Health Home Implementation Webinar

Session #49 – December 10, 2014

Program Updates

Agenda

- Health Home and MLTC ASAs
- Model Contract Language between MCOs and DOH
- Updates to MCO Contact Information
- MAPP Update
- 2014 Q3 CMART Data Submissions

Guidance for Providing Care Coordination and Management to Medicaid Members Enrolled in MLTC Plans and Health Homes

Statewide Guidance-MLTC Plans and Health Homes

- The role of Managed Long Term Care (MLTC) Plans is to provide coordination of long term care services and supports as provided by the MLTC benefit package for eligible individuals who need more than 120 days of community based long term care services.
- Health Home care management is a State Plan service that is required to be offered to all members that meet Health Home eligibility requirements.
- Eligible individuals enrolled in MLTC Plans may also be enrolled in a Health Home.
- Health Home care management services are carved out of the MTLC benefit package, thus both the MLTC Plan and the Health Home have been allowed to bill for their respective services. This guidance is provided to assist MLTC plans and Health Homes to formalize their respective roles by entering into an Administrative Service agreement (ASA).

Statewide Guidance-MLTC Plans and Health Homes

- Earlier this year an Administrative Services Agreement (ASA) template was distributed to Health Homes and Managed Long Term Care (MLTC) Plans working in New York City to transition Adult Home residents to the community as part of a structured settlement. This ASA template is used to delineate the respective roles of the Health Home and the MLTC plan when both are serving recipients, to ensure that services are not duplicated.
- **On Wednesday November 26, 2014 the Department released this ASA template for Statewide use along with additional guidance and a suggested care planning tool that can be used to more clearly define the roles of the Health Home care manager and the MLTC Plan care coordinator**.
- Reference to the ASA will be included in the MLTC Plan contracts with the Department with the next amendment.

Administrative Health Home Services Agreement (ASA) Between MLTC Plans and Health Homes

- An Administrative Service Agreement (ASA) is completed to establish roles and responsibilities between Managed Long Term Care Plans and Health Homes for the provision of care management service including but not limited to the New York City Impacted Class Members of the Disability Advocates Inc. II Stipulation and Order (commonly referred to as DAI II).

- The template ASA allocates a primary role for the service coordination of long term care services to the MLTC Plan and a primary role for the service coordination of behavioral health care and other services and supports that are outside of the MLTC benefit package to the Health Home.

Administrative Health Home Services Agreement (ASA) Between MLTC Plans and Health Homes

- MLTC Plans are responsible for coordination with the Health Home and are not responsible for Health Home management or performance or any services outside the scope of their benefit package.
- While **the template ASA provided by the Department is not intended to be altered**, a description of the in-plan and out of plan services and the respective responsibilities of the MLTCP and the Health Home and any other clarifying language can be included as an Appendix to the ASA. A suggested template for this Appendix has also been developed.
- MLTC Plans and Health Homes have requested additional guidance on documenting their collaborative approach to care coordination in the client's care plan record. A suggested template for a client level Care Planning and Coordination form has also been developed.

Collaboration Between Health Homes and MLTC Plans

- The goal is that individuals who are Medicaid eligible and enrolled in a MLTC Plan will be given the option to enroll in Health Homes.
- Individuals can be enrolled in a Health Home and MLTC Plan at the same time, but services must be coordinated.
- The MLTCPs and Health Homes must enter into an ASA that clearly defines the respective care manager roles and a collaborative working relationship.
- The distributed ASA Template:
  - Incorporates comments provided by Health Homes and MLTC Plans
  - Is modeled from current ASAs between Health Homes and Mainstream Plans.

ASA Template

Areas the ASA Template addresses (including but not limited to):

- Health Home and MLTC must establish clearly defined roles in providing collaborative care management – MLTC is responsible only for coordination and not for Health Home management or performance.
- Enrollee's Plan of care;
- Existing protocols/policies;
- Communication regarding changes in participant status;
- Quality, data, and reporting requirements;
- Non-discrimination;
- Confidentiality;
- Eligibility verification – Medicaid and Programmatic;
- Information sharing process;
- Dispute resolution;
- Grievances and appeals; and
- MLTC Plans will not be required to develop MOUs.

Defining Care Planning Roles

Between Health Homes and MLTC Plans:

- For individuals enrolled in an MLTC Plan/Health Home, both the MLTC Plan and the Health Home are authorized to bill for the resident – it is expected that the Health Home and MLTC will work collaboratively to coordinate and develop person-centered care plans.
- MLTC Plans will receive (or continue to receive for existing enrollees) a capitation payment for each individual enrolled in MLTC Plan.
- Health Homes will bill (or continue to bill) the State on a Per Member Per Month (PMPM) basis for providing care management to fee-for-service members

Defining Care Planning Roles

- It will be the responsibility of the Health Home and the MLTC Plan to determine which care manager will serve as the lead care manager for each individual client. This decision will be based on the primary needs of the client and must be documented using the Care Planning and Coordination form or similar format.
- MLTC Plans and Health Homes are encouraged to identify liaisons to participate in periodic meetings that will include a MLTC Plan care coordinator and Health Home care management staff. The goals of these periodic meetings should be:
  - Insure a team approached focus to care coordination and avoid duplication
  - Improve positive outcomes for the member
  - Discuss quality improvement initiatives

Review of Care Planning and Coordination For Partial MLTC Plans And Health Homes Form

The ability of the MLTC Plans and Health Homes to define their respective roles using the *Care Planning and Coordination For Partial MLTC Plans And Health Homes form* or similar format will serve to document that the MLTC Plan care coordination and Health Home care management services are not duplicated.

Summary

The ability of the MLTC Plans and Health Homes to define their respective roles and to ensure care management services are not duplicated is supported by:

- Following the guidance provided;
- Signing the Administrative Services Agreement and using the Appendix;
- Using the Care Planning and Coordination Form (or equivalent documentation).

Questions

Contact Us

- Health Home Provider Line: 518-473-5569
- Health Home Bureau Mail Log (BML): https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action
- Managed Long Term Care: 518-474-6965

New Model Contract Language between MCOs and NYSDOH

- Health Home related sections of the contract between the State and MCOs (Model Contract) have been revised for consistency with language in the State Plan Amendment. Language has been submitted to CMS for approval. Changes include:

1. Plans shall provide regular information to Participating Providers regarding Health Home care management
2. Plans shall provide referrals to contracted Health Home care management for:
   - Adults with chronic illnesses and physical or developmental disabilities;
   - Enrollees with Serious Mental Illness; and
   - Enrollees identified as having HIV infection.

New Contract Language (Cont'd)

Enrollee Assignments to a Health Home:

3. SDOH will transmit suggested assignments based on a loyalty analysis of claims and encounter data.
4. Plans will analyze their own data and either accept SDOH assignment or assign Enrollee to another Health Home and notify SDOH.
5. Plans may recommend other Enrollees for Health Home assignments, based on an analysis of its own data.
6. Plan may consider Health Home assignments referred through the community referral process, as described in the Health Home Provider Manual.
7. To ensure services are not duplicated, contracts with Health Homes must establish clear lines of responsibility between the Plan and the Health Home.

New Contract Language (Cont'd)

8. Plans shall:
   - inform the Enrollee's Health Home when the Plan is made aware of any inpatient admission or discharge of the Enrollee;
   - assist the Health Home and its care management partners with outreach and engagement of Enrollees, to the extent possible;
   - assist their contracted Health Homes with the collection of required care management and patient experience of care data, to the extent possible.

Managed Care Contacts for Health Homes and Care Management Agencies

- Request was made to DOH to ensure contacts at managed care plans were familiar with Health Homes
  - assist with providing more current information on members
  - discuss HH member logistics with lead HH and care management agencies
- 18 Managed Care Plans called and surveyed
  - Primary contact for General Health Home & Care Management Information and
  - Point person for facilitating ASAs and Health Home administration issues

Managed Care Plan Contacts for Health Homes and Care Management Agencies

Plan Name	Representative	General HH/ CM Information	ASAs & Administration	Email	Phone
Affinity	Anand David		x	ADavid@affinityplan.org	718-794-6480
	Israel Romano	x		iromano@affinityplan.org	718-794-6429
	Bronx, Kings, Nassau, Manhattan, Orange, Queens, Richmond, Rockland, Suffolk, Westchester				
Amida Care (SNP)	Maria DaSilva		x	mdasilva@amidacareny.org	646-757-7145
	Stephane Howze	x		showze@amidacareny.org	646-545-7034
	Bronx, Kings, Manhattan, Queens, Richmond				
CDPHP	Sheila Nelson		x	Shnelson@cdphp.com	518-641-5240
	Chris Zeppieri	x		Chzeppieri@cdphp.com	518-641-3429
	Albany, Broome, Columbia, Fulton, Greene, Montgomery Rensselaer, Saratoga, Schenectady, Schoharie, Tioga, Washington				
Emblem	Carol Redmond		x	CRedmond@emblemhealth.com	646-447-6826
	Sylvia Quinones	x		SQuinones@emblemhealth.com	631-844-2498
	Kings, Manhattan, Nassau, Queens, Richmond, Suffolk, Westchester, Bronx				
Excellus	Lori Lubba		x	Lorraine.lubba@excellus.com	585-238-4581
	Amy Sanborn	x		Amy.sanborn@excellus.com	315-731-2528
	Broome, Herkimer, Livingston, Monroe, Oneida, Ontario, Orleans, Otsego, Seneca, Wayne, Yates				
Fidelis	Lisa Pfeifer	x		lpfeifer@fideliscare.org	716-564-8106
	Louise Donato		x	ldonato@fideliscare.org	518-445-3976
	Albany, Allegany, Bronx, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Kings, Jefferson, Lewis, Livingston, Madison, Manhattan, Monroe, Montgomery, Nassau, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Suffolk, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Westchester, Wyoming, Yates.				

MCP and Health Home Contacts

- Contacts for Managed Care Plans
  - Found on Health Home Website:
    - http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/
- Contacts for Managed Long Term Care Plans
  - http://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm
- Contact Information for Designated Health Homes
  - http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_contacts.htm

Updating Contact Information

- Health Homes
  - Respond to DOH quarterly surveys
  - Send updates to the Health Home BML
- Managed Care Plans
  - Send updates to the Health Home BML
- Responses to inquiries and voice mail messages should be current, clear and informative

MAPP STATEWIDE IMPLEMENTATION FOR HEALTH HOMES DECEMBER 10, 2014

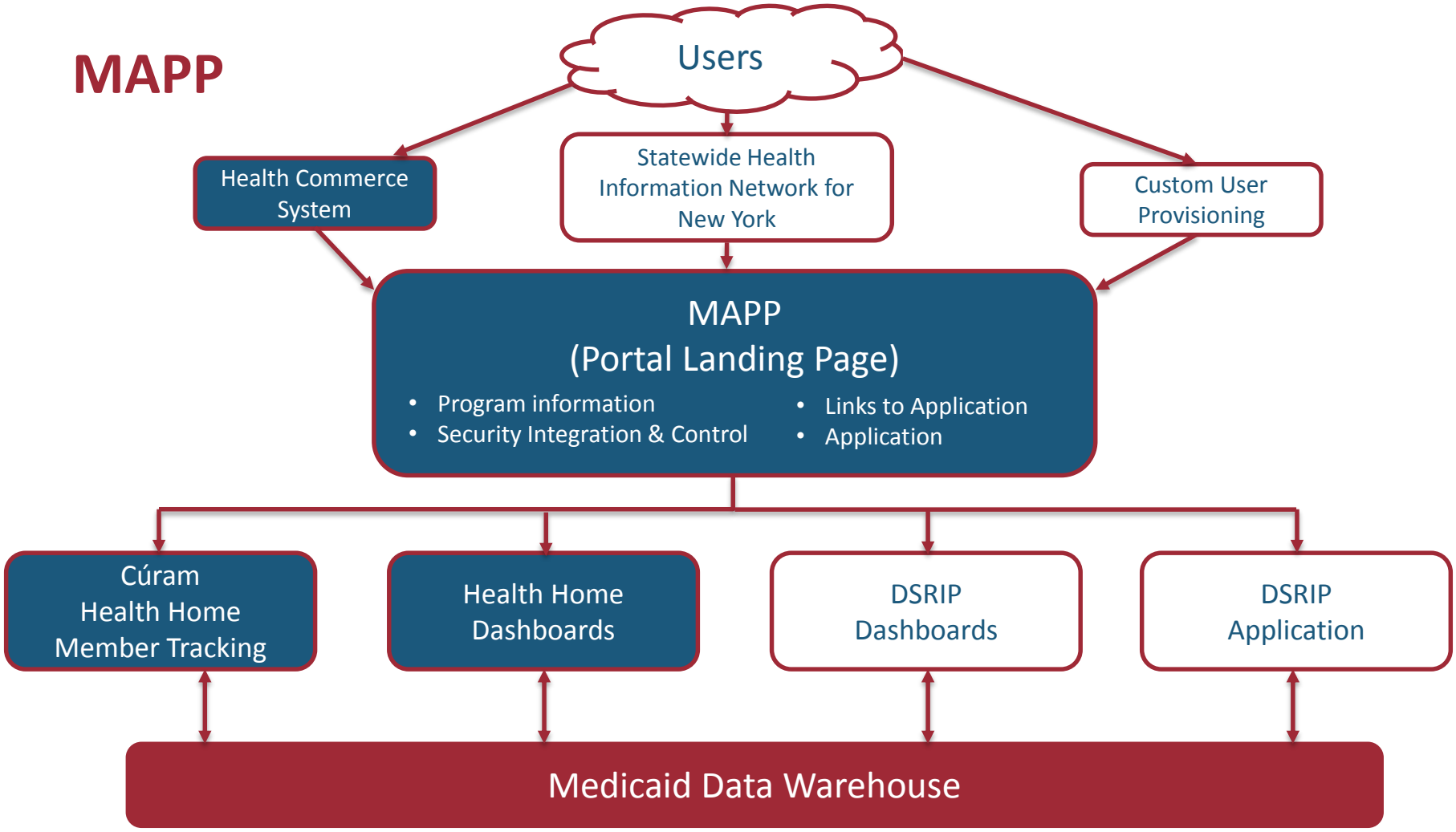
AGENDA

- MAPP Overview
- Statewide Implementation Phases
- Phase 1 Implementation

WHAT IS MAPP

- MAPP: Medicaid Analytics Performance Portal
- MAPP supports both Health Homes and DSRIP performance management technology needs
- MAPP Technology:
  - Serve as retail front-end to the Medicaid Data Warehouse for PPS / Health Home community
  - Robust dashboard capabilities provided by Salient
  - Online tools available in portal technology to support DSRIP
  - Health Homes Business and Care Management Functionality
  - Data management and analytics to drive performance

MAPP


Users
Health Commerce System
Statewide Health Information Network for New York
Custom User Provisioning
MAPP
(Portal Landing Page)
• Program information
• Security Integration & Control
• Links to Application
• Application
Cúram Health Home Member Tracking
Health Home Dashboards
DSRIP Dashboards
DSRIP Application
Medicaid Data Warehouse

STATEWIDE IMPLEMENTATION FOR HEALTH HOMES

- Phase 1
- Phase 2
- Phase 3

PHASE 1

- Replace existing Member assignment and tracking system and its associated functionality
- Provide more timely access to data from Medicaid Data Warehouse
- Provide enhanced user access to include Care Management Agencies
- Dashboard / Analytics capabilities
- Design for DOH-HH-CMA interoperability

Target Deployment – February 27, 2015

PHASE 1 SCOPE

- Identification of Health Home eligible population
- Assign eligible individuals to Health Homes
- Outreach of CMAs and Health Homes to potential members
- Enroll individual into a Health Home once outreach is complete
- Referral of potential members
- Billing Support
- Transfer of individuals between Health Homes
- Dashboards to evaluate the performance of the Health Home program

PHASE 2

- Member Tracking Children Functionality
- Referral Capability
- Assessment functionality
- Children consent

Target Deployment – July 2015

PHASE 3

- Care Plan functionality building blocks
- Enhanced Interoperability Capability
- RHIO/SHIN-NY integration – start
- Additional dashboard/analytic capabilities

Target Deployment – December 2015

PHASE 1 STATEWIDE IMPLEMENTATION

- **Organization and Staff Set-up In Health Commerce System**
- **Training**
- **MAPP Roles**
- **Communication**

PHASE 1 HEALTH COMMERCE SYSTEM

- Organizational Set-up In HCS
  - ✓Health Homes and Managed Care Organizations already set up
  - ✓Care Management Agencies are being set up
    - ➢ Submit organization information to DOH
    - ➢ Follow instructions to complete process

    * Ensure that Care Management Agencies in your network have completed this step.

- HCS User Accounts for Staff
  - ✓ All MAPP Users must have their own active HCS User Account
  - ✓ Work with HCS Coordinator to complete this process

    * HCS Organization Account must be set up before Care Management Agencies can complete this step.

PHASE 1 HEALTH COMMERCE SYSTEM

- HCS Roles for Staff

MAPP SPOC	single point of contact that will coordinate, manage, and support the organization's MAPP implementation
MAPP Gatekeeper	local administrator that will coordinate and authorize user access to the Medicaid Analytics Performance Portal
MAPP User	assigned to all users who will access the Medicaid Analytics Performance Portal

- ✓ HCS Roles must be assigned to all staff.
- ✓ HCS Role assignments will be used to facilitate communication concerning MAPP Implementation.
- ✓ HCS Roles must be assigned prior to participating in training.

PHASE 1 TRAINING

- **MAPP Administration**
  - Webinar for MAPP Gatekeepers
- **Navigation and Overview**
  - Web-based Training
  - Pre-requisite for all training
- **MAPP End-User**
  - One-day regional, Instructor-led Training
  - Customized for Health Homes and Managed Care Organizations (up to 5 staff per agency)
  - Customized for Care Management Agencies who will send one “super user” representative.

MAPP ROLES

MAPP Administration	The MAPP Administration user will have the ability to create and manage their organization's MAPP users and assign the MAPP access type or role (Worker, Screener, and Read-Only user role) to each user.
MAPP Screener	The MAPP Screener will be able to lookup a Medicaid member in MAPP to determine if a member is already in assignment, outreach or enrollment status with a Health Home.
MAPP Read Only	The MAPP Read Only user will be able to lookup a Medicaid member in MAPP to determine if a member is already in assignment, outreach or enrollment status with a Health Home. Additionally, the Read Only user will be able to view information for their members in MAPP but not create, accept or upload information to MAPP.

HEALTH HOME AND MANAGED CARE NEXT STEPS

Staff Set up In HCS	1. Identify MAPP SPOC. 2. Identify MAPP Gatekeeper. 3. Identify staff that will require access to the MAPP. 4. Identify your organization's HCS Coordinator. The HCS Coordinator will need to: • confirm that each staff member has their own active HCS User Account. If there is no HCS user account, use the HCS paperless process. • assign staff to one of the HCS roles (MAPP Gatekeeper, MAPP SPOC, and MAPP User)	By December 31, 2014
MAPP Gatekeeper Training	1. Registration information will be emailed to MAPP Gatekeepers and MAPP SPOC. 2. Webinar will be held in January. 3. MAPP Gatekeeper will assign appropriate role to staff	By January 31, 2015

HEALTH HOME AND MANAGED CARE NEXT STEPS

MAPP Web-based Training	1. Registration information will be emailed to MAPP SPOC. 2. MAPP SPOC will ensure appropriate staff register.	By February 6, 2015
Regional Instructor-led Training	1. Registration information will be emailed to MAPP SPOC. 2. MAPP SPOC will ensure appropriate staff register. MAPP SPOC will ensure that staff schedules are adjusted to enable staff to attend training course as a group.	By February 27, 2015

CARE MANAGEMENT AGENCIES

Organizational Set-up in HCS	1. Organization submits HCS Director and Coordinator account requests to DOH by December 19, 2014. 2. DOH will generate account requests. 3. HCS Director and Coordinator will complete account application process (print application, have completed application notarized, and mail notarized, original application to the Commerce Accounts Management Unit (CAMU)). 4. CAMU will process application within two weeks of receipt.	By December 19, 2014
Staff Set up In HCS	1. Identify MAPP SPOC. 2. Identify MAPP Gatekeeper. 3. Identify staff that will require access to the MAPP. 4. Identify your organization's HCS Coordinator. The HCS Coordinator will need to: • confirm that each staff member has their own active HCS User Account. If there is no HCS user account, use the HCS paperless process. • assign staff to one of the HCS roles (MAPP Gatekeeper, MAPP SPOC, and MAPP User)	By January 31, 2015

CARE MANAGEMENT AGENCIES

MAPP Gatekeeper Training	1. Registration information will be emailed to MAPP Gatekeepers and MAPP SPOC. 2. Webinar will be held in January. 3. MAPP Gatekeeper will assign appropriate role to staff	By January 31, 2015
MAPP Web-based Training	1. Registration information will be emailed to MAPP SPOC. 2. MAPP SPOC will ensure appropriate staff register.	By February 6, 2015
MAPP User Training	1. Staff will complete the recorded demonstration sessions. 2. MAPP SPOC will ensure appropriate staff register.	By February 27, 2015
CMA MAPP Super User Training	1. Registration information will be emailed to MAPP SPOC. 2. MAPP SPOC will ensure appropriate staff register. MAPP SPOC will ensure that staff schedule is adjusted to enable staff to attend training course.	By March 31, 2015
Care Management Agency Follow-up Training	1. MAPP SPOC will coordinate training course for Care Management Agency staff. Training will be delivered by person who completed regional instructor-led training. 2. Topics to be determined based on staff needs.	As Needed

PHASE 1 COMMUNICATION

- MAPP SPOC

- Engage Staff in MAPP Implementation

Health Home Care Management Assessment Reporting Tool

- Quarter 3 data was due November 3rd, 2014

- Today's discussion will be on:
  - Q3 data submission
  - one page reference guide,
  - FAQ update
  - Updated HH-CMART tool distribution

Intake Items	Valid Response Values/Notes	Each Submission
PlanID	Plan ID if enrolled in a managed care plan or 8888888 for FFS members. If plan changes during reporting period, provide most up-to-date or current Plan ID	Only **change** if member changes Health Plan
HHID	Value as assigned for lead Health Home	Once entered, **NO CHANGE**
ReportDate	Jan-March = 1/YYYY; Apr-Jun = 2/YYYY; July-Sep = 3/YYYY; Oct-Dec = 4/YYYY	**CHANGE** for each submission
CIN	Medicaid Client Identification Number; Value as specified	**NO CHANGE**
DOB	Date prior to TriggerDate; 09/09/9999 (Missing)	Once entered, **NO CHANGE**
ProgramType	HH Behavioral Health; HH Chronic Adult; HH Children; HH Dev Disabled; HH Long Term Care; HH Substance Use; HH HIV; Not Able to Contact; Review Pending; Missing	Once entered, **NO CHANGE**
AbleContact	Yes; No; Yes_Hiatus Period; No_Hiatus Period; TCM-HH Conversion	**NO CHANGE** after AbleContact = Yes or TCM-HH Conversion
ContactDate	09/09/9999 (Missing); Blank Cell (Not contacted)	**NO CHANGE** after Contacted
OutreachEffort	Greater than or equal to zero; 999 (Missing); Should be 0 (zero) for initial conversion of TCM-Conversion Members; re-engagement - May count outreach again	**NO CHANGE** after Contacted; After Contacted, Zero entered
AppropriateCM	Yes; No; Not Able to Contact; Review Pending	**NO CHANGE** after Contacted
AssessedCM	Yes; No; Not Able to Contact; Review Pending	**NO CHANGE** after AssessedCM = Yes
AssessDate	09/09/9999 (Missing); Blank Cell (Not assessed)	**NO CHANGE** after Assessed
OptOut	Opted Out; Did Not Opt Out; Not Appropriate HH; Not Able to Contact; Review Pending	**NO CHANGE** after OptOut = Opted Out or Did Not Opt Out
EngagedCM	Yes; No	Once entered, **NO CHANGE**

Health Home Care Management Assessment Reporting Tool FAQ Update

Health Home CMART FAQs are developed from Health Home community feedback and requests for clarification about the system. They are posted on the Health Home website here:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/hh_cmart_faq.pdf

We encourage all feedback so we can develop more FAQs and share this information with the Health Homes

NEW FAQ

- **Q:** How does DOH suggest reporting a member who's been contacted but not assessed and has since been lost to follow-up? Our staff was unable to establish the interest or willingness to engage in services before being lost to follow-up. In this situation how would the following fields be filled out:
  - Program Type
  - OptOut
  - AppropriateCM
- **A:** In this situation, all three fields should be set to REVIEW PENDING. While there was contact with the Member, there was never a definitive conversation about needs (Program Type, AssessedCM, and Appropriateness) nor a conversation about participation (OptOut).

Health Home Care Management Assessment Reporting Tool

- DOH sent two HH-CMART updates on November 19, 2014
  - Updated version of the Access database tool (added MCPs)
  - New copy of the MCP list in the Technical Specification Document

- More information about the HH-CMART can be found here: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/index.htm

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