legally permissible age). Youth who are not controllable by their parents may access probation services at the request of their parents or the police as Persons in Need of Supervision (PINS).

Youth who are arrested for criminal offenses may be released, or detained in a local juvenile detention center. The county juvenile probation department conducts assessments on both PINS and arrested youth, and some will be diverted from further processing. Arrested youth aged 15 or younger and PINS youth less than age 18 may have a petition filed with family court. Older youth or younger youth who committed very serious offenses may be processed in adult criminal court.

Youth who are adjudicated juvenile delinquents may be placed on probation, assigned to an alternative to probation, placed with OCFS or LDSS. Placed youth may be released into the community or may transfer to an adult prison if convicted of a serious crime. Some youth

have various mental health or substance abuse diagnoses in addition to their criminal or PINS behaviors.

The State Agency Partners are exploring mechanisms to establish connectivity between Health Homes and the juvenile justice population. Health Home care managers will need to establish relationships with LDSS and probation.

Home and Community Based Services (HCBS) and State Plan Services

The Children's Medicaid Redesign Team (MRT) Behavioral Health Subcommittee has made recommendations that will make a wider array of services available to children eligible for Medicaid.

The MRT Subcommittee has recommended the Medicaid benefits authorized in the State Plan (and available to all children/youth enrolled in Medicaid) be expanded to include Mobile Crisis Intervention, Community Psychiatric Supports and Treatment (CPST), Other Licensed Practitioner, Family Peer Support Services, Youth Peer Advocacy and Training, and Psychosocial Rehabilitation. In addition, the Subcommittee has recommended the following list of Home and Community Based Services be made available to children who meet Level of Need criteria and are not eligible for medical institutional care (to be determined) and children who qualify for institutional Level of Care or are at risk of medical institutional placement.

Recommended HCBS Services (as of the release of this draft Application): Skill Building, Family/ Caregiver Supports and Services, Crisis Respite, Planned Respite, Prevocational Services, Supported Employment, Community Advocacy and Support, Non-Medical Transportation, Day Habilitation, Adaptive and Assistive Equipment, Accessibility Modifications, and Care Coordination (for children not enrolled in Health Home). The intensity of service to be provided has not yet been determined. However, it is anticipated the intensity of services to be provided will be congruent with functional criteria and that most of the children eligible for Health Home will be eligible for such services.

The State plans to submit to CMS the 1115 Behavioral Health Children's Amendment by December 31, 2014 which will include the new State Plan services (for which all Medicaid children would be eligible) and the eligibility criteria for the HCBS services listed above. Subject to CMS approval, it is anticipated that these services will be available as part of the transition to Managed Care on January 1, 2016.

As these services will be helpful in implementing a comprehensive care management plan for children in Health Homes, Health Homes will be expected to become familiar with HCBS services and providers, include HCBS providers in their network, and include the services in the development of care plans where appropriate.

Functional Assessments

Consistent with input received from stakeholders, the State is considering requiring children enrolled in Health Homes to be assessed using the Child and Adolescent Needs and Strengths Assessment of New York (CANS-NY). The CANS is a decision support tool with standardized language that will assist the care manager in developing a care plan and appropriateness for Health Home. The use of the CANS does not preclude the use of other assessment or evaluative tools by care managers to assist them in developing care plans or determining Health Home eligibility.

It is anticipated that New York will work collaboratively with the author of the CANS-NY to revise the tool to assist with eligibility determination for new HCBS services, needs and strengths identification that incorporates all domains (and child serving systems), that will guide the plan of care development and acuity level (see discussion below regarding Health Home Payments).

High Fidelity Wraparound Care Management

The State is considering requiring Health Homes to employ the High Fidelity Wraparound (HFW) approach to a small subset (e.g., one percent) of youth enrolled in Health Homes that could benefit from the specialized and intensive care management approach of HFW. HFW is consistent with the delivery of the core Health Home services described in this Application, but it requires a low care manager to child ratio (1:10); frequent and intensive engagement between the care manager and child/family; and certification, training and monitoring to ensure fidelity to the model. HFW Care coordination also uses:

- A care manager who facilitates the formation of a child and family team that develops, implements and monitors one integrated plan of care across child-serving systems. The care planning process, which is driven by the child and family results in a plan of care accounts for all of the child's health, behavioral health educational/vocational, child welfare and justice-related goals, in addition to goals that address the social services needs of the family health.
- A Family Support Partner who helps the parent(s)/caregiver(s) navigate the various service systems and ensure that their perspective is represented throughout the process, consistent with the parents/caregivers' preferences and desires. The Family Support Partner is treated as an inherent part of the HFW care coordination process, rather than as a service named in the plan of care.

The State is seeking stakeholder input on the development of detailed criteria for determining eligibility for HFW-HH (Health Home) care coordination, but in general is considering targeting children with complex behavioral health needs that are also involved in multiple child-serving systems (e.g., child welfare, juvenile justice, substance abuse treatment facilities, inpatient psychiatric care).

For more information on HFW please see <http://www.nwi.pdx.edu>.

Health Home Payments and Transitional Provisions

The State Agency partners are working to develop proposed Health Home care management rates for children. The current framework under which the proposed rates are being developed includes the following considerations:

- Similar to the approach used to transition Adult Targeted Case Management Programs to Health Home, legacy care management payments will be developed for OMH Children's Targeted Case Management Programs and those rates will remain in effect for two years. In addition, legacy care management rates for Waiver providers will be developed for the programs that will begin to transition to Health Home in January 2016.
- A tiered rate structured (e.g., HFW, High, Medium, Low) is being developed that is based upon the acuity/functional status of the child.
 - Consistent with considering requiring the use of the CANS-NY assessment tool, the State is considering use of the CANS (as revised as described above) to develop an algorithm to determine acuity and assignment to a rate tier.
 - Development of the tiered rates will consider case load size (lower case loads tied to higher rates, higher caseloads tied to lower rates).
 - Such rates would be effective during 2015 and would be the mandated government rates in effect under the first two years of Managed Care (i.e., 2016 and 2017, with 2016 being the effective date for moving the behavioral health benefit and HCBS services into Managed Care).
- A flat rate for "outreach" activities to children and their families will be considered.

The State anticipates final recommendations for Health Home rates for children will be subject to State Plan approval by CMS.

Data Collection and Tracking Requirements

Health Homes and their network partners serving children will be expected to have the capability to submit files documenting enrollment status through the existing Health Home Member Tracking System (HHMTS). Specifications for the HHMTS may be found at http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_information.htm.

In addition, Health Homes and their network partners serving children will be required to submit, on a quarterly basis, process data on the delivery of Health Home care management services through the Health Home - Care Management Assessment and Tracking Systems (HH-CMART).

Note that both the HHMTS and the HH-CMART will begin transitioning to a comprehensive web-based portal, known as the Medicaid Analytics Performance Portal (MAPP) that is now under development. Health Homes and care managers will be provided with training and technical assistance to transition member tracking and reporting to the MAPP.

Currently, Health Homes are required to complete and submit scores on a functional assessment known as the FACT-GP as well as a brief functional Health Home questionnaire. These tools have not been validated for children. As discussed above, the State Agency Partners are considering the use of the CANS-NY which, if employed, would be conducted in lieu of the FACT-GP and functional Health Home questionnaire when serving children.

Quality Measures

A critical component to providing effective care management to children will be the ability of Health Homes, care managers, Plans, systems of care, families, providers and the State to effectively evaluate and monitor the quality of care and health outcomes of children.

In addition to the quality measures included in the current State Plan and Health Home Core Set of Quality Measures required by CMS which can be applied to or measured for children, the State is considering using the following list of quality measures to track performance and help Health Homes, care managers and Plans manage to quality outcomes. Please see the link below to review the CMS Health Home Core Set of Quality Measures:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/smd-13-001-hh-qm.pdf

Please see the link below to review the State Plan quality measures:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/spa13-18.pdf.

Some or all of the list could be added to the list of quality measures included in the State Plan, but the intent would be to use all the quality measures below to help evaluate performance. The list of measures provided in the table below are measures for which data is available and thus no additional data collection efforts are necessary.

The State anticipates that the list of quality measures will develop over time, and new measures could be added. For example, the proposed measures for the next HEDIS have measures for children that involve use of antipsychotic medicines and monitoring for children on antipsychotics that would be useful in measuring outcomes.

NEW Quality Measures	
Measure Name	Measure Source/Other Programs that Use Measure
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents	QARR, CMS Pediatric Recommended Core Measures, CHIPRA
Appropriate Treatment for Children with Upper Respiratory Infection	QARR, CMS Pediatric Recommended Core Measures

NEW Quality Measures	
Measure Name	Measure Source/Other Programs that Use Measure
Appropriate Treatment for Children with Pharyngitis	QARR, CMS Pediatric Recommended Core Measures, CHIPRA
Childhood Immunization Status	QARR, CMS Pediatric Recommended Core Measures
Immunization for Adolescents (Combination 1)	QARR
Annual Dental Visit	QARR
Well-Child Visits in the First 15 Months of Life	QARR
Well-Child Visits in the 3rd, 4th, 5th & 6th Year	QARR
Adolescent Well-Care Visits and Preventative Care	QARR
Lead Testing	QARR
Follow Up After Hospitalization for Psychiatric Reasons	QARR
Medication Management for Asthma 75% (ages 5 - 18)	QARR
Asthma Medication Ratio (ages 5 - 18)	QARR
Follow Up Care for children Prescribed ADHD Medication: Initiation and Continuation	QARR
Cardiometabolic Monitoring for Youth Using Atypical Antipsychotics	PSYCKES

Health Home Assignment Lists for Children

The State is considering procedures for identifying children and making initial assignments to Health Homes. Methods for identifying potentially eligible children include using Medicaid claims data and information obtained from other sources. Methods for determining Health Home assignment include connectivity to the Health Home and its network of providers (e.g., primary care, specialty providers, and foster care agencies). Children may also be referred for Health Home services from other sources (e.g., the educational system, Early Intervention, primary care providers, Plans, LDSS and SPOA).

Phasing in the Enrollment of Children into Health Homes

As indicated earlier in this Application, the State anticipates it will begin enrolling children into Health Home beginning January 1, 2015. Some stakeholders have suggested the State consider phasing in enrollment. Considerations for determining approaches to phasing in children in Health Homes include the “readiness” of designated Health Homes to begin serving children, and identifying regions or populations under which to implement a phase-in approach. As indicated earlier in Part I of this Application, children enrolled in the OCFS Bridges to Health Programs (for SED, MFC, and DD) Waivers, OMH HCBS Waiver, and

DOH CAH I and II, will begin to convert to Health Home on January 1, 2016. The State will be working to develop a detailed plan to transition and phase-in children enrolled in Waivers to Health Homes and managed care

Consent Procedures

Currently, the Health Home program uses a uniform Health Home Patient Information Sharing Consent form for Medicaid members to provide their consent to join a Health Home and to authorize the Health Home and the partners listed on the form to receive and exchange all of the Medicaid member's health information. (The current form may be viewed at <http://www.health.ny.gov/forms/doh-5055.pdf>).

The State will be working to develop a Health Home Patient Information Sharing Consent form for children. The State's goal, to the extent possible, is to develop a uniform consent form. The form will recognize the rights of minors to consent to certain types of health care without the permission of their parent/guardian and to whether parents/guardians or others can access their health information.

To authorize the Department to share certain information (e.g., assignment lists) with lead Health Homes prior to member consent, newly Designated Health Homes will be required to complete and submit a Data Exchange and Application Agreement (DEAA) with the Department. In addition, Health Home network partners that may receive member lists prior to member(s) consenting to Health Home services will also be required to complete a DEAA subcontractor packet with the designated Health Home.

Part II:

Health Home Application to Serve Children

Application Information

Application ID: Submitted Date:

Organization Name: NPI#:

Corporation Name (optional):

Correspondence Address:

City: State: NY Zip Code:

Telephone Number: County:

Type of Organization:

Licensure/Certification Number:

Pay-To-Address:

City: State: NY Zip Code:

Organization Contact Person:

Title: Telephone Number:

Fax Number: E-mail:

Proposed Health Home Service Region:

Who May Submit a Health Home for Children Application

Current Health Homes may apply to expand their network to serve children. While this is the preferred approach because it leverages the existing infrastructure of Health Homes and provides the “built-in” care management capacity to transition children to adult care management, the State will accept and review Applications from Medicaid providers that intend to build a network of predominantly children’s providers to primarily serve children. As described in more detail below, Applicants will be required to meet all the qualifications of the State Plan Amendment authorizing Health Homes, including the Health Information Technology standards.

Application Review Process

Applications will be reviewed by a multi-agency team including staff from State and Local Agencies, including DOH, DOH AI (AIDS Institute) OCFs, OMH, OASAS and NYC DOHMH. In reviewing Applications, the review team will consider (among other things) the comprehensiveness of the Health Home’s Application, including the required multi-system components of the provider network, the inclusion of care managers with the experience to serve children, and the demonstrated ability to tailor the delivery of the six core services to the needs of children, and overall access to children’s Health Home services.

General Directions

Please note that responses to all required questions must be thorough and complete. Responses must be fully contained within this application form, except where specifically otherwise indicated. In completing your Application, please consider the information and requirements provided in Part I of this Application.

For purposes of this Application and in the context of Health Home, “family” is defined as the primary care-giving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive or self-created unit of people residing together, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren). Persons within this unit share bonds, culture, practices and a significant relationship. Birth parents, siblings and others (relatives, grandparents, guardians, foster parents) with significant attachment to the individual living outside the home are included in the definition of family.

Section A Governance Structure

Please check the appropriate box:

- You are a Designated Health Home (i.e., you are now operating a Lead Health Home designated by the State) and your application to serve children does not include a change in your current governance structure.
- You are a Designated Health Home and your application includes an anticipated change to your governance structure to better serve children. Please describe in detail the nature of the change in governance and how it will improve and enhance the ability of your Health Home to serve children.
- You are an organization(s) seeking a new Health Home Designation. Please describe the governance structure of your proposed Health Home to Serve Children. Please describe in detail if your Health Home network of providers will be designed to primarily serve children or to serve children and adults, or the extent to which you plan to serve adults.

General Qualifications

As described in more detail below, Health Home Applicants will be required to meet the infrastructure standards and qualifications and deliver the core Health Home services described in the State Plan (a copy of the State Plan can be reviewed at http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/spa13-18.pdf). In addition, and as described in more detail below, Applicants will be required to demonstrate their ability to tailor the State Plan requirements to serve the unique needs of children. Other general qualifications include the following:

- 1) Health Home providers/plans must be enrolled (or be eligible for enrollment) in the NYS Medicaid program and agree to comply with all Medicaid program requirements.

- 2) Health Home providers can either directly provide, and/or subcontract for the provision of, Health Home care management services. In the case of children in foster care, Voluntary Foster Care Agencies will provide the care management (see the “Health Home Care Management for Children in Foster Care” section of this Application for additional information). The Health Home provider remains responsible for all Health Home program requirements, including services performed by the subcontractor.
- 3) Care coordination and integration of health care services will be provided to all Health Home enrollees by an interdisciplinary team of providers, where each individual’s care is under the direction of a dedicated care manager who is accountable for assuring access to medical and behavioral health care services and community social supports as defined in the enrollee care plan.
- 4) Hospitals that are part of a Health Home network must have procedures in place for referring any eligible individual with chronic conditions who seeks or needs treatment in a hospital emergency department to a DOH designated Health Home.

Section B

General Experience

- Provide a general description of the experience your Health Home (including your lead partners) or your organization (if you are not currently a designated Health Home) has in providing integrated services to children.
- Identify the health care professionals and other members of your current interdisciplinary Health Home team that will provide care management and coordination of integrated services to children in your **current** Health Home network (as of the date of the release the Application) or your organization (if you are not currently a designated Health Home) with expertise in serving children. Describe the nature of their expertise in serving children.
- Describe the nature of any current relationships your Health Home or your organization has established with the education, foster care or juvenile justice systems.

Section C

Region of Service and Capacity

Please describe the region/area of service for which your Health Home will serve children. Please provide information regarding the anticipated capacity of your Health Home to serve children (i.e., How many children can your proposed structure initially serve? How do you plan to grow capacity over time?).

Section D

Network Requirements

As part of the requirements of this Application, currently designated Health Homes must affirm that the current network of providers as filed with the Department of Health is accurate and complete as of the due date of this Application. Please note it is not necessary

that the network of providers on file include the additional providers that are identified by you in this Application to serve children.

It is expected that Applicants which are currently designated Health Homes will expand their network of providers, as described in more detail below, to ensure access to care managers and services, including an interdisciplinary team, that can meet the complex needs of children.

Applicants that are not currently designated Health Homes will need to ensure their proposed Health Home networks have the breadth of providers required to serve children and/or adults as indicated by the Applicant in Section B and D of this Application. In addition to the network requirements described below for serving children, the proposed networks of Applicants who are not currently designated Health Homes should include managed care plans, medical providers (e.g., hospitals, substance use disorder providers, primary care practitioners, clinics, ambulatory care, preventive and wellness care, patient centered medical homes, pharmacies/medication management services, and Federally Qualified Health Centers, specialists, and home health services); behavioral health care providers (e.g. acute and outpatient mental health, substance use disorder treatment services and rehabilitation providers, etc.); and community based organizations and social services providers (e.g., public assistance support services, housing services); and former targeted case management entities (OMH, Managed Addiction Treatment Services (MATS), HIV/AIDS COBRA TCMs).

All Applicants must provide a complete list of its Health Home provider network. The Final Application will include a form for submitting provider network information. The form will require the following network partner information: provider or organization name, NPI, service address, type of licensure (Article 16, 28, 31, 32), special certifications of all providers in the network, and the date the provider began their affiliation with the Health Home. As noted above, currently designated Health Homes will not be required to restate their existing networks in the Application, provided they affirm the network partner list they have submitted to the Department of Health is both accurate and current.

The following is a list of types of service providers, developed in consultation with stakeholders, Applicants should consider in developing a comprehensive network to serve the unique and complex needs of children eligible for Health Homes. The breadth and comprehensiveness of the network (along with the proposed region of service and access to providers) will be a focus of the evaluation of each Application.

Care Managers with Expertise in Serving Children

- Persons and entities that have experience in providing care management for children, including Voluntary Foster Care Agencies, Bridges to Health (B2H), OMH Targeted Case Management providers (Intensive Case Management, Supportive Case Management, Blended Case Management), OMH HCBS Waiver agencies and Care at Home Waiver Agencies.

- Voluntary Foster Care Agencies. Health Homes that submit Applications to serve children must contract with Voluntary Foster Care Agencies to provide the care management for children in foster care. It is expected that contracts between Voluntary Foster Care Agencies and Health Homes will make it the responsibility of the Voluntary Foster Care Agency to ensure that the requirements and delivery of Health Home care management by its Voluntary Foster Care Agency care manager comply with statutory and regulatory mandates for health care oversight for children in foster care. Please see “Working Together Health Care Services for Children in Foster Care” at: http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp

In addition, the contract between the Voluntary Foster Care Agency Health Home care manager and the Health Home will need to establish that the Voluntary Foster Care Agency care manager will provide all the Health Home care management services required to be provided under the Health Home Program. Health Home payments made to the Voluntary Foster Care Agency care manager for Health Home services are limited to payment for those services and are not for other non-Health Home services the care manager may provide as an employee of the Foster Care Agency.

If individual Voluntary Foster Care Agencies choose not to provide the care management for children under their care and custody, Health Homes will contract with a downstream care management provider to provide a care manager in its network.

Health Homes and Voluntary Foster Care Agencies may also agree to contract to provide care management for Health Home children who are not placed in foster care or were formerly placed in foster care. In addition, Health Homes and the Voluntary Foster Care Agencies will be required to establish agreements to ensure transitional arrangements are in place for children that transition in and out of foster care that consider continuity of care and the best interests of the child and family.

Providers with Expertise in Serving Children

- Pediatric Health Care and Specialty Providers, including:
 - ✓ Primary Care
 - ✓ Developmental Health
 - ✓ Behavioral Health
 - ✓ Substance Use Disorder Services
 - ✓ HIV/AIDS
 - ✓ Dental and orthodontics
- Children’s Hospitals
- Local Departments of Social Services (LDSS)
- Local Departments of Health and/or Mental Hygiene
- Local Governmental Units (LGUs)
- School-based Health Centers and School-based Mental Health Clinics
- Waiver Service providers (as services become authorized under the 1115 Waiver)

- Youth and Family Peer Supports
- OMH designated/certified/licensed programs (Children’s Community Residences, Children’s Day Treatment, Residential Treatment Facilities, Article 31 Clinics)
- OASAS certified programs(Intensive Residential Services, Chemical Dependence Inpatient Rehabilitation, Residential Rehabilitation Services for Youth, Article 32 Clinics)
- Housing providers with expertise in providing housing for families

Provider List

To assist Applicants, the State has prepared the attached draft list of providers (see Attachment D) with expertise in providing care management and other services to children. Please note the State worked collectively across agencies to attempt to prepare a comprehensive list of providers. However, if we have inadvertently missed a provider that should be added to the list please inform the state via email at hhsc@health.ny.gov.

Connectivity with Systems of Care that Impact Children

As part of building and expanding a Health Homes network to serve children, Health Homes must demonstrate connectivity to the systems of care that serve children. In addition to Voluntary Foster Care Agencies and LDSS, Local Government Units, and County Single Point of Access (SPOA), Health Homes need to establish regional relationships with the juvenile justice system, Early Intervention and the educational system (i.e., Preschool Special Education and Committee on Special Education).

Please describe how your Health Home will establish and maintain connectivity with these systems of care.

Section E

Providing and Tailoring the Provision of Core Health Home Requirements to Meet the Needs of Children

The State Plan (please see http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/spa13-18.pdf) and Section 1945 (h) (4) of the Social Security Act defines Health Home services as “comprehensive and timely, high quality services” and includes the following Health Home services that must be provided by designated Health Home providers:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support, which includes authorized representatives;
- Referral to community and social support services, if relevant; and
- The use of HIT to link services, as feasible and appropriate

The current State Plan requires Health Homes to meet the following core Health Home requirements described in the shaded boxes that follow.

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/smd-13-001-hh-qm.pdf

As indicated below, please describe how the provision of each of the following Core Health Home requirements will be delivered and tailored to meet the complex needs of children eligible for Health Homes. Your responses should clearly demonstrate the level of competency and skill that will be provided in delivering the core requirements.

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

To the extent the High Fidelity Wraparound approach is employed for a defined subset of Health Home eligible children (see Part I of this Application for more information), Health Homes care managers would also be required to:

- Receive training and certification in High Fidelity Wraparound
- Convene a multidisciplinary Child and Family Team, which includes a family support partner consisting of both service providers and natural supports, to develop and implement an individualized, strength-based plan of care
- Ensure there is one care plan per child/family which integrates all of the child's health, behavioral health, educational/vocational, child welfare and justice-related

goals, plus goals to address the social services needs of the family. It should also include strategies to help the family to identify and increasingly draw upon natural supports over time.

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

- Completing a comprehensive assessment, inclusive of medical, behavioral, rehabilitative and long term care and social service needs.
 - Completing and revising, as needed, the child's person centered plan of care with the child to identify the child's needs and goals, and include family members and other social supports as appropriate.
 - Consulting with multidisciplinary team, primary care physician, and specialists on the child's needs and goals.
 - Consulting with primary care physician and/or specialists involved in the treatment plan.
 - Conducting clinic outreach and engagement activities to assess on-going and emerging needs and to promote continuity of care and improved health outcomes.
 - Preparing crisis intervention plans.
- a) Describe how your Health Home plans to deliver and tailor the services and activities listed above to serve children.
 - b) Provide a description of the proposed care manager position for children, including professional discipline/qualifications, and relevant education, training and experience.
 - c) Describe how the approach to care management will be family-and-youth driven, and how it will support a system of care that builds upon the strengths of the child and family.
 - d) Describe your approach to collaborating with a multi-disciplinary team to develop a plan of care and how the parent, guardian, and family will be involved in the development of the care plan.
 - e) Describe your approach and procedures for ensuring the LDSS, (which has custody of the child while in foster care) and the Voluntary Foster Care Agency will provide care management for children in foster care and how that care manager will interact with the Health Home.
 - f) Describe how the care manager will interact with other systems of care for children (education, juvenile justice) and how they will be incorporated in the multi-disciplinary team.

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.

To the extent the High Fidelity Wraparound approach is employed for a defined subset of Health Home eligible children (see Part I of this Application for more information), Health Homes care managers would also be required to facilitate development of a child and family team and individualized plan of care; monitor and update the plan of care in conjunction with the family team, maintain a 1:10 caseload ratio, and meet specific standards for meeting with and contact with the child/family.

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

- Coordinate with service providers and health plans to secure necessary care, share crisis intervention and emergency information.
 - Coordinate with treating clinicians to assure that services are provided and to assure changes in treatment or medical conditions are addressed.
 - Conduct case reviews with the child/family and interdisciplinary team to monitor/evaluate client status/service needs.
 - Crisis intervention – revise care plan/goals as required.
 - Advocate for services and assist with scheduling of services.
 - Monitor, support, and accompany the client to scheduled medical appointments.
 - Provide conflict free case management.
- a) Describe how your Health Home plans to deliver and tailor the services and activities listed above to serve children.
- b) Describe any approaches you would take to promote the health of the child and the family as a unit, including how your Health Home would approach the delivery and coordination of care management to a child and a parent who may either be concurrently enrolled or eligible for Health Home.
- c) Describe your processes for ensuring there is 24 hour access to the Care Manager, including procedures for crisis management/de-escalation.

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.

Examples of activities that constitute providing Comprehensive Transitional Care include:

- Follow up with hospitals/ER upon notification of child’s admission and/or discharge to/from an ER, hospital/residential/rehabilitative setting.

- Facilitate discharge planning and follow up with hospitals/ER upon notification of a child's admission and/or discharge to/from ER/ hospital/residential/rehabilitative setting.
 - Link child/family with community supports to ensure that needed services are provided.
 - Follow up post discharge with child and family to ensure needed services are provided.
 - Notify and consult with treating clinicians, schedule follow up appointments, and assist with medication reconciliation.
- a) Describe how your Health Home plans to deliver and tailor the services and activities listed above to serve children.
 - b) Provide your approach and procedures for ensuring continuity of care for children that are entering and leaving or transitioning from one system of care to another, including education, foster care, and juvenile justice.
 - c) Describe your approach and procedures for incorporating comprehensive discharge planning (e.g., from the hospital or other treatment facilities) in the plan of care, including the approach to involving the family in the discharge and plan of care process.
 - d) Describe your approach to tailoring and transitioning care management for children that become adults and remain eligible for Health Home.
 - e) In instances where it is necessary and in the best interests of the child, describe your approach and procedures for transitioning a child in foster care, or any other child, from one Health Home care manager to another.

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.

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

- Develop, review, revise child’s plan of care with child and family to ensure plan reflects child/family’s preferences, education, and support for self-management.
 - Consult with child/family/caretaker on advanced directives and educate on client rights and health care issues as needed.
 - Meet with child and family, inviting any other providers to facilitate needed interpretation services.
 - Refer child and family to peer supports, support groups, social services, entitlement programs as needed.
- a) Describe how your Health Home plans to tailor the services and activities listed above to serve children. Please keep in mind the definition of family as defined in Part II, General Directions.
 - b) Describe your approach to ensuring the plan of care is built around the strengths of the child and family.
 - c) Describe you approach to encouraging involvement of the child and family in identifying the needs of both the child and the family.

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.

To the extent the High Fidelity Wraparound approach is employed for a defined subset of Health Home eligible children (see Part I of this Application for more information), Health Homes care managers would be required to assist the family to identify and build upon natural supports in their communities.

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

- Identify resources and link child/family to community supports as needed
 - Collaborate and coordinate with community based providers to support effective utilization of services based on child/family need
- a) Describe how your Health Home plans to deliver and tailor the services and activities listed above to serve children.
 - b) Describe how your Health Home will identify and provide linkages to community-based resources for children and their families, including peer supports.

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

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

Initial Standards

6a. Health Home provider has structured information systems, policies, procedures and practices to create, document, execute, and update a plan of care for every patient.

6b. Health Home provider has a systematic process to follow-up on tests, treatments, services and, and referrals which is incorporated into the patient's plan of care.

6c. Health Home provider has a health record system which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers and which allows for population management and identification of gaps in care including preventive services.

6d. Health Home provider makes use of available HIT and accesses data through the regional health information organization/qualified entity to conduct these processes, as feasible.

Final Standards

6e. Health Home provider has structured interoperable health information technology systems, policies, procedures and practices to support the creation, documentation, execution, and ongoing management of a plan of care for every patient.

6f. Health Home provider uses an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers. If the provider does not currently have such a system, they will provide a plan for when and how they will implement it.

6g. Health Home provider will be required to comply with the current and future version of the Statewide Policy Guidance

(http://health.ny.gov/technology/statewide_policy_guidance.htm)

which includes common information policies, standards and technical approaches governing health information exchange.

6h. Health Home provider commits to joining regional health information networks or qualified health IT entities for data exchange and includes a commitment to share information with all providers participating in a care plan. RHIOs/QE (Qualified Entities) provides policy and technical services required for health information exchange through the Statewide Health Information Network of New York (SHIN-NY).

6i. Health Home provider supports the use of evidence based clinical decision making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance.

- a) If you are a currently designated Health Home please confirm in your application you have met the initial standards. In addition, please confirm whether you have met the final standards, and if you have met the final standards please confirm you acknowledge you have an agreement in place with DOH to meet such final standards. Please provide information on how you plan to work with network providers and care managers to ensure these health IT standards are implemented.

In addition, please describe if your health IT systems now recognize and accommodate the rights of minors to consent to certain types of health care (minor consented services) without the permission of their parent /guardian, and whether parents/guardians or others can access their health information. If your health IT systems do not accommodate the ability to segregate health care information in this manner, please described how your organization accommodates the consent rights of minors.

- b) If you are an organization seeking a new Health Home designation, please provide information regarding your capability to meet the initial and final health IT standards described above. In addition, please provide your organization’s plan for achieving final health IT standards within eighteen (18) months of your Health Home designation. Please provide information on how you plan to work with network providers and care managers to ensure these health IT standards are implemented and how you intend to accommodate the rights of minors to consent to certain types of health care without the permission of their parent/ guardian, and whether parents/guardians or others can access their health information.

Section F
Attestation

In addition to the requirements your Health Home attested to at the time it was designated Applicants must attest to the following:

1. Health Home services will include the following:
 - a) Coordination of care and services post critical events, such as emergency department use, hospital inpatient admission and discharge;
 - b) Language access/ translation capability;
 - c) 24 hour 7 days a week telephone access to a care manager;
 - d) Crisis intervention;
 - e) Links to acute and outpatient medical, mental health and substance abuse services;
 - f) Links to community based social support services-including housing; and
 - g) Beneficiary consent for program enrollment and for sharing of patient information and treatment.
2. To the extent required, Health Homes will collect data and report on specific quality measures as defined earlier in this Application under “Quality Measures”.

3. Contractual agreements are in place with all organizations for which there is a financial arrangement prior to the first request for reimbursement when partnerships involve a financial arrangement.
4. Payments which are subject to State mandated rates and other transitional provisions and rates implemented by the State will be made at rates which are not less than those mandated rates.

Section G
Rights of the State

The rights of the State provided below are unchanged from the rights included in the Health Homes Application governing the initial designation of all Health Homes.

1. The State reserves the right to assign beneficiaries to specific Health Home.
2. The State reserves the right to cancel a Health Home provider’s approved status based on upon failure of the provider to provide Health Home services in accordance with the NYS Health Home Provider Qualification Standards, provide quality Health Home services to its clients, or upon other significant findings determined by the State.
3. The State reserves the right to cancel the program at any time for lack of funding, and/or if, after evaluation of the program, desired results in quality, efficiency and decreased costs are not shown, or any other reason determined by the State.
4. The State confirms that the rights of minors to consent to certain types of health care without the permission of parent/guardian and to whether parents/guardians or others can access their health information as per State law/regulation.

The Application includes the following Attachments.

Application Attachments	
Attachment A	Form for Submitting Comments to Draft Application
Attachment B	Form to Submit a Letter of Interest
Attachment C	New York State Health Home Model for Children
Attachment D	Draft List of Providers with Expertise Serving Children