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Health
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Dan Renwick and Courtney Tomeny November 29, 2016

Children's Health Homes

Health care needs of children have been advanced and altered throughout the course of public policy. With the adoption of the Affordable Care Act of 2010, there has been a shift towards Children's Health Homes in New York State. Health Home providers are tasked with understanding the evolving policy and preparing to launch on December 1, 2016.

Scope of the Problem

The Health Homes Initiative was launched for adults in New York in 2012 but the Children's Health Home initiative was put on hold. Now, Children's Health Homes are due to start the enrollment process in December 2016, however, many of these anticipated Health Home providers are unclear on what the policy requires them to do in order to operate effectively, as they have never operated within a Health Home system or have never managed the health care of children before. These new Health Homes providers are striving to become informed in this process and understand the policies as they prepare for the influx of children Health Home enrollees come December 2016.

Current Policy

The Health Homes Initiative was introduced in the Affordable Care Act of 2010 in Section 2703. Section 2703 provides each state with an option to launch Health Homes for Medicaid enrollees with chronic conditions. States that decided to go ahead with the implementation of Health Homes were required to submit a Medicaid State Plan Amendment (SPA). New York State submitted a final Medicaid SPA on March 2, 2015 which was approved and allows for New York State to launch Health Homes for children.

Health Homes are not physical places, but rather, a system of care put in place to coordinate health care for those with chronic conditions. As Medicaid defines it, "Health Homes providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person" (Medicaid). The focus on the "whole person" is critical to Health Homes providers as Health Homes cover a wide range of health care needs. Children's Health Homes will be able to provide a system of care for children who qualify for Medicaid and have special health care needs. In the National Survey for Children with

Special Health Care Needs that examined 2009-2010, it was discovered that only 51.4 % of children with special health care needs and public insurance who were in need of care coordination, actually received effective care coordination. The aim of the Health Homes Initiative is to provide these children with efficient health care for their individual needs.

The services provided by Health Homes for children and adults in New York State are not open to all citizens. To be eligible to receive services through Health Homes, citizens must meet several requirements. Health Home enrollees must first qualify for Medicaid. In addition to being eligible for Medicaid, participants must have certain medical conditions that need to be met to receive the services Health Homes provide. In order to qualify for Health Homes, a person must have two or more chronic conditions, one chronic condition and be at a high risk of developing another, or have at least one serious mental health condition. Chronic conditions include but are not limited to; substance abuse disorders, asthma, diabetes, heart disease or obesity. However, each state can include more qualifying chronic conditions. The New York State Plan Amendment delves further into each category of chronic conditions.

Policy Requirements

Care Managers

To combat the undetermined influx of new clients, the policy allows Health Home organizations to access the needs of their organization following the policy being enacted. This leeway allows Health Home organizations to determine what is best for their organization whether that is adjusting the roles of their current care managers or hiring more employees to accommodate for the new referrals. The responsibilities of a targeted care manager and a care manager are very similar. The most significant difference between care managers and case managers is the educational requirement. The educational requirements means care managers must have a Bachelor's Degree in specific fields. Additionally, the new policy does not require organizations to hire targeted care managers, in the hopes it will make the transition easier for all.

Enrolled children will be given an assigned care manager to oversee all of their healthcare needs. “Health Home providers will assign each individual a dedicated care manager who is responsible for overall management of the individual’s plan of care. The Health Home care manager is clearly identified in the individual’s 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” (health.ny.gov).

Under the new policy requirements, care managers will have an extended role in collaborating information and referrals for the child or family they work with and will require them to be the point person for each of their clients. There are six core services that care managers will be required to fulfill under the new policy. They are: comprehensive care

management, care coordination and health promotion, transitional care, patient and family support, referrals to community and social support groups, and to use Health Information Technology (HIT) to link services.

Health Information Technology (HIT) requires care managers to develop and execute a Health Homes Plan of Care that is developed in collaboration between the child/family and their multidisciplinary team. This plan will highlight all involved providers on the child's care plan. The care manager is the single point of contact for creating, documenting, executing and updating the individualized child centered Health Homes Plan of Care that integrates medical, behavioral health, rehabilitative, long term care, community and social services, family and peer supports.

Care managers will also complete the child's Child and Adolescent Needs and Strengths-NY (CANS-NY). This will help provide information to create the best plan for children with mental, emotion, or physical needs. To best ensure the most recent information about the child is documented, the care manager will continue to update the Care Plan with new information as it is received. The Health Home Care Plan should include, facilitate, and be consistent with the Functional Assessment Service Plan (FASP). The care manager is responsible for coordinating and arranging medical services for the child, along with encouraging treatment recommendations. This requires care managers to ensure priority appointments for their clients within their Health Homes provider services to limit additional expenses. Care managers are responsible for their clients access to timely treatment and care. Care managers are expected to be available 24 hours / seven days a week to provide information and emergency consultation information. Timely follow up care post discharge from the hospital is an additional responsibility for care managers. This includes: receipt of a summary care record from the discharging entity, medication reconciliation, timely scheduled appointments with service providers, and to make sure the child showed up to the scheduled appointments. If a child misses one of these scheduled appointments, then it is the care manager's responsibility to discover why the appointment was missed and to reschedule.

Prioritizing Enrollment

In order to manage the initial capacity when Children's Health Homes launch in December 2016, Health Home providers should prioritize child enrollment by those who meet the Medicaid criteria and have the highest need for a Health Home provided care manager. Children with the highest need include those on various NYS Health Waiting Lists, such as the Office of Mental Health's Wait List and the Bridges to Health Wait List. Other criteria that requires prioritization includes children who have been discharged from inpatient/residential/day treatment setting within the past thirty days, as well as any children who have been prescribed three or more psychotropic medications. Any child considered "medically fragile" who has multiple chronic conditions and has been in inpatient treatment should be enrolled as soon as possible.

Children with multiple system involvement (ex. child welfare, criminal justice) should be given priority in the enrollment process. According to various organizations, the enrollment process should start slowly and increase over time. However, in the case of a heavy influx of new patients, prioritizing children by need base will allow for a more effective operation as a Health Home provider.

Referral Outreach

Health Homes should communicate with care management providers to assess their capacity to accept new referrals prior to sending them assignment files. Such communication will help ensure care management providers will be able to act promptly in their efforts to locate and enroll prospective members. After a Health Home receives a referral, care management providers should begin outreach immediately. If the Health Home receives an assignment list during the 1st to the 15th of each month, immediate outreach is recommended. If Health Homes receive an assignment list after the 16th of the month, outreach can begin immediately, but may be initiated the following month to take advantage of the full month of outreach. Outreach must begin no later than the 5th business day of the following month if the Health Homes choices is to defer outreach. Health Homes shall require documentation from care management providers regarding any failure to commence outreach activities within these timeframes. Such documentation should state the reasons for not meeting such timeframes and should propose a corrective action plan. Health Homes should thereafter report such deficiencies and corrective action plans to the Managed Care Organization (MCO) and the State.

Key Organizations

- **Catholic Charities Diocese of Syracuse**: Catholic Charities works within the community to stomp out injustice, hunger, and promote development. Over 60,000 people benefit from their services annually and are expanding their influence in their community. Catholic Charities informed us that Health Homes will have initial operating flexibility. They predict that the initial influx of referrals will be small but steadily increase over time.

- **Council of Family and Child Care Agencies:** COFCCA works with children, adults, and families in the Capital Region to help promote equality, justice, and development. They seek to achieve these goals by working to strengthen the capacity of its member agencies to provide high quality services. After reaching out to COFCCA, they informed us that some Health Home providers have chosen to hire or promote within to add additional care managers.

- **Schuyler Center for Analysis & Advocacy:** The Schuyler Center is a nonprofit agency that works to ensure New York's policies benefit everyone. They are an advocacy organization that helps shape policies improving health, welfare, and human services. The Schuyler Center provided us with the basic information of the policy and helped to connect us with a wider range of resources.

Glossary of Terms

Children's Health Home: A Medicaid program that provides a care manager to help eligible children get the service and health care they need to stay healthy.

Chronic Condition: Chronic conditions that are included in Section 2703 of the Affordable Care Act include mental health, substance abuse, asthma, diabetes, heart disease and being overweight.

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Community Policy Institute

The Community Policy Institute builds capacity surrounding policy within the Capital Region. We provide researched-based policy information to our community partners who use the information to modify best practices and advocate for policies that will further the development and effectiveness of direct community engagement.

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Dan Renwick
Courtney Tomeny

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Children's Health Home Structure

Health Homes must fulfill six fields in order to operate efficiently and within the policy regulations in New York State. All six individual services work to provide an inclusive and effective care model.

Comprehensive Care Management

- Assess health needs, health literacy, and develop care plans. Begins with a health assessment to identify all health needs of the individual and then integrates these needs into a care plan. Care plan outlines goals and a time frame for health care and health improvement. Periodic reassessment to ensure that the individual's care requirements are met.

Care Coordination

- Ensure Medicaid users have access to all needed services. Requires a Health Home provider to monitor and evaluate the changing needs of enrollee through the assignment of a care manager (CM).
- C.M.s oversee and coordinate all aspects of each care plan, and are required to communicate with an individual's physicians and be aware of all changes in the individual's conditions.
- Responsible for ensuring collaboration between primary care physicians and other health providers, specialists, etc.

Health Promotion

- Care managers are also responsible for health promotion services including educating patients about the importance of immunizations and screenings, healthy eating, and living a healthy lifestyle.

Comprehensive Transitional Care

- Address and monitor all types of care services such as transition from inpatient care to other settings and services. Transitions can be stressful for families and enrollees, so creating a smooth transition process increases the effectiveness of care the individual/family receives. Communication between the individual's care manager and the rest of their team is necessary to ensure the most efficient plan of action that meets the needs of the individual.

Patient and Family Support

- Educating and empowering patients and families to be part of the health team and to make decisions about treatment options
- Ensures that the individual's plan of care is accessible and discussed

Referral to Community and Social Support Services

- Puts a system of collaboration in place to work effectively with community based resources.