Bassett Healthcare Network
Community Health Navigation

Policy Title: Core Billable Health Home Care Management Services

Policy Number: BCHN001

Original Date: 9/30/2022 **Last Revised:** 12/13/2024 **Effective Date:** 3/1/2025

Approved By: Miranda Blakeslee

Applicable to: Health Homes Serving Adults (HHSA)

Purpose: To explain and clarify the roles and responsibilities of Lead Health Homes (HH), downstream Care Management agencies (CMA) and Managed Care Organizations (MCOs) for the provision of Health Home services; and for Managed Care members, the Medicaid Managed Care benefit package care management services to enrollees as required by the Medicaid Managed Care Contract.

Contents

Definitions

Core Billable Health Home Services
Services provided to the member by the assigned care manager that are essential to the care and success of the member throughout enrollment. Such services are required to be provided each month in order for a CMA to be able to bill service provision to that member.

High Medium Low (HML)
An attestation of service provision that is sent to Medicaid for billing.

Health Information Technology (HIT)
The application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making.

Multidisciplinary Team (MDT)/Interdisciplinary Team (IDT)/ Review Meeting/Case Conference/Care Conference/Care Team Meeting members - Consists of the Health Home care manager, member, member supports (including parent, guardian, legally authorized representative), Medicaid Managed Care Plan (MMCP), healthcare, and service providers, collaterals and others approved by the member to ensure member needs are addressed in a comprehensive manner. The composition of a Multidisciplinary Team may vary at any point in time during the member's enrollment and from member to member. These terms can be used interchangeably. A non-hierarchal group of healthcare professionals who are discipline oriented but work in parallel with one another to provide comprehensive, individualized care to the member. The focus is to support the members' needs and objectives, address any potential challenges, and increase the likelihood of successful outcomes. In addition to professionals, non-professionals and family/supports identified by the member may be part of the Multidisciplinary Team (MDT)/ Interdisciplinary Team (IDT)/Case Review Meeting/Case Conference/Care Conference/Care team at any point in the member's HH enrollment.

Telehealth - use of electronic information and communication technologies to deliver health care to patients at a distance. NYS Medicaid covered services provided via telehealth include assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a NYS Medicaid member. This definition includes audio-only services when audio-visual is unavailable, or a member chooses audio-only.

Telehealth Provider - as defined in Public Health Law (PHL) §2999-cc, may be a physician, physician assistant, dentist, nurse practitioner, registered professional nurse, podiatrist, optometrist, psychologist, social worker, speech language pathologist, physical therapist, occupational therapist, diabetes educator, asthma educator, genetic counselor, hospital, home cares services agency, hospice, alcoholism and substance abuse counselor, Early Intervention service coordinator, day and residential program, care manager, peer recovery advocate, mental health practitioner, or any other provider as determined by the Commissioner pursuant to regulation.

Telemedicine or Audio-Visual Telehealth - uses two-way synchronous electronic audio-visual communications to deliver clinical health care services to a patient at an originating site by a telehealth provider located at a distant site.

Telephonic (Audio-only) - uses two-way electronic audio-only communications to deliver services to a patient at an originating site by a telehealth provider. For complete billing instructions for telephonic services, providers can refer to the "Billing Rules for Telehealth Services", "Telephonic (Audio-only) Reimbursement Overview" section of this manual.

Policy

The Bassett Community Health Navigation Health Home (HH) is providing this guidance to Care Management Agencies (CMA) to address the requirements for serving members throughout their enrollment. Care management integrates and coordinates healthcare providers (such as primary, acute,

and behavioral health (mental and substance abuse) and community-based services and supports (such as housing, social services, etc.) with a focus on optimizing health outcomes and quality of life for enrolled members.

The HH and CMAs commits to ensuring members are receiving individualized, person-centered care and ongoing coordination of collaborative healthcare services as identified in the member's plan of care. Care Managers (CM) complete ongoing assessments to manage member's needs to promote member retention and engagement, providing continuity of care and ensure care needs continue to be met effectively.

A CM is the single point of contact for directing all patient-centered care and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual arrangements with appropriate service providers, of comprehensive, integrated services.

Procedure

CMs must provide at least one of five core (exclusive of HIT) HH services per month to meet minimum billing requirements. The mode of contact may include but is not limited to: face to face meeting(s) (no minimum requirement), mailings, electronic media and telephone calls that are reciprocal in nature, and case conferences.

CM will ensure active, ongoing and progressive engagement will be documented in the care management record to demonstrate active progress towards outreach and engagement, care planning and/or the member achieving their personal goals. Except for member interviews to make assessments and plans, contacts do not need to be face-to-face or direct encounters. They may include contacts with collaterals or service providers in fulfillment of the member's plan.

Eligibility Verification Throughout Enrollment

CM must identify and confirm a member's eligibility for enrollment as identified in *BCHN002: Standards and Requirements for Referrals, Eligibility Verification, Outreach and Enrollment into Health Home Care Management Services.* Individuals cannot be enrolled in more than one care management program funded by Medicaid.

The Health Home is required to upload the Initial Appropriateness via the Consent and Member Program Status Upload file within 30 days of signed consent, if this is not met the MAPP HHTS will prevent any billing from occurring.

The CMA is required to complete an Initial Appropriateness +/- 30 days from enrollment and/or re-engagement (segment start date) from an Excluded Settings. The CMA must complete a Continue Eligibility for Services Tool 12 months post enrollment and/or segment start date, and every six months thereafter.

The CM must continue to identify and confirm a member's eligibility for continued enrollment in HH services.

- Information in the member's care management record matches the most current insurance information obtained:
  - Programs: Must reflect current HARP code, if applicable
  - Eligibility: Health Plan Information ("Fee-for-service" or current MCO)
- CM will complete a Bassett Medicaid Check in the Care Management Record each month prior to rendering services confirming Medicaid eligibility.

Core Billable Health Home Services

CM will complete at minimum one Core Health Home Service in order to bill for a member's enrollment, each month. Each core service is identified below with examples of service provision

within each category:

Comprehensive Care Management

Completion of a comprehensive health assessment inclusive of medical, behavioral, rehabilitative and long-term care, and social service needs is a requirement. In addition to the comprehensive assessment, collaboration to prepare and complete the members crisis intervention plan, Social Determinants of Health assessment and plan of care are required to be updated or reviewed at minimum, annually. For further detailed guidance refer to *BCHN013 – Standards of the Comprehensive Assessment and Practice of Person-Centered Care.*

Completing/revising a person-centered plan of care with the member and/or care team to identify member's needs/goals. The individual's plan of care integrates the care team who make up the continuum of care, including:

- Medical,
- Behavioral health services,
- Rehabilitative,
- Long term care and
- Social service needs

Conducting outreach and engagement activities to assess on-going emerging needs and to promote continuity of care and improve health outcomes.

Care Coordination and Health Promotion

The CM is responsible and accountable to coordinate all aspects of the members care, including, but not limited to:

- engagement and retention in care
- an assigned and dedicated care manager who serves as the point of contact for the coordination of member care and services
- accepting accountability to support effective collaborations between members of the Multidisciplinary team providing evidence-based referrals and follow-up and consultations that clearly define roles and responsibilities.
    - Collaborate with clinicians on an as needed basis, changes in the individual's condition that may necessitate treatment change (i.e., written orders and/or prescriptions).
    - Collaboration through care team meetings, including all members of the interdisciplinary team annually or as needed.
        - Consent is required for all communication/collaborate on the members behalf.
        - If at any time, the CMAs and/or CMs are having difficulty with a clinician or other service provider the health home may be able to assist in cultivating a working relationship.
- tracking and sharing information and care needs across providers to monitor outcomes and initiate changes in care, as necessary, to address the individual's needs.
- Coordinating and arranging for the provision of services;
- Advocate for services and assist with scheduling of needed services.
- Supporting adherence to treatment recommendations;
- Monitoring and evaluating an individual'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.

- CM will monitor the member's care needs and ensure sharing of information to facilitate collaboration between the member, involved Healthcare and Service Providers, Caregivers, Family/Social supports, and the member's MCO:
    - Monitor/assist with scheduling and follow-up of Provider appointments.
    - Monitor/assist with scheduling transportation for appointments and services.
    - Monitor/assist with fulfilling written orders/prescriptions.
    - Monitor/follow-up on scheduled tests and prescribed treatments.
    - Monitor for changes in Health Conditions/Acuity.
    - Monitor for potential conflicts in treatment: If the CM becomes aware of a potential conflict in treatment, the CM will notify the member, the involved Providers, and the member's MCO within 24 hours. CM will coordinate to assist in resolution. Examples of conflicts in treatment include:
        - Contraindicated treatment: A provider prescribed a medication which may be contraindicated with a patient's usage of other medications or substance use
        - Conflict of treatment protocol: A provider prescribes treatment which may be in opposition to another provider's treatment or the member's preferences
- Monitor/support/accompany the client to scheduled medical appointments.
- CM will coordinate with members MCO when requested to carry out responsibilities to provide notice of enrollee rights under Section 13.6 of the Medicaid Managed Care Contract for Adults.
    - The MCO shall provide CM with information about the means employed to contact the member, including the dated of attempted contact, the outcome of the attempted contact, and the address and/or telephone number used to contact the member.
- Link/refer members to needed services to support care plan/treatment goals, including medical/behavioral health care; patient education and self-help/recovery and self-management.
    - The HH and CMAs will ensure the availability of priority appointments for HH 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.
- During a crisis CM will provide intervention identified in crisis intervention plan and will revise care plan/goals as required.

CMAs will have guidance 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. Referrals include, but are not limited to:

- smoking cessation,
- diabetes,
- asthma,
- hypertension,
- self-help recovery resources,
- other services based on individual needs and preferences.

The Health Home and partnering CMA's will have 24 hour/seven days a week availability for a care manager to provide information and emergency consultation services to members in need.

Comprehensive Transitional Care

The CM will monitor a member's EMR/HIXNY/PSYCKES or any other sources available to ensure prompt identification of an individual's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.

The CM will follow up with hospitals/ER within 24 hours of notification of a member's admission and/or discharge to/from an ER, hospital/residential/rehabilitative setting.

- When CM becomes aware of a member's admission to a detox facility they must attempt to make a face to face contact:
  - During the stay of a member that has been admitted.
  - Within 24 hours of discharge from the detox facility.
- The CM will coordinate with the hospital/residential/rehabilitative setting to facilitate safe discharge planning.
  - The CM will coordinate with the member and facility to receive a care and discharge summary, medication reconciliation, timely scheduled appointments at recommended outpatient providers.
  - The CM will verify scheduled appointments, ensure member attendance to appointments, and will outreach and re-engage individuals in care if appointments are missed.
- Include members care team (providers, family, caregivers, and social supports) to facilitate interdisciplinary collaboration for services.
- CM must document/update the Hallmark event and all required contacts in the Care Management Record.

The CM will follow up with the member within 48 hours of notification of discharge from an inpatient unit, ER hospital, residential center, or detention center to assist member with facilitating the care transition.

- Member's discharging from residential centers, detention centers, rehabilitation centers, and/or other long-term care facilities will need an initial appropriateness tool completed +/- 30 days from re-engagement.
- Upon re-engagement, member's information must be updated in accordance with policy. This may be an update to comprehensive assessments, Plan of Care, SDOH assessment, crisis/safety plan, etc.

The CM will link member's with community supports to assure that needed services are provided throughout transition.

Member & Family Support

The CM will work with members to identify supports that will aid in achieving success with their Plan of Care. Member will provide consent for CM to be able to collaborate with supports throughout enrollment. When appropriate and consented for, it is essential the member and/or family supports are involved in:

- Development/review/revision of the individual's plan of care with the member, family and/or caregiver to ensure that the plan reflects individual's preferences, education and support for self- management, recovery and other resources.
  - CM will make plan of care is accessible, upon request, to the individual and families or caregivers, per member's preferences.
  - CMA/CM will provide access to plans of care and options for accessing clinical information.
- Providing an informed decision developing advanced directives and education on client rights and health care issues, as needed.
- Communication and sharing information with individuals and their families with consideration for language, literacy, and cultural preferences.
- Referrals of member/family to peer supports, support groups, and self-care programs to increase member's knowledge of their disease, engagement and self-management capabilities, and improve adherence to prescribed treatment.
- Collaboration/coordination with community-based providers to support effective utilization of services based on client/family need.

Referral and Community & Social Support Services

Identify resources and links member with community-based supports as needed.

- CM will assist member with identifying and utilizing peer supports, support groups and self-care programs to increase enrollees' knowledge about their disease, engagement and self-management capabilities, and to improve adherence to prescribed treatment.
- Plan of care will include community-based and other social support services, and healthcare services that respond to individual's needs and preferences that contribute to achieving members goals.

Collaborate/coordinate with community-based providers to support utilization of services based on client/family need.

- CM will assist Members with identifying available Providers and Community Resources to meet identified needs, and will actively manage appropriate referrals to assist the Member with accessing and engaging with referred services to meet their needs.
- CM must consult with the Member's MCO when referring to a new Provider.
- CM must inform the Member of available options and allow the Member to choose from available network providers based on the Member's preferences.
- As referrals are made, CM will update the Member's Care Management Record with related provider/resource information and documents.
- CM will promote member's education about their health conditions and their engagement in evidence-based prevention and wellness and available self-help recovery resources by linking Members with resources applicable to their health needs, such as:
    - Smoking Cessation
    - Diabetes
    - Asthma
    - Hypertension
    - Other services based on individual needs and preferences
- Use of Health Information Technology (HIT) to Link Services
- Refer to BCHN016: *HIT Access and Requirements Policy* formore in-depth information regarding HIT requirements of the HH.
- CMA will use available HIT and access data through regional health information to comply with the standards for implementation of services.
    - CMA has structured information systems, policies, procedures and practices to create, document, execute, and update a plan of care for every patient.
    - CMA provider has a systematic process to follow-up on tests, treatments, services and referrals which is incorporated into the patient's plan of care.
    - CMA 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.
    - CMA makes use of available HIT and accesses data through the regional health information organization/qualified entity to conduct these processes, as feasible.
- The lead Health Home and CMAs utilize HIT as feasible to facilitate interdisciplinary collaboration among all providers, the enrollee, family, caregivers, and local supports.
- The lead Health Home provides 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.

- CMAs utilize 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.

Ongoing Communication & Documentation Requirements

NYS Medicaid expanded coverage of remote services to include audio-only visits, to increase access to services, eliminate barriers, supplement oversight of chronic conditions, and improve outcomes.

Decisions on what type of visit the NYS Medicaid member receives should be based on their choice and best interest. Provider preference or convenience are not relevant. Providers must use professional judgment to determine whether audio-only services meet patient needs and whether a visit is eligible for audio-only based on criteria below.

- The Department anticipates limited occasions when audio-only visits are appropriate for medical visits (non-behavioral health (BH) or community health worker (CHW) services).
    - For example, during weather emergencies when the patient is unable to use audio-visual technologies or when the visit could not occur unless provided via audio-only telehealth.

NYS DOH will monitor audio-only billing and take steps to limit overuse and prevent misuse of audio-only services. NYS Medicaid covers audio-only visits for NYS Medicaid members when all the following conditions are met:

- audio-visual telehealth is not available to the patient due to lack of patient equipment or connectivity;
- audio-only is the preference of the patient;
- the provider must make either audio-visual or in-person appointments available at the request of the patient;
- the service can be effectively delivered without a visual or in-person component, unless otherwise stated in guidance issued by the NYS DOH (this is a clinical decision made by the provider); and
- the service provided via audio-only visits contains all elements of the billable procedures or rate codes and meets all documentation requirements as if provided in person or via an audio-visual visit.

Patient Rights and Consent

The provider will confirm the identity of the NYS Medicaid member and provide basic information about the services that they will be receiving via telehealth. Written consent by the NYS Medicaid member is not required, but the provider must document informed consent in the chart of the patient before or during the first visit in which telehealth services are provided. Telehealth sessions/services shall not be recorded without the consent of the NYS Medicaid member.

Informed consent means that telehealth provider educates and informs the member about telehealth to assist them in making an informed choice to receive telehealth services. This must include the following:

1. The telehealth provider must confirm that the NYS Medicaid member is aware of the potential advantages and disadvantages of telehealth, be given the option of not participating in telehealth services and information regarding their right to request a change in service delivery mode at any time.

2. The telehealth provider must inform NYS Medicaid members that they will not be denied services if they do not consent to telehealth devices or request to receive services in-person.
3. Where the NYS Medicaid member is a minor and the service requires parent/guardian consent, consent shall also be provided by the parent/guardian or other person who has legal authority to consent to health care on behalf of the minor.

Informed consent shall be obtained through a process of communication between the telehealth provider and NYS Medicaid member.

Documentation Guidance

Each Member served must have a separate care management record that must be maintained.

Each Member served must have a completed DOH 5055 consent on file in the members care management record. The DOH 5055 must be maintained and updated per the members request to add/elimination individuals/entities from the document.

- When a CM is completing changes to a DOH-5055, a note must be documented to accompany those changes.
- All changes to the DOH-5055 must be signed and dated by the member.
- In situations where, verbal consent has occurred:
    - CM must document a note clearly stating the member communication granting the consent.
    - Verbal consent serves as consent for a contact to be made within 24 hours of consent being granted.
        - CM must obtain consent via the DOH-5055 for further contacts to be made with the verbally consented individual/entity, or;
        - CM must obtain and document an additional verbal consent for additional contacts to be made following the 24-hour period.

CM must document all contacts and actions relevant to a member's care in the members care management record.

- Billable Core Health Homes Services should be documented as a Billable Note.
- Interactions not meeting billable requirements should be documented as a Non-billable Note.
- Each Member, each month should have documentation of at minimum one billable core health home service to meet billing requirements.

At the end of each calendar month, a member is able to be billed for as long as the following have been completed:

- Eligibility has been verified, including Bassett Medicaid Check.
- At minimum, one core health home service has been provided.
- Supporting documentation of diagnostic information is uploaded (completed with a member's initial intake, but should be updated as changes occur)
- Completed HML with up-to-date information.

At the end of each calendar month, members who are unable to be billed for require the following:

- Eligibility has been verified, including Bassett Medicaid Check.
- Non-billable contact note(s) demonstrating multiple attempts/methods to reach the member.
- Supporting documentation of diagnostic information is uploaded (completed with a member's initial intake, but should be updated as changes occur)
- In some cases, a CM and their Supervisor may need to determine if this member meets criteria to be entered into DSE in the following calendar month. (Refer to

BCHN008: *Continuity of Care and Re-Engagement of Enrolled Members*)

- Completed HML with up-to-date information, indicated a "No" for billable services.

Even while conducting routine activities, CMs may not always be able to assess member eligibility and appropriateness for continued enrollment. Therefore, it is necessary that periodic standardized screenings are conducted by all CMAs through completion of the Continued Eligibility Screening (CES) Tool.

- The CES Tool evaluates members based upon active Medicaid (eligible and compatible with HH services), qualifying diagnosis, significant risk factors, other risk factors, and member engagement in HH care management.
    - The use of the CES Tool was implemented for HHSA effective November 1, 2023, as follows:
        - New Members enrolled on/after 11/1/23: Complete CES Tool 12 months post-enrollment and every 6 months thereafter.
        - Existing Members Complete CES Tool at time the member's annual enrollment date, and every 6 months thereafter.
            - In the event an Initial Appropriateness (IA) was done throughout the year, post enrollment, a CES Tool would not be required for 12 Months post the IA completion.
                - For example, a member enrolled 6/18/2020. The member went into an Excluded setting 11/14/2023, discharged from the Excluded Setting on 1/14/2024. An Initial Appropriateness was completed on 2/1/2024, a CES Tool is not required until 2/1/2025.
- For members who are Health Home Plus (HH+), HH+ Eligible, or Adult Home Plus (AH+) the CES Tool should NOT be completed. When a member is stepped down from HH+ or AH+, the CES Tool would be due 12 months following the date of step down, regardless of when their re-assessment is due.
- The CES Tool must be completed by the CMA Supervisor or Quality Improvement staff, or if completed by the HHCM, the CMA Supervisor must review and confirm the final outcome. Completion of the CES Tool must be documented in the member's record.
    - If there are any concerns related to the completion of the CES Tool, the CMA Supervisor has the discretion to complete a new CES Tool for submission into the MAPP HHTS. This new CES Tool must be completed within the same time period allotted for the first CES Tool. Completion of a second CES Tool must also be documented in the member's record.

- The date of completion and outcome is recorded in the Electronic Health Record (EHR) and, in turn uploaded into the MAPP HHTS via the Consent and Member Program Status Upload file. MAPP HHTS generates the due date for the next CES Tool based on the completion date and outcome. This is shared with Health Homes via the Consent and Member Program Status Download file. The outcomes are as follows:
    - Recommend Continued Services – complete CES Tool at next required timeframe – 6 months
    - Recommend Disenrollment– require that disenrollment be completed within 60 calendar days.
    - If the outcome of the CES Tool recommends Disenrollment from the HH program, HHs and CMA/HHCMs must refer to and follow disenrollment procedures within the BCHN004 Health Home Member Disenrollment Policy.
    - More Information Needed –requires further evaluation to include the member and other providers for a conclusive outcome. Another CES Tool must be completed within 60 calendars days (a second 'More Information Needed' result is not acceptable)
- For guidance and instruction to complete the CES Tool CM's and

Supervisors may refer to the Continued Eligibility Screening (CES) Tool Guidance.

- This will provide CMs and Supervisors a timeline for CES Completion, guide to correct completion of each question and definitions of the results and how to move forward.

In addition to the above record requirements, the care record must contain at a minimum, but not limited to the following components:

- All completed and signed HH consents
- Records of eligibility determination and evaluations
- Copy of Notice of Determinations issued to the member
- Initial comprehensive assessments, annual comprehensive assessment, and an abbreviated comprehensive assessment (as needed).
- Initial and subsequently updated Plan of Care containing goals, objectives, timeframes, and other required components, per policy
- Copies of any releases of information signed by the member (or member's representative)
- Medical, behavioral health, social services or any other referrals made for the member
- Progress notes
- Additional assessments (SDOH Assessment, HCBS Assessment, etc.)
- Safety/Crisis plan
- Discharge plans
- Copy of medical records
- Pertinent correspondence with member or member representative
- Any additional documentation as identified by applicable State and Federal regulations

Training

HH will provide CMA staff with resources and trainings regarding adequate core service delivery required for billing. BCHNHH will ensure to look for any patterns or trends in billing standards and services provided and address accordingly as needed. Discussion will take place in QMP meetings if adjustments to work flows or additional trainings need to be considered.

HH and CMA staff must receive training on protocols related to eligibility for enrollment and continued enrollment in the Health Home Program including, but not limited to:

1. Initial eligibility requirements and continued eligibility, responsible for appropriateness assessments
2. Appropriateness criteria - selection and timeline requirements
3. Reporting Initial Appropriateness and uploading into MAPP HHTS
5. Documentation requirements For HHs and CMA staff Only
6. Completing CES Tool, staff responsible, and timeline requirements
7. Reporting CES Tool outcomes and uploading into MAPP HHTS
4. Documentation requirements

Quality Monitoring

Health Homes have a core billable services provision quality assurance process in place to comply with Health Home policies and procedures as outlined in the Health Home Quality Management Program policy.

Supporting Policies and Resources

Health Home Minimum Billing Standards
Billable Services Guide
Notes Desk Guide
Continued Eligibility Screening (CES) Tool

Continued Eligibility Screening (CES) Tool Guidance.
Use of the Continued Eligibility for Services (CES) Tool
Telehealth Policy Manual