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Health Home Managed Care Work Group Meeting

December 15, 2015

Agenda

- Welcome
- Schedule of Key Dates
- New Tools –Expanded Functionality in Current HHTS, Release of Health Home Dashboards
- Billing for Community Mental Health Assessments and Training
- Status of Completed Trainings and Completed Community Mental Health Assessments
- BH HCBS Plan of Care Workflow
- Non-Medical Transportation
- Strategic Task Force Updates, Expansion to Upstate
- Conflict Free Case Management – Supervisory Structures
- Work Group to Identify Required Documentation for HML Clinical and Functional Indicators
- Health Home Plus
- Health Home Serving Children – Upcoming Webinar
- Health Home Development Funds
- 2016 HH/MCO Workgroup Meeting Dates

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MAPP/HHTS Updates

Schedule of Key Dates

Action	Date
Expanded Access to Current HH Tracking System	***December 15, 2015***
Health Home Dashboards Released	***December 2015***
Phase 1 of MAPP	March 2016
Pre-population of HH High Medium Low Rates (Clinical Functional Indicators Available in MAPP)	Begins April 2016
Health Home Billing Attestations (Adults and Children)	May 1, 2016
Adult Behavioral Health Transition ROS	July 2016
Extend Legacy Rates and Direct Billing	through August 31, 2016
High Medium Low HH Rates take effect Enrollment of Children in Health Homes Begins	September 2016 September Service Dates for HML

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Expanded Access and Functionality of the Current Tracking System

- As of today, December 15, the CMA gatekeeper identified in the Health Home DEAA will have access to the Member lookup function in the current Health Home Tracking System (HHTS).

- The CMA gatekeepers will receive a notification with instructions on how to access the member lookup function in the current HHTS.

- This will enable CMAs to access the HHTS to determine if a member is currently in assignment, outreach or enrollment status with a Health Home.

- The HHTS system will now recognize the Managed Care Plan for members who enrolled in Medicaid through the exchange.

Please Note: Due to reporting frequencies, there may be a lag in the exchange member's Plan being available to the HHTS

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Release of Salient Dashboards

Release of Health Home Dashboards

- The Health Home Dashboards will be released before the end of the year. Information will be transmitted to provide instructions on when and how to access them.
- The Health Home Dashboards will reside in MAPP. Each individual user must have their own HCS User Account AND a MAPP Role (i.e., worker, screener, read-only) assigned by their organization to access MAPP.
- Information was disseminated via email on December 8th notifying future users of the MAPP Health Home Tracking System (HHTS) that they will have access to MAPP on December 21, 2015.
- MAPP HHTS users (Managed Care Plans, Health Homes, Care Management Agencies) will have access to the following MAPP applications:
  - ✓ Security Administration tab for Gatekeepers
  - ✓ Health Home Dashboards for MAPP HHTS users
- If you are a MAPP HHTS user and you did not receive the December 8th email, please contact the MAPP Gatekeeper for your agency to ensure that you have been assigned a MAPP role and that your contact information is correct.

Release of Health Home Dashboards

Health Home Dashboards:

- The Health Home Dashboards are a performance management tool for Plans, Health Homes and Care Managers
- The Health Home Dashboards contain enrollment and utilization data, and can be customized to display information by Health Home, Plan, Care Management Agency, and across the entire Health Home Program.
- The following Dashboards will be available:
  - ✓ Health Home Program Enrollment *(including HARP-**eligible** members, not enrolled)*
  - ✓ Managed Care Plan Assignment Work Flow
  - ✓ Health Home Assignment Work Flow
  - ✓ Care Management Agency Enrollment Performance
  - ✓ Health Home Dollars Paid for Members Not in Tracking
  - ✓ ER Utilization For Enrolled Health Home Members
  - ✓ IP Utilization for Enrolled Health Home Members
  - ✓ Primary Care Utilization for Enrolled Health Home Members

MAPP Customer Care – Support for Health Home Dashboards

A webinar on the Salient Health Home Dashboards will be held on January 6, 2016.

Questions regarding access of the Health Home Dashboards should be directed to the MAPP Customer Care Center (CCC) at MAPP-CustomerCareCenter@CMA.com or by phone at 518-649-4335. If contacting the CCC via email, use the subject line: *MAPP Health Home Portal.*

HCS issues (i.e. passwords) should be directed to the Commerce Accounts Management Unit (CAMU) at 866-529-1890.

Health Home Performance Team

- In the New Year, the Department will launch a Health Home Performance Team.
- The Health Home Performance Team will be a collaborative effort between NYSDOH, State agency partners, and the Lead Health Home to monitor and improve performance.
- The work of the Team will include periodic meetings with each Health Home to review Dashboard data, follow up from results of site visits, answer questions and provide any other assistance to the Health Home.
- Additional details will be provided at the January Health Home/MCO work group meeting.

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Community Mental Health Assessment Updates on Training and Billing Information

Identifying HARP Members Enrolled in Plan for Purpose of Conducting Community Mental Health / BH HCBS Assessments

- ***Prior*** to conducting the BH HCBS Eligibility Assessment or the Community Mental Health Assessment (CMHA) for a HARP flagged individual, the Assessor must verify the individual is ***enrolled in a HARP through EPACES/EMEDNY***

- In order to properly identify HARP enrolled members, providers should check eMedNY. The HHTS does not display a member's coverage code or RE code.

Provider Name	Provider ID
AMERIGROUP NEW YORK LLC	04004537
AMIDA CARE INC	02191582
HEALTH INSURANCE PLAN OF GREATER NE	04082293
HEALTHFIRST PHSP INC HARP	04003696
METROPLUS HEALTH PLAN INC	04053201
METROPLUS PARTNERSHIP CARE SN	02191362
NEW YORK STATE CATHOLIC HEALTH PLAN	04004486
UNITEDHEALTHCARE OF NEW YORK	04054091
VNS CHOICE SELECT HEALTH SNP	03420871

Identifying HARP Enrolled Members
HARP-specific Restriction Exception (RE) Codes

- A series of HARP specific Restriction Exception (RE) Codes have been established. As HARP members enroll in a HARP program and are assessed, their HARP specific RE code will change:
  - ✓ Initially, HARP eligible members will be identified with the H9.
  - ✓ Members enrolled in a HARP/SNP plan will be identified with the appropriate H1 or H4 RE Code.
  - ✓ The results of the CMHA may trigger the member's RE code to transition to H2, H3, H5 or H6.
- Eligibility Assessments should only be administered to members enrolled in a HARP for the purpose of determining BH HCBS Eligibility.
- Assessments ***should not*** be conducted to determine HARP eligibility at this time.

	HARP Specific Restriction Exception (RE) Codes
RE Code	**RE Code Description**
H1	HARP ENROLLED W/O HCBS
H2	HARP ENROLLED WITH TIER 1 HCBS
H3	HARP ENROLLED WITH TIER 2 HCBS
H4	SNP HARP ELIG W/O HCBS
H5	SNP HARP ELIG With HCBS TIER 1 HCBS
H6	SNP HARP ELIG With HCBS TIER 2 HCBS
H9	HARP ELIG PENDING ENROLLMNT

Billing Rules for Community Mental Health / BH HCBS Assessments – *12-15 DRAFT*

- Based on feedback from the last HH/MCO workgroup meeting, DOH modified the approach to billing.

- The assessing entity will send an invoice directly to the HARP. The HARP will bill Medicaid and directly pay the assessing entity for conducting the assessment.

  Care managers that choose to use the CMH for care planning purposes for members that are not enrolled in a HARP may do so, but ***payment may not be made for CMHs performed on members that are NOT enrolled in a HARP.*** *Care managers should note the CMH does not assess for physical health needs and thus may not provide all the information required to develop comprehensive plan of care.*

- The billing rates for the NYS Eligibility Assessment and the NYS Community Mental Health Assessment, as well as the POC rate (for individuals not enrolled in HH) are live as of December 18.

Billing Rules for Community Mental Health / BH HCBS Assessments – *12-15 DRAFT*

- In cases where it is determined by the Eligibility Assessment that a HARP enrolled member is not eligible for BH HCBS, or declines to have a CMH A conducted, the assessor may only submit an invoice to the HARP for, and the HARP may only bill Medicaid for, the Eligibility Assessment (billing rate $80).

- In cases where it is determined by the Eligibility Assessment that a HARP enrolled member is eligible for BH HCBS, the assessor may only submit an invoice to the HARP for, and the HARP may only bill Medicaid for, the Full Assessment (billing rate $185).

- Care managers working with members not enrolled in a Health Home may submit an invoice to the HARP, and the HARP may bill Medicaid for the development of the initial Plan of Care (billing rate $325).

- For Health Home members, the development of the plan of care is part of the PMPM Health Home rate and care managers should not submit an invoice for the development of the Plan of Care.

Weekly Data Transmission on Completed CMH Assessments Will be Transmitted to the Plans – *12-15 DRAFT*

- Data on Brief and Full Assessments that were completed for HARP plan members in the prior week will be provided to HARP MCOs on a weekly basis.

  Note: If no assessments were completed for members enrolled in your Plan in any given week, your Plan will not receive a file for that week.

- The data will be provided to the **HARP plan contact** using the secure file transfer application in HCS.

- Plans may use this information, along with invoices submitted to the Plans by the downstream provider conducting the assessment, to bill Medicaid directly and pay the assessing entity for the completion of the assessment.

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Upcoming CMH Related Trainings

- **Scales and CAPS** - The purpose of this course is to explain the key concepts related to the Scales and Clinical Assessment Protocols (CAPs) reports generated by the New York State Community Mental Health Assessment. This course will be available in the UAS-NY by next week.

- **December 16, 2015, 2-3pm** – Updated Adult BH HCBS Plan of Care Training for Health Home Care Managers, Lead Health Home Agencies, CMAs, Adult BH HCBS providers in New York City, and Health Plans. The webinar will be recorded and posted to the MCTAC website, along with the presentation slides, shortly following the webinar for those unable to attend.

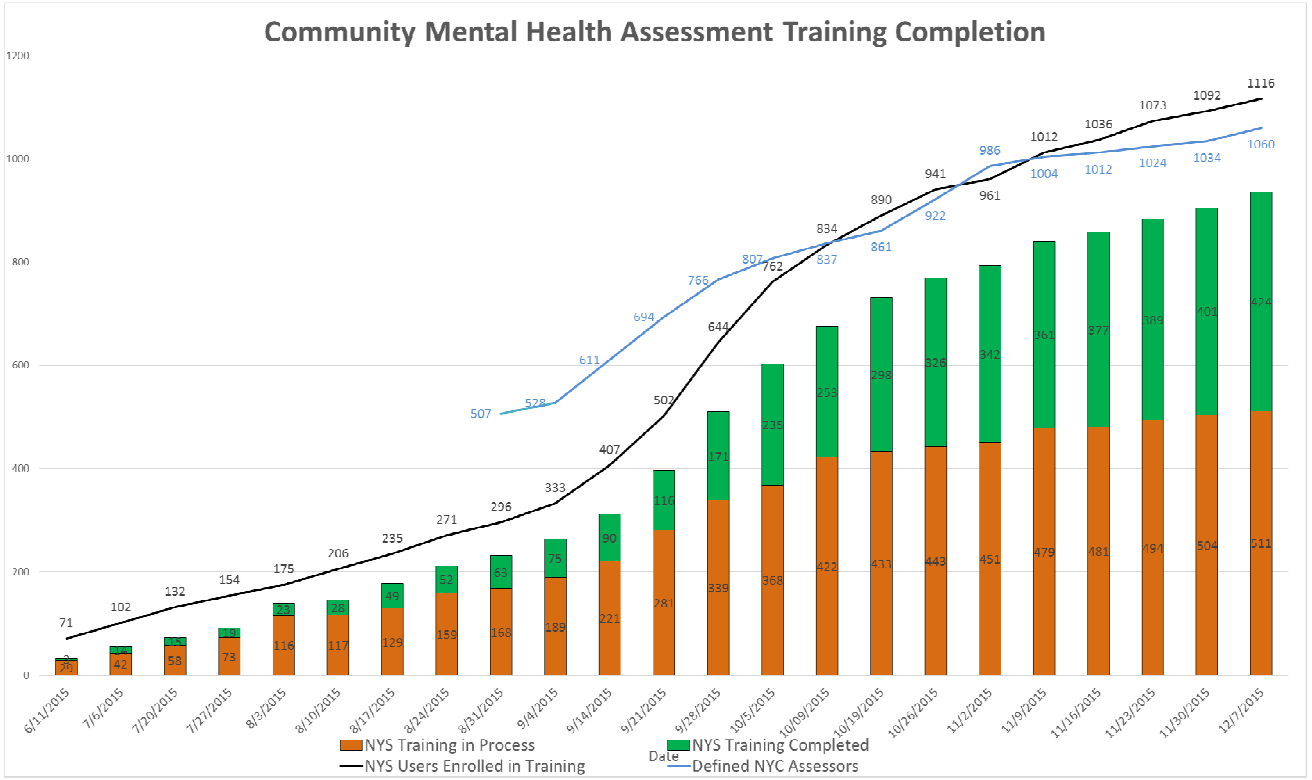
- ***?? Questions on Billing Guidance***

Status of Completed Trainings for Community Mental Health (CMH) Assessments

Community Mental Health Assessment Trainings Completed	
Enrolled Users	1,116
In process (Completed at least one activity)	511
Completed Course	424

Health Home Care Managers who will be conducting Community Mental Health Assessments must complete required training. HCS access is required to access training and conduct assessments. Information on how to access training can be found at: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/harp_hiv_snp.htm under the heading NYS CMH Training.

Status of Completed Trainings for Community Mental Health Assessments



Completed Community Mental Health Assessments

As of December 7, 2015	# of CMH Assessments Completed for HARP Enrolled Members
Eligibility Assessment	33
Full Assessment	8
Total	41

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Behavioral Health Updates

Adult BH HCBS Plan of Care Approval Workflow for Individuals Enrolled in HARPs or HARP Eligibles Enrolled in HIV SNPs December 2015

Key:

- **BH HCBS Eligibility Assessment**= subset of questions from NYS Community Mental Health Assessment and other BH HCBS eligibility questions
- **Full Assessment**= NYS Community Mental Health Assessment to help determine array of BH HCBS

A
Individual enrolled in a HH; Health Home Care Manager (HHCM) conducts NYS Community MH Assessments:

HHCM Conducts BH HCBS eligibility assessment[1]
If eligible, HH Care Manager conducts Full BH HCBS assessment[2]

B
HHCM develops and submits Proposed Plan of Care (POC)[3]; MCO approves POC:

Individual and HHCM identify individual's goals. HHCM presents a menu of services inclusive of State Plan, BH HCBS, physical health services, community and natural supports that are supportive of goal(s), and driven by individual choice of services and providers.

HHCM may (but is not required to) include specific HCBS providers. HHCM records the services in the Proposed Plan of Care and submits to MCO (14 Days).
MCO approves POC[4] and issues a LEVEL OF SERVICE Determination[5] for BH HCBS listed in POC (3 Business days).

C
HHCM (with MCO) refer to BH HCBS providers:

BH HCBS Provider assesses for frequency, scope, and duration of service in collaboration with the individual.

Three visits/14 days will be paid for under the Level of Service Determination.

D
MCO authorizes BH HCBS and HHCM implements POC:

BH HCBS Provider contacts MCO to obtain PRIOR AUTHORIZATION[4] for Frequency, Scope, Duration (3 Business days).

MCO sends BH HCBS Authorization Letter to HHCM and BH HCBS Provider.

BH HCBS provider contacts HHCM within 3 business days of receipt of Authorization to ensure engagement and scope of services.

HHCM updates and implements POC and shares with the MCO and the individual.

E
Monitor Ongoing Plan of Care:

HHCM/MCO monitors POC; ensures that individual is receiving BH HCBS reflected in POC; HHCM revises POC when necessary incorporating individual's input and choice[6]. When POC is revised MCO reviews and notification by the HHCM to the individual is required.

[1] The Eligibility Assessment can be done telephonically or face-to-face

[2] The BH HCBS full assessment must be done face to face. Eligibility and Full Assessments can be done in one face-to-face meeting if desired. Assessment process to be completed in 30 days as best practice, but not more than 90 days of Health Home enrollment unless the timeframe is extended by DOH as necessary for a limited period to manage the large number of assessments anticipated during the initial HARP enrollment period.

[3] POCs that include recommended BH HCBS must meet Centers for Medicare & Medicaid (CMS) requirements and will include scope, duration and frequency of BH HCBS; individual must be given a choice of BH HCBS providers from the MCO's network and there must be documentation in the POC that choice was given to the individual.

[4] MCO approval of the POC is not an authorization for services. All services listed in the POC are made available to the individual only as actually ordered by the service provider and authorized by the MCO (in accordance with the MCO's service authorization requirements and procedures).

[5] Level of Service Determination and Prior Authorization for at least three provider visits must be completed within three (3) business days of receipt of necessary information, but no more than 14 days from the initial request and the extension of up to 14 days when specifically requested or justified in the enrollee's interest.

[6] Every time the POC is updated it needs to be shared with the plan.

Step B

Level of Service Determination must be completed within three (3) business days of receipt of necessary information, but no more than fourteen (14) days after receipt.

B

HHCM develops and submits Proposed Plan of Care (POC);[3]

MCO approves POC:

Member and HHCM identify individual's goals. HHCM presents a menu of services inclusive of State Plan, BH HCBS, physical health services, community and natural supports that are supportive of goal(s), and driven by individual choice of services and providers. HHCM may (but is not required to) include specific HCBS providers. HHCM records the services in the Proposed Plan of Care and submits to MCO (14 Days).

MCO approves POC[4] and issues a LEVEL OF SERVICE Determination[5] for BH HCBS listed in POC (3 Business days).

B.1
Health Home Care Manager

1. Identifies with the individual their goal(s) and BH HCBS services that will support the member's goal (s)
2. Provides List of In-Network Providers for individual choice before or after Proposed Plan of Care is submitted
3. Submit Proposed Plan of Care to the plan for Level of Service Determination

B.2
MCO

1. MCO approves POC and issues a LEVEL OF SERVICE Determination and authorization for at least 3 visits to the BH HCBS listed in POC.
2. Level of Service Determination must be completed within three (3) business days of receipt of necessary information, but no more than fourteen (14) days after receipt.

BH HCBS Provider

No action Required

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Step C

The HCBS provider has 3 visits and 14 days from the 1st visit with the individual to assess and plan for frequency, scope, and duration of service.

C

HHCM (with MCO) refer to BH HCBS providers:

BH HCBS Provider assesses for frequency, scope, and duration of service in collaboration with the individual.

Three visits/14 days will be paid for under the Level of Service Determination.*

C.1
Health Home Care Manager

1. HHCM helps individual engage with In-Network BH HCBS provider of choice.

C.2
BH HCBS Provider

1. During first 3 visits/14 days the HCBS Provider assesses for frequency, scope, and duration of service in collaboration with the individual.

MCO

1. Continues to work with the HHCM, BH HCBS provider, and individual to offer support and further coordination.

*** Overall timeline can increase or decrease based on timeliness of referral engagement.**
Visits must comply with daily hour limits per the Billing Manual at:
http://www.omh.ny.gov/omhweb/bho/billing-services.html

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Step D

Prior Authorization must be completed within three (3) business days of receipt of necessary information, but no more than fourteen (14) days after receipt.

MCO authorizes BH HCBS and HHCM implements POC:

BH HCBS Provider contacts MCO to obtain PRIOR AUTHORIZATION[4] for Frequency, Scope, Duration (3 Business days).

MCO sends BH HCBS Authorization Letter to HHCM and BH HCBS Provider.

BH HCBS provider contacts HHCM within 3 business days of receipt of Authorization to report on engagement and scope of services.

HHCM updates and implements POC and shares with the MCO and the individual.

D.1
BH HCBS Provider

1. BH HCBS provider contacts the MCO to notify of the initial assessment visits under the Level of Service Determination AND obtains Prior Authorization
2. BH HCBS provider contacts the HHCM within 3 business days of receipt of Authorization to ensure engagement and scope of services.

D.2
MCO

1. MCO approves service for frequency, scope, and duration.
2. Prior Authorization must be completed within three (3) business days of receipt of necessary information, but no more than fourteen (14) days after receipt.
3. MCO sends BH HCBS Service Authorization Letter to HHCM and BH HCBS Provider.

D.3
Health Home Care Manager

1. HHCM updates POC as necessary and shares with the individual and MCO.

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Step E

On-going monitoring and care coordination with plan, providers, individual, and Health Home.

E
Monitor Ongoing Plan of Care:

HHCM/MCO monitors POC; ensures that individual is receiving BH HCBS reflected in POC; HHCM revises POC when necessary incorporating individual's input and choice. When POC is revised MCO reviews and notification by the HHCM to the individual is required.

E.1
Health Home Care Manager

1. HHCM updates Frequency, Scope, Duration of HCBS service into completed POC.
2. HHCM shares POC with MCO
3. Every time the POC is updated it needs to be shared with the plan.

E.2
BH HCBS Provider

1. Continues to provide services in accordance with POC to further engage individual in reaching their goal(s).
2. Periodic concurrent review with MCO.
3. On-going coordination with the HHCM.

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Non-Medical Transportation Grid

- Non-Medical Transportation may be available to individuals receiving BH HCBS in HARPs and HIV SNPs
  - Non-Medical Transportation will be paid FFS, the same way regular Medicaid transportation is paid. Regular Medicaid transportation covers trips to and from Medicaid-covered medical appointments
- There are two types of Non-Medical Transportation that would be included in this Grid:
  - Trips to and from BH HCBS that are included in the POC
  - Trips to and from non-HCBS destinations (e.g. job interview) that are specifically tied to a goal related to recovery from mental health or substance use disorders in the individual's POC (see the guidance manual linked below for examples of qualifying trips)
- HH care managers are responsible for completing the "NYS Behavioral Health Home and Community Based Services (BH HCBS) Plan for Transportation Grid" (Grid) based on the BH HCBS services and goals in the POC (see next slide for Grid)
- The Grid is **only** to be filled out if the individual requires **Non-Medical Transportation**, and this grid should NOT include regular Medicaid transportation (i.e. trips to Medicaid-covered medical appointments)
- The care manager will send the completed Grid to the MCO along with the POC. The MCO will be responsible for forwarding the Grid once the POC is approved to the transportation manager that will coordinate the transportation for other Medicaid covered transportation
- Guidance for BH HCBS Non-Medical Transportation Services for Adults in HARPs and HARP Eligibles in HIV SNPs can be found at https://www.omh.ny.gov/omhweb/guidance/hcbs/html/services-application/
- MCTAC training on NMT to be announced shortly for NYC Health Homes, Care Managers, MCOs and Logisticare (the NYC Transportation Manager)

Non-Medical Transportation Grid

Attachment A: NYS Behavioral Health Home and Community Based Services (BH HCBS) Plan for Transportation Grid

1. Participant Information

Participant Name: _____ DOB: _____

Care Management Program: _____ Medicaid ID: _____ Date of Plan: _____

Address _____ City _____ County _____ Zip code _____

2. MCO Information

MCO _____ Telephone _____ Fax _____

County _____ Address _____ City _____ State _____ Zip code _____

3. Transportation Provider Information

Transportation Provider _____ NPI _____ Telephone _____ Fax _____

County _____ Address _____ City _____ State _____ Zip code _____

Transportation Provider _____ NPI _____ Telephone _____ Fax _____

County _____ Address _____ City _____ State _____ Zip code _____

Transportation Provider _____ NPI _____ Telephone _____ Fax _____

County _____ Address _____ City _____ State _____ Zip code _____

4. Non-Medical Transportation

Goal (from Plan of Care)	BH HCBS or Specific Activity/ Support/ Task	Type of Transportation Service Needed	Trip Destination/ Location	Start Date/ End Date	Frequency	Non-HCBS Trip?*
						Y / N
						Y / N
						Y / N

Date _____ Completed By_____ Telephone_____ Email_____ Fax_____

*Non-HCBS trips are subject to the $2,000 per year per participant cap for Non-Medical Transportation. Trips to BH HCBS and trips using public transportation will not apply to the cost cap.

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HARP-Eligible Members and Plan Assignment File

The following are reasons why a HARP-eligible member may not be pushed to the Plan assignment file:

1) The member is currently in a non-mainstream plan (i.e. MLTC);

2) The member's current coverage code or RE code is not compatible with the Health Home program; or

3) The member has an outreach or enrollment segment that ended in the last three months.

HARP Eligible and HARP Enrolled Members

- Prior to enrolling members in HARPs, the Department identified HARP eligible members using claims data and labelled with 2014 HARP flag. This generated a HARP eligible list of 59,000 in NYC.
- Members are flagged as HARP eligible on the assignment files if they meet any of the following:

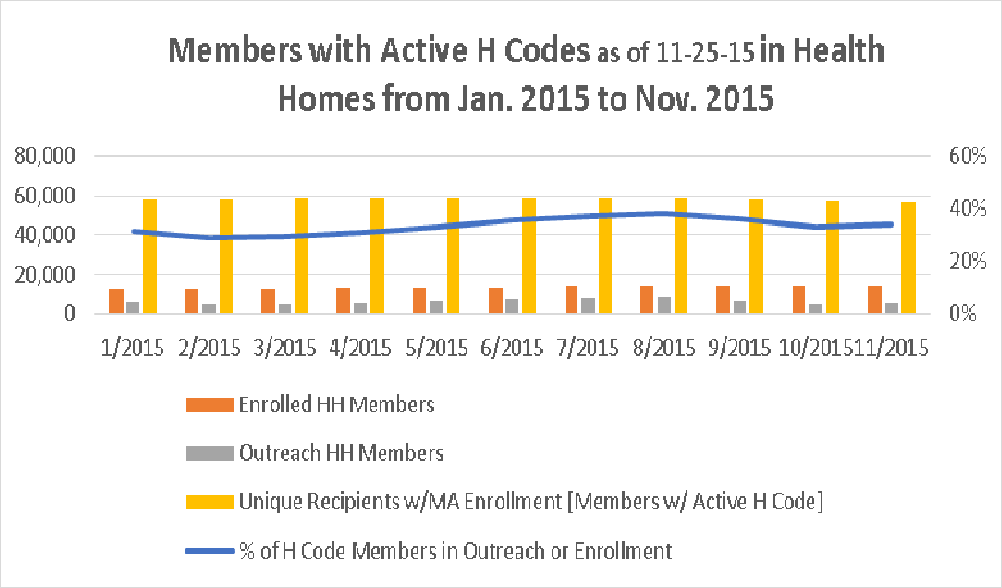
  ✓The member has an HARP specific H RE code
  ✓The member is in the CY 2014 HARP population table
  ✓The member is enrolled in a HARP/SNP

Strategic Task Force: Progress on Enrolling *HARP-eligible* Members Into Health Homes

- ✓ As of 11/25/15, of the 59,000 HARP eligible members almost 14,000 were enrolled
- ✓ 17,301 have been enrolled at some time during calendar year 2015
- ✓ 5600 are currently in Outreach – this Fall we have seen number of members in outreach decrease
- ✓ Nearly 27,000 were in Outreach in 2015
- ✓ Over 41,000 unique members, or 70% of those HARP eligible, have been in Outreach or Enrolled in 2015

Month Year	Enrolled + Outreach HH Members	Enrolled HH Members	Outreach HH Members	Unique Recipients w/MA Enrollment [Members w/ Active H Code]	% of H Code Members in Outreach or Enrollment
1/2015	18,165	12,082	6,083	58,146	31%
2/2015	16,821	12,268	4,553	58,348	29%
3/2015	17,310	12,573	4,737	58,545	30%
4/2015	18,062	12,815	5,247	58,738	31%
5/2015	19,461	12,992	6,469	58,934	33%
6/2015	20,930	13,227	7,703	59,071	35%
7/2015	22,119	13,654	8,465	59,056	37%
8/2015	22,557	13,926	8,631	59,025	38%
9/2015	21,074	14,037	7,037	58,343	36%
10/2015	18,996	14,061	4,935	57,698	33%
11/2015	19,507	13,894	5,613	57,063	34%
Totals	41,285	17,301	26,799	59,081	70%

Strategic Task Force: Progress on Enrolling *HARP-eligible* Members Into Health Homes



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Strategic Task Force: Progress on Enrolling *HARP-enrolled* Members Into Health Homes

- ✓ As of 11/25/15, of the 40,000 HARP enrolled members, over 10,000 were enrolled
- ✓ 12,709 have been enrolled at some time during calendar year 2015
- ✓ 4,045 are currently in Outreach
- ✓ 19,318 were in Outreach sometime during in 2015
- ✓ 29,929 unique Medicaid members, or 74% of those enrolled in a HARP, have been in Outreach or Enrolled during 2015

Health Home Outreach and Enrollment for Members (40,402 With Active H1 H4 H6 Codes as of 11-25-15)					
Month/Year	Enrolled + Outreach HH Members	Enrolled HH Members	Outreach HH Members	Unique Recipients w/MA Enrollment [H1 H4 H6 members]	% of H Code Members in Outreach or Enrollment
1/2015	13,344	8,946	4,398	40,181	33%
2/2015	12,291	9,079	3,212	40,232	31%
3/2015	12,648	9,269	3,379	40,297	31%
4/2015	13,215	9,472	3,743	40,348	33%
5/2015	14,279	9,617	4,662	40,392	35%
6/2015	15,375	9,763	5,612	40,401	38%
7/2015	16,250	10,083	6,167	40,400	40%
8/2015	16,674	10,303	6,371	40,397	41%
9/2015	15,540	10,424	5,116	40,376	38%
10/2015	14,119	10,482	3,637	40,324	35%
11/2015	14,423	10,378	4,045	40,218	36%
Totals	29,929	12,709	19,318	40,402	74%

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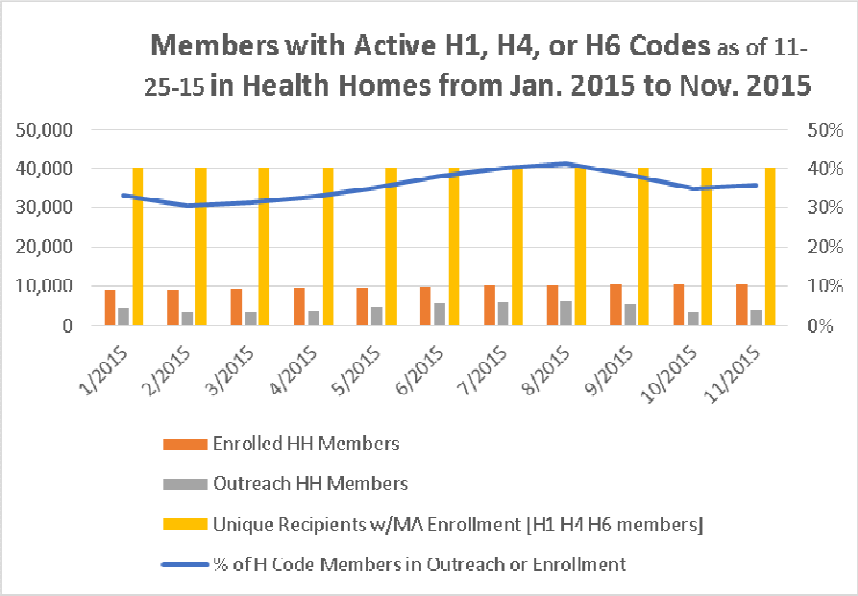
Strategic Task Force: Progress on Enrolling *HARP-enrolled* Members Into Health Homes



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Strategic Task Force: Upstate

- HARP enrollment begins Upstate in July 2016
- Convening a separate Upstate Task Force in January to share what the NYC-based Task Force has accomplished in terms of HARP-member enrollment, including best practices, lessons learned and guidance developed from your work.
- After some initial meetings, the Update Group will be merged with the NYC-based Strategic Task Force.

Conflict Free Case Management Supervisory Structures

If both a “Service” (as referred to herein services include behavioral health, physical health, Home and Community Based Services, social supports) and Health Home Care Management are being provided by individuals at the same agency, then the agency must have procedures in place to ensure there is structural and supervisory separation between the service provider and the Health Home care manager as high up within the organizational structure of the agency as possible.

Separation of services and lines of supervision must reflect the following:

- Services cannot be provided by staff that deliver or manage Health Home Care Management services.

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Conflict Free Case Management Supervisory Structures

- Health Home Care Management services cannot be provided by staff that deliver or manage other Services.

- Health Home Care Management staff and Health Home Care Management supervisors must report to a program coordinator or director who has no responsibility for any staff providing Services. Wherever possible, the coordinator/director should be a cabinet or executive level manager in the agency.

- Similarly, the Services staff and Services supervisors must report to a program coordinator or director who has no responsibility for Health Home Care Management services or oversight of Health Home Care Management staff.

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Update From Health Home/MCO Coalition

Documenting MAPP High, Medium, and Low Clinical and Functional Indicators

- Health Homes and CMAs have asked for guidance on the documentation they should obtain/maintain in order to support responses to the clinical and functional indicators in MAPP.
- The State provided some suggestions for documentation and feedback distributed at the last HH/MCO workgroup meeting.
- Based on feedback from the last HH/MCO workgroup meeting, a subgroup has been created to outline suggestions for HML documentation criteria. Neil Pessin has agreed to head this group.
- Work of this group and guidance must be finalized by March 2016 (in advance of April 2016 pre-population date for HML in MAPP).

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Health Home Plus

Health Home Plus (HH+) for Assisted Outpatient Treatment (AOT)

Updated Guidance to be issued this month includes:

- Understanding the shared risk/responsibility with LGU
- Role of SPOA, Assignment/Referral
- Clarification on billing the HH+ rate code:
  - ✓ Four face-to-face contacts per month
  - ✓ Communication/documentation with LGU
  - ✓ HHCM written into the Court Order
- Working with individuals refusing to sign HH consent form
- Plan of Care and AOT Treatment Plan
- The updated Guidance can be viewed at the link below, and will be available through the DOH Health Home website as well:

http://www.omh.ny.gov/omhweb/adults/health_homes/hhp-final.pdf

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Health Homes Designated to Serve Children

Health Home Serving Children
Design and Implementation Updates Webinar

- Webinar has been scheduled for tomorrow **December 16, 2015**, time was changed to 11:30 to avoid conflict with Strategic Task Force Meeting. Topics will include:
  - ✓ Update on Readiness Activities of Contingently Designated Health Homes
  - ✓ Update on SPA for enrolling children in Health Homes
  - ✓ Prioritization approach for enrolling children in Health Homes
  - ✓ Discussion of proposed standards for providing care management (e.g., training, best practices, plan of care elements, criteria for disenrollment) with time for provider and stakeholder feedback
  - ✓ Definition of Complex Trauma as discussed with CMS, approach to document complex trauma
  - ✓ Updates on discussion with CMS regarding approach to serving children that are eligible and enrolled in both Health Home and Early Intervention Program

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Health Home Development Funds

Health Home Development Funds

- DOH has received the first set of semi-annual reports from all 31 Health Homes. The first semi-annual report was due September 15.
- Health Homes will receive a letter acknowledging their semi-annual report along with any questions or comments from DOH.
- As discussed at the last HH MCO WG meeting, DOH will be sending a summary of how all the Health Homes are using their HHDFs to each Health Home by the end of the year.
- A monthly call will be scheduled for Health Homes to ask questions and discuss uses of HHDF. **The first call is scheduled for January 26th, 3-4 pm.**
- The next round of HHDF payments will be made by the end of the year.

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January – March 2016 Health Home MCO Work Group Meeting Dates

Next HH/MCO Workgroup Meeting Dates

January 19	OASAS, 1450 Western Ave, Albany
February 16	OASAS, 501 7th Ave, NYC
March 16	OASAS, 1450 Western Ave, Albany

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DISCUSSION