NEW YORK STATE | Department of Health | Medicaid Redesign Team

Health Home Managed Care Work Group Meeting

April 7, 2015

Agenda

- Update: Behavioral Health Transition to Managed Care
- Strategic Task Force to Increase HARP Enrollment
- Review and Comments on Consolidated Draft Standards Document
- July 1 Billing Procedures
- Results of Health Home Billing Survey
- Update on Training Activities

Transition of Behavioral Health Benefit to Managed Care HARP Plans and Health Home

- April 2015
  - Anticipated CMS approval
  - NYC Implementation: HARP Passive Enrollment Maximus Letters Distributed in Phases by Birthdate:
    - Approximately 20,000 April/May distribution for July enrollment
    - Approximately 20,000 May/June distribution for August enrollment
    - Approximately 20,000 June/July distribution for September enrollment
- July 1, 2015
  - Behavioral Health Medicaid State Plan services available to both Mainstream and HARP
  - MCOs Begin to Manage and Pay for BH Services and Health Home PMPM and interRAI Assessment Payments for HCBS eligibility and Plans of Care
  - NYC HARP Passive Enrollment Begins (July-September)

Health Homes and Behavioral Health Transition to Managed Care

- All HARP members and HARP eligible HIV-SNP members will be offered Health Home care management services
- It is anticipated that Health Homes will develop person-centered care that integrates physical and behavioral health services and includes HCBS services (see Appendix for more information)
- The interRAI Community Mental Health (CMH) suite has been customized for NYS and includes:
  - Brief Assessment to determine HARP and HCBS eligibility
  - Full Assessment to identify needs and assist in the development of a care plan including HCBS services
  - It is anticipated that Health Homes will conduct CMH assessments
- The CMH tool has been automated and will be accessed through the Health Commerce System (HCS)

Qualifications of Care Managers Conducting Community Mental Health (CMH) Assessments

Health Home Care managers that perform Community Mental Health (CMH) assessments or reassessments must meet the following qualifications:

- Education:
  - A bachelor's degree in any of the following: child & family studies, community mental health, counseling, education, nursing, occupational therapy, physical therapy, psychology, recreation, recreation therapy, rehabilitation, social work, sociology, or speech and hearing; OR
  - NYS licensure and current registration as a Registered Nurse and a bachelor's degree; OR
  - A Bachelor's level education or higher in any field with five years of experience working directly with persons with behavioral health diagnoses; OR
  - A Credentialed Alcoholism and Substance Abuse Counselor (CASAC).
- Experience:

  Two years experience (a Master's degree in a related field may substitute for one year's experience) either:
  - Providing direct services to persons diagnosed with mental disabilities, developmental disabilities, alcoholism or substance abuse; OR
  - Linking persons who have been diagnosed with mental disabilities, developmental disabilities, alcoholism or substance abuse to a broad range of services essential to successfully living in a community setting.
- Training and Supervision:
  - Specific training for the designated assessment tool(s), the array of services and supports available, and the client-centered service planning process. Training in assessment of individuals whose condition may trigger a need for HCBS and supports, and an ongoing knowledge of current best practices to improve health and quality of life.
  - Mandated training on the interRAI Community Mental Health Assessment instrument and additional required training
  - Must have supervision from a Master's level clinician

The State may waive such qualifications, on a selected basis and under circumstances it deems appropriate which may include care manager capacity issues.

Payments for Community Mental Health (CMH) Assessments

- Behavioral Health rates include a separate Managed Care fee paid by the Plans to the Health Homes and other designated entities that conduct brief and full CMH
  - Brief Assessment determines eligibility for HCBS services
  - Full Assessment helps develop plan of care and identify HCBS services
- Brief Assessment (only): $80
  - It takes approximately 30 minutes to complete Brief Assessment
- Full Assessment: $185
  - It takes approximately 90 minutes to complete Full Assessment

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 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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HCBS Plan of Care Requirements

April 7, 2015

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

- Strategic Task Force to quickly ramp up enrollment for HARP-eligible members in NYC by July 1
  - Includes leadership from OMH, OASAS, AIDS Institute and OHIP State Agencies, and Plans, Health Homes and Care Managers
- Identify barriers/systemic gaps contributing to low enrollment rates.

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

- Identify actionable items for HHs, MCOs and/or CMAs to address barriers/systemic gaps to improve outreach and enrollment efforts.
  - HH Development Funds – (HHDF) $190.6 million
    - ✓Member Engagement and Health Promotion
    - ✓Workforce Training and Retraining
    - ✓Clinical Connectivity and HIT
    - ✓Joint Governance Technical Assistance
- Form specialized, intensive outreach and engagement teams to focus on boots-on-the-ground enrollment. HHDF may not be used to support activities that are billable under the PMPM (no duplicate payment/paying for the same activity twice).
- Establish monthly enrollment targets and monitor performance.

Save the Date: Strategic Task Force Meeting April 23, 2015

- Meeting of State Agencies and Health Home and Managed Care Plan representatives
- April 23, 2015; 10:00 – 12:00
  - NYC OMH Field Office, 330 Fifth Ave, 9th Floor, Conference Room A
  - 1 representative per agency, please (space limitations)
- Please RSVP to Debbie Reamer at debbie.reamer@health.ny.gov and identify a primary contact at your Plan and Health Home to participate in the Task Force and attend the meeting on April 23, 2015.

State Agency Team Working to Update HARP Eligible Population

- The HARP population is being updated with more recent data (from 2012 to 2014) and this CY 2014 HARP population will be used to identify HARP members for passive enrollment.
- The 2014 HARP member population will be identified in the current (pre-MAPP) tracking system and MAPP (July 1, 2015 – accommodates two factor authentication requirements to protect PHI).
- Current pre-MAPP system is being updated to include 2014 HARP "flagged" data (2012 HARP flag will also be available)
  - The Health Home Tracking System (HHTS) is expected to be updated by April 10, 2015.
  - HHs and MCOs were notified of the change and the enrollment download file format changes on April 6, 2015.
  - The file format changes will be posted to the HH website once the HHTS changes have been implemented.

2014 NYC HARP-Eligibles

- 118,000 HARP Eligible Members Statewide
- Prioritize enrollment of NYC members who will be enrolled in HARP beginning in April – 67,005 2014 NYC HARP-eligible members
- March 2015 (As of 4/1/15):
  - ✓16,545 or 25% in outreach or enrolled
    - 13,245 enrolled
    - 3,300 in outreach
- From HH inception January 2012 to March 2015
  - ✓42,493 or 63% in outreach or enrolled
    - 18,100 enrolled - Reflects that some members have been discharged/no longer enrolled
    - 30,343 in outreach – 45% of HARP eligibles have been identified as in outreach at some point since January 2012

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Standards Discussion /Comments from Work Group

- Documents consolidated into one document to help clearly define standards and requirements, and the roles of Health Homes and Plans
- Comments received on documents (standards grid, outreach enrollment, intensive outreach) focused on:
  - ✓interRAI Qualifications / Length of Tool
  - ✓Communication and Data Sharing
  - ✓Timeframes for Assignments (Plan to HH to CMA)
  - ✓Outreach / Intensive Outreach
  - ✓HARP members that want HCBS Services and Decline Health Home Enrollment

Summary of Comments from HH/MCO WG on Assignment and Outreach Guidance

Communication and Data Sharing

- ✓ Communication between Hospitals (ER and Inpatient) and Health Homes does not always happen – Hospitals often do not know if member enrolled in HH or do not check
  - Proposed Recommendation: MAPP (this Fall) is being designed to help resolve this issue
  - Proposed Recommendation: Educate Hospitals on Health Homes
- ✓ Health Homes reported the difficulty enrolling patients is predominantly lack of data rather than a lack of outreach efforts – managing data received from different sources can be a challenge
  - Proposed Recommendation: Each HH uses funds available to appoint a dedicated Health Home Roster Manager to:
    - ✓ Process all alerts immediately
    - ✓ Make efficient and direct connections with the CMA attempting to find/working with the patient
    - ✓ Collaborate with DOHMH, DHS, and other organizations that can assist with data and alerts prior to signing a HH consent
    - ✓ Assist with management of enrolled patients via MCO alerts
  - ✓ This approach has been tested by Health Home with criminal justice system with success
- ✓ Requirements that MCOs inform their provider network about HHs and how they can benefit eligible members
  - ✓ Proposed Recommendation: Would need to be limited to online information and the current PCP notifications – otherwise too costly
- ✓ Requiring MCO and HH to be partners in data sharing is critical

Note: MAPP will include new fields in assignment file for MC Plans to use to provide supplementary address informati

Summary of Comments from HH MCO WG on Assignment and Outreach Guidance

Timeframes for HH Assignment from Plan, to Health Home, to Care Manager – General Agreement: Establishing Timeframes Would Be Helpful

2 Days for AOT Members

- ✓ Most HH and MCOs indicated a two day timeframe for each stage is too short. One Health Home indicated the two day timeframe is manageable
- ✓ Ability to meet any timelines is dependent on capacity which varies across HHs and care management agencies
- ✓ HHs typically draw down assignment lists on a monthly basis – usually at the beginning of the month

3 Days for All other Members

- ✓ Hardship for all the same reasons identified for the 2 day timeframe for AOT members
- ✓ Making assignments on a rolling basis for HH MCO and Care Managers is problematic (its inefficient, depends on capacity in general, capacity issues in rural counties)
- ✓ Uncertainty regarding cash flow (shift to HML rates and future assignments) make timeframe problematic

- **Proposed Recommendations:**
  - MCOs make assignments to HHs on a prescribed schedule (e.g., minimum of weekly or monthly?)
  - HH pull assignments on prescribed schedule (ideally daily, but at least weekly) and assign to CMA within 5 business days
  - CMAs must begin outreach within the month they are assigned
  - Solution strikes a balance between timeliness of assignments and ability to perform meaningful outreach when assignment is made

Summary of Comments from HH MCO WG on Assignment and Outreach Guidance

Proposed Recommendations continued :

- Develop separate timeframes for community referrals made to HH (requires Plan approval) and for members that are on Assignment List
- For community referrals HH must assign to CMA in 3 days and CMA must outreach in 10 days
- For Assignment List member HH has 30 days to assign to CMA
- 3 days is reasonable for Plan to make a list assignment to HH
- Assignment list should be posted on set schedule
- Assignment files should ideally be downloaded daily, but must be downloaded at least weekly (DOH)
- 9 days total, 10 days total from assignment to outreach
  - Plan has 3 days to assign to HH
  - HH has 3 days to assign to CMA
  - CMA has 3 days to begin outreach
- Critical assignments for members released from facilities: Facility should be required to reach out to HH to schedule an appointment before discharge

Summary of Comments from HH MCO WG on Assignment and Outreach Guidance

Outreach

- Health Homes need clear policies that outreach must be progressive and consist of more than telephonic.
- Outreach efforts should continue until member is located and enrolled unless member declines
- Health Homes need clear policies that outreach must be progressive and consist of more than telephonic – provide clearer guidance on what constitutes progressive outreach, is progressive outreach during a cycle or across cycles? (April 2012 Health Homes Special Edition Medicaid Update Article)
- Outreach efforts should continue until member is located and enrolled unless member declines
- Outreach efforts and standards must be mindful of HIPPA and other regulations and laws (cannot contact clinicians for information without member consent)
- Peer supports must be on staff of Health Home – respect confidentiality and privacy of member
- Collecting best practices from each HH's providers with the highest conversion rates, and developing an Outreach Learning Collaborative (one upstate and one downstate) for CMAs to share these best practices and provide training/education.
- Telephonic outreach is not effective for highest needs members and needs to be "boots on the ground"
- Community Health Workers and peer supports should be engaged to help train Health Homes for outreach
- Outreach should be tied to billing (MAPP Phase II will capture outreach efforts)

Summary of Comments from HH MCO WG on Assignment and Outreach Guidance

Intensive Outreach

- Intensive outreach will dis-incentivize routine outreach – it should not be reward but done as part of current outreach efforts
- Cannot distinguish between actionable items that would constitute “routine” outreach and “intensive” outreach
- Consider a combination of value based and flat outreach fee structure for Intensive outreach
- Persons that conduct intensive outreach should be staff of Health Home for which it conducts that effort
- Providing a higher rate/”bonus” payment (paid at enrollment) to members assigned for outreach to CMA for which there is little or no contact information on the assignment files (i.e. PO box only, no phone number)
- Providing a higher rate/”bonus” payment (paid at enrollment) to members with some of the high risk factors identified in the HML structure (homelessness, uncontrolled substance use, etc.)
- Use Health Home Development Funds to provide training platform across the Health Homes and develop collective marketing strategies within the provider community and directly to potential members
- Limit routine outreach for low risk members to two 90 day attempts – future outreach efforts are not billable
- Should not be for members that have opted out of Health Homes

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July 1, 2015 Billing Practices and Policies

April 7, 2015

Background: Current (prior to July 1, 2015) Billing and Assignment Algorithm Procedures

Prior to July 1: Assignment Algorithms and Billing Procedures

- Members working with a legacy care manager prior to January 2012 were enrolled in a Health Home selected by their legacy care manager.
- FFS Members - Assigned to HH by DOH based on HH loyalty match to network. Health Home bills directly (if member is working with downstream legacy care manager, CMA bills)
- Managed Care Members – DOH provides suggested HH loyalty to match to MC Plan – Plan accepts assignment or makes another HH assignment (if member is working with downstream legacy care manager, CMA bills).
- Legacy providers bill directly for all fee-for-service and managed care members they work with, whether the members were enrolled with the legacy provider prior to the HH program or assigned to the legacy provider after HH implementation.
- The biller of the Health Home service is responsible for determining Health Home eligibility.

Billing Rules: July 1, 2015

- CMS authorized the extension of legacy rates through June 30, 2015
- CMS also authorized flat outreach fee - $135
- Effective July 1, 2015 direct billing by legacy providers will be eliminated
- High, Medium, and Low rates for HARP and non-HARP members with functional and clinical adjustments will take effect
- Direct billing for Health Home payments by downstream legacy care managers will be eliminated (exception is ACT providers)
  - Care manager submits HML and clinical functional indicators into MAPP. HHs, Plans and care managers have access the MAPP rate information and can access online or download all information needed to submit claim and make payments to care managers.
  - Plans submit claims to eMedNY for outreach/ care management billing instances using billing support in MAPP, Plan pays Health Home, Health Home pays downstream care managers.
- Behavioral Health benefit for adults is moved to Managed Care and enrollment begins (HARP and non-HARP plans)

Health Home Rates: High Medium and Low Rates with Clinical and Functional Adjustments Effective July 1, 2015

- Billing guidance has been posted to the Website http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_billing_practices.htm
- In ***New York City only***, Health Homes and mainstream Managed Care Plans will bill the non-HARP rate for members not enrolled in a HARP Plan. HARP plans will bill the HARP rate for members enrolled in a HARP plan. The enrollment process is detailed in billing guidance
- ***In all areas of the State outside of New York City***, Health Homes and Managed Care plans will bill the HARP rate for members that are eligible for HARP until such time as a HARP plan is available in the member's region. Once a HARP plan is available in the member's region the member must be enrolled in a HARP in order for Health Home or Managed Care plans to bill the HARP rate. Individuals who have been pre-identified by the State through an analysis of claims and encounter data and referrals that have been identified as newly HARP eligible through initial InterRAI assessment will be flagged as HARP eligible in the Medicaid Analytics Performance Portal.
  - The 2014 HARP population is the "flag" that will be used determine which members can be billed the HARP rate
  - The HARP/non-HARP rates will be loaded to both Health Homes and Managed Care plans (rate codes yet to be determined).

Other Billing Rules Effective July 1, 2015

- **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 that 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:** Return to Assignment list and distribute to member's Plan for assignment by the Plan to Health Home it contracts with.
  - ✓ Example: Member enrolled in Plan A, but in outreach with HH B which does not have a contract with Plan A. Once member is in hiatus, Plan A reassigns member to contracted HH C.
- **Plan is Responsible for verifying Health Home eligibility (this may be delegated by the Plan to Health Home)**

Billing Support Workflow in MAPP

- Care Management Agencies will submit monthly billing information (High, Medium, Low functional questionnaire) into MAPP
  - Submitted either individually for each member online or by uploading a file
  - CMA will respond to HML questions (Incarceration, Viral Load, T-Cell Count, Homelessness, Mental Health/Substance Abuse Status), indicate if a billable service was provided, submit diagnosis information.
  - MAPP will only accept information for members that have been submitted to MAPP in a billable status for the month submitted.
- If CMA does not want to submit this information to MAPP, HH can submit on behalf of CMA
- Billing Support, available online or through file download, indicates entity responsible for billing Medicaid, places member into High, Medium, or Low rate code, and provides all information needed to submit claim.

Billing Support Workflow in MAPP

- Billing Support will query MDW (Medicaid Data Warehouse) for payment/denial information regarding a claim. All providers associated with the member will have access to billing information submitted to Billing Support by users and pulled from MDW by MAPP.
- Once submitted by CMA, HH and MC will be able to see billing support information, which combines Tracking information (MCP/HH/CMA association, segment type), submitted HML information, and claim payment/denial information.
- **BILLING SUPPORT DOES NOT SUBMIT A CLAIM TO MEDICAID. The responsible biller (ACT for ACT members, MC for non-ACT Plan members and HH for non-ACT FFS members) must submit claim to eMedNY and send payment to downstream providers.**

Health Home Billing Survey

- A survey was sent out on March 19 to all Health Homes to :
  - Determine existing timeframes for billing and payment at each point in the billing cycle (results are prior to MAPP implementation)
  - Determine which Health Homes are using billing agents or other entities to assist with billing and accounts receivable
  - Identify “bottlenecks” in the existing billing processes
  - Help assess the capability of Health Homes to bill and pay on a timely basis when direct billing is eliminated on July 1, 2015
  - Obtain suggested timeframes for mandating timeframes for billing

Health Home Billing Survey – 30 Respondents

- Has your Health Home met with all of your Care Management Agencies to discuss the elimination of the authorization for direct billing on July 1, 2015?

  Yes – 73.33% (22)

  No – 26.67% (8)

- Has your Health Home developed and tested a system to pay downstream care management agencies (CMAs) when the authorization for direct billing is eliminated?

  Yes - 46.67% (14)

  No - 53.33% (16)

- Are you actively working now to develop and test a system that will be operational by July 1, 2015?

  Yes - 93.75% (15)

  No - 6.67% (1)

- Does your Health Home use a third party (e.g., a billing agent) to handle billing functions?

  Yes - 51.85% (14)

  No - 48.15% (13)

Health Home Billing Survey

Each Health Home was asked to provide timeframes for key steps in the billing process, broken out by each MCO they work with. 13 Health Homes responded to this section.

Number of days from the date of service to the date your Health Home receives the bill from the CMA, for each CMA that is not a direct biller (this information will be provided in MAPP July 1);

- 8 Health Homes received bills in 30 days or less
- 3 Health Homes received bills between 15-45 days
- 1 Health Homes received bills in 90 days
- 1 Health Home did not provide a response

Health Home Billing Survey

Number of days from the date your Health Home receives the bill from the CMA to the date your Health Home bills the MCO, for each CMA that is not a direct biller (this information will be provided in MAPP July 1)

- 6 Health Homes billed in 7 days or less
- 2 Health Homes billed in 14 days
- 2 Health Homes billed in 30 days
- 1 Health Home billed in 44 days
- 2 Health Homes did not respond to this question

Health Home Billing Survey

- Number of days from the date your Health Home submits the bill to the MCO to the date your Health Home is paid.
  - 2 Health Homes were paid in 30 days, for all MCOs
  - 2 Health Homes were paid in 30-45 days, for all MCOs
  - 1 Health Home was paid in 30-60 days, for all MCOs
  - 1 Health Home was paid in 69 days, for all MCOs
  - 1 Health Home was paid in 80 days, for all MCOs
  - 1 Health Home did not respond to this question
  - 3 Health Homes provided payment times for each individual MC0, times ranged from 34-123 days

Health Home Billing Survey: Number of days from the date your Health Home submits the bill to the MCO to the date your Health Home is paid.

HH	AVG	HHP	Affinity	Emblem	Fidelis	IHP	MVP	Health First	United	Wellcare	Excellus	CDPHP	Metro Plus	Amida	VNS	HIP	Ameri-group
1	30	✓	✓	✓	✓	✓	✓										
2	80	✓	✓	✓	✓			✓	✓	✓							
3					94		61				34						
6			64		94			123	58				86	54	63	67	
7			65	75	94			123	58	58			86	54	63	67	
8	30		✓	✓	✓			✓	✓	✓			✓		✓		✓
9					75							90					
10	69		✓	✓	✓			✓	✓	✓				✓	✓		✓
11					50				60								
12					30-45				30-45								
13											30-60						

Health Home Billing Survey

Number of days from the date your Health Home receives payment to the date your Health Home pays the CMA, for each CMA that is not a direct biller.

- 1 Health Home pays in 2-3 days
- 1 Health Home pays in 7 days
- 1 Health Home pays in 10 days
- 2 Health Homes pay in 14 days
- 1 Health Home pays in 15 days
- 1 Health Home pays in 20 days
- 2 Health Homes pay in 30 days
- 1 Health Home pays in 30-60 days
- 2 Health Homes did not respond

Health Home Billing Survey

For each step listed in the previous question, indicate what the maximum time frame in days that should be mandated to complete each step:

	Bill Received From CMA	Health Home Bills MCO	MCO Pays Health Home	Health Home Pays CMA
Health Home 1	20	14	30	14
Health Home 2	30	3	30	7
Health Home 3	14	14	60	14
Health Home 4	15-30	30	30-45	30
Health Home 5	5	5	30	15
Health Home 6	14	14	60	14
Health Home 7	5	15	30	30
Health Home 8	14	5	30	5
Health Home 9	44	44	14	14
Health Home 10	30	10	10	30
Health Home 11	30	5	35	5
Health Home 12	10	10	365	30
Health Home 13	15	15	60	60
Health Home 14	30	10-30	90-200	30-90

	Possible Option for Timeframes
Bill Received From CMA	Billing Info in MAPP
HH Bills MCO	Billing Info in MAPP
MCO Pays Health Home	30
Health Home Pays CMS	14
Total	44

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Health Home Billing Survey

Health Homes were asked if they used a billing agency. 12 Health Homes responded to this section.

- 9 Health Homes use BTQ Financial
- 3 Health Homes use other agencies:
  - DNA Healthcare
  - Spectrum Human Services
  - Solutions4 Community Health

Health Home Billing Survey

Health Homes were asked to identify any barriers they foresee to ensuring prompt payment, once MAPP is operational. 15 Health Homes responded to this section.

- 9 Health Homes said barriers would exist with MCOs, e.g., need for MCOs to use electronic remittances, delays in payment, and difficulties communicating with MCOs on denied claims
- 3 Health Homes said the MAPP system itself could pose a barrier if their current systems are not compatible and they are not given the file layout in enough time to create linkages.

Health Home Billing Readiness Requirements

1. By May 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 July 1, 2015

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

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

Options for Managing Cash Flow Impact from Billing Delays

- Health Homes work with downstream care managers to test and implement changes to facilitate readiness
- Health Home Development funds can be used for system readiness
  - One Health Home plans to use the 30% it is reimbursed for prior expenditures for authorized purposes to develop a “revolving fund” to assist downstream providers that may experience cash flow implications under new billing rules
- At least one Plan has indicated it would consider making advance payments to reduce cash flow disruptions
- Taking providers off Medicaid lag

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MAPP Implementation Timeline

- **As discussed previously, go live pushed back due to two factor authentication.**
- **April/May 2015 –** MAPP update during each bi-weekly webinar
  - Topics will include: MAPP File Specifications, HH Performance Dashboards, Billing Readiness
- **Early June 2015 –** Web Based Training (WBT) available to MAPP users
  - All users must complete WBT prior to gaining access to MAPP
- **Last two weeks of June 2015 –** Managed Care and Health Home workers attend Instructor Led Training (ILT)
  - SPOCs will receive additional information regarding the ILT schedule
- **July 1, 2015 – MAPP Go Live & Elimination of Direct Billing by Converting Care Management Agencies (excluding ACT providers).**
- **Post July 2015 –** ILT for one worker per CMA and continued training for new MCP/HH/CMA users.

March/April 2015 MAPP Training Activities

Course Name	Description
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**]
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**]
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**]
MAPP Cúram Member Tracking ("GateKeeper" Role)	This course provides instructions on how to authorize new users to the MAPP Portal. (WBT) [**All gatekeepers**]
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**]
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**]
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**]

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

Training for Community Mental Health Assessment Instrument

- Community Mental Health Assessment instrument modules are being developed to provide web-based training using the UAS training platform, schedule for availability mid-May
  - There are 12 training modules – each module takes about one hour
- Health Homes and others will access training via the UAS and must complete required training modules prior to being able access/use the CMH tool
- Care Managers must have access to HCS to access MAPP
- Care Managers must have their own HCS user account to access the CMH training

Care Managers' Progress Toward Accessing HCS (NOT Training)			
DOH Requested HCS Applications from CMA	HCS Applications Received & Processed from CMA	Remaining CMA HCS Applications Still Not Received	CMAs That Have Assigned All MAPP Roles in the HCS System
258	190	68	70

Training – Health Home Care Management, HCBS and CMH Assessment Training

Training Module	Timeline

• 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
	April/May 2015

New York City Web-Based Health Home InterRAI Training Begins	May 15, 2015 (Rest of State beginning September 2015) ***(Downstream care managers must have access to HCS to access training)***
What workflow looks like both generally and specifically for HH care managers.	May/June 2015

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Appendix – Informational Resources

April 7, 2015

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 July 1, 2015

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 July 1, 2015

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 July 1, 2015

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 July 1, 2015

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.				