NEW YORK STATE | Department of Health | Medicaid Redesign Team

Health Home Managed Care Work Group Meeting

July 8, 2015

Agenda

- Welcome
- Health Homes Standards Update
- Administrative Services Agreements
- Health Home Development Funds Report
- Billing Readiness Attestation
- MAPP and HCS Updates
- Report from the Strategic Task Force to Increase HARP Enrollment
- Plan of Care Requirements
- HCBS Workflow
- Data Sharing
- Billing for Duplicate Service Claims & MLTC
- Criminal Justice Survey
- Health Homes Redesignation
- Health Homes Designated to Serve Children

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Health Homes Standards Document

Status of Health Home Standards Document

- Edits received to date have been incorporated-latest version attached.
- Several comments were received on outstanding issues to be addressed; but these do not impact the language of the standards:
  - ✓Need to define the template and process for Health Homes and MCOs to share Plans of Care;
  - ✓Need to define the process for Health Homes to request a waiver of the required credentials for staff performing interRAI assessments;
- Several comments need additional discussion-see attached compilation of comments.

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Administrative Service Agreements

Changes to Administrative Services Agreements between Health Homes and MCOs

Workgroup members were asked to review proposed changes to the existing template for ASAs between Health Homes and MCOs, including:

- Incorporating Health Home standards by reference;
- Eliminating requirement for 3% withhold by MCOs;
- Revisions to terms under which the contract can be severed, including incorporating the requirement that Health Homes first be given an opportunity to remediate any deficiencies.

Comments were due by June 22. Attached version reflects comments and edits received as of July 6. Original proposed changes are in red text and additional changes are in blue text. Only minor edits were received.

Changes to Administrative Services Agreements between Health Homes and MCOs *(con't)*

One comment received on the ASA regarding language in Article III-Payment, Section 3.1.

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.

The commenter asked if the parameters around payment could be standardized in the contract, instead of allowing the frequency to be established as agreed to by the MCO and Health Home. Thoughts from the group?

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Health Home Development Funds

Health Home Development Funds

As of June 30, 30 of the 31 designated Health Homes have submitted a preliminary report on proposed uses of Health Home Development Funds. Reports have been under review for:

- The completeness of the reports;
- The extent to which the proposed uses of funds conforms with the federally authorized purposes and the published list of examples;
- The degree of detail that has been provided about how CMAs were involved in funding decisions;
- The specificity with which alignment with DSRIP projects is described.

Health Home Development Funds

In addition, reports were evaluated to determine the degree to which the funds will be used to strengthen and expand the capabilities and capacity of the Health Home in these key areas:

- Enrollment of HARP members;
- Further development of HIT platforms;
- The ability to bill and pay for network care management agencies and downstream providers;
- As applicable, the expansion of your Health Home to serve children.

Response Letters to the preliminary assessments are being completed and will be sent out to Health Homes shortly.

Reminder, the first semi-annual required report is due on September 15, 2015. For more information how to complete the report please refer to the Health Home Funding Opportunities section of the HH website.

NOTE: Payments due in June will be delayed-expected in mid-July.

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Health Home Billing Readiness Attestation

Health Home Billing Readiness Attestations

As of June 30, DOH has received 9 attestations that the Health Home has procedures in place and have tested their ability to bill MCO's for Health Home services and pass Health Home payments down to CMA's and downstream providers.

- Health Homes need to indicate in their attestations the time frame they expect to be able to send payments to CMA's and downstream providers.
- If Health Homes will not be ready by the January 1, 2016 deadline for these requirements, they need to submit a letter of deficiency as soon as possible.
- If Health Homes need assistance, they need to consider using a portion of the Health Home Development Funds money to improve existing procedures and be ready for the January 1, 2016 deadline.

If you have not submitted a billing readiness attestation please do so as soon as possible. The attestations need to be submitted no later than October 1, 2015.

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MAPP and HCS Updates

MAPP Development and HCS Access

- Target Go Live date for MAPP for Health Homes is August 17, 2015 (8/15/15 is a Saturday).
- MCOs, Health Homes and CMAs must have HCS accounts to access MAPP.
- MAPP MCO worker trainings will take place **7/20/15 – 7/30/15** and MAPP HH worker trainings will take place **8/4/15 – 8/14/15**. Schedule of webinar based trainings will be sent to each organization's single point of contact (SPOC). Training for Health Homes Designated to Serve Children functions is anticipated for late fall of 2015.

MAPP Development and HCS Access

- A list of CMAs that have obtained Health Home HCS access and the list of registered SPOC staff, as well as file formats and archived webinars, is posted at: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_mapp.htm.
- Internal meetings being held to:
  - ✓Finalize system functionality and specifications;
  - ✓Develop user testing;
  - ✓Discuss interoperability issues.

MAPP User Acceptance Testing (UAT)

- DOH has contacted MCP and HH workers to determine provider's interest in submitting test files to MAPP for HH.
- MCPs and HHs that have expressed interest in submitting test files to MAPP for HH will receive additional instructions.
- Test file submission dates for HHs and MCPs are tentatively scheduled for July 23rd to July 27th

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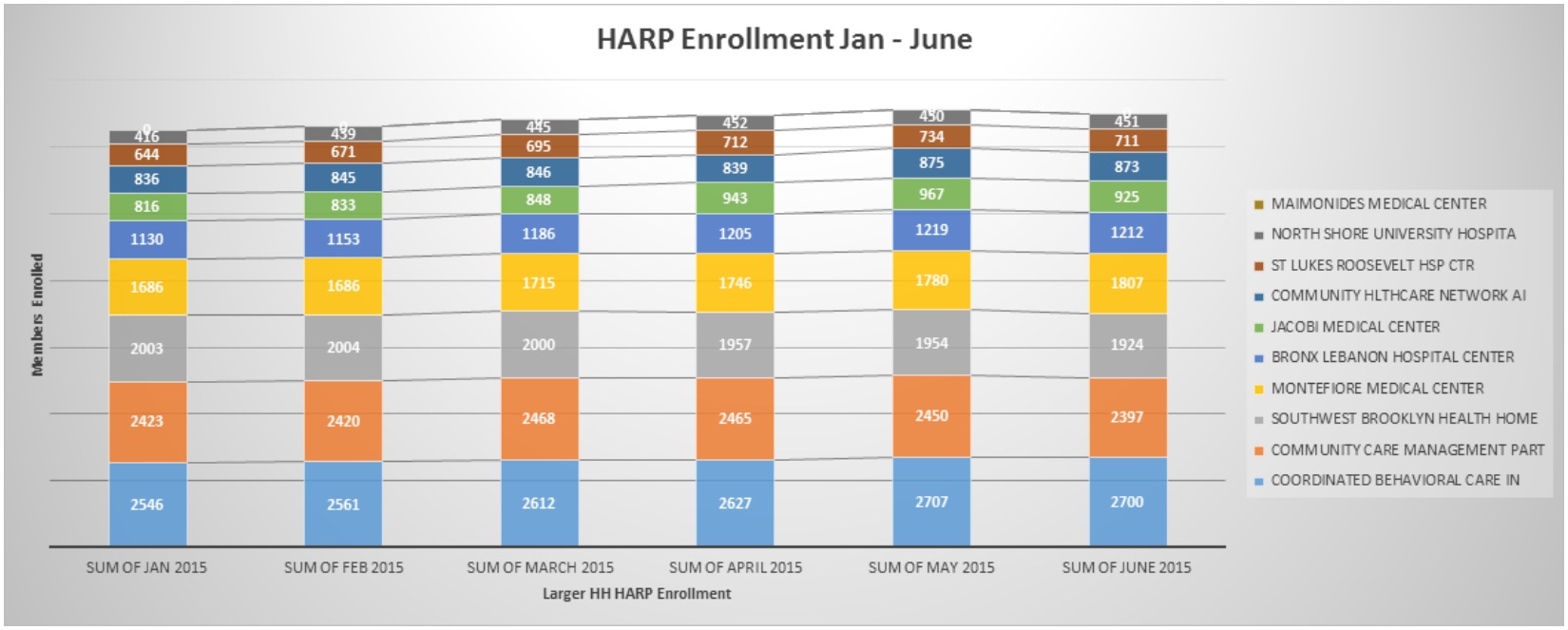
Behavioral Health Updates

Strategic Task Force for HARP Enrollment

Purpose: To ramp up HARP-eligible member enrollment into Health Homes.

- Progress: Slow increase in Outreach/Enrollment
- From July 2 call, the data shows 20,823 in Outreach or Enrollment for May, up from 19,611 from our last meeting 3 weeks prior
  - ✓June number not yet complete due to entry lag into HHTS
- DOH and OMH reviewing strategies to increase enrollment.

Enrollment of HARP-Eligible Members by Health Home as of July 1, 2015



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Presentations to the Task Force on July 2 Call

- UHC presented data on their early pilot of MCO “Feet-on-the-Street,” looking at their top 5% of health care utilizers.

  - ✓From this pool, they engaged 250 members (20%) of the 1,282 referred.

    - ○ These 20% were referred to the Health Home and enrolled.

- Mt. Sinai Health Home presented a similar project to UHC’s of looking at the highest utilizers across their 4 hospitals and worked a list of 53 members.

  - ✓Of the 53, twenty opted out of services.
  - ✓26 were interested but not always consent-able due to intoxication or other issues.
  - ✓5 individuals were enrolled.

Strategic Task Force for HARP Enrollment

- Still a lot of confusion in the field around HARPS and Health Homes.
- Health Home services confused with Home Health Care by EDs and Hospitals.
- Education and marketing strategies continue to be important.

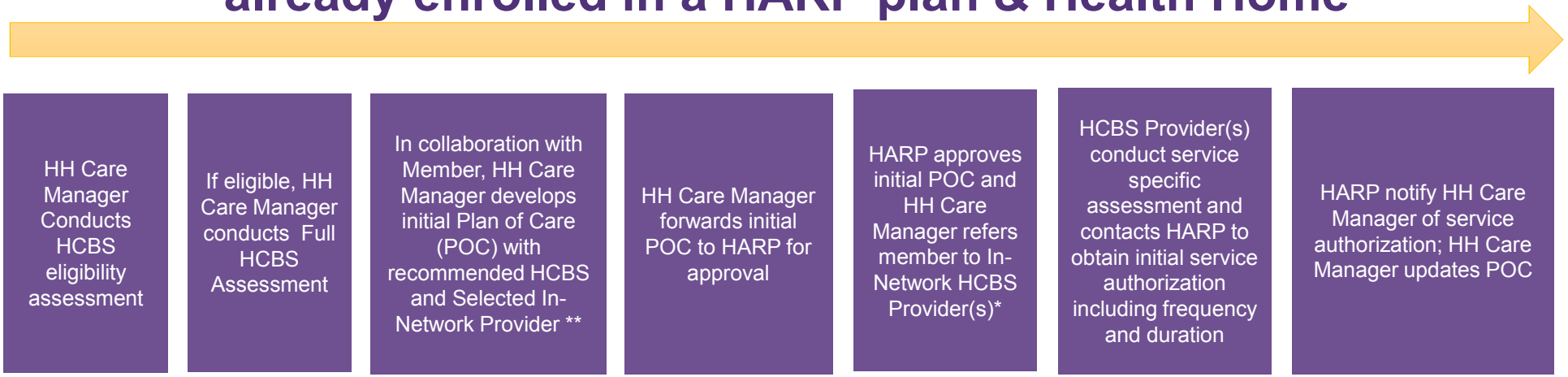
Other potential strategies to increase HARP enrollment

- Work with the Medicaid Data Warehouse (MDW) to ensure that Health Home Tracking System is working as expected (e.g., address HARP flag issue in tracking system).
- Provide 12 months of claims for HARP-eligible members, instead of last 5 claims, to Health Homes.
- Consider waiver of hiatus status for members who may benefit from extending outreach beyond 3 months.
- Eliminate requirements for disenrollment after 2 months of no contacts. Require review of prior service use with MCO prior to disenrollment. NOTE: The requirement for disenrollment after 2 months of no contact is not a State requirement. This may be a policy of specific Health Homes.
- Encourage MCOs and HHs to collaborate on efforts that augment HH care manager efforts with MCO case manager interventions, including MCO case manager field work.
- Consider using MCO funds for incentive payments to members to encourage HARP eligible people to enroll in Health Homes

Proposed process for HARP eligible on DOH list already enrolled in a HARP plan & Health Home

- The figure on Slide 24 outlines a proposed process for HARP eligibles on the DOH assignment lists who are already enrolled in a HARP Plan and Health Home, for the following steps:
  - ✓ Initial HCBS eligibility assessment
  - ✓ Full HCBS assessment
  - ✓ Developing the plan of care
  - ✓ Sharing the plan of care with the HARP plan
  - ✓ Obtaining service authorization
- This process is currently under discussion to determine whether it can be simplified and how it can be supported in MAPP/HCS.

Proposed process for HARP eligible on DOH list already enrolled in a HARP plan & Health Home



*Individuals have choice to receive HARP, Health Home and HCBS services. Appropriate firewalls and mitigation strategies will be put in place to ensure that the process is conflict free. Members will have a choice of a minimum of two providers.

** Initial POC will include recommended Home & Community Based Services (HCBS), Choices from plan's network for provider selection (minimum of two) and selected providers

Key:

- **HCBS Eligibility Assessment**= subset of questions from Community Mental Health Suite of InterRAI and other HCBS eligibility questions
- **Full Assessment**= Community Mental Health Suite of InterRAI to determine array of HCBS services
- **Completed POC**=Plan of Care that includes Frequency and Duration of HCBS Services

Data Sharing and Data Exchange for Intensive Outreach

- MCOs would need a modified BAA or a BAA with a Data Use Agreement for each CMA with which they would like to share administrative data for Outreach
- MCO can use real-time data on hospital or ED admission to alert Health Homes of members' presence, for engagement by the Health Home/CMA.

Plan of Care Requirements

- Plan of Care (POC) needs to be submitted to MCO for review and approval in order to access HCBS services. The POC must meet federal requirements.
- Consensus that a standardized template would be preferred-staff are developing a draft which will be shared with Health Homes and MCOs for comment (looking at samples from other States-ideas and suggestions are welcome)
- Looking into whether MAPP for Health Homes can be used to upload and share Plans of Care. May not be available immediately and an interim solution may have to be developed.

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Billing Issues

Denied Duplicate Claims

- DOH will review denied duplicate claims for Health Home services denied for “duplicate claim in history”; this analysis will occur after the MAPP for Health Homes go live date.
- Denied claims will be reviewed for appropriateness.
- The billing entity will submit the TCNs of the denied claims – additional information on where to send this information will provided after the MAPP for Health Homes go live date.
- A provider with more than three denied claims for a member will receive an offline payment not to exceed three months of Health Home services.
- Guidance on this process will be posted on the DOH website after MAPP for Health Homes goes live.

Billing for MLTC

- Health Home care management is a State Plan service and the State must provide Health Home services for individuals who qualify and want to be enrolled. Individuals have to be in an Managed Long Term Care (MLTC) plan to access long term care services.
- An individual may be enrolled in both a Health Home and an MLTC plan and both may bill. The Health Home bills fee-for-service for MLTC plan members, the payment does not flow through the MLTC plan.
- MLTC plans must contract with Health Homes for adult home residents transitioning to the community under a Stipulated Settlement, and the Administrative Services Agreement (ASA) is mandatory. A new version of the ASA will be released shortly that has specific language for adult home residents.
- MLTC plans are not required to contract with Health Homes for non-class members, but if they choose to contract with Health Homes, an ASA should be in place.
- Until an ASA is in place, both the Health Home and MLTC plan may bill provided the care planning tool coordination is completed and on file for the individual member. This guidance, the revised ASA and the care planning coordination tool will be released shortly.

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Criminal Justice Pilot Health Home Survey

Criminal Justice Pilot Health Home Survey

- An electronic survey was sent out to all of the Criminal Justice Pilot Health Homes.
- The intent was to understand how the programs have evolved since its implementation, the goals of the program initiatives, and established best practices.
- Out of the six Criminal Justice Pilot Health Homes, five responded, or 83%.

Key Results: Criminal Justice Linkages

- All five sites stated they currently work with local jails, though there are no established collaborations with state prisons as of yet.
- Two sites (40%) are working with parole and/or probation.
- One site (20%) is currently working with community re-entry task forces.
- All five sites reported established agreement(s) – E.g. DEAA and Business Partnership Agreements.
- A few of the sites described their process for communicating with the Criminal Justice System for diversion.

Key Results: Criminal Justice Linkages *(con't)*

- Huther Doyle has an Agency Board that consists of the County DA, Sheriff, founding Drug Court Judge, and a representative of the Rochester City Police. The Board discusses linkages and coordination of programming.
- Lake Shore has Care Managers present in the courts, allowing them access to the jail/holding center. They also have working relationships with Erie County's Forensic Mental Health Team.

Key Results: Population Engagement

- Four sites (80%) reported engagement of the criminal justice population prior to the pilot.
  - E.g. – Community Healthcare Network had always served individuals released from incarceration. Their interdisciplinary team approach (model of care) has been maintained.
- Some current population engagement plans:
  - Identification of eligible individuals
  - Establishment of connections/partnerships between justice professionals and Care Managers
  - Attempting to have Care Managers enter the jails for early interventions and prevention of rearrests

Key Results: Improvement of Preventive Care & High Patient Satisfaction

Steps sites are pursuing towards preventive care:

- Identification of members/candidates and linkage to needed services;
- Disease management for chronic conditions;
- Promotion of health literacy/ Health Home Initiative promotion.

Key Results: Improvement of Preventive Care & High Patient Satisfaction *(con't)*

- Steps sites have taken towards high patient satisfaction:
  - Systems implemented such as monthly meetings, conferences and system partnerships
  - Utilize a person-centered approach
  - Specifically some sites have stated:
    - Brooklyn Health Home – "Open Door Policy" for guidance and support.
    - Huther Doyle – Has routine patient surveys that demonstrate high patient satisfaction
    - Lake Shore – Requires that Care Managers attend mandatory trainings for Cultural Competency and Trauma Informed Care, as well as has access to interpreters.

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Health Home Redesignation

What is Redesignation?

After the initial three year period of designation, DOH and its State Implementation Partners (OMH, AI, and OASAS) will collaboratively review performance to assure all Health Homes across the State are in compliance with Health Home standards.

Redesignation of Health Homes will be determined based on:

- compliance with Federal and State requirements designed to meet Health Home goals to reduce preventable hospitalizations and emergency room visits, and avoid unnecessary care;
- governance and operational integrity; and,
- improved health outcomes of members.

A Two-Part Process

Pre-Survey:

NYSDOH will collect and review data to evaluate the overall performance of Health Homes.

Site Visits:

Site visits will be conducted at each Health Home and will include the presence of up to three Care Management agencies per Health Home.

Tools

NYSDOH, in conjunction with State Implementation Partners (OMH, AI, OASAS, Managed Care) and CASA Columbia, has developed a Redesignation Tool that will be used to collect and evaluate pertinent information.

1. Health Home Policy Review
   - ✓ Required policies
   - ✓ HIT standards
   - ✓ Staffing
   - ✓ General administration
2. Record Review

The Site Visit

DOH Health Home staff will be conducting site visits along with State Implementation Partners (OASAS, OMH, AI), and CASA Columbia.

Site visits will be conducted in order of the Health Home's phase of enrollment (Phases 1, 2, and 3) and based on outcome of data analysis.

Site visits are expected to take at least two full days at each Health Home.

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Health Homes Designated to Serve Children

Health Homes Designated to Serve Children

- Applications were due March 2, 2015.
- The State received 22 applications.
- On June 15, sixteen Health Homes were approved pending the acceptance and implementation of contingencies.
- Readiness activities, webinars, and trainings continue through December 31, 2015.

Health Homes Designated to Serve Children

Health Home	Designated to Serve Children Pending the Acceptance and Implementation of Contingencies
Catholic Charities of Broome County	Encompass Catholic Charities Children's Health Home Albany, Allegany, Broome, Cattaraugus, Chautauqua, Cayuga, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Wayne, Warren, Washington, Wyoming, Yates
Greater Rochester Health Home Network LLC	Cayuga, Chemung, Livingston, Monroe, Ontario, Seneca, Steuben, Wayne, Yates, Allegany, Genesee, Orleans, Wyoming
Central New York Health Home Network (CNYHHN Inc.)	Albany, Rensselaer, Schenectady, Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, St. Lawrence
North Shore LIJ Health Home	Queens, Nassau, Suffolk
Coordinated Behavioral Care, Inc. dba Pathways to Wellness Health Home	Bronx, Brooklyn, Manhattan, Queens, Staten Island
St. Mary's Healthcare	Fulton, Montgomery
Niagara Falls Memorial Medical Center	Niagara
Hudson River HealthCare, Inc. (HRHCare)	Nassau, Suffolk

Health Homes Designated to Serve Children

Health Home	Designated to Serve Children Pending the Acceptance and Implementation of Contingencies
St. Luke's-Roosevelt Hospital Center dba Mount Sinai Health Home	Bronx, Brooklyn, Manhattan, Queens, Staten Island
VNS – Community Care Management Partners, LLC (CCMP)	Bronx, Brooklyn, Manhattan, Queens, Staten Island
Adirondack Health Institute, Inc.	Clinton, Essex, Franklin, Hamilton, St. Lawrence, Warren, Washington
VNS of Northeastern NY (Care Central)	Saratoga, Schenectady
New Children's Health Home – Partnership to Be Formed Among: Montefiore Medical Center dba Bronx Accountable Healthcare Network Health Home, Open Door Family Medical Centers dba Hudson Valley Care Coalition, Hudson River Healthcare dba Community Health Care Collaborative (CCC), and Institute for Family Health	Bronx, Columbia, Dutchess, Greene, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester

Health Homes Designated to Serve Children

Health Home	Designated to Serve Children Pending the Acceptance and Implementation of Contingencies
Children's Health Homes of Upstate New York, LLC (CHHUNY)	Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming, Yates
Collaborative for Children and Families	Bronx, Brooklyn, Manhattan, Nassau, Queens, Staten Island, Suffolk, Westchester
Kaleida Health-Women and Children's Hospital of Buffalo	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming

Anticipated Schedule of Activities for Expanding Health Homes to Better Serve Children	Due Date
Draft Health Home Application to Serve Children Released	**June 30, 2014 - Completed**
Due Date to Submit Comments on Draft Health Home Application to Serve Children	**July 30, 2014 - Completed**
Due Date to Submit Letter of Interest	**July 30, 2014 - Completed**
Final Health Home Application to Serve Children Released	**November 3, 2014 - Completed**
Due Date to Submit Health Home Application to Serve Children	**March 2, 2015 – Completed**
Review and Approval of Health Home Applications to Serve Children by the State	**March 2, 2015 to June 15, 2015 - Completed**
HH and Network Partner Readiness Activities	June 15, 2015 to ***December 31, 2015***
State Webinars, Training and Other Readiness Activities	Through ***December 31, 2015***
Begin Phasing in the Enrollment of Children in Health Homes	***January 1, 2016***
Children's Behavioral Health Services and other Children's Populations Transition to Managed Care	*January 2017 (NYC/LI)* *July 2017 (ROS)*

Updates, Resources, Training Schedule and Questions

- Please send any questions, comments or feedback on Health Homes Serving Children to: hhsc@health.ny.gov or contact the Health Home Program at the Department of Health at 518.473.5569
- Stay current by visiting our website: http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm

Health Homes Designated to Serve Children
Timeline for Enrollment

- To help actively ensure a smooth launch of Health Home Serving Children design and mitigate readiness risk, the date to begin enrolling children in Health Homes is being delayed by three months or from October 1, 2015 to January 1, 2016.

- This allows:
  - ✓Time for Designated Health Homes to Serve Children meet contingencies and complete other administrative/readiness activities
    - Time for new Care Management Agencies(CMAs) with expertise in serving children with complex needs to forge relationships with new and existing Health Homes
  - ✓Time for Health Homes, Care Management Agencies and plans to complete and participate in key trainings – MAPP, CANS-NY
  - ✓Timing of CMS approval of State Plan Amendments

DISCUSSION