Children's Health Home

Training for Providers

May 2025

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Overview of Health Home

Background*

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

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

Goals of Health Home

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

Core Health Home Services

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

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

Core Health Home Services (continued)

- **Patient and Family Support**
  - Patient's individualized plan of care reflects patient and family or caregiver preferences, education and support for self-management, self-help recovery, and other resources as appropriate.
- **Referral to Community Supports**
  - The Health Home provider identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.
- **Use of Health Information Technology (HIT) to Link Services**
  - Health Home providers will make use of available HIT and access data through the regional health information organization/qualified entities to conduct these processes as feasible.

For detailed description of each core service please see:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/provide r_qualification_standards.htm

Health Home Entities

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

Responsibilities of HHCMs

- Connects child/family with Providers and community supports
- Communicates with all Providers the child is in the care of as well as his/her MMCP to ensure integration of services, care coordination, and prevention of duplicate services
- Provides transitional care and follow-up from inpatient to other settings
- Determines and documents the child's Health Home and HCBS eligibility, and reassesses (when needed) to confirm continued eligibility
- Creates an individualized Plan of Care that engages the child and family in the process
- Conducts ongoing comprehensive care management and monitors the Plan of Care implementation through conversations with the child and his/her family

Health Home Eligibility

Health Home Eligibility Criteria

- To be eligible for Health Home:
  - A child must be enrolled in Medicaid or Child Health Plus (CHPlus),
  - Be appropriate for intensive level of care management that HH provides, AND
  - Have two or more chronic conditions or one single qualifying chronic condition
- Single qualifying conditions for children:
  - Sickle Cell Disease
  - HIV/AIDS
  - Serious Emotional Disturbance (SED)
  - Complex Trauma
- Chronic Condition Criteria is NOT population specific, such as being in foster care, under 21, in juvenile justice etc. does not alone/automatically make a child eligible for Health Home
- The HHCM is responsible for documenting and verifying children meet the eligibility criteria by working with health care professionals to determine and document eligibility conditions

More information on Eligibility Criteria in Appendix

Health Home Eligibility

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

Health Home Interaction

Health Home Tracking System - MAPP

MAPP provides an online interface to the MMCPs, HHs, and CMAs to collaborate in real-time and track a Member's status.

Users can:

- Refer members to HHs
- Upload/download member information and transactions
- Coordinate across MMCPs, HHs, and CMAs using workflows and notifications
- View Member's Medicaid information

MAPP Children's Referral Portal

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

RR/E Codes – Enrollment in Health Home

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

C-YES, Independent Entity (IE)

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

Children's Health Home Requirements

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

CFTSS and Aligned HCBS

- Child and Family Treatment and Support Services (CFTSS) are an outgrowth of NYS Medicaid Redesign that a child does NOT need to be enrolled in a HH to access
- For Children's Home and Community Based Services (CHCBS), HH enrollment is not mandatory
- If the child/family chooses to enroll in a HH, the HHC determines HCBS eligibility and creates/manages the Plan of Care (POC)
- If the child/family opts out of HH, eligibility is determined and POC must be created by C-YES, the IE, to allow access to these services

Resources

Resources

- List of NYS Health Homes by County
- Health Homes Serving Children (HHSC)
- DOH Health Home Program Email: hhsc@health.ny.gov
- Subscribe to DOH Health Home listserv
- C-YES (Independent Entity)
  - Can be contacted at 1-833-333-CYES (1-833-333-2937);
  - TTY: 1-888-329-1541

Resources

- State Issued Guidance Related to the Children's Waiver: 1115 Waiver/Home and Community Based Services (HCBS)

- Care Coordination for Individuals with Intellectual and Developmental Disabilities: Overview of Services Available through the 1915(c) Consolidated Children's Waiver and 1915(c) Comprehensive OPWDD Waiver

Health Homes Serving Children List of Acronyms

- ACS: NYC Administration of Children
- Services
- AI: AIDS Institute
- ALP: Assisted Living Program
- ASA: Administrative Service Agreement
- BAA: Business Associate Agreement
- BHO: Behavioral Health Organization
- CAH: Care at Home
- CBO: Community Based Organizations
- CMA: Care Management Agency
- CFTSS: Children and Family Treatment and Support Services
- CPST: Community Psychiatric Support and Treatment
- C-YES: Child and Youth Evaluation Service
- DEAA: Data Exchange Agreement Application
- EI: Early Intervention
- eMedNY: Electronic Medicaid system of New York
- FFS: Fee For Service
- HCBS: Home and Community Based Services
- HCS: Health Commerce System
- HH: Health Home
- HHSC: Health Home Serving Children
- HHTS: Health Home Tracking System
- HIT: Health Information Technology
- IE: Independent Entity
- LDSS: Local Department of Social Services
- LGU: Local Government Unit

Appendix: More Information on Health Home Eligibility Criteria

Serious Emotional Disturbance (SED)

- SED Definition for Health Home - SED is a single qualifying chronic condition for Health Home and is defined as a child or adolescent (under the age of 21) that has a designated mental illness diagnosis in the following Diagnostic and Statistical Manual (DSM) categories* as defined by the most recent version of the DSM of Mental Health Disorders AND has experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis
- Functional Limitations Requirements for SED Definition of Health Home -To meet definition of SED for Health Home the child must have experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis. The functional limitations must be moderate in at least two of the following areas or severe in at least one of the following areas as determined by a licensed mental health professional:
    - Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
    - Family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
    - Social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
    - Self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
    - Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

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

Complex Trauma – Single Qualifying Condition for Health Home

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

Definition of Complex Trauma

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

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

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

D. Wide-ranging, long-term adverse effects can include impairments in:
   I. Physiological responses and related neurodevelopment,
   II. Emotional responses,
   III. Cognitive processes including the ability to think, learn, and concentrate,
   IV. Impulse control and other self-regulating behavior,
   V. Self-image,
   VI. Relationships with others, and
   VII. Dissociation.

Health Home Appropriateness Criteria

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