Health Home MCO Work Group

November 24, 2014

Redesign Medicaid in New York State

FIDA, MLTC, and Health Homes

FIDA Update

- The Fully Integrated Duals Advantage (FIDA) program is a three-year Demonstration that will run from January 2015 through December 2017.
- The Memorandum of Understanding (MOU) between the Centers for Medicare and Medicaid Services (CMS) and the New York State Department of Health (NYSDOH) was signed on August 26, 2013.
- To be a FIDA Plan, a plan must be approved as a Managed Long Term Care (MLTC) plan, be approved as a Medicare Advantage (with prescription drug) plan, and meet all the FIDA requirements.
- Currently, 22 Plans have completed the readiness-review process and are deemed ready to participate in the FIDA program. This is based on many elements such as systems, staffing, network adequacy, marketing, and training.
- Plans have executed a three-way contract with CMS and DOH.

Who is Eligible for FIDA?

Must be:

- Age 21 years of age or older;
- Entitled to benefits under Medicare Part A and enrolled under Parts B and D and receiving full

  Medicaid benefits;
- Living in a demonstration county:

  Region I: Bronx, Kings, New York, Queens, Richmond, and Nassau.

  Region II: Suffolk and Westchester.

And meet one of the following three criteria:

- Require community-based Long Term Services and Supports (LTSS) for more than 120 days,
- Are Nursing Facility Clinically Eligible and receiving facility-based LTSS, **or**
- Are eligible for the Nursing Home Transition Diversion Waiver program.

FIDA Enrollment

Region I: NYC & Nassau

- **January 1, 2015**, effective date for individuals in Region I who choose to opt-in to the Demonstration.
- **April 1, 2015**, effective date for individuals who are Passively Enrolled in Region I. Passive Enrollment will occur over a five-month period.

Region II: Suffolk & Westchester

- **April 1, 2015,** effective date for individuals in Region II who choose to opt-in to the Demonstration.
- **July 1, 2015,** effective date for individuals who are Passively Enrolled in Region II.

FIDA Enrollment

- There are two types of enrollment:
  - **Opt-in Enrollment,** which is initiated by an individual.
  - **Passive Enrollment,** which is enrollment by the State that the individual can decline by opting out.
- Current Health Home (HH) members will **NOT** be passively enrolled into FIDA.
- All enrollments (opt-in and passive) will be through the Enrollment Broker, New York Medicaid Choice.
- Participants may disenroll at any time during the Demonstration.

FIDA Interdisciplinary Team (IDT)

- A key aspect of FIDA is the Interdisciplinary Team. Plans are required to use an IDT approach.
- Each Participant must have an individualized comprehensive care planning process in order to maximize quality of life.
- The IDT, led by an accountable care manager, will ensure the integration of the Participant's medical, behavioral health, substance use, community-based or facility-based LTSS, and social needs.
- The IDT will be person-centered, based on the Participant's specific preferences and needs, and deliver services with respect to linguistic and cultural competence, and dignity.

FIDA & Health Homes

- Since Plans will be required to use an IDT, Plans are **NOT** required to contract with HHs to provide care management.
- However, Plans do have the ability to contract with a HH.
- How does FIDA impact HHs?
  - Individuals enrolled in a HH who subsequently enroll in FIDA **need** to disenroll from the HH.*
  - FIDA Plans will need to coordinate with the HH to prevent duplicate care coordination, but these individuals could continue to receive the HH services.

* Updated 5.29.18: Effective 1/1/2018 FIDA members cannot enroll in a Health Home. Medicaid members have a choice of enrollment in a FIDA Plan or in a Health Home.

MLTC Statewide Enrollment

Enrollees in MLTC	As of November 1, 2014
New York City	117,785
Rest of the State	20,455
Total Statewide:	138,240
Types of Plans	**Number Actively Enrolling**
Partial	32 (25 serve NYC)
PACE	8 (2 serve NYC)
MAP	8 (8 serve NYC)
Total:	48

Changes to MLTC in 2014

- In accordance with NY State's Special Terms and Conditions (STC) #28, the State is required to develop an independent and conflict-free LTSS evaluation process.

- As of October 1, 2014, the State has implemented a Conflict-Free Evaluation and Enrollment Center (CFEEC) for individuals seeking Community-Based Long Term Care (CBLTC) services for more than 120 days.

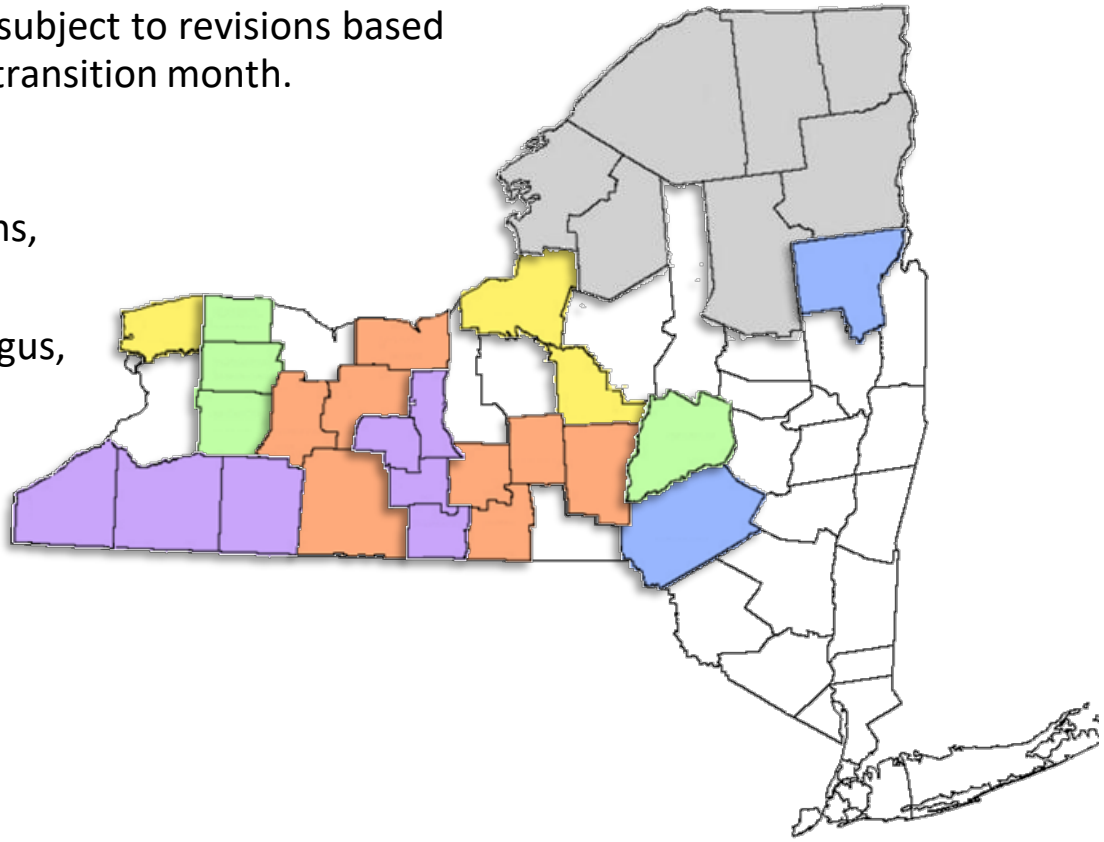
MLTC Changes Scheduled for 2015

- Contingent upon development of appropriate benefits in MLTC, the following will move into MLTC:
  - Nursing Home programs
  - Nursing Home Transition and Diversion (NHTD) waiver participants
  - Traumatic Brain Injury (TBI) waiver participants
  - Assisted Living Program participants

MLTC Transition

An updated transition timeline for the remainder of the upstate counties was submitted to CMS. This information is also posted on the MRT web site. This timeline is subject to revisions based upon CMS' discrete approval of each transition month.

- **December 2014:** Genesee, Orleans, Otsego, and Wyoming
- **January 2015:** Allegany, Cattaraugus, Chautauqua, Chemung, Schuyler, Seneca, and Yates
- **February 2015:** Clinton, Essex, Franklin, Hamilton, Jefferson, Lewis, and St. Lawrence



EEC Activity as of November 1, 2014

- CFEEC implementation began on November 1, 2014, in Region 2 which consists of Kings, Queens, Nassau, & Richmond.

Total evaluation activity	
New Appointments Scheduled	928
Appointments Conducted	677
Total Approved Evaluations	599
Total Denied Evaluations	64
Total Nurse Missed Evaluations	0
Total Consumer No Shows	12
Total Rescheduled Evaluations	125
Total Programmatic notices sent	286
Total incoming calls	2,614
Total complaints	0
Total number of disputes	0
Total number of fair hearings requested	0

Collaboration Between HHs and MLTC Plans

- The goal is that individuals who are Medicaid eligible will be given the option to enroll in HHs.
- Individuals can be enrolled in a HH and MLTC Plan at the same time, but services must be coordinated.
- The MLTCPs and HHs must enter into an Administrative Service Agreement (ASA) that clearly defines the respective care manager roles and a collaborative working relationship.
- An ASA Template between HH and MLTC has been developed and will be distributed to MLTC Plans and HHs.
  - Comments provided by HHs and MLTC Plans have been incorporated.
  - The Template will be modeled from current ASAs between HHs and MCOs.

ASA Template

- Areas the ASA Template addresses (including but not limited to):
  - HH and MLTC must establish clearly defined roles in providing collaborative care management – MLTC is responsible only for coordination and not for HH management or performance.
  - Enrollee's Plan of care;
  - Existing protocols/policies;
  - Communication regarding changes in participant status;
  - Quality, data, and reporting requirements;
  - Non-discrimination;
  - Confidentiality;
  - Eligibility verification – Medicaid and Programmatic;
  - Information sharing process;
  - Dispute resolution;
  - Grievances and appeals; and
  - MLTC Plans will not be required to develop MOUs.

Defining Care Management Roles

- Between HHs and MLTC Plans
  - For individuals enrolled in an MLTC Plan/HH, both the MLTC Plan and the HH are authorized to bill for the resident – it is expected that the HH and MLTC will work collaboratively to coordinate and develop person-centered care plans.
  - MLTC Plans will receive (or continue to receive for existing enrollees) a capitation payment for each individual enrolled in MLTC.

CONTACT US

Questions and/or Comments:

CFEEC e-mail: CF.Evaluation.Center@health.ny.gov

MRT 90 website:
http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm

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Redesign Medicaid in New York State

Transitioning Behavioral Health Benefits to Managed Care for Adults and Children, Children's Health Homes

Update: Behavioral Health Transition to Managed Care

- BH Team continues to work in collaboration with DOH, OMH, OASAS, OCFS, NYC, stakeholders, and local governmental units in order to successfully transition BH.
- Behavioral Health services will be transitioned to managed care under the authority of the 1115 Waiver (Partnership Plan).
- NYS meets biweekly with CMS to discuss our BH design. Discussions have been productive.
- Timeline:
  - **Adults in NYC:** April 2015
  - **Adults in ROS:** October 2015
  - **Children Statewide:** January 2016

Qualified Managed Care Plans and HARPs - Adults

Qualified Managed Care Plan

- Medicaid eligible
- Benefit includes Medicaid state plan covered services
- Organized as benefit within MCO
- Management coordinated with physical health benefit management
- Performance metrics specific to BH
- BH medical loss ratio

HARP

- Specialized integrated product line for people with significant behavioral health needs
- Eligible based on utilization or functional impairment
- Enhanced benefit package - All current PLUS access to HCBS
- Specialized medical and social necessity/ utilization review for expanded recovery-oriented benefits
- Benefit management built around higher need HARP patients
- All HARP members eligible to be enrolled in HH
- Performance metrics specific to higher need population and HCBS
- Integrated medical loss ratio

NYC RFQ Process has been Completed - Adults

- All 10 NYC Plans submitted RFQ applications to manage State Plan behavioral health services
- Of those 10 Plans, 7 applied to be a HARPs
- Rigorous review process – DOH/OMH/OASAS
- In-person follow-up meetings with the Plans
- Designation process
- Next steps:
  - Plan readiness reviews prior to implementation date
  - Rest of State RFQ process

Proposed HCBS Menu for HARP Members –Adults

HARP Eligible Members will Receive Health Home Care Coordination

- Rehabilitation
  - Psychosocial Rehabilitation
  - Community Psychiatric Support and Treatment (CPST)
- Crisis Intervention
  - Short-Term Crisis Respite
  - Intensive Crisis Respite
  - Mobile Crisis Intervention
- Habilitation
- Empowerment Services and Peer Supports
- Support Services
  - Family Support and Training
  - Non-Medical Transportation
- Individual Employment Support Services
  - Prevocational
  - Transitional Employment Services
  - Intensive Supported Employment
  - On-Going Supported Employment
- Educational Support Services
- Self-Directed Services

* InterRAI Assessment Tool will be used to determine eligibility for HCBS services

InterRAI: Assessment Tool for Determining HCBS Eligibility and Developing Plan of Care

- Eligibility for HCBS services will be determined by the InterRAI functional assessment tool that includes several suites designed for specific populations
- The State has been working to adapt the Community Mental Health suite of the interRAI to develop a shorter HARP and HCBS Eligibility tool, and a Full Assessment tool which will be utilized to inform the Plan of Care.
- It is anticipated that Health Home care managers will be conducting both the HARP/HCBS Eligibility Assessment, and the Full Functional Assessment using these tools.
- The Full Assessment is currently being finalized, and the Eligibility Assessment will be reviewed following an analysis of assessments collected in the initial implementation in New York City.

Schedule for Testing and Training

Anticipated Implementation Schedule for interRAI in NYC; Study in Upstate Counties (DRAFT)	
Event	Anticipated Date
Integration of HARP-HCBS Eligibility Study, Pilot Research Design	Completed
Development of Training Plan with University of Michigan/interRAI, CIM, State Staff	Initial Training completed for FEGS 10/27-10/29/14 Training Work Group established November 2014
Begin Assessing HARP eligible individuals in FEGS Health Homes Data submission to University of Michigan by CIM per schedule	October 2014 After 50, then following completion of 600 Full CMH Assessments
Rollout of training of NYC Health Home Care Managers/Care Coordinators	January 2015
Review/modify assessment tool as needed based upon assessor and recipient feedback	January 2015
Initial Data analysis for establishing algorithms and threshold scores for HARP and HCBS eligibility	Based upon rate of data submission

Next Steps

- Trainings with NYC Health Home Care Managers will begin
- The State will be working with Health Homes to prepare them to access the Health Commerce System
- The Managed Care Technical Assistance Center (MCTAC) will be hosting a webinar next month to Engage HH Providers

Health Home Standards for Health Home Members

- Multi-agency workgroup convened in 2014 to examine policies related to care management for HARP enrollees
- Initial focus: Eligibility determination for Home and Community Based Services (HCBS)
- Recent work: Standardization of Health Home care management expectations. NYS requests feedback from HH-MCO Workgroup regarding draft interpretive guidance related to standards and best practices for the provision of Health Home Services

Proposed Interpretive Guidance

- Identifies key domains from ASA Article II and HH Provider Qualification Standards:
  - Identification and Outreach
  - Comprehensive Assessment
  - Plan of Care
  - Care Transitions
  - Member Referral and Follow-Up
  - Staffing/Access
  - Patient Registry and Electronic Health Records
- The guidance pertains to Health Home services for all Health Home eligible members, Health and Recovery Plan (HARP) enrollees, and Health Home Plus members

Proposed Guidance: Identification and Outreach*

- The Health Home should:
  - Assign care managers to members based upon care manager experience and defined member characteristics including, but not limited to, acuity, presence of co-occurring SMI/SUD or co-morbid conditions, and patterns of acute service use;
  - Ensure that care managers have access to Health Home administrative data to inform real-time decision making regarding outreach and engagement efforts;
  - Communicate with managed care organization (Plan) staff to review Plan data regarding behavioral and general medical/surgical service use as indicated to support outreach and engagement;
- Health Home staff working with difficult to engage HARP members should have experience working with individuals with serious mental illness and/or serious substance use disorders.
- Health Homes should use behavioral health peers to support outreach and engagement for HARP enrollees.

***Selected guidance: see document for full list**

Proposed Guidance: Identification and Outreach*

- Health Home care managers working with *Health Home Plus* members must have a caseload ratio no greater than 1 staff to 12 Health Home Plus recipients – that is, each AOT/Health Home Plus will represent 8.5% of a full-time Health Home care manager's available care management time if the caseload also includes non-Health Home Plus members.

- Individuals with Assisted Outpatient Treatment (AOT) court orders must receive Health Home Plus services. Upon enrollment:

  - AOT individuals should either already be receiving CM services via a HHCM legacy provider or must be assigned to a legacy HHCM provider via the LGU AOT process;

  - The legacy HHCM provider must inform the Health Home when the recipient has been placed on court ordered AOT or when the court order has expired or has not been renewed;

  - The Health Home must inform the Managed Care Plan of the member's AOT status.

***Selected guidance: see document for full list**

Proposed Guidance: Care Transitions*

The Health Home should:

- Ensure that Health Home care managers communicate with inpatient providers whenever a Health Home enrolled member is admitted (and the Health Home is notified of the admission) to share clinical information and support discharge planning;
- Define high-risk member subpopulations (e.g., those with multiple recent prior hospitalizations/emergency room visits) for which Health Home care managers will be required to visit the member during hospitalization (when notified of the admission) and participate in care transition planning;
- Collaborate with Plans to develop and implement protocols for intensive care transition initiatives for identified high-need populations;

***Selected guidance: see document for full list**

Proposed Guidance: Referral and Follow Up*

The Health Home care manager should:

- Contact members within 48 hours of discharge from an inpatient unit (when notified of the admission), or sooner if clinically indicated, to facilitate the care transition. This communication should include review of upcoming appointment dates and times, medication reconciliation and prescription refills, and potential obstacles to attending follow-up visits and adhering to treatment plan;

- For Detox discharge the Health Home should attempt to make face-to-face contact during the stay and within 24 hours of discharge to ensure that the patient is aware of follow-up appointments and to provide supports to getting to appointments.

***Selected guidance: see document for full list**

Proposed Guidance: Staffing and Access*

The Health Home should:

- Determine care manager caseloads based upon defined characteristics including, but not limited to, acuity, presence of co-occurring SMI/SUD or co-morbid conditions, patterns of acute service use, and care manager expertise.
- Ensure that the caseload size is sufficient to allow for in person contact for Health Home members who are in need of intensive outreach and support.
- Ensure adequate behavioral health leadership, supervisory capacity, and clinical experience for staff working with HARP members;
- Ensure that Health Home staff working with difficult to engage HARP members have experience working with this population;

Health Home care managers assigned to Health Home Plus members must meet the minimum qualification standards listed in Health Home Plus guidance available at: http://www.omh.ny.gov/omhweb/adults/health_homes/hhp-final.pdf

***Selected guidance: see document for full list**

Proposed Guidance: Electronic Health Records*

The Health Home should have policies and procedures that describe:

- Its HIT and electronic health record capabilities for:
  - Making data regarding past use of general medical and behavioral health services available to care managers to support care planning and coordination; and
  - Ensuring that care plans and service use information can be readily exchanged and accessible to other providers serving the member;
- How it will use data for predictive modeling and risk stratification to identify members in need of enhanced monitoring and outreach;
- How it will identify high-need members with notification flags in its electronic health record;

***Selected guidance: see document for full list**

Next Steps

- Feedback from HH-MCO Consolidated Workgroup, Payment and Standards Sub-Work Group
- NYS is proposing that the standards be implemented as best practices and that timelines and approaches for possibly incorporating such standards and best practices in the ASA be discussed.
- MCO standards related to care management will be incorporated into MCO contracts by reference as part of the 2015 behavioral health MCO rollout
- NOTE:
  - The proposed guidance is not intended to prevent Health Homes and Plans from adding other guidance or elements to the ASA for which the Health Home and the Plan mutually agree
  - NYS will provide future additional guidance related to Health Home care management activities for children and adolescents

Design - Children's Services Transition to Managed Care – January 2016

- No separate product line for children's BH services like the HARP
- Current children's waiver populations will transition to managed care
  - OMH Seriously Emotionally Disturbed (SED) Waiver
  - OCFS Bridges 2 Health (B2H) Waiver for SED, Medically Fragile (MF) & DD children in Foster Care
  - DOH Care at Home (CAH) I&II Waiver for MF children
- Proposed expansion of State Plan Services
- Proposed expansion of HCBS Services under 1115 amendment
  - The authorization to offer the HCBS Services to children meeting Level of Need (LON) and Level of Care (LOC) criteria will be part of the 1115 amendment application
  - The intensity of HCBS services will be congruent with LON and LOC determination

Proposed New State Plan Services - Children

- Mobile Crisis Intervention
- Community Psychiatric Supports and Treatment (CPST)
- Other Licensed Practitioner
- Psychosocial Rehabilitation Services
- Family Peer Support Services
- Youth Peer Advocacy and Training

Proposed HCBS Array - Children

- Care Coordination (only for those ineligible for, or opt out of, Health Home)
- Skill Building
- Family/Caregiver Support Services
- Crisis & Planned Respite
- Prevocational Services
- Supported Employment Services
- Community Advocacy and Support
- Non-Medical Transportation
- Day Habilitation
- Adaptive and Assistive Equipment
- Accessibility Modifications
- Palliative Care

* CANS-NY Assessment tool (as modified) will be used to determine eligibility

Use of the Child and Adolescent Needs and Strengths Assessment of New York (CANS-NY)

- CANS-NY is anticipated to be used:
  - Determine need for Home Community Based Services (part of Behavioral Health transition to Managed Care)
  - Determine acuity for Health Home Rates
  - Assist in determining if children meet HH eligibility functional criteria
- The CANS-NY tool is being modified to improve its ability to capture the various children's populations that would be eligible for Health Home and HCBS services, including infants and toddlers and medically fragile children

Next Steps: Managed Care Design for Children

- Finalize Modifications to CANS-NY tool
- Finalize Proposed Benefit Package
- Network Standards & Performance Metrics
- Analysis of Potential Numbers of Children in Cohorts
- Finalize the State Plan Amendment
- Draft the 1115 Amendment

Managed Care Readiness
Managed Care Technical Assistance Center (MCTAC)

- NYS has partnered with MCTAC as a training, consultation, and educational resource center that offers resources to ALL mental health and substance abuse providers in New York State
- The goal of MCTAC is to provide training and intensive support on quality improvement strategies, including business, organizational and clinical practices to achieve the overall goal of preparing and assisting providers with the transition to Medicaid Managed Care

Tailoring Health Homes to Better Serve Children - Health Home Application to Serve Children

- On June 30, 2014 the State issued a draft design document, that included a draft Health Home Application to Serve Children, and sought stakeholder feedback on a variety of topics including:
  - Eligibility requirements
  - Requirements for expanding Health Home networks to reflect the needs of children
  - Requirements for demonstrating Health Homes can "tailor" delivery of core Health Home services to better serve children
  - Connectivity with programs and systems that impact children (foster care, education, Early Intervention)
- Comments and Letters of Interest were due July 30, 2014
  - More than 40 Health Homes, Medicaid providers, children's advocates and other stakeholders submitted comments
  - 34 Letters of Interests Submitted
    - 21 Currently Designated Health Home (some of which indicated the potential formation of partnerships among Designated Health Homes)
    - 13 New Organizations

Tailoring Health Homes to Better Serve Children - Health Home Application to Serve Children

- Final Health Home Application to Serve Children posted on November 3, 2014
- Webinar Held on November 5, 2014 (see DOH Health Home Website for details)
  - Eligibility (trauma), phase-in of children beginning October 2015, use of CANS-NY to determine acuity for rates (High, Medium, Low structure), standards for care managers and engagement), assignment and referral, consent
- State has had preliminary discussions with both CMS (September 10, 2014) and SAMHSA (November 20, 2014)
  - Discussions regarding expansion of HH criteria to include trauma positively received by CMS and SAMHSA
- State working to complete and test modifications to CANS-NY, develop Health Home rates for children, develop consent forms and procedures, informational webinars and training, modifications to MAPP for children

Schedule for Phasing-in Enrollment of Children in Health Homes

Anticipated Schedule of Activities for Expanding Health Homes to Better Serve Children	Due Date
Draft Health Home Application to Serve Children Released	June 30, 2014 - **Completed**
Due Date to Submit Comments on Draft Health Home Application to Serve Children	July 30, 2014 - **Completed**
Due Date to Submit Letter of Interest	July 30, 2014 - **Completed**
Final Health Home Application to Serve Children Released	November 3, 2014 - **Completed**
Due Date to Submit Health Home Application to Serve Children	March 2, 2015
Review and Approval of Health Home Applications to Serve Children by the State	March 2, 2015 to June 15, 2015
HH and Network Partner Readiness Activities	June 15, 2015 to September 30, 2015
State Webinars, Training and Other Readiness Activities (See November 5 PPT for Schedule)	Through September 30, 2015
Begin Phasing in the Enrollment of Children in Health Homes	October 2015
Children's Behavioral Health Services and other Children's Populations Transition to Managed Care http://www.health.ny.gov/health_care/medicaid/redesign/care_management_for_all.htm	January 2016

Redesign Medicaid in New York State

Implementation Funds,
Functional and Clinical Adjustments to High Medium Low Rates,
Payment Standards

Status of Implementation of Health Home Development Funds

- MRT Waiver includes $190.6 million for Health Home Development Funds
- State is now engaged in discussions with CMS on necessary amendments to the State Plan, and methodology for distributing the funds. Based on initial discussions and contingent upon CMS final approval:
  - CMS is requiring funds be distributed through a rate add on to the per member per month HH rate to be paid to the lead Health Home
  - First payment will be made in March of 2015 and will be based on claims with dates of service from August 1, 2014 to February 28, 2015. Additional payments will be made quarterly (June, September, December and Marc) through DSRIP Year 2 (ends December 31, 2016) for claims with dates of service in prior quarter
  - ***Paid claims will be reconciled against the tracking system, the rate add on will apply only to paid claims (outreach and engagement) which have a corresponding segment in the tracking system***

Status of Implementation of Health Home Development Funds

- Per Waiver, funds must be used for the following purposes:
  - Health Information Technology
  - Joint Governance Technical Assistance
  - Workforce Training and Retraining
  - Member Engagement and Health Home Promotion
- Reporting (e.g., semi-annually) on the use of funds will be required. Reports must document discussions with downstream providers on uses of funds, how funds were used to benefit network partners and should consider approaches for aligning with DSRIP projects.
- Subject to CMS approval, Funding for retrospective expenses that can be documents (e.g., HIT investment) will be allowed (may be subject to limits)

Modifying Health Home Payments for Functional and Clinical Adjustments

- Tiers of High Medium and Low (HML) PMPM rates have been developed for both HARP and non-HARP Health Home members – rates based on base CRG acuity
- HH/MCO subgroup has been working since June to identify functional and clinical adjustments that would adjust HML rates (e.g., move a member in low rate category to medium or high rate category) adjust Health Home members will be slotted into specific rate tiers depending on their base acuity
- Work is proceeding to incorporate the HML rates and algorithm to adjust rates based on clinical and functional indicators into MAPP

High, Medium, Low Rates

Proposed Health Home Payments under High, Medium, Low as of 10-16-14 *				
Population	**Region**	**Low**	**Medium**	**High**
HARP	Downstate	$125.00	$311.00	$479.00
non -HARP	Downstate	$62.00	$249.00	$383.00
HARP	Upstate **	$117.00	$293.00	$450.00
non -HARP	Upstate **	$58.00	$234.00	$360.00
* Proposed single statewide Outreach rate of $125 to $135				
** Reflects approximate 8% increase to address rural issues.				

Proposed Health Home Payments with Transition to Managed Care

Attribute	Low	Medium	High
Base Acuity (unadjusted)	<= 2.5	Between 2.5 and 5.0	>=5.00
Clinical Adjustments			
Risk	< 30%	between 30% and 50%	> 50%
HIV Viral Load	< 200	between 200 and 400	> 400
HIV T-cell Counts	> 350	between 200 and 350	< 200

Proposed Health Home Payments with Transition to Managed Care

Functional Adjustments		
	Medium	**High**
Homelessness	Meets HUD Category 2: Imminent Risk of Homelessness definition	Meets HUD Category 1: Literally Homeless definition
Incarceration	Recent Incarceration between seven and twelve months	Recent Incarceration within six months
IP Stay for Mental Illness	IP Stay for Mental Illness within seven and twelve months	IP Stay for Mental Illness within six months

Proposed Health Home Payments with Transition to Managed Care

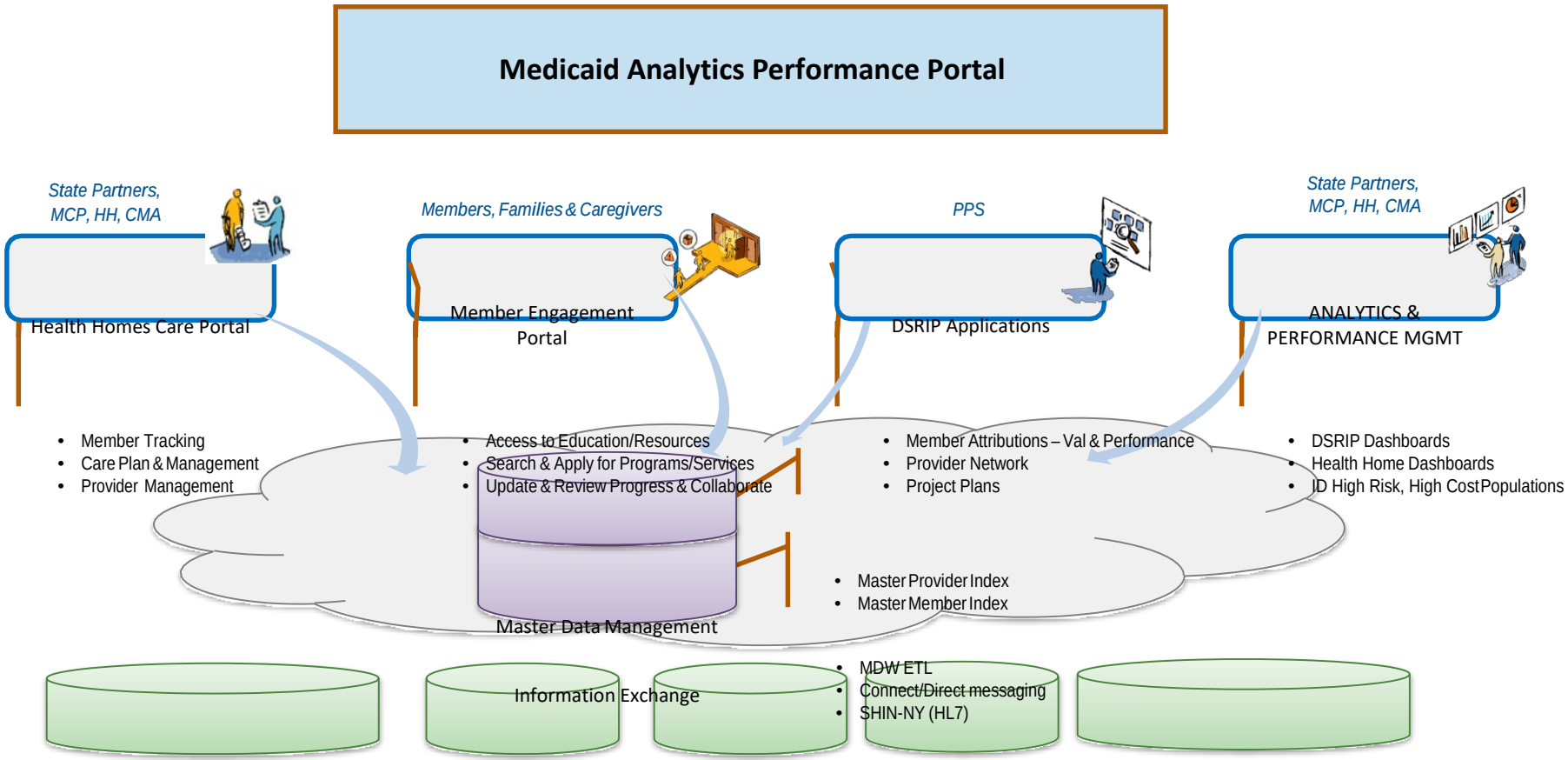
Functional Adjustments		
IP Stay for SUD Treatment	**Medium**	**High**
	IP Stay for SUD Treatment within 7 and 12 months	IP Stay for SUD Treatment within six months
SUD Active Use/ Functional Impairment		Positive Lab test **OR** other documentation of substance use **OR** LDSS positive screening for referral to SUD service **OR** referral for SUD service from parole/probation within last 30 days **AND** documentation from family and/or criminal courts that indicates domesticviolence and/or child welfare within the last 60 days **OR** documentation from Drug court within the last 60 days **OR** police report alleging SUD involvement including, but not limited to, operating a vehicle under the influence, harassment, disorderly conduct, and/or public lewdness within the last 60 days.

MAPP UPDATE

MAPP AGENDA

- MAPP Overview
- MAPP Timeline for HH Phase 1
- Health Homes – Curam Demo
- Health Homes Analytics – Salient Demo

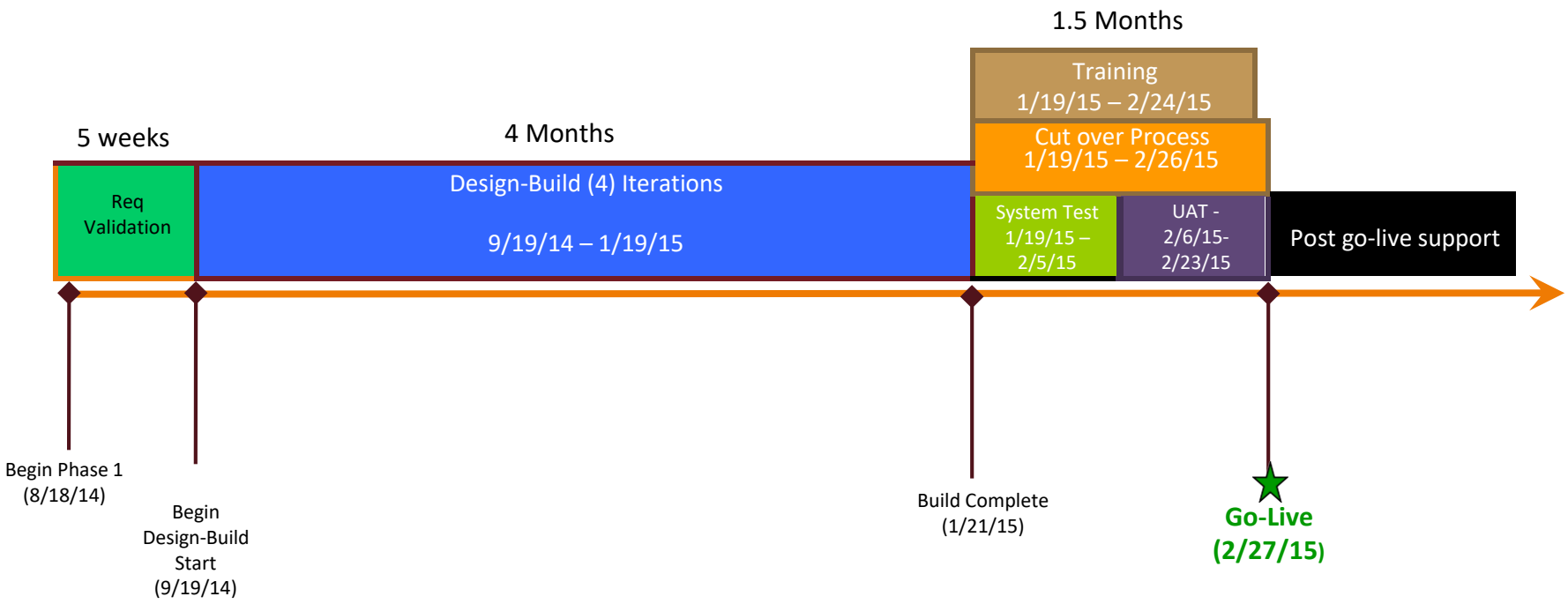
MAPP CONCEPTUAL DIAGRAM



DETAILED SCOPE FOR HEALTH HOMES PHASE 1

- Identification of Health Home eligible population
- Assigning eligible individuals to Health Homes
- Outreach of CMAs and Health Homes to potential members
- Enrolling an individual into a Health Home once outreach is complete
- Referrals of potential members
- Billing Support
- Transfer of individuals between health homes
- Member Batch lookup and export
- Dashboards to evaluate the performance of the Health Home program

PHASE 1: HEALTH HOMES SCHEDULE



NYHH MAPP - Phase 1 is 112 Work Days