NEW YORK STATE | Department of Health | Medicaid Redesign Team

Schedules of Key Dates, Recent Events, Inquiries and Reminders

February 19, 2016

Schedule of Key Dates

Action/Activity	Date
Updates to Dashboard that were Released January 2016	February 5, 2016
MAPP HTTS Test Environment Open for File Testing for HH/MCO Workers	February 23, 2016
Semi-Annual Health Home Development Fund Report Due	March 1, 2016
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
Revised Administrative Services Agreements Due	July 1, 2016
Adult Behavioral Health Transition ROS (see details on next slide)	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

Schedule of Key Dates
Adult Behavioral Health Transition ROS

Action/Activity	Date
Plan Readiness Review Process	November 2105 – March 2016
Strategic Task Force Upstate Began	January 2016
First Phase of HARP Enrollment Notices Issued	April 1, 2016
Medicaid Mainstream Managed Care Plans and HARPS implement non-HCBS behavioral health services and phased HARP enrollment begins	July 1, 2016
BH HCBS in ROS become available for HARP and HIV SNPs	October 1, 2016

Health Home Dashboards and Development Fund Reports

- Health Home Dashboards were updated on February 5 to include a “by” for HARP-enrolled members
- Next Health Home Development Fund Semi-Annual Report due March 1, 2016
  - ✓Report template and summary grid of HHDF uses/spending is available on the Health Homes website under the *Health Home Funding Opportunities* tab
  - ✓Monthly HHDF calls will begin at the end of February with lead Health Homes.

Administrative Services Agreements Updates and Due Dates

- Administrative Services Agreements (February 12, 2016 Email Announcement)
  - April 1, 2016 (dates of service) is the effective date for the elimination of 3% withhold from HH PMPM paid by Plans to Health Homes
  - Per request from Plan Associations due date for revised ASA, dated January 2016, has been extended from February 29, 2016 to July 1, 2016
  - Key contract provisions updated to be consistent with ASA
  - Home Dashboards were updated on February 5 to include a “by” for HARP-enrolled members
  - There is no withhold on the CMHA Fee or the Plan of Care Fee for Non- Health Home members

Billing Readiness Attestations Update

- Billing Readiness Attestations are due on May 1, 2016.
- As of February 12, 2016 NYSDOH has received 9 of 16 attestations for HHSC, and 23 of 31 attestations from adult Health Homes.
- Consistent with *Health Homes Standards and Requirements* document (October 2015) Health Homes should attest they have direct billing procedures and systems in place, and have tested their ability to bill MCOs for Health Home services within 14 days of notification from the CMA, and pass down Health Home payments to the downstream providers within 14 days of receiving the payment from the MCOs.
- MCOs are required to make payments to HHs within 14 days

MAPP-HHTS

- March 23, 2016 – MAPP HHTS Go Live Date
- Additional information will be sent by MAPP customer care to all MAPP-HHTS registered users, will include training information
- Mapp Customer Care at (518) 649-4335 or submit an email to MAPP-CustomerCare@cma.com can help with questions
- March 13, 2016 is the last day to access HHTS – Between March 14, and March 22, there will be no access to either current HHTS or MAPP HHTS
- Bi-Weekly MAPP – HHTS Webinar will provide additional guidance and support
  - On the alternate week, an added Bi-Weekly MAPP HHTS Implementation Webinar will be scheduled to provide Q and A session

Health Home Billing Rules for Conducting Outreach to Members in Inpatient Settings

- Health Homes may bill for outreach on members not enrolled in Health Homes that are in in-patient settings
  - Outreach billing rules apply (3 months on and 3 months off)
  - If member is enrolled in Health Home during period the billing rules for providing members enrolled in Health Home care management services provided in Section 3.7 of the HH Billing Manual

Health Home Billing Rules for Health Home Enrolled Members in In-Patient Setting

Section 3.7: Payment for Health Home Members During an Extended Inpatient Stay

Who Qualifies?

Health Home care management services can continue for Medicaid beneficiaries who are enrolled in Health Home and 1) admitted for treatment in an inpatient facility and 2) whose discharge is anticipated within 180 days from the following inpatient settings:

- Hospital or other medical facility licensed under article 28 of Public Health Law; or
- An inpatient psychiatric unit of a hospital licensed under article 28 of Public Health Law; or
- Residential treatment facility for children and youth; or a State operated psychiatric hospital or a free standing psychiatric hospital licensed under article 31 of Mental Hygiene Law; or
- Hospital based or freestanding inpatient detoxification programs and chemical dependence inpatient rehabilitation programs, licensed under article 32 of Mental Hygiene Law; or
- Chemical dependence residential rehabilitation programs for youth licensed under article 32 of Mental Hygiene law.

Health Home Billing Rules for Health Home Enrolled Members in In-Patient Setting

Section 3.7 Continued: Billing Rules for HH Enrolled Members in In-Patient Settings

- In the month of admission and/or discharge, Health Homes services can be billed at the active care management rate, provided at least one of the Health Home core services is provided.
    - Care management services must be provided for the purposes of discharge planning and must be translated into the patient care management plan.
    - The care manager must share the member's care plan and coordinate with all of the member's providers to make sure that all needed services are in place to ensure a safe, timely discharge.
    - The care management agency must keep the member actively engaged during the process
- In the interim months of the admission, payment will be made at the outreach and engagement rate, provided a three month period has lapsed since the Health Home last billed for outreach and engagement for that member with appropriate delivery of Health Home related services, as described above
- Pursuant to the limitations of outreach and engagement billing rules, one of the four intervening months over the six month period will not be billable.
    - There will be guidance on how to reflect the appropriate segment/status in MAPP-HHTS post go live

More Information on Billing Rules for Members In-Patient Facility

Webinars:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/2014-04-30_hh_implement_session36.pdf

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/2014-05-28_implementation_update_session_38.pdf

Reminder:

Care Managers MUST Verify Member is Enrolled in HARP *Prior* to Conducting Community Mental Health Assessments (CMHAs)

- Assessments on Non- HARP enrolled members were still being conducted in January (62 Eligibility, 10 Full)
- To date, 190 Eligibility and 46 Full CMHAs have been completed on members NOT enrolled in Health Homes
- Note there is no mechanism or authority to pay for assessments conducted on Non- HARP enrolled members

Reminder:
Care Managers MUST Verify Member is Enrolled in HARP *Prior* to Conducting Community Mental Health Assessments (CMHAs)

- CMHA Eligibility Assessments (CMHAs) 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.
- ***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***
  - ***https://www.emedny.org/selfhelp/ePACES/ePACES_Help.pdf***
  - ***https://www.emedny.org/hipaa/QuickRefDocs/ePACES-Enrollment_Overview.pdf***
- 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
- Note RE code and coverage information will be displayed MAPP-HHTS – but data will NOT be real time – ***source of truth is always EPACES/EMEDNY.***

Reminder:
Care Managers MUST Verify Member is Enrolled in HARP *Prior* to Conducting Community Mental Health Assessments (CMHAs)

- 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.

RE CODE	HARP Specific Restriction Exception (RE) Codes
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

Frequently Asked CMHA Questions

- Who should be assessed?
  - ✓HARP Plan enrolled members with **H1 or H4** restriction codes.
- Will the Health Home be reimbursed for HARP eligible members (H9) who were assessed prior to 1/1/16?
  - ✓Unfortunately these assessments cannot be submitted for payment.
- What is the time frame to complete the CMHA?
  - ✓The CMHA should be completed within 30 days of enrolling a HARP Plan member in a Health Home however an MCO can still accept the claim if the assessment is completed after the 30 day period.
- Can the Health Home instruct CMAs to delay the assessment until further guidance is issued?
  - ✓The CMHA should not be delayed for HARP Plan enrolled members.
  - ✓All Health Home's should be clearly messaging that the CMHA should be administered and BH POC's submitted to the MCO'S without further delay.

Frequently Asked POC Questions

- Can we allow the MCO access to the Health Homes care management system to communicate the BH POC?
  - Yes, allowing the MCO access to the care coordination platform is an acceptable way to communicate however if there are delays in granting access a reasonable workaround must be established to avoid further delays.
- Can a BH POC be developed without a list of approved BH HCBS Providers?
  - Yes the BH HCBS providers can be identified in collaboration with the MCO, the initial BH POC can be submitted with recommended services and an exchange of in network BH HCBS providers can be shared by the MCO.
  - The Health Homes should clearly message to the CMAs that the MCO can be a partner in assisting with finding providers for BH HCBS as well as any other services that the member might need.

POC Process and Training

- Every Health Home enrolled member is required to have a comprehensive Plan of Care already in place – required by six core HH services and standards documents – ***fundamental mission of Health Homes***
- ***BH HCBS need to be part of the comprehensive plan of care – and needs to include all the elements in the BH HCBS template***
    - The BH HCBS Plan of Care template was developed to simplify the process of communication with MCOs.
- Trainings are being developed to assist CMAs in developing comprehensive plans of care that include BH HCBS POC
- Please maintain an ongoing list of questions including any challenges that your CMAs are experiencing to be shared with the State in preparation for these trainings