New York City Department of Health and Mental Hygiene, Division of Family and Child Health, Bureau of Early Intervention
Guidance on Health Home Implementation in the New York City Early Intervention Program (10.02.2017)

Background to Health Homes

A Health Home is a Medicaid care management service model where an individual's providers communicate with one another to address the patient's needs in a comprehensive manner. This is done primarily through a **care manager** who oversees and connects an individual to services they need to stay healthy, out of the emergency room and out of the hospital. Health Home services are provided through a network of providers that delivers direct care and works collectively with organizations, health plans and community-based organizations to ensure the child is connected to all necessary services.[1]

ACRONYM	Stands for
HH	Health Home
CMS	Centers for Medicare and Medicaid Services
IDD	Intellectual and developmental disabilities
OSC	Ongoing Service Coordination in Early Intervention
CMA	Care Management Agency
HHCMA	Health Home Care Management Agency (Not approved to provide OSC by New York State Department of Health's Bureau of Early Intervention)
HHCMA/OSC	Health Home Care Management Agency/Ongoing Service Coordination (Approved by New York State Department of Health's Bureau of Early Intervention)
CANS-NY	Child and Adolescent Needs and Strengths assessment tool that determines Health Home acuity
NYEIS	New York Early Intervention System used to enter information about referrals, services, Individualized Family Service Plans (IFSPs), amendments, authorizations, etc.

Health Home Implementation in New York State

Health Home services for adults were implemented in New York State (NYS) in January 2012. The State Plan Amendment for children was approved by the Centers for Medicare and Medicaid Services (CMS) on April 7, 2016, and the enrollment of children into Health Homes began in December 2016. The next phase of Health Home implementation

[1] https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

will be to expand eligibility to serve Medicaid members with intellectual and developmental disabilities (IDD) and to identify single qualifying IDD conditions that would make an individual eligible for Health Homes. This process is expected to begin in 2018.

Health Homes are an optional Medicaid benefit. Medicaid enrollees may refuse to enroll in a Health Home.

How Health Homes Are Structured to Support the Early Intervention Population

All Health Homes are required to have a network of care management agencies (CMAs) to meet the needs of the population's and members' characteristics including, but not limited to: serious mental illness (SMI), serious emotional disturbance (SED), substance use disorder (SUD), complex trauma, co-occurring medical or comorbid conditions, patterns of acute service use or are specific to children. Children's Health Homes must have network CMAs with the expertise to serve various subpopulations, including children enrolled in the Early Intervention Program (EIP). To ensure that a CMA identified to serve the Early Intervention (EI) population has the expertise to provide EI ongoing service coordination (OSC), the CMA must be cross-trained to provide EI OSC and Health Home care management, be approved by the NYS Department of Health's Bureau of Early Intervention (NYS BEI) and approved by the lead Health Home and the NYS Department of Health's Health Home program as an approved Health Home Case Management Agency (HHCMA). Therefore, these agencies have care coordination responsibilities for children beyond that of other HHCMAs. HHCMAs that are also approved by NYS BEI to provide ongoing service coordination are identified as HHCMA/OSC**.**

NOTE to: Early Intervention and Health Home Care Management Agencies

HHCMAs and EI agencies interested in being cross-trained and approved as an agency to provide both EI OSC and Health Home care management **MUST** complete the ***Notification of Interest*** form and the additional steps outlined at the link below: health.ny.gov/health_care/medicaid/program/medicaid_health_homes/health_homes_and_children.htm.

Health Home Availability and Readiness to Serve the NYC Early Intervention Population

The enrollment of EI children into Health Homes began in July 2017 for four HHCMA/OSCs. Those agencies are listed below. The NYS Department of Health has indicated that additional HHCMAs for children that are also approved as an EI agency for the provision of OSC are expected to be identified on a rolling basis.

HEALTH HOMES AND CARE MANAGEMENT AGENCIES SERVING NYC

Health Home (Abbreviation)	Health Home (Full Name)	Care Management Agency Approved to provide OSC by NYS BEI (HHCMA/OSC)	Boroughs Served
BAHN	Montefiore Medical Center – doing business as Bronx Accountable Healthcare Network Health Home	Blythedale Hospital	Bronx
CCF	Collaborative for Children and Families	Liberty Resources, St Mary's Hospital for Children, Center for Human Development and Family Services (CHDFS), New York Foundling	Bronx, Brooklyn, Manhattan, Queens, Staten Island
MSHH	St. Luke's-Roosevelt Hospital Center – doing business as Mt. Sinai Health Home	St. Mary's Hospital for Children, CHDFS	Bronx, Brooklyn, Manhattan, Queens, Staten Island
PWHH or CBC	Coordinated Behavioral Care, Inc. – doing business as Pathways to Wellness Health Home	Ohel Children's Home and Family Services	Bronx, Brooklyn, Manhattan, Queens, Staten Island

Note: Health Homes and CMAs are approved on a rolling basis. For timely information on HHs and CMAs serving NYC, go to:
health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm

The New York City Health Department's Bureau of Early Intervention (NYC BEI) meets with new HHCMA/OSCs indicating a readiness to serve children in NYC, to exchange information about mutual contacts and to explain NYC policies and procedures. HHCMA/OSCs should contact NYC BEI's Technical Assistance Unit (TAU) to establish and maintain needed relationships to ensure quality care for children and families.

The TAU will meet with the HHMCA/OSC and obtain contacts, staffing and information necessary to effectively collaborate and communicate with NYC BEI. Referrals and assignments should not be delayed pending the provision of this information.

Eligibility for Health Homes

NYS's Health Home eligibility criteria are as follows:

1. The individual must be enrolled in Medicaid.
2. The individual **must have:**

a. Two or more chronic conditions (refer to NYS eligibility requirements for more information on the list of conditions: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/health_home_chronic_conditions.pdf)

OR

b. One single qualifying chronic condition:
   - ✓ HIV/AIDS
   - ✓ complex trauma
   - ✓ serious emotional disturbance

3. Meet the Health Home appropriateness criteria [2]

The HHCMA determines eligibility for Health Homes care management services. The Child and Adolescent Needs and Strengths for New York State (CANS-NY) assessment tool is used by the HHCMA to determine the acuity.[3] Acuity determines the reimbursement rate for a child in a Health Home.

Based on the current list of chronic conditions, the enrollment of children in the EI population is not expected to exceed 300 children in NYC initially. The number of EI children that qualify for Health Homes is expected to grow once the list of chronic conditions is expanded to include disability categories.

Intersection of Early Intervention Service Coordination and Health Home Care Management Services

Referrals

1. Children Enrolled in a Health Home Care Management Agency at the Time of Early Intervention Referral

Children who are enrolled in a Health Home and are potentially eligible for the EIP should be referred by the HHCMA.

a. HHCMAs that are **not** approved EI ongoing service coordination providers should fax the NYC Early Intervention Referral Form to the regional office in the borough of the child's residence. The referral form can be found at: http://www1.nyc.gov/assets/doh/downloads/pdf/earlyint/ei-referral-form.pdf
   i. The Regional Office Referral Unit will identify the name of the HHCMA in the "primary referral source" field in NYEIS.

[2]https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/health_home_chronic_conditions.pdf
[3]https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/cans_0_5.pdf

ii. The Regional Office Referral Unit will indicate the following under the "secondary referral source" in NYEIS: "Health Homes Care Management Agency."
iii. The Regional Office Referral Unit will indicate the following under the "Comments" section of the referral screen in NYEIS: Indicate that the child is being referred by a Health Home, the name of the HHCMA agency and the name and contact information for the HHCMA care manager.

b. HHCMA/OSCs must make referrals to the EIP utilizing NYEIS and following the NYEIS referral protocol provided in the NYC Policy and Procedure Manual: Policy 1-A.1 (https://www1.nyc.gov/assets/doh/downloads/pdf/earlyint/earlyint-policy-manual.pdf)
    i. The HHCMA/OSC agency will identify itself in the "primary referral source" field in NYEIS.
    ii. Under the "secondary referral source" field in NYEIS, enter: "Health Homes Care Management Agency."
    iii. Under the "Comments" section of the referral screen in NYEIS: Indicate that the child is being referred by a Health Home, the name of the HHCMA/OSC agency and the name and contact information for the HHCMA/OSC care manager.

c. If the HHCMA knows that a child is being served through the Administration for Children's Services (ACS) or agencies contracted with ACS, the HHCMA should make referrals using the EI/ACS Referral Hotline at 877-885-KIDZ (5439).
    i. The Developmental Monitoring Unit (DMU) will ask if the child is enrolled in a Health Home
    ii. The DMU will enter the following information into the Referral Screen in NYEIS:
        - Enter the HHCMA name in the "primary referral source" field in NYEIS.
        - Under the "secondary referral source" field in NYEIS, enter: "Health Homes Care Management Agency."
        - Under the "Comments" section of the referral screen in NYEIS, indicate that the child is being referred by a Health Home, the name of the HHCMA and the name and contact information for the Health Home care manager.
    iii. For cases being routed to the regional office, the DMU will document the following:
        - Identify the HHCMA as the primary referral source.
        - Under secondary referral source write: Health Home, care manager: "Enter name of care manager."

- Under the "Comments" section of the referral screen in NYEIS, indicate that the child is being referred by a Health Home, the name of the HHCMA and the name and contact information for the Health Home care manager.
- Indicate if the child was referred by a Health Home on the DMU Transmittal Sheet

iv. For cases that were referred by an HHCMA and are being transferred from the "At-Risk Queue" in NYEIS to the "New Case Queue", the DMU will ensure that the "Comments" section reflects the name of the HHCMA, and that the name and contact information for the Health Homes care manager will be entered.

2. Children Not Enrolled in a Health Home at the Time of Early Intervention Referral

a. All referrals to the EIP must be made utilizing the protocols provided in the NYC Policy and Procedure Manual: Policy 1-A.1 (https://www1.nyc.gov/assets/doh/downloads/pdf/earlyint/earlyint-policy-manual.pdf)

Initial Service Coordination Assignment

The NYC BEI regional offices will assign an initial service coordination (ISC) agency utilizing the following approach:

1. If the HHCMA/OSC that is making the referral is also approved as an EI provider for the provision of ISC, that agency will be assigned as the ISC agency to ensure continuity of care.
2. If the HHCMA/OSC that is making the referral is not approved as an EI provider for the provision of ISC, the NYC BEI regional offices will assign an ISC agency as per usual procedure.
    a. To ensure continuity of care, NYEIS will contain contact information for the HH/Care Manager.
3. If the HHCMA that is making a referral is not an approved EI provider, the NYC regional offices will assign an ISC agency as per usual procedure.
    a. To ensure continuity of care, NYEIS will contain contact information for the HH/care manager.

Initial Service Coordination

1. Children Enrolled in a Health Home at the Time of Early Intervention Referral

a. The assigned ISC will complete all required ISC activities as described in the NYC Policy and Procedures Manual and the toolkits issued by the NYS BEI.
    i. If the HHCMA/OSC **is also approved as an ISC provider agency**, and was therefore assigned as the child's ISC to ensure continuity of care:
        - HHCMA/OSC may not conduct ISC tasks as a portion of Health Home activities.
            - ISC tasks are considered unique and distinct from Health Home activities.
            - ISC activities are billed through the EIP.
            - A service authorization for ISC must be entered in NYEIS as with any other ISC provider.
        - The ISC will obtain parent consent to share information with the child's HHCMA/OSC.
    ii. If the HHCMA/OSC that made the referral **is <u>not</u> also approved as an ISC provider agency**, and was therefore not assigned as the child's ISC:
        - The ISC will obtain parent consent to share information with the child's HHCMA to ensure continuity of care
    iii. If the HHCMA that made the referral is not a HHCMA/OSC, and was therefore not assigned as the child's ISC:
        - The ISC will obtain parent consent to share information with the child's HHCMA to ensure continuity of care

2. Children Not Enrolled in a Health Home at the Time of Early Intervention Referral

a. If the ISC in collaboration with the child's multidisciplinary evaluation (MDE) team believes that the child is potentially eligible for Health Homes (refer to eligibility criteria above), a discussion must first occur with the family to ensure that the family understands the benefit of Health Home services, and the family gives verbal consent to make a referral.
    i. A referral can be made in one of the following ways:
        - If the Early Intervention ISC agency is also a HHCMA/OSC, the ISC should discuss the referral with the HHCMA/OSC staff.
            - The referral for Health Home services will be made via the Medicaid Analytics Performance Portal (MAPP).
            - If this referral method is used, the ISC agency that is also a HHCMA/OSC can retain the case.
        - If the Early Intervention ISC agency is not a HHCMA/OSC, the ISC should contact the HHCMA/OSC

agencies listed in the chart titled: HHCMA serving NYC on page 3 of this document to make a referral.

- If the EI ISC agency has a sub-contract with a HHCMA/OSC, the ISC will contact the sub-contracted HHCMA/OSC to make a referral for Health Home services.

- When a referral is made utilizing any of the methods outlined above, alignment with the child's managed care plan must occur.
- Parental consent for Health Home enrollment must be obtained by the HHCMA prior to the child's enrollment into the Health Home.

Multidisciplinary Evaluations

Children who are eligible for Health Homes, or potentially eligible for Health Homes, should be evaluated by the EIP with the sole purpose of establishing eligibility for EI. Some HHCMA/OSCs may also be approved to provide evaluations and services through the EIP. **All evaluations (MDEs and supplemental evaluations) are for EI purposes only, and are not to be authorized for the purpose of determining Health Home eligibility**.

The EIP is not responsible for providing any evaluations for the purpose of determining initial or on-going eligibility for Health Homes.

1. **Children Enrolled in a Health Home at the Time of Early Intervention MDE**

    a. The MDE must be conducted and submitted as required by chapter 4 of the New York City Policy and Procedure Manual: https://www1.nyc.gov/assets/doh/downloads/pdf/earlyint/earlyint-policy-manual.pdf)

2. **Children Not Enrolled in a Health Home at the Time of Early Intervention MDE**
    a. The MDE team, in collaboration with the parent and the ISC, should discuss whether the child is potentially eligible and appropriate for Health Homes during the evaluation process (refer to eligibility criteria above).
        i. Regardless of the child's eligibility status for the EIP, if the team believes that the child is potentially eligible for Health Homes, the ISC must follow the steps described under number 2 in the ISC section above to make a referral to a HHCMA with verbal consent from the parent.

Individualized Family Service Plan Meeting and Ongoing Service Coordination

1. **Children enrolled in a Health Home at the time of the Individualized Family Service Plan (IFSP) meeting**

When a child is found eligible for the EIP, the HHCMA/OSC that made the referral can be assigned with parental consent as the family's OSC agency to ensure continuity of care.

a. If a child is enrolled in a HHCMA at the time of referral, OSC will be authorized in the NYEIS using the following method:
    i. If the child is being served by an HHCMA which is also a HHCMA/OSC agency, that agency will be assigned.
    ii. Approved HHCMA/OSC agencies are listed in NYEIS and are expected to fulfill all required OSC activities.
    iii. As with Medicaid Care Management programs, the EIOD should select the HHCMA/OSC as the OSC provider and authorize one (1) unit of service coordination to ensure that the HHCMA/OSC provider can view and work on the case in NYEIS.
    iv. The IFSP team must specify in the "Comments" section of the child's IFSP in NYEIS that, "If the child becomes disenrolled from Health Homes while still in EP, the HHCMA/OSC care manager is required to notify the regional office within two business days."
b. If the HHCMA is not a HHCMA/OSC agency:
    i. The regional office contacts the HHCMA that made the referral to EI.
        - This information is listed on the child's home page in NYEIS.
    ii. The regional office will request that the child's HHCMA contact the lead Health Home and notify the regional office which HHCMA/OSC will need to be assigned in their network.
    iii. Approved HHCMA/OSC agencies are listed in NYEIS and are expected to fulfill all required OSC activities.
    iv. As with Medicaid Care Management programs, the EIOD should select the HHCMA/OSC as the OSC provider and authorize one unit of service coordination to ensure that the HHCMA/OSC provider can view and work on the case in NYEIS.
    v. The IFSP team must specify in the "Comments" section of the child's IFSP in NYEIS that, "If the child becomes disenrolled from Health Homes while still in EI, the HHCMA/OSC care manager is required to notify the Regional Office within two business days."

2. **Children who are not enrolled in Health Homes during the IFSP meeting**

When a child who is in EI is potentially eligible for a Health Home (refer to eligibility criteria above), the child's EIOD and other members of the IFSP team should discuss Health Homes at the IFSP meeting.

a. If the child has already been referred to the HHCMA/OSC by the ISC with verbal parental consent, the EIOD will inquire if eligibility has been established for Heath Home services.
    i. If Health Home eligibility has been established:
        - The IFSP team should authorize the HHCMA/OSC that established eligibility as the provider of OSC.
        - As with Medicaid Care Management programs, the EIOD should select the HHCMA/OSC as the OSC provider and authorize one (1) unit of service coordination to ensure that the HHCMA/OSC provider can view and work on the case in NYEIS.
        - The IFSP team must specify in the "Comments" section of the child's IFSP in NYEIS that, "If the child becomes disenrolled from Health Homes while still in EI, the HHCMA/OSC care manager is required to notify the regional office within two business days."
b. If the child has NOT been referred to a HHCMA by the ISC to establish Health Homes eligibility:
    i. If during the initial IFSP meeting it is determined that a referral to Health Homes will be made, a discussion with the family should include the benefit of selecting an OSC who is also a HHCMA/OSC.
        - To reduce the need for a change in OSC should the child be found eligible for Health Homes, the referral for Health Home eligibility determination should be made to a HHCMA/OSC.
        - Approved HHCMA/OSCs are listed in NYEIS and are expected to fulfill all required OSC activities.
        - The EIOD should select the HHCMA/OSC as the EI OSC provider and authorize an appropriate number of OSC units to deliver services in EI.
        - The IFSP team must specify in the "Comments" section of the child's IFSP in NYEIS that, "If the child becomes eligible for Health Homes while still in EI, the HHCMA/OSC service coordinator is required to notify the regional office within two business days."
    ii. The IFSP team will also discuss:
        - When Health Home eligibility is established, the OSC service authorization in NYEIS created for the HHCMA/OSC to deliver EI OSC must be closed and a new service authorization to the same HHCMA/OCS must be created (rather than amending the current service authorization) to ensure that no billing conflicts occur.
            - As with Medicaid Care Management programs, the IFSP team will authorize one unit of service

coordination to ensure that the HHCMA/OSC can view and work on the case in NYEIS.

- An agreed-upon date for handoff between the EI OSC and the HHCMA/OSC must be established.

c. If a family initially does not want to be referred to a HHCMA but later chooses to refer their child, the EI OSC should follow the above steps listed under "b". It is not necessary for an IFSP meeting to be convened to refer the child to a Health Home. However, a meeting can occur with all parties (parent, EI OSC, HHCMA/OSC and other providers as applicable) to transition the child from EI OSC to HHCMA/OSC to maintain continuity of care.

3. Children who are in Foster Care

If a child is in foster care, they are in the care and custody of the ACS. In some cases, the parent will retain the right to make decisions about EI and Health Home enrollment, despite the fact that the child is in foster care.

In cases where the parents' rights have been terminated or surrendered, or where the parents' whereabouts are unknown, EI will appoint a surrogate parent (usually the foster parent) to make EI decisions. In these cases, the foster parent/EI surrogates can give verbal consent to *refer* to Health Homes.
However foster parents/EI surrogates cannot give consent to *enroll* a child into a Health Home. The HHCMA will obtain consent from foster care case managers to enroll the child in Health Homes. [4]

When completing an IFSP for a child in foster care who is potentially eligible for a Health Home, the IFSP team must specify in the "Comments" section of the child's IFSP in NYEIS that, "Child is in Early Intervention and foster care. Please note that the parents retain the right to make decisions about Health Home enrollment even when the child is in foster care, unless the parents' rights have been terminated or surrendered, or the foster care agency has followed proper procedures to override the parents' rights to make health care decisions for the child. If that is the case, the foster care case manager must share the obtained consent to enroll a child into a Health Home. In addition, if the child becomes disenrolled from a Health Home for any reason while in services with a HHCMA/OSC provider, the Health Home care manager is required to notify the regional office within two business days."

Billing for Health Home Activities

Once the HHCMA/OSC is assigned, all billing for EI OSC activities will be done through the Health Home and paid at the Health Home acuity rate. Health Home care management is not billed under Code 35. Therefore, providers do not need to wait for

[4]https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hhsc_consent_for_children.pdf

deactivation of Code 35 when enrolling a child in a Health Home or initiating Health Home service delivery.

When the child is eligible for Health Homes and a warm hand off date is determined, the EI OSC service authorization in NYEIS must be closed and billing for EI OSC must end according to that agreed upon transition date. A new service authorization for OSC will be created and approved for the HHCMA/OSC. The IFSP team will authorize one unit of service coordination to ensure that the HHCMA/OSC can view and work on the case in NYEIS. Once the new service authorization is created in NYEIS, the HHCMA/OSC will begin billing outside of the EI system for Health Homes care management services based on acuity.

Since Health Homes eligibility must be established before an HHCMA/OSC can be authorized in NYEIS with one unit of service coordination, an agreement on the transition date for billing purposes must be established on a case-by-case basis between EI ongoing service coordination providers and HHCMA/OSC providers.

A Health Home bills on a per member per month (PMPM) basis that starts on the first day of the month. The change from EI service coordination to HHCMA/OSC must be effective as of the last day of the previous month. The OSC and Health Home care manager will agree on the transition date for the child to be enrolled in the Health Home.

Health Home Disenrollment

The HHCMA/OSC must notify the EIP if a child is discharged from the Health Home (for reasons such as Medicaid ineligibility, the family has requested disenrollment, etc.), HHCMA/OSC agencies are required to notify the regional office in the borough of the child's residence within two business days. The EIP will immediately:

- Contact the family to ensure that the family is provided with a choice as to the new EI OSC provider.
    - The HHCMA may be authorized as an EI OSC if the parent requests to maintain continuity of care.
- The regional offices will ensure that the HHCMA/OSC service authorization is closed **before** creating a new service authorization with a new OSC service authorization and approved in NYEIS (rather than amending the current service authorization).
- Since the child will already be receiving EI services, eligibility for the EIP will not need to be re-established.

In order to ensure that appropriate communication occurs when children are disenrolled from a Health Home, the EIOD must ensure that the "Comments" section of the child's IFSP specifies that notification to the regional office is required within two business days.

Children Transitioning Out of Early Intervention

1. **Children enrolled in Health Homes**
   The child's HHCMA/OSC care manager is responsible for completing all required transition activities for the child and family with parental consent, when applicable.

   Note: If the child continues to meet Health Home eligibility and appropriateness, the child will remain in Health Homes (with proper consent) when transitioning out of EI. The HHCMA/OSC can continue to serve the member and/or work with their Health Home to transition the member to a new HHCMA.

2. **Children who are not enrolled in Health Homes but are potentially eligible while transitioning out of EI**
   As part of developing an EI transition plan, service coordinators should discuss referral to Health Home care management services for children who are potentially eligible.

   Note: Families who have children with complex medical needs who will be losing EI service coordination may want to take this opportunity to continue with care management services offered through an HHCMA after EI.

Frequently Asked Questions
Health Homes and Early Intervention

1. **Can a Health Home Care Management Agency provide Initial Service Coordination?**
    a. A Health Home care manager may not bill EI ISC tasks to Health Homes. ISC tasks in EI are considered unique and distinct from Health Home activities. However, if a HHCMA is also an approved EI provider agency, it is permissible for that agency to be assigned as the ISC provider and bill for EI ISC through the NYEIS.

       If a child is first in a Health Home prior to EI and is then referred to EI, EI ISC and Health Home care management can occur in parallel and both be billed. In this situation, the HHCMA will bill Health Homes and the EI ISC will bill EI for EI ISC tasks.

2. **When can the Health Home eligibility process be initiated for children in Early Intervention?**
    a. The Health Home eligibility process can be initiated at any time. However, an HHCMA/OSC cannot be assigned as an ongoing service coordination agency until the child has had an initial IFSP.

3. **Do parents have to have ongoing service coordination through a Health Home?**
    a. No. Parents may consent or refuse Health Home care management services. However, if a family consents to Health Home participation while they are in EI, a HHCMA/OSC must be assigned as their OSC.

4. **If a child does not have Medicaid, can they receive Health Home care management service?**
    a. No. Only Medicaid-eligible children may have Health Home care management.

5. **Can any portion of the Health Home eligibility process/evaluation be authorized through Early Intervention?**
    a. No. Health Home eligibility must be determined outside of the EIP process. However, EI documentation of the child's condition and any other relevant program records can be shared and utilized with the HHCMA with appropriate written consent.

6. **Can an Early Intervention service coordinator refer a child to a Health Home?**
    a. Yes. An EI SC may refer a Medicaid eligible child to a Health Home with the parent's consent. Anyone can make a referral to a Health Home.

However, verbal consent for a referral to a Health Home needs to be from the parent/guardian or legally authorized representative.

7. **When a child is in foster care, who can consent to refer the child to a Health Home and who can consent for a child to be enrolled in a Health Home?**
    a. In most cases, when a child is in foster care, the parent still retains the rights to make decisions about EI and Health Home enrollment. Therefore, in most cases, the child's parent must consent to the referral and to enrollment in the Health Home.

       In cases where the parents' rights have been terminated or surrendered, or where the parents' whereabouts are unknown, EI appoints a surrogate parent (usually the foster parent) to make EI decisions. In these cases, the foster parent/EI surrogate can provide verbal consent to make a referral to Health Homes in foster care, but cannot provide consent to enroll the child in a Health Home. Consent for enrollment in a Health Home must instead be obtained from the foster care case manager that oversees the child's case. Consent for enrollment may also be provided by the foster care case manager if the foster care agency has followed proper procedures to override the parents' right to make health care decisions for the child.

8. **Do parents have to give consent to share information between a Health Home and Early Intervention?**
    a. Yes. Parents must give written consent for the information exchange.

9. **Who is responsible for convening an IFSP meeting when a child is receiving Health Home care management/Ongoing Service Coordination?**
    a. The Health Homes care management or OSC is responsible for requesting the IFSP meeting which is directly correlated to the Health Home required interdisciplinary team meeting for a Plan of Care development.

10. **Do all Early Intervention auto-eligible conditions qualify as Health Home chronic conditions?**
    a. Not at this time. Conditions such as autism spectrum disorder, Down syndrome, developmental delay, etc. are not qualifying conditions. Please refer to the current list of Health Home chronic conditions: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/health_home_chronic_conditions.pdf