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Health Home Managed Care Work Group Meeting

May 4, 2015

Agenda

- New Schedule for Behavioral Health Transition to Managed Care for Adults, MAPP, HML Rates and Billing Procedures
  - MAPP Training and InterRAI CMH Assessment Training
  - Health Home Billing Readiness
- Finalizing Health Home Standards
- Process for Plan approval of Plan of Care
- HCBS Plan of Care Requirements
- Administrative Services Agreements, Contracts between Health Homes and CMAs
- HARP Members Not Enrolled in Health Homes
- Health Home Plus-AOT and ACT billing
- Standardized Elements for Plans of Care
- Report from the Strategic Task Force to Increase HARP Enrollment

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New Schedule for Behavioral Health Transition to Managed Care for Adults, MAPP, HML Rates and Billing Procedures

Managing Multiple Changes in the Transition to Managed Care and New Billing Structures

- In response to concerns raised at the last Work Group meeting regarding the timing of the implementation of Medicaid Analytics Performance Portal (MAPP); High, Medium and Low rates; the elimination of direct billing; the prioritization of the enrollment of HARP identified members in Health Home; InterRAI Community Mental Health assessment training; and conducting assessments for HCBS services; the State has revised the schedule to:
  - Provide distance between the implementation of MAPP and the High, Medium and Low Rates
  - Provide time to pre-populate in MAPP the clinical and functional indicators of High, Medium and Low rates (see Appendix for rates and indicators)
  - Provide more time to ensure payment methods are in place to pay downstream care managers when direct billing is eliminated
  - Extend, again the legacy rates – additional unplanned resources should help providers manage cash flow
  - Provide more time to train and perform InterRAI Community Mental Health Assessment on HARP members by phasing in enrollment and then making HCBS services available

Date	New Schedule for Behavioral Health Transition to Managed Care for Adults, MAPP, HML Rates and Billing Procedures
Mid-May	InterRAI Community Mental Health Training begins
July 2015	First phase of HARP enrollment letters distributed in NYC
Mid-July	**MAPP Training Begins**
August 15, 2015	**MAPP Released:** • **Current Health Home Rates and Legacy Rates remain in effect** • **Care management agencies will pre-populate/report High, Medium and Low functional and clinical indicators in MAPP**
October 1, 2015	• NYC Mainstream Plans and HARPs implement non-HCBS behavioral health services for enrolled members • Begin to enroll children in Health Homes (see April 29, 2015 Webinar – DOH Website)
October 2015 through December 2015	Phase-in schedule for Enrolling NYC HARP members • Approximately 20,000 enrollment letters distributed July/August for October enrollment • Approximately 20,000 enrollment letters distributed August/September for November enrollment • Approximately 20,000 enrollment letters distributed September/October for December enrollment
January 1, 2016	• HCBS Behavioral Health Services begin for HARP Population in NYC • **Direct Billing is Eliminated** • **High, Medium and Low with Functional and Clinical Indicators takes effect**
April 1, 2016	First Phase of HARP enrollment letters distributed in Rest of State
July 1, 2016	Rest of State Mainstream Plan and HARPs implement non-HCBS behavioral health services and phase-in schedule for HARP enrollment begins

2015 MAPP Training Activities

Date	Training Session	Description of Training Session
Early July 2015	MAPP Cúram Member Tracking Overview and Navigation	This course introduces the Medicaid Analytics Performance Portal (MAPP), including its purpose, benefits and scope. This course also covers basic navigation. (WBT) [**All users**]
Late July – Early Aug. 2015	MAPP Cúram Member Tracking (Health Homes)	This course provides instructions on how to perform member tracking tasks in MAPP Cúram for the Health Homes job role. (ILT) [**up to 5 workers per Health Home**]
Late July – Early Aug. 2015	MAPP Cúram Member Tracking (Managed Care Plan)	This course provides instructions on how to perform member tracking tasks in MAPP Cúram for the Managed Care Plans job role. (ILT) [**up to 5 workers per Managed Care Organization**]
Late July 2015	MAPP Cúram Member Tracking ("GateKeeper" Role)	This course provides instructions on how to authorize new users to the MAPP Portal. (WBT) [**All gatekeepers**]
Late July 2015	MAPP Cúram Member Tracking ("Read Only" Job Role)	This course provides instructions on how to search and view information in MAPP. (WBT) [**All staff with Read-only role**]
August 2015	MAPP Cúram Member Tracking Introduction	This course provides a non-interactive demo on how to perform member tracking tasks in MAPP. (online video) [**All Care Management Agency users**]
August 2015	MAPP Cúram Member Tracking (Care Management Agency)	This course provides instructions on how to perform member tracking tasks in MAPP Cúram for the Care Management Agency job role. (ILT) [**One worker per Care Management Agency**]
Late July – Early Aug. 2015	MAPP Cúram Member Tracking Overview and Navigation	This course introduces the Medicaid Analytics Performance Portal (MAPP), including its purpose, benefits and scope. This course also covers basic navigation. (WBT) [**All users**]

WBT – Web Based Training *ILT – Instructor Led Training*

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Training
Health Home Care Management, HCBS and CMH Assessment Training

Date	Training Module
May 15, 2015 New York City (Rest of State beginning March 2016)	Web-Based Health Home InterRAI Training Begins (Downstream care managers must have access to HCS to access training)

June 2015	• Managed Care 101
	• Training on HCBS Services
	  • Provide foundational knowledge on each HCBS service, how they fit into plan of care, how they relate to other State services
	  • Clear distinction btw MH vs. SUD
	• What workflow looks like both generally and specifically for HH care managers

Other Billing Rules Effective January 1, 2016

- **Referrals for members not already on assignment list**
  - ✓ **Policy:** Referrals made to Health Home or Plan must be approved or assigned by the Plan
- **Plan members who are enrolled in a Health Home that their Plan does not contract with:**
  - ✓ **Policy:** Preserve continuity of care by requiring Plan to pay out of network to Health Home – Plan must approve the plan of care developed by out of network Health Home
  - ✓ Example: FFS member enrolled in HH B with legacy downstream care manager that direct bills. The FFS member is enrolled in Plan A. Plan A does not contract with HH B, Plan A must pay HH B out of network for HH services provided by legacy downstream care manager. HH B makes payment to legacy downstream care manager.
- **Plan members who are in hiatus and assigned to Health Home that their Plan does not contract with:**
  - ✓ **Policy:** When hiatus period is complete, member will return to Plan's assignment list for assignment by the Plan to Health Home it contracts with (HH w/o contract will not start outreach)
  - ✓ Example: Member enrolled in Plan A but in outreach with HH B, which does not have a contract with Plan A. Upon end of hiatus period, member's assignment to HH B will end, member will be added to Plan A assignment list, and Plan A will reassign member to contracted HH C.
- **Plan is Responsible for verifying that member is Health Home eligible and appropriate for program (this may be delegated by the Plan to Health Home)**

Health Home Billing Readiness Requirements

- **By October 1, 2015, each Health Home must submit to DOH either:**

  a) Attestation

  i. That the Health Home has procedures in place that will allow it to pay CMAs within X days of receiving payments from the Plans

  ii. The Health Home has tested their ability to bill Managed Care Organizations for Health Home services and pass Health Home payments down to Care Management Agencies, including a description of such testing procedures; Or

  b) Letter of Deficiency

  i. Identify issues Health Home encountered when billing Managed Care Organizations for Health Home services and passing Health Home payments down to Care Management Agencies.

  ii. Include possible solutions and timeframes for resolving deficiency prior to January 1, 2016

  iii. DOH will work with these Health Homes to overcome billing issues

- Inability to successfully pass Health Home payments to CMA by October 1, 2015 will negatively affect a Health Home's re-designation review and may impact the ability to enroll new members.

Two Health Homes have already provided attestation!!!

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Finalizing Health Home Standards

Standards Discussion /Comments from Work Group

- Standards need to be finalized to complete standards
  - Standards will be incorporated into survey tools for Health Home re-designation site visits to begin in the Fall of 2015 and incorporated by reference into Health Home/MCO ASAs.
- Mark up of revised Standards distributed for review – reflect comments received and response to two issues raised at last HH MCO WG meeting
  - Can a Registered Nurse (RN) supervise staff performing the InterRAI Community Health Assessment?
  - Clarify requirements for AOT (e.g., Health Home Plus) and ACT (next section).
- Other outstanding standard issues include timeframes for:
  - Assigning Members
  - Billing
  - Conducting Community Mental Health Assessments

Timeframes for Making Health Home Assignments

- MCOs must assign DOH list identified, plan identified or individuals identified by another provider (e.g. local government unit, behavioral health service provider) to HHs within xx? business days
- Health Homes must assign individuals to Health Home care managers within xx? business days from the day the Plan makes an assignment to the Health Home
- Health Home care managers must begin outreach within xx? business days after receipt of referral from a Health Home
  - General discussion around current practice of some HHs that make assignments on a prescribed schedule
  - Example: If HH sends list during the 1st to the 15th of the month – outreach begins immediately, if HH sends list on the 16th or later outreach can begin immediately or the following month but no later than the 5th day
- ***Discussion***

Timeframes of Completing Assessments and Making Payments

- Health Home care managers shall complete brief InterRAI assessments to determine HCBS eligibility within xx? days and full InterRAI assessment within xx? days

Discussion

- MCOs must make payments to Health Homes within xx? days
- Health Homes must make payments to Care Managers within xx? days

Discussion – prescribed schedule?

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Process for Managed Care Plans to Approve Plans of Care

HARP ELIGIBLE ON DOH LIST
ALREADY ENROLLED IN A HARP PLAN & HEALTH HOME

HH Care Manager Conducts HCBS eligibility assessment

If eligible, HH Care Manager conducts Full HCBS Assessment

Full Assessment will identify strengths & Challenges within particular domains.

Based on identified challenges and an individual's goals, HH Care Manager and Member collaboratively develop the preliminary Plan of Care

Open Question: is preliminary plan of care shared with MCO prior to referral to HCBS services?

Based on services identified in Plan of Care, Member is referred to HCBS Provider(s)*

HCBS Provider(s) conduct service specific assessment(s). Provides additional information to HH Care Manager and signs off on plan

HH Care Manager Updates the Plan with HCBS provider specific information and forwards it to the MCO for review and approval

Post HCBS Provider Assessment, will plans do initial authorization for services or wait for a period of time

Key:

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

*Individuals have choice to receive HARP, Health Home and HCBS services. Appropriate firewalls and mitigation strategies must be put in place to ensure that the process is conflict free.

Explanation of Initial Enrollment Process

1. Individuals initially identified by NYS as HARP eligible, who are already enrolled in an MCO with a HARP, will be passively enrolled in that Plan's HARP.
2. Individuals identified for passive enrollment will be contacted by the NYS Enrollment Broker.
3. They will be given 30 days to opt out or choose to enroll in another HARP
4. Once enrolled in a HARP, members will be given 90 days to choose another HARP or return to Mainstream Plan before they are locked into the HARP for 9 additional months (after which they are free to change Plans at any time).

Explanation of Initial Enrollment Process

5. Individuals initially identified as HARP eligible who are already enrolled in an MCO without a HARP will not be passively enrolled. They will be notified of their HARP eligibility and referred to the NYS Enrollment Broker to help them decide which Plan is right for them.
6. HARP eligible individuals in an HIV SNP will be able to receive HCBS services through the HIV SNP. They will also be given the opportunity to enroll in another HARP. They will be notified of their HARP eligibility and referred to the NYS Enrollment Broker to help them decide which Plan is right for them.

New York State Process for Conflict Free HCBS/Service Assessment/Approval

- All individuals who meet the HARP targeting criteria **must be offered all of the following**:
  - HARP Enrollment and Plan Selection
  - Health Home Enrollment
  - Use of HCBS if eligible
- HARP enrollees may choose the provider they prefer from a list of at least 2 providers where possible for each HCBS included in the Plan of Care.
- With respect to conflict-free care management requirements for Health Homes:
  - To promote and ensure integrated care that is in the best interests of the client, it is possible that an individual may receive care management and direct care services from the same entity, however, in these instances the care management and direct service components must be under different administrative/supervisory structures.
  - There will be utilization management and quality oversight by the Managed Care Plans for Medicaid services.
  - There are appeal, grievance, fair hearing, and beneficiary complaint processes in place for both Managed Care and Health Home services.

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HCBS Plan of Care Requirements

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Administrative Services Agreements

Administrative Services Agreements (ASAs) for Health Homes and MCOs

- Health Homes enter into ASAs with MCOs to provide care management to eligible Plan members. The State developed an ASA template that could be customized (with approval from the DOH Bureau of Managed Care Certification and Surveillance).
- DOH is working on revisions to the ASA to:
  - Incorporate provisions for HCBS and HARP assessment payments;
  - Rescind the 3% administrative fee that MCOs currently withhold from Health Homes and some direct billers (reflected in premium build);
  - Incorporate expectations for MCOs to hold Health Homes accountable for performance, but with reasonable protections for Health Homes (e.g., notice, opportunity to remediate, etc.)

Contracting Between Health Homes and CMAs

The State has not developed contract templates for Health Homes to use with their CMAs, however, Health Homes should be revisiting contract terms to reflect new billing practices and services, similar to the considerations for revised Health Home/MCO ASA templates, e.g.,

- Incorporate provisions for HCBS and HARP assessments and payments;
- Eliminate the 3% administrative fee that Health Homes withhold from CMAs on behalf of MCOs;

In addition, Health Homes should be looking to engage HCBS service providers in their networks.

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HARP Members Not Enrolled in Health Homes

Care Management for HARP Members who Want HCBS Services and Decline Health Home Enrollment

- To encourage connectivity and enrollment in the Health Home, the preferred approach is for the Plan to contract with the HH to conduct the CMH assessment and develop the HCBS plan of care (POC)
  - HH (or other State designated entity) the Plan contracts with does CMH assessments (brief, full, and annual required Assessments for members receiving HCBS services)
  - HH (or other State designated entity) the Plan contracts with does HCBS plan of care, and any required updates to the HCBS plan of care. Single payment for initial POC and updates to be determined.
    - Plan approves HCBS Plan of Care.
    - Plan of care must be developed in accordance with HCBS Plan of Care requirements
  - Plan monitors implementation of HCBS plan of care in accordance with HCBS and Medicaid Managed Care Model Contract requirements, which includes ensuring the member accesses services included in the plan of care; periodic updating of the care plan as a member's needs change; and arrangement for CMH re-assessment at least annually.
  - The MCO must continue to work with the member to encourage Health Home enrollment and must monitor claims and encounter data of the member and look for opportunities (critical times e.g., appearance at emergency room or inpatient hospitalization) when it may make sense to have the Health Home outreach again to the member.

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Health Home Plus, AOT and ACT Requirements

Health Home Plus, AOT and ACT Requirements

- Clarifying AOT guidance
- Expand population to CNYPC and satellites and State PC discharges in addition to current AOT population
- May allow non-legacy providers to serve these populations and claim the HH+ rate code

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Standardizing Elements of Plans of Care

Plans of Care and Terminology

- Health Home Plan of Care
- HCBS Plan of Care (for Health Home members part of person-centered care plan)
  - Health Home and HCBS Plan of care must meet Health Home and CMS requirements
- MCO Integrated Service Plan
- Psychosocial Rehabilitation Recovery Plan
- Provider Treatment Plan

Plan of Care (POC) Guideline Challenges

1. Identify key elements that should be in every HH Care Management POC
2. Include elements that Mainstream MCOs/HARPs typically incorporate into Individualized Service Plans
3. Ensure POC addresses documentation requirements for individuals eligible and referred for HCBS
4. Allow flexibility for HHs, Mainstream MCOs/HARPs, and providers to document necessary POC elements within their unique EHRs
5. Standardize procedure for Mainstream MCOs/HARP review of POC

Draft of Possible Standard Plan Elements

1. For all individuals enrolled in a Health Home, the plan of care must include the following specific elements:
    a. The individual's stated **Goal(s)** related to treatment, wellness and recovery;
    b. The individual's **Preferences and Strengths** related to treatment, wellness and recovery goals;
    c. Functional **Needs** related to treatment, wellness and recovery goals;
    d. Key **Community Networks and Supports**;
    e. Description of planned **Care Coordination Interventions and Timeframes**;

Draft of Possible Standard Plan Elements

2. The individual's **Signature** documenting agreement with the plan of care; and Documentation of participation by all **Key Providers** in the development of the plan of care. For individuals enrolled in a HARP, the plan of care must include the following additional specific elements:

a. Documentation of results of the Home and Community Based Services **(HCBS) Eligibility Screen** (e.g., Not Eligible, Eligible for Tier 1 HCBS only, Eligible for Tier 1 and Tier 2 HCBS)**;**

b. For individuals eligible to receive HCBS, a **Summary of the interRAI Functional Needs Full Assessment;** and

c. For individuals eligible to receive HCBS, **Recommended HCBS** that target the individual's identified goals, preferences, and strengths

Plans of Care

Next Steps

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Report from the Strategic Task Force

Strategic Task Force to Increase HARP-Eligible Enrollment in Health Homes

- The Strategic Task Force was established to focus on strategies for accelerated Health Home enrollment for HARP-eligible members in New York City.
- Includes leadership from OMH, OASAS, AIDS Institute and DOH State Agencies, and Plans, Health Homes and Care Managers.
- Identify barriers/systemic gaps contributing to low enrollment rates.
- First meeting: April 23, 2015

Strategic Task Force to Increase HARP-Eligible Enrollment in Health Homes: Report from April Meeting

- Health Home enrollment of the 67,000 HARP eligible members in Health Homes has been increasing steadily but needs to be accelerated. Currently 20% are enrolled.
- It was clarified that the 2012 HARP list was for informational purposes, to allow Health Homes to get a “jump start” on enrollment. The 2014 list is the official list that will be used for passive enrollment in HARPs. About 80% of the members in the earlier list carried over into the 2014 list.
- The 2012 and 2014 HARP eligible flags that were in the assignment files will now be visible in the tracking system to allow Health Homes to more accurately identify and target HARP eligible members.

Strategic Task Force to Increase HARP-Eligible Enrollment in Health Homes: Report from April Meeting

- OMH and OASAS member specific behavioral heath services data was shared with MCOs on April 23rd – includes information on housing, clinic, PROS service members have used as of March 2015, with provider contact information.
- MCOs can share this data with Health Homes to assist in outreach to HARP eligible members, Health Homes can share it with CMAs (via DEAAs)
- Clarification is needed on how CMAs can use this data-many providers will not release information on clients, citing privacy concerns. State agency members of the Task Force will be meeting with State legal staff to work through this issue. Gaining access to NYC databases (e.g., HRA, HHS Worker Connect) was also identified as an opportunity.

Strategic Task Force to Increase HARP-Eligible Enrollment in Health Homes: Report from April Meeting

Behavioral health service data can be used for outreach as follows:

1) Health Homes/CMAs can send lists of eligible members to the client's service providers with a request that the provider educate the client on the benefits of the Health Home program.
2) The provider can give the client Health Home/CMA contact information and encourage them to reach out to the Health Home/CMA

These activities do not breach any privacy rules but to be effective requires providers be educated about the benefits of Health Home

The group recommended that State agencies reach out to their licensed providers and programs to educate them about the services and benefits provided by Health Homes

Strategic Task Force to Increase HARP-Eligible Enrollment in Health Homes: Report from April Meeting

United Health Care and HealthFirst presented their strategies for actively working with Health Homes to increase enrollment. Examples include:

- Promoting Health Home services to providers as well as members and their families (lack of familiarity with Health Home care management services is a significant barrier).
- Sending alerts to Health Homes when members are in the ER or have an inpatient or detox episode.
- Training Health Homes to use on-the-ground, active approaches vs. contacts by telephone or letter, using nurses and community health workers.
- Monitoring Health Home performance.

Strategic Task Force to Increase HARP-Eligible Enrollment in Health Homes: Report from April Meeting

Next Steps:

- Health Homes and MCOs were asked to provide dedicated points of contact for Strategic Task Force activities.
- MCOs and Health Homes must collaborate on how to use behavioral health data.
- State agencies will consult with counsel to develop clear guidance on the extent to which data can be shared
- Providers and practitioners must be educated on their responsibility to link potential members to Health Homes.
- The State will be reviewing reports on proposed uses of Health Home Development funds to evaluate how resources will be used to increase outreach and enrollment of HARP eligible members.

Strategic Task Force to Increase HARP-Eligible Enrollment in Health Homes: Report from April Meeting

Next Steps

- Health Home Development Fund (HHDF), NYS requests that Health Homes:
  - Propose to use HHDF resources for new outreach and enrollment efforts targeting and prioritizing members who will be enrolled in Health and Recovery Plans (HARPs);
  - Include in these proposals plans to step down funds to CMAs for creation of intensive outreach teams targeted to HARP members;
- The State will work with Health Homes to provide guidance on the use of HHDF for outreach and enrollment efforts that do not duplicate payment for the same activity
- Review new outreach and enrollment proposals with NYS and participate in regular meetings with DOH/OMH/OASAS to monitor progress of enrollment of HARP eligible individuals

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Appendix – Informational Resources

Conditionally Designated Plans (Pending Completion of Readiness Reviews)

Plan Name	Conditional Designation Status	Partnering with BHO
AFFINITY HEALTH PLAN INC	Mainstream	Beacon Health Options
AMERIGROUP NEW YORK LLC	Mainstream/ HARP	No
AMIDA CARE INC (HIV SNP)	Mainstream/ HIV-SNP	Beacon Health Options
HEALTH FIRST PHSP INC	Mainstream/ HARP	No
HLTH INSURANCE PLAN OF GTR NY (EMBLEM)	Mainstream/ HARP	Beacon Health Options
METROPLUS PARTNERSHIP CARE and HIV SNP	Mainstream/ HARP/ HIV-SNP	Beacon Health Options
NYS CATHOLIC HEALTH PLAN INC (FIDELIS CARE)	Mainstream/ HARP	No
UNITED HEALTHCARE OF NY INC	Mainstream/ HARP	Optum
VNS CHOICE SELECT HEALTH (HIV SNP)	Mainstream/ HIV-SNP	Beacon Health Options
WELLCARE OF NEW YORK INC	Mainstream	No

Behavioral Health State Plan Services -Adults

- Inpatient - SUD and MH
- Clinic – SUD and MH
- PROS
- IPRT
- ACT
- CDT
- Partial Hospitalization
- CPEP
- Opioid treatment
- Outpatient chemical dependence rehabilitation
- Rehabilitation supports for Community Residences (excluded until further notice)

Home and Community Based Services - HARPs

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

New services added to BH 1115 waiver amendment (for OASAS mainstream and HARP populations)

- Residential Redesign - Plans allowed to purchase medical/clinical services in OASAS residential programs
  - Three phases (captures OASAS Intensive Residential, Community Residential, Supportive Living and Medically Monitored Detox:
    - Stabilization – Introduction of medical/clinical staff. Individual will receive medically-directed care to treat acute problems and adjust early to recovery.
    - Rehabilitation – Individual will learn to manage recovery within the safety of the program.
    - Re-integration – Individual will further develop recovery skills and begin to re-integrate into the community.
  - Clinic to Rehab - Allows for provision of community based substance use disorder services

New services added to BH 1115 waiver amendment (for OMH mainstream and HARP populations)

- Licensed Behavioral Health Practitioner Services
  - Allows for provision of community based (offsite) mental health services
  - Providers must operate within an agency licensed by the Office of Mental Health (pursuant to 14NYCRR Part 599).
  - More information on program, staff, and rates will be forthcoming.
- Behavioral Health Crisis Intervention
  - Moved from HCBS
  - Allows for off site crisis
  - NYS is developing program requirements

DRAFT Sample Questions in the MAPP Monthly Data Collection for High, Medium, Low HARP/Non-HARP Rates *DRAFT*

*DRAFT * Sample Questions in the MAPP Monthly Data Collection for High/Medium/Low HARP/Non-HARP Health Home Rates *DRAFT *		
Quest. #	Question in MAPP	COMMENT
1.	Does the member meet the HARP criteria based on claims and encounters?	This will be auto populated within MAPP by DOH
2.	Base Acuity	This will be auto populated within MAPP by DOH
3.	Risk	This will be auto populated within MAPP by DOH
Clinical Adjustments		
4.	What is the member's Diagnosis code (primary reason for Health Home eligibility)?	This field will not be edited at go live and is optional.
5.	Is the member HIV positive?	Questions 5a and 5b appear when the response to Q5 is "Yes"
5a.	What is the member's viral load?	Questions 5a and 5b appear when the response to Q5 is "Yes"
5b.	What is the member's T-Cell count?	Questions 5a and 5b appear when the response to Q5 is "Yes"
Functional Adjustments		
6.	Is the member homeless?	Question 6a appears when the response to 6 is "Yes".
6a.	Does the member meet the HUD Category 1 or HUD Category 2 level of homelessness?	Drop down box with two options: HUD Category 1 and HUD Category 2
7.	Was the member incarcerated within the past year?	Question 7a appears when the response to 7 is "Yes".
7a.	When was the member released?	must enter a valid date. Date must be in the past
8.	Did the member have a recent Inpatient stay due to mental illness?	Question 8a appears when the response to 8 is "Yes".
8a.	When was the member discharged from the mental illness inpatient stay?	must enter a valid date. Date must be in the past
9.	Did the member have a recent inpatient stay for substance abuse?	Question 9a appears when the response to 9 is "Yes".
9a.	When was the member discharged from the substance abuse inpatient stay?	Question 9a appears when the response to 9 is Yes.
10a.	Did the member have a Positive Lab test OR other documentation of substance use?	Each question must have response: Y/N. Must have at least 1 Y to 10a-10c <u>AND</u> at least one Y in 11a-11b
10b.	Did the member have an LDSS positive screening for referral to SUD service?	
10c.	Was member referred for SUD service from parole/probation within last 30 days?	
11a.	Is there documentation from family and/or criminal courts that indicates member involvement in a domestic violence and/or child welfare incident within the last 60 days?	
11b.	Is there documentation from Drug court OR a police report alleging member's SUD including, but not limited to, operating a vehicle under the influence, harassment, disorderly conduct, and/or public lewdness within the last 60 days.	
12	Was a Health Home core service provided this month?	Y/N

Health Home Rates: High Medium and Low Rates with Clinical and Functional Adjustments Effective January 1, 2016

Attribute	Low	Medium	High
Base Acuity (unadjusted)	<= 2.5	Between 2.5 and 5.0	>=5.00
Clinical Adjustments			
Predictive 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

Health Home Rates: High Medium and Low Rates with Clinical and Functional Adjustments Effective January 1, 2016

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

Health Home Rates: High Medium and Low Rates with Clinical and Functional Adjustments Effective January 1, 2016

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 domestic violence 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.

Health Home Rates: High Medium and Low Rates with Clinical and Functional Adjustments Effective January 1, 2016

Health Home Rates - High, Medium and Low				
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
Other Health Home Rates				**Rate**
Health Home Plus *	Downstate			$800.00
Health Home Plus *	Upstate			$700.00
Adult Home **	Downstate			$700.00
Outreach	Statewide			$135.00
* Limited to AOT members that are not receiving ACT services.				
** Limited to Impacted Adult Home members assessed for transition to the community. If an impacted Adult Home member transitions to the upstate region, the rate is $563.				