Health Home Implementation Webinars

Session #42– August 6, 2014
Adult Home Supportive Case Management Transition

NEW YORK state department of HEALTH

Agenda

- Adult Home SCM Transition
- MAPP Update

Statewide Supportive Case Management Guidance

The New York State Department of Health and

the Office Of Mental Health

August 6th, 2014

Adult Home Supportive Case Management

Purpose of Today's Call

Today's call is to provide general Statewide guidance on the transition of Adult Home Supportive Case Management (AH TCM) programs to Health Home Care Management.

Agencies operating AH-SCM in Adult Homes that are part of a stipulated settlement in New York City to transition Adult Home members to the community have been provided guidance separately as some of the procedures may differ for the agencies involved in that settlement.

Instances where the process may differ are indicated throughout the presentation.

Adult Home Supportive Case Management

Definition

- Supportive Case Management (SCM) is provided to Adult Home residents by Supportive Case Managers who work as a team with Peer Specialists as part of an integrated approach to address the needs of the Adult Home population.
- The model funds one team, which is comprised of one full-time SCM Case Manager and one half-time Peer Specialist.
- Each team serves a maximum of 30 residents.
- A Supervising Case Manager or Coordinator of Case Management provides supervision to the SCM and Peer Specialists.
- Adult Home Case Management takes referrals from the Adult Home and does not take referrals from Single Point of Access (SPOA).

Adult Home Supportive Case Management

Definition Cont'd

- SCM is organized around goals aimed at providing access to services that encourage people to:
  - Resolve problems that interfere with their attainment or maintenance of independence or self sufficiency
  - Maintain themselves in the community rather than an institution
- Case managers:
  - Promote hope and recovery by using strengths-based, culturally appropriate, and person-centered practices
  - Maximize community integration and normalization
  - Provide leadership in ensuring the coordination of resources for individuals eligible for mental health services

OMH Adult Home Supportive Case Management Transition to Health Homes

- Consistent with the Medicaid State Plan Amendment authorizing the implementation of Health Homes, the Office of Mental Health (OMH) has been working with the Department of Health (DOH) to transition OMH's Targeted Case Management (TCM) programs to the Health Home program.
- On June 30th, 2014 OMH provided guidance Statewide to SCM providers on Adult Home Supportive Case Management (AH-SCM) programs converting to the Health Home program. As of September 1, 2014, it is expected that all OMH AH-SCM programs statewide will have completed the conversion to the Health Home program.
- Agencies involved in the stipulated settlement in NYC to transition AH members to the community were provided with specific guidance related to the transition.

OMH Adult Home Supportive Case Management Transition to Health Homes

- Many agencies operating AH-SCM programs have other TCM programs that have converted to Health Home Care Management; others may be new to Health Home Service model. Agencies operating AH-SCM have been advised to reach out to Health Homes for assistance with the transition. Note that for the AH-SCM settlement in NYC, AH-SCM will be working with specific Health Homes involved with the impacted population.
- Note that while all other requirements (e.g., DEAAs, use of the Health Home Tracking System) are the same, specific AH-SCM billing rules apply. While AH-SCM will bill directly as do other "legacy" programs, there was no legacy rate established for AH-SCM services thus AH-SCM will bill Health Home rates.
- Guidance on the conversion is posted on the OMH Website at http://www.omh.ny.gov/omhweb/adults/health_homes/ahscm-guidance-Bronx-Richmond-ros-july-2-2014.pdf

OMH Adult Home Supportive Case Management Transition to Health Homes

Choosing the Health Home

- AH-SCM programs have been advised to identify the Health Homes in which their agency has contracted and should assign their members to the Health Home(s) that best meets their member's needs. This decision should be based on the Health Home network partners and Managed Care Plans with which the Health Home has partnered. AH-SCM programs should contact the Health Home(s) to discuss member assignment. Lists of New York designated Health Homes and contact information is available on the Health Home website at: http://www.health.ny.gov/health_care/Medicaid/program/Medicaid_health_homes/hh_contacts.htm
- Note that for the NYC AH settlement members, a Health Home has already been assigned, so the AH-SCM will be working with a Health Home that has already been identified.

OMH Adult Home Supportive Case Management Transition to Health Homes

Data Exchange Agreements

- The first step in the transition is for the AH-SCM and the Health Home to complete a Data Exchange Application Agreement or DEAA to allow them to exchange member information. The agency which runs the AH-SCM program may already have a DEAA with one or more Health Homes for a legacy TCM program that previously converted to HHCM. If this is the case, and the AH-SCM is not working with NYC settlement members, then a separate DEAA is not required.
- For AH-SCM programs working with NYC settlement members, a specific DEAA template has been developed. Health Homes working with the NYC settlement members will provide this template to AH-SCM programs they will be working with.

DEAAs

- Once an AH-SCM program has chosen or identified the Health Home(s) with which it will affiliate, the Health Home should be requested to send the AH SCM a “subcontractor DEAA” for completion and execution.
- The AH SCM must return their executed subcontractor DEAA to the Health Home for its execution.
- The Health Home will submit the fully executed subcontractor DEAA to DOH for approval.
- Once approved, an official Approval Letter will be generated, signifying the appropriateness of sharing DOH data with the AH SCM.

OMH Adult Home Supportive Case Management Transition to Health Homes

Assigning Members to a Health Home

Upon completion of the required DEAA between an AH-SCM provider and a Health Home, Adult Home residents meeting eligibility requirements may be enrolled in that Health Home. The AH-SCM provider must submit to the Health Home or Health Homes in which they will be partnering a list of the AH-SCM members that are to be enrolled with that Health Home.

Contracting with a Health Home

The agency which runs the AH-SCM program may already have a contract (separate from the DEAA sub-contractor agreement) with one or more Health Homes for a legacy TCM program that previously converted to HHCM. This contract covers payments and other operational issues. The Health Home and the AH-SCM program can discuss whether existing contract will cover the AH-SCM transition activities or whether a separate contract or amendment is necessary.

OMH Adult Home Supportive Case Management Transition to Health Homes

Health Home Member Tracking System

- Each AH-SCM will be provided information from the Health Home about how the Health Home(s) collects information to populate the Health Home Member Tracking System (HHMTS), which is the NYS DOH Health Home member database, with member information.
- Once the Health Home receives member tracking information from the AH-SCM program, the Health Home will submit that information to the NYS HHMTS. AH-SCM providers do not have direct access to the DOH HHMTS, but Health Homes are responsible for submitting information to and downloading information from the HHMTS on behalf of the AH-SCM program.

OMH Adult Home Supportive Case Management Transition to Health Homes

Health Home Member Tracking System Cont'd

- Each AH-SCM member must be submitted to the HHMTS with a begin date corresponding to the first of the month during which Health Home Services were provided. All existing AH-SCM members should be submitted to the HHMTS with a value of "E" in the Enrollment/Outreach Code field and a direct biller indicator value of "Y."
- The "Y" value for the direct bill indicator means that the AH-SCM program is a converting care management agency and will bill Medicaid directly for all Health Home services at the 1386 rate code, through 12/31/2014, as outlined in the Health Home converting case management billing policy. Additionally, once the member signs the Health Home consent form with the Health Home they are enrolled in, the member's consent date must be submitted to the Health Home Member Tracking System

OMH Adult Home Supportive Case Management Transition to Health Homes

Responsibilities of the Health Home

It is the responsibility of the Health Home to ensure that care managers assigned to AH-SCM Health Home members:

- Meet staffing requirements;
- Meet core competency training and qualifications;
- Are familiar with a Health Home procedures and reporting requirements; and
- Can develop a person-centered plan of care that reflects the preferences, goals, strengths and service needs of the Adult Home resident, including those that may choose to transition from the Adult Home to the community.

OMH Adult Home Supportive Case Management Transition to Health Homes

Supportive Case Management Billing Procedures

- AH-SCM providers are considered converting care management agency programs and therefore will bill Medicaid directly for a per-member-per-month (PMPM) for all members enrolled in the Health Home using rate code 1386.
- AH-SCM billing using the Health Home rate code may begin when the AH-SCM has been notified by the Health Home that a subcontractor Data Exchange Application Agreement (DEAA) has been executed and approved.
- Note that once an AH-SCM provider transitions to billing the Health Home rate code 1386, the PMPM will vary depending on the member's acuity. Acuity is derived from Medicaid claims and encounter history.

OMH Adult Home Supportive Case Management Transition to Health Homes

Supportive Case Management Billing Procedures Cont'd

- AH-SCM programs can work with their Health Home to obtain a list of acuities for their members. By multiplying the acuity times the applicable base rate (upstate or downstate) the AH-SCM program can calculate the applicable PMPM for each member.
- For members without an established acuity, the acuity level will be set at a level that will provide a PMPM approximately equal to the OMH AH-SCM rate.
- Each AH-SCM program should calculate the PMPM for their members and contact OMH if they have any concerns about potential impact to program revenue.

OMH Adult Home Supportive Case Management Transition to Health Homes

Supportive Case Management Billing Procedures Cont'd

- AH-SCM programs can work with their Health Home to obtain a list of acuities for their members. By multiplying the acuity times the applicable base rate (upstate or downstate) the AH-SCM program can calculate the applicable PMPM for each member.
- For members without an established acuity, the acuity level will be set at a level that will provide a PMPM approximately equal to the OMH AH-SCM rate.
- Each AH-SCM program should calculate the PMPM for their members and contact OMH if they have any concerns about potential impact to program revenue.

OMH Adult Home Supportive Case Management Transition to Health Homes

Supportive Case Management Billing Procedures Cont'd

- Health Homes and AH-SCMs must work together to ensure that only one claim is submitted for any member for any month of service.
- Only one claim (i.e., AH-SCM or HH) can be submitted for any individual for any month of service (i.e., duplicate billing is not permitted) with the exception of the first month Health Home billing occurs, which will be referred to as the transition month, as described in the following section.
- Once the AH-SCM program begins billing under the Health Home rate codes, the AH-SCM program is no longer subject to the AH-SCM regulations and is subject to the Health Home billing rules.

OMH Adult Home Supportive Case Management Transition to Health Homes

Transition to Health Home Medicaid Billing

- Due to this change in billing rules, AH-SCM programs will submit two claims to Medicaid for the transition month, i.e., the first month they begin billing the Health Home rate code. This is necessary because the date of service used for a Health Home rate code claim is different than the date of service used for an AH-SCM rate code claim.
- The date of service listed on an AH-SCM claim is the first of the month following the month when services were provided. For example, under the AH-SCM billing rules, a claim submitted for services provided in April 2014 would have a date of service of May 1, 2014.

OMH Adult Home Supportive Case Management Transition to Health Homes

Transition to Health Home Medicaid Billing Cont'd

- The date of service listed on a Health Home claim is the first of the month during which services were provided. For example, under the Health Home billing rules, a claim submitted for services provided in May 2014 would have a date of service of May 1, 2014.
- The AH-SCM program must submit one claim with a date of service for the first of the month using the OMH AH-SCM rate code (for billing the previous months services under OMH AH-SCM) and another claim with the same date of service using the Health Home rate code 1386 (for services provided in the current month).
- AH-SCM programs are not allowed to continue billing the AH-SCM rate codes after this transition month.

OMH Adult Home Supportive Case Management Transition to Health Homes

Additional Information

Information on Health Home billing and tracking and other resources, including a link to the Health Home Provider Manual, can be found at the Health Home website:

http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes

Additional DOH Resources

- To send a message to the Department of Health's Health Home Bureau Mail Log:

  https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action

- Health Home Provider Line Phone Number: (518) 473-8864

Medicaid Analytics Performance Portal (MAPP) Update - Survey #1 Results

- In total, 238 surveys were completed in response to the July 23, 2014 webinar. The responses by organization type are summarized below.

Organization Type	# of Responses	Response Percent
Managed Care Plan	14	5.9%
Health Home	78	32.8%
Care Management Agency	146	61.3%
Total	238	100.0%

- Summarized survey results will be available for public review in the MAPP section of the Health Home website within the next two weeks.

Useful Contact Information

- Visit the Health Home website: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

- Get updates from the Health Homes listserv. To subscribe send an email to: listserv@listserv.health.state.ny.us (In the body of the message, type SUBSCRIBE HHOMES-L YourFirstName YourLastName)

- To email Health Homes, visit the Health Home Website and click on the tab “Email Health Homes” http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

- Call the Health Home Provider Support Line: 518-473-5569