Compiled Comments on the Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations.
Includes Comments Received as of July 6, 2015

The attached table is a compilation of comments received on the *Health Home and Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations*. Included is the Department's response/next step to each comment.

OVERALL COMMENTS

The guidelines do not flow in a consistent manner that are easy to follow and translate into a HH P&P manual -If possible, could guideline documents mimic those of OASAS and OMH, which clearly section off standards according to topics and clinical aspects of treatment. For example: staffing requirements, care plan requirements, assessment requirements. This would facilitate an easier formulation of a comprehensive HH P&P.

It is difficult to know when requirements are pertaining to all Health Home patients versus just HARP enrollees. There seems to be some crossover in certain sections.

Standard	Comment	Response/Next Steps
Six Core Health Home Requirements: **2c**. The Health Home provider must describe the relationship and communication between the dedicated care manager and the treating clinicians that assure that the care manager can discuss with clinicians on an as needed basis, changes in the individual's condition that may necessitate treatment change (i.e., written orders and/or prescriptions).	Is there a specified way in which the HH CM should describe what the communication is? Could this standard be more specific? Do you mean a progress note or describe in the interventions of a care plan?	Each Health Home is responsible for developing policies and procedures for meeting these requirements.

Standard	Comment	Response/Next Steps
2d. The heath home provider must define how care will be directed when conflicting treatment is being provided	Should this be done through a policy? Or is this standard referring to the treatment plan?	Same as above.
2g. The Health Home provider supports care coordination and facilitates collaboration through the establishment of regular case review meetings, including all members of the interdisciplinary team on a schedule determined by the Health Home provider. The Health Home provider has the option of utilizing technology conferencing tools including audio, video and /or web deployed solutions when security protocols and precautions are in place to protect PHI.	Is there a frequency for the case review? Can this be done on an "as needed basis"?	The requirement states that this be done on a schedule "as determined by the Health Home provider".
3a. The Health Home provider has a system in place with hospitals and residential/rehabilitation facilities in their network to provide the Health Home prompt notification of an individual's admission and/or discharge to/from an emergency room, inpatient , or residential/rehabilitation setting.	Not all hospitals and providers participate in the RHIO so alerts will not always go through to the HH providers. Could there be language put in there to that effect?	This requirement is independent of RHIO connectivity. Health Homes are required to have systems in place for notifications within their network. These requirements are part of the State's Medicaid State Plan Amendment and the language cannot be changed.

Standard	Comment	Response/Next Steps
3b. The Health Home provider has policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings, providers and community-based services to help ensure coordinated, safe transitions in care for individuals who require transfers in the site of care.	We have policies and procedures in place within our network but not with local EDs, hospitals, etc. We can only establish linkage agreements with local hospitals.	The Health Home is responsible for managing transitions for their members regardless of the setting.
4. Enrollee and Family Support	For this section, there should be a clarification that it is only when the patient has and wants family, friends, etc., involved in their care. Sometimes patients are estranged from their family, or their family is the source of their trauma or stress.	Health Home policies and procedures should reflect that attempts to include the member's family and friends etc. and member choices in this regard should be documented.

Standard	Comment	Response/Next Steps
Timeframe around outreach: B.5: As a best practice, after receipt of a referral from a Health Home, Health Home care management providers should begin outreach immediately if the Health Home sends an assignment list during the 1st to the 15th of the month. If Health Home sends an assignment list on the 16th of the month or later outreach can begin immediately or the following month but no later than the 5th business day of the following month.	If a care management agency has the capacity to take 100 people each month, splitting that into 50 at the beginning of the month and 50 later does not benefit prospective Health Home enrollees. Many Health Homes pull assignments once per month. While we certainly can pull those more frequently, the net result will be the same. However—referrals from outside organizations as well as HARP-eligible assignments can and should be processed with more frequency.	Revision made for clarity: As a best practice, after receipt of a referral from a Health Home, Health Home care management providers should begin outreach immediately. As a best practice, if the Health Home sends an assignment list during the 1st to the 15th of the month, outreach should begin immediately. If a Health Home sends an assignment list on the 16th of the month or later outreach can begin immediately, but may be initiated the following month to take advantage of the full month of outreach, but no later than the 5th business day of the following month.

Standard	Comment	Response/Next Steps
Plan of Care: **B.7:** Health Homes must submit plans of care, for review and approval by the enrollee's MCO as required **F.15:** MCOs will review plans of care for consistency with assessment results and known member health needs, and make a coverage and medical necessity determination within timeframes established in the Medicaid Managed Care Model Contract. For services included in the plan of care, MCOs will review requests for prior authorization (where applicable) in a timely manner and in accordance with the plan of care.	In discussions with MCO staff, we reached a consensus that until MAPP is fully functional, HHs and MCOs should send and receive plans of care via secure email through the Health Commerce System. This will make it easier for HHs and MCOs to track the status of plans of care awaiting approval or follow-up. As we discussed at the last HH/MCO meeting, more firm parameters need to be placed around this requirement in order to make it manageable for both the MCOs and Health Homes. An abbreviated plan of care submitted through MAPP would suffice from AHI Health Home perspective. Communicating these plans of care via e-mail or other method (i.e. HCS Secure File Transfer) does not have the needed trail to ensure accountability for all parties. For efficiency's sake, there must be a standardized plan of care template so that each MCO and each HH does not have to use a customized version for each organization with which it deals.	The State is working to develop the format and process by which Plans of Care will be shared between Health Homes and MCOs. While the use of the MAPP will be explored, an interim solution, such as a domain within the HCS to share Plans of Care, may have to be used.

Standard	Comment	Response/Next Steps
Plan of Care, continued: B.16: Health Homes shall ensure that the approved plan of care is reassessed at least annually, and more frequently when warranted by a significant change in the member's medical and/or behavioral health condition. Such reassessment shall document the member's progress in meeting his or her goals from prior plans of care and shall be documented in the member's record.	Should there be a timeline for each part of the process: xx days of referral for InterRAI, xx days to develop Plan of Care, xx days to share Plan of care with MCO, xx days MCO to return to care management agency/health home for review/revision/approval?	Timelines are specified for HARP and HARP eligible SNP Enrollees in Section D. Need feedback from the workgroup on whether timeframes should be incorporated in Standards or part of the individual contracts/operating procedures between Health Homes and MCOs.
	Due to the volume of enrolled patients, this is not feasible for CMAs to do for every patient. Was this meant for HARP patients or all Health Home patients?	Under review.
	Best practice should have care plans reassessed at least every six months.	Care plans can be reassessed as needed but as written the minimum requirement is to do so at least annually.

Standard	Comment	Response/Next Steps
Credentials for those developing Plans of Care B.17: The plan of care should be developed by experienced and qualified individuals.	How are these individuals defined? Need more clarity. What are the education requirement for "qualified individuals"?	Under review.
B.1.b): Health Homes should ensure care managers have access to other pertinent administrative data that may not be available in MAPP to inform real time decision making regarding outreach and engagement efforts.	This should specify that this can only be done if the MCO shares the data with the HH. Only certain MCOs provide additional information to assist with outreach. What is deemed other pertinent administrative data and at what intervals should Health Homes receive this information?	Guidance will be provided on an ongoing basis on best practices for use of data.
Assessments B.15: Health Homes must have policies and procedures in place to ensure consistent use of any State required eligibility and assessment tools to ensure high inter-rater reliability standards.	Any standardized tools should have a single Inter Rater Reliability test and used consistently by all users of the standard tools.	That is the intent of this standard-the degree to which inter-rater reliability is assessed will be evaluated as part of Health Home site visits.

Standard	Comment	Response/Next Steps
AOT Enrollees: C.4: Health Home care management providers working with court ordered AOT individuals must adhere to all Health Home Plus AOT Guidance issued by the State including : a) Provide face-to-face contact four times per month b) Work with the LGU's AOT coordinator as per local policy; c) Comply with all statutory reporting requirements under Kendra's Law d) Have a caseload ratio no greater than 1:12 (i.e. 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.	Or as defined by court order and LGU. If face-to-face and/or caseload ratios are not met, the HH+ rate cannot be billed.	Standard revised as follows (note the standard already specifies that the Health Home care management providers must work with the LGU as per local policy, language added re: court order.) C.4: Health Home care management providers working with court ordered AOT individuals must adhere to all Health Home Plus AOT Guidance issued by the State. If this standard is not met, the Health Home Plus rate cannot be billed. a) Provide face-to-face contact four times per month b) Work with the LGU's AOT coordinator as per local policy; c) Comply with the court order and all statutory reporting requirements under Kendra's Law d) Have a caseload ratio no greater than 1:12 (i.e. 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.

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Qualifications for Health Home Care Managers that perform HCBS assessments: D.4 (c) (iii) The State may waive such qualifications on a selected basis and under circumstances it deems appropriate which may include care manager capacity issues.	Please define these processes prior to implementing these standards	Guidance for submitting requests to the State for waivers of these education and experience requirements is being developed.
Providing services to HARP members that opt-out of Health Home enrollment: **D.7:** (see also F.30-32) For HARP Members that Opt-out of Health Home Services, but elect to receive HCBS, Health Homes may contract with MCOs to conduct NYS Eligibility Assessment and NYS Community Mental Health Assessment and to develop HCBS plans of care for members that opt out of Health Home care management services. The HCBS plans of care must still be developed in accordance with HCBS plan of care requirements.	Health Homes have concerns about providing services to non-engaged members. MCOs would find it difficult to contract with all Health Home downstream care management providers and further there is no fee or code for plan of care development as a separate service. Is there a fee set for the development of the Plan of Care for non-health home engaged members and a code?	Need further discussion on these concerns. A fee and rate codes are being established for these services.

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Use of MAPP: F.5: After enrollment in the Health Home, MCOs must share current claims data and demographic information, including information received from New York Medicaid Choice, with Health Homes, and must enter the most recent demographic information in MAPP.	DOH demonstrated the MAPP functionality by entering the demographic information directly in MAPP for one member. Is there a batch update capability that would allow us to enter information for more than one member at a time?	MAPP will include the capability to do batch updates with the initial roll-out currently planned for August 17, 2015.
Communication Protocols: **B. 1.a):** Health Homes must use information and performance data, including outreach and enrollment data, dashboards and other data made available through Medicaid Analytic Performance Portal (MAPP), and hold periodic meetings with care managers and MCOs to evaluate and improve performance.	What performance standards will the MCOs implement? Does "periodic" need to be more specific?	Guidance will be provided on an ongoing basis on best practices for use of data.

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B.1.b): Health Homes should ensure care managers have access to other pertinent administrative data that may not be available in MAPP to inform real time decision making regarding outreach and engagement efforts.	This should specify that this can only be done if the MCO shares the data with the HH. Only certain MCOs provide additional information to assist with outreach. What is deemed other pertinent administrative data and at what intervals should Health Homes receive this information?	Guidance will be provided on an ongoing basis on best practices for use of data.
Communication Protocols (cont.): **B.4:** When Health Home care management providers are notified or become aware of an enrollee's admission to a detox facility they must attempt to make a face-to-face contact 1) during the stay of an enrollee that has been admitted to a detox facility and 2) within 24 hours of discharge from a detox facility to ensure that the enrollee is aware of follow-up appointments and to provide supports for getting to appointments.	HH CMAs might not be aware of the patient's admission to a detox facility until after they have been discharged. Additionally, some detox facilities might not allow the HH CM onto the units due to HIPPA. The face to face contact AND the 24 hour follow-up might be too intensive of a requirement for some of the CMAs to follow, considering caseload size.	The Health Home is required to attempt face-to-face contact. Efforts to meet this requirement should be documented and efforts made to adjust caseload size as needed for enrollees as needed.

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F.7: MCOs must have policies and procedures in place to inform and assist Health Homes in responding when critical events occur, including when a member 1) has presented at a hospital ER/ED and was not admitted 2) is admitted to inpatient hospital or 3) is in crisis and presents at a location that provides additional opportunities to outreach to a member.	Suggestion: MCOs to directly inform the assigned HH CMA in order to expedite the alert notification and linkage to patient. This will expedite the alert going to the CM that can actively go and engage with the patient.	Mechanisms to allow direct data-sharing between MCOs and CMAs are being under discussion.
Care Management Assignment: **B.6:** Health Home care management providers must assign care managers to enrollees based upon care manager experience and defined member characteristics including, but not limited to, acuity, presence of co-occurring or co-morbid Serious Mental Illness (SMI)/Substance Use Disorder (SUD) or co-occurring medical co-morbid conditions, and patterns of acute service use.	Acuity or HML? What will determine if a member is deemed HML?	High Medium and Low (HML) will be determined through populating fields in the MAPP that will adjust the member's base acuity.

Standard	Comment	Response/Next Steps
Claims Submissions: B. 13: Health Homes must submit claims to MCOs within 120 days after the date of service to be valid, however, there is nothing to preclude the MCOs and the Health Homes from agreeing to other terms which are more favorable to the Health Home.	What is the timeframe that MCOs must comply with when submitting their claims to the State on behalf of the HH?	The Administrative Services Agreement (ASA) template used by Health Homes and MCOs currently states: *"Each month the MCO shall bill NYSDOH for Health Home Services for Health Home Participants and Outreach and Engagement for Health Home Candidates. MCO shall pay Health Home for Health Home Services billed to the MCO within thirty (30) days of MCO receipt of payment from NYSDOH, or such other frequency as agreed to by MCO and Health Home.*
HCBS Assessments: **D.1:** Health Home care managers will perform Home and Community Based Services (HCBS) Eligibility Assessments to determine if HARP members are eligible for Home and Community Based Services	It should be noted that patients will be assessed ONLY if they do not opt-out of HARPs and do want HCBS services.	**D.1:** Health Home care managers will perform Home and Community Based Services (HCBS) Eligibility Assessments to determine if HARP members are eligible for Home and Community Based Services, for members who do not opt out of HARP enrollment and who wish to receive such services.

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HCBS Assessments (Cont.) **D.2:** As a best practice Health Home care managers shall complete NYS Eligibility Assessment (brief interRAI) to determine HCBS eligibility within 10 days, but not longer than 21 days of an individual's assignment to the care management provider.	Due to current caseload size, this time frame is not feasible. Suggested time frame for initial eligibility screen should be 30 days.	Under review.
D.3: Health Home care managers will perform HCBS reassessments at least annually and when there is a significant change in status for HARP members receiving HCBS such as hospitalization and loss of housing.	It is not feasible to perform an entire HCBS reassessment (21 pages) each time a patient is hospitalized. For those patients who are frequent substance users or have a low baseline (SPMI) this will be very time consuming.	Under review.

Standard	Comment	Response/Next Steps
Conflict Free Standards: 1. Health Homes that provide care management and direct services, must ensure that the provider providing care management is not the same as the provider providing direct care services and that these individuals are under different supervisory structures 2. Health Home care managers are restricted from assessing a person for whom they have financial interest or other existing relationship that would present conflict of interest 3. Enrollees shall be provided with a choice of providers from among all of the MCO's network providers of a particular service. Health Homes shall document the enrollee's selection in the plan of care.	Are these specific to HARP enrollees?	Conflict free provisions must be put into place for all enrollees.