



**Department
of Health**

**Office of
Mental Health**

**Office of Alcoholism and
Substance Abuse Services**

**Office of Children
and Family Services**

Health Homes Serving Children with Serious Emotional Disturbance

November 21, 2016

Agenda for Today's Presentation

- ✓ Welcome – Commissioner, Dr. Ann Sullivan
- ✓ Goal: Leverage the expertise of OMH TCM providers and the Single Points of Access (SPOAs) to preserve the delivery of high quality care management to children with Serious Emotional Disturbance (SED) under the Health Home program
 - ✓ The goals of the OMH TCM program are consistent with the expectations and requirements of the six core Health Home services, including:
 - ✓ assessing child/youth strengths and needs,
 - ✓ coordinating treatment planning,
 - ✓ linking community resources,
 - ✓ being available to help in a crisis and
 - ✓ advocating for and with the child/youth/family, and working across organizational and disciplinary boundaries
- ✓ Review new processes and requirements for transitioning and integrating OMH TCM care management, SED children that have been traditionally served by TCM and SPOAs in the Health Home Model for children with the December 5, 2016 launch of Health Homes Serving Children (HHSC)



Current Role of the SPOA and OMH TCM Providers

- Counties are statutorily required to determine the needs of individuals with mental health services, including care management – the SPOA fulfills this role in the children’s system
- SPOA is the known County entity to access and determine appropriate need for *mental* health services
- SPOA also interfaces with a variety of referral sources
 - ✓ Community providers
 - ✓ Schools
 - ✓ Families
 - ✓ Probation Departments
 - ✓ Clinics, etc.



Current Role of the SPOA and OMH TCM Providers

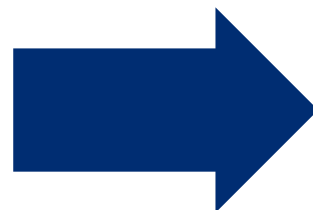
- Today, SPOA makes direct assignments to referrals for care management to children with SED to an OMH TCM provider
 - ✓ ***There are 78 OMH TCM providers – those providers, and the children they serve will transition to HHSC beginning December 5, 2016***
- The SPOA also has knowledge of services that are available and would be helpful to the Health Home in developing care plan as they:
 - ✓ Assess the current needs of a child/family and gather necessary supporting documents for connecting children to services.
 - ✓ Assist families and providers in navigating multiple child-serving systems
 - ✓ Identify the availability of county resources for families and providers
- The SPOA manages referrals, vacancies, waitlist for high end services and community programs



Designated Health Home Care Management for SED Children

Prior to Health Home Launch

Targeted Case
Management
Provider



After HHSC Launch

Designated Health
Home Care
Management Agency
for SED Children



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Designated Health Home Care Management Agency for SED

OMH Region	Number of Medicaid Funded SPOA Assignments (July 2016)
NYC	1,095
LI	186
CNY	456
WNY	697
HR	395
Total:	2,829

State will provide data that aligns each Designated Health Home Care Management Agency for SED with its number of SPOA assignments, Health Home, Plan, SPOA, and County



New Process for Serving SED Children in Health Home

Role of the SPOA and Health Home Care Manager Assignments

- **Current Health Home Requirements:**
 - ✓ Health Homes and Care Management Agencies are **required** to ensure that CMAs providing Health Home care management are qualified to meet the needs of the child and family (e.g., be able to meet the care management needs of a child with SED, that has HIV, or has multiple chronic conditions)
- ***New Process: Beginning in December, Children that are identified to be eligible for Health Home because they have or potentially have an SED through the SPOA process will be referred by the SPOA to a “Designated Health Home Care Management Agency (CMA) for SED”***
 - Designated HH CMAs for SED will be existing OMH TCM Programs that are transitioning to Health Home
 - SPOA will assign SED children to Designated HH CMA for SED
 - SPOA assignments must reflect alignment between Health Home, Designated HH CMAs for SED, and Managed Care Plans for children enrolled in Plans
 - Health Home has BAA with Designated HH CMA for SED, Plan the child is enrolled in has ASA in place with that same Health Home



New Process for Serving SED Children in Health Home

Role of the SPOA and Health Home Care Manager Assignments

- SPOA assignments are limited, on a Designated HH CMA for SED basis, to the current capacity for Medicaid children served by the existing TCM, (i.e., 3,000 children statewide) - “SPOA Assignment”
- Designated HH CMA for SED will “assign” children with a CANS-NY acuity of High or Medium to a SPOA Assignment
 - Children with CANS-NY acuity of low or that step down from High or Medium to Low will continue to be served by HH CMA for SED but does not count towards SPOA Assignment
- SPOA will track and report the number of assignments made to each Designated HH CMA for SED to OMH and DOH and each Lead Health Home – ***this will be a manual process that will occur outside of the MAPP HHTS***
- SPOAs will use **only use the MAPP HHTS** to make a referral for assignment through the MAPP HHTS Children’s Referral Portal if the Designated HH CMA for SED does not have capacity to serve that child (i.e., their SPOA Assignments are filled) or for other non-SED referrals



New Process for Serving SED Children in Health Home

Role of the SPOA and Health Home Care Manager Assignments

- SPOA recommendation is subject to family/child choice, family may choose and be informed of other Health Homes CMAs non-designated for SED
- Health Homes may also make assignments to Designated HH CMAs for SED
- HH CMAs non-designated for SED that may be working with children and families with SED Children may continue to directly enroll such children through the MAPP HHTS Children's Referral Portal



New Requirements for Serving SED Children in Health Home

Case Load Sizes for Designated HH CMAs for SED

- **Current Health Home Requirements:**
 - ✓ Health Homes are **required** to provide a level of service, (e.g., number of contacts and methods of contact), that support the needs of the child and the family and meet the Health Home core requirements
 - ✓ Health Homes and care managers serving children with high acuity per the CANS-NY are **required** to keep their case loads mix predominantly to children of the High acuity level
 - ✓ Children with High and Medium acuity per the CANS-NY are **required** to receive two Health Home services per month, one of which must be a face-to-face encounter with the child
 - ✓ Case load sizes have been built into the development and calculation of the Health Home rates for children – presumption is CMAs will manage case loads around these assumptions
 - ❑ The rates assume underlying case load ratios of 1:12 for “High”, 1:20 for “Medium” and 1:40 for “Low”
- **New Requirements: Designated HH CMAs for SED will be required to maintain the case load ratios built into the rates for children that are referred by the SPOA**
 - **1:12 for High**
 - **1:20 for Medium**
 - **1:40 for Low**



New Requirements for Serving SED Children in Health Home

Care Manager Qualifications

- **Current Health Home Requirements:**
 - ✓ Care Managers that serve children with an acuity level of “high” as determined by the CANS-NY are **required** to have:
 - A Bachelors of Arts or Science with two years of relevant experience, or
 - A License as a Registered Nurse with two years of relevant experience, or
 - A Masters with one year of relevant experience.
 - Providers may seek a waiver qualifications waiver from the State
- **New Requirements: Designated HH CMAs for SED serving children with medium acuity that do not have CMA qualifications of at least an associates degree with one year of relevant experience must notify the State and seek a waiver from such qualifications**



Case Example: SPOA* refers to Designated HH CMA for SED Designated CMA has Capacity – CANS-NY is High or Medium

- SPOA determines child has an SED and is eligible for Health Home and gets verbal consent from parent or guardian to make referral for Health Home (Children in Foster Care can only be referred by the LDSS)
- SPOA refers to Designated HH CMA for SED where there is HH, Plan and CMA Alignment
- Designated HH CMA for SED has SPOA Assignment Capacity and accepts assignment
- Designated HH CMA obtains consent to conduct CANS-NY assessment and enroll the child in Health Home
- Designated HH CMA enrolls the child in Health Home through MAPP HHTS Children's Referral Portal and conducts the CANS-NY
- CANS-NY algorithm is High or Medium – child occupies a SPOA Assignment
- Designated HH CMA for SED provides care management to High or Medium acuity child
- Designated HH CMA for SED continues to provide care management when the child steps down from High or Medium to Low

*or Lead Health Home



Case Example: SPOA* refers to Designated HH CMA for SED Designated CMA has Capacity – CANS-NY is Low

- SPOA determines child has an SED and is eligible for Health Home and gets verbal consent from parent or guardian to make referral for Health Home (Children in Foster Care can only be referred by the LDSS)
- SPOA refers to Designated HH CMA for SED where there is HH, Plan and CMA Alignment
- Designated HH CMA for SED has SPOA Assignment Capacity and accepts assignment
- Designated HH CMA obtains consent to conduct CANS-NY assessment and enrolls the child in Health Home
- Designated HH CMA enrolls the child in Health Home through MAPP HHTS Children's Referral Portal and conducts the CANS-NY
- CANS-NY algorithm is Low – child does not occupy a SPOA assignment
- Designated HH CMA for SED provides care management to that Low acuity child

*or Lead Health Home



Case Example: SPOA refers to Designated HH CMA for SED Designated TCM *does not* have Capacity

- SPOA determines child has an SED and is eligible for Health Home and gets verbal consent from parent or guardian to make referral for Health Home (Children in Foster Care can only be referred by the LDSS)
- SPOA refers to Designated HH CMA for SED where there is HH, Plan and CMA Alignment
- Designated HH CMA for SED does not have any SPOA assignment capacity
 - SPOA may refer to another Designated HH CMA for SED, if practical and if available
- If there are no other Designated HH CMAs for SED with SPOA assignment capacity, the SPOA makes a referral through the MAPP HHTS Children's Referral Portal
- The child is assigned by Health Home to a HH CMA with experience in serving SED children



Tracking SPOA Assignments to Designated Health Home CMAs for SED

- SPOAs will submit a monthly roster to State and each Lead Health Homes that tracks :
Children for which there was capacity and assignment accepted by Designated CMA for SED
 - ✓ Name and CIN of child assigned to Designated HH CMA for SED,
 - ✓ Date of child assigned and accepted by Designated HH CMA for SED
 - ✓ Name and MMIS number of Designated HH CMA for SED and name and MMIS of Health Home

Children for which there was no capacity and referral was made through the MAPP HHTS

- ✓ Name(s) and MMIS of Designated HH CMAs for SED and name and MMIS of Health Home for which there was not capacity at time of SPOA assignment
- ✓ Name and CIN of child referred through the MAPP HHTS Children's Referral Portal



Requirements for Designated Health Home Care Management Agencies for SED

CANS-NY Acuity	HIGH	MEDIUM	LOW
SPOA Referrals	SPOA referrals for which a CANS-NY is complete by Designated CMA for SED for which acuity is High is placed in SPOA Assignment	SPOA referrals for which a CANS-NY is complete by Designated CMA for SED for which acuity is Medium is placed in SPOA Assignment	SPOA referrals for which a CANS-NY is complete by Designated CMA for SED for which acuity is Low is NOT placed in SPOA Assignment, however, there needs to be room within the agencies CMA program to seamlessly move children in and out of low acuity
Required Caseloads	<u>Required:</u> 1:12	<u>Required:</u> 1:20	<u>Required:</u> 1:40
Staff Qualifications	<p>*Health Home Qualification Requirements</p> <ul style="list-style-type: none"> • A Bachelors of Arts or Science with two years of relevant experience, or • A License as a Registered Nurse with two years of relevant experience, or • A Masters with one year of relevant experience. 	<p>*Qualifications consistent with existing SCM Standards:</p> <ul style="list-style-type: none"> • An Associates with one year of relevant experience <p>*Designated HH CMAs that deviate from the qualifications required for High case load as required by the HH model (this is the same as their ICM standard) or the SCM standard must notify the State and seek a waiver from OMH.</p>	Staff must be qualified to meet the needs of the child

Performance and Quality Oversight

- Oversight and Monitoring by State Agency Team will be Performed for ALL Health Homes Serving Children
 - This will include HH CMAs as well as designated HH CMAs for SED
 - Standards employed across the Health Home program, including those for HH CMAs for SED will be evaluated against performance outcomes
 - Site Visits, Chart Reviews, Data Reviews, Quality Metrics
- Health Homes or Plans that are concerned about the quality of care management of a Designated HH CMA for SED may request DOH and OMH jointly review the Designation of such HH CMA for SED – State will review and respond to request within 10 business days



Important Timeframes and Steps for Completing the Transition of TCM Children to Health Home

- All Medicaid children enrolled in OMH TCM must have a CANS-NY completed and be enrolled in Health Home **on or before January 31, 2017**
- This will provide Designated HH CMA for SED/OMH Providers time to phase over your current client population to Health Home in a smooth manner and not disrupt cash flow



Transitioning Current TCM Children to Health Homes

Pre-Population of CANS-NY Assessment in the UAS-NY and Consents

- A CANS-NY assessment is required for every child enrolled in Health Home: tool determines Health Home acuity for billing and is used to assist in the development of care plan
- To facilitate the transition of TCM children to Health Home, beginning on October 24, 2016 (prior to the December launch date of Health Homes), OMH TCM providers, were given access to the UAS-NY to begin to pre-populate CANS-NY assessment tool for Medicaid children now being served by TCM.
- Currently, 213 CANS-NY have been started
- Pre-population guidance was issued to OMH TCM providers on August 24, 2016 and additional guidance on October 24, 2016.
- **Reminder:** To access the UAS-NY, OMH TCM providers must have access to the HCS, access and be trained in the UAS-NY and be properly trained and certified in CANS-NY assessment tool



Transitioning Current TCM Children to Health Homes

Pre-Population of CANS-NY Assessment in the UAS-NY and Consents

- Prior to entering a CANS-NY within the UAS-NY, the functional Assessment Consent form must be completed with the member (if appropriate), the parent, guardian or legally authorized representative
 - Within the UAS-NY system, verification of consent will be requested
- Additionally, consent must be obtained from the member (if appropriate), parent, guardian or legally authorized representative to **enroll** the child in Health Homes
- Consent forms are available on http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm



Important Timeframes and Steps for Completing the Transition of TCM Children to Health Home

- MAPP HHTS Referral Portal, the system used to enroll a child in Health Home, will be available in December 2016.
- Between now and that date, TCM/Designated HH CMAs for SED Providers should continue to pre-populate CANS-NY assessments within the UAS-NY
- ***CANS-NY assessments should not be signed and finalized until AFTER the child is enrolled in Health Home using the MAPP HHTS Children's Referral Portal*** (this is an order of events issue – you may continue to pre-populate but child must be enrolled in Health Home prior to finalizing CANS-NY)
- TCM/Designated HH CMAs for SED providers will enroll children/create an enrollment segment in the MAPP HHTS Children's Referral Portal where *there is alignment between the OMH TCM provider, the Health Home (OMH TCM provider has BAA with Health Home) and Managed Care Plan (the Plan the child is enrolled in has Administrative Service Agreement (ASA) in place with Health Home)*
- TCM provider should ensure that the Health Home the child is enrolled in through the MAPP HHTS is the **SAME** as what is indicated in the UAS-NY CANS-NY assessment intake/demographic to ensure the MAPP HHTS can properly receive CANS-NY information (important for billing!)
- **ONLY** then should the CANS-NY assessment be signed and finalized for the CANS-NY acuity to be run



Transitional Billing Rules

- In the month that TCM/Designated HH CMA for SED provider, enrolls the child in Health Home through the MAPP HHTS Referral Portal AND signs and finalizes CANS-NY and performs Health Home billable service (the Health Home enrollment month), TCM/Designated HH CMA for SED will:
 - Submit claim to the State for **OMH TCM services** provided in the **prior month**
 - Will receive payment **from the Health Home for Health Home services** provided in the Health Home enrollment month as determined by the Health Home acuity (High, Medium or Low) generated by the signed and finalized CANS-NY in UAS
- This process will enable TCM/Designated HH CMA for SED to phase-in the enrollment of their children between now and the end of January 2017



Transitional Examples for Enrolling TCM Children in Health Homes

Example 1:

- TCM/Designated HH CMA for SED Provider obtains consent to conduct CANS-NY assessment and prepopulates in November 2016 (should obtain Health Home consent to enroll at this time)
- In December 2016 child is enrolled in Health Home through MAPP HHTS Children's Referral Portal by TCM/Designated HH CMA for SED Provider
- CANS-NY assessment is signed and finalized in December 2016, *ensuring enrolled Health Home matches to identified Health Home in the UAS-NY*
- TCM submits claim to State with 12/1/16 date of service for OMH TCM services conducted in November 2016
- TCM/Designated HH CMA for SED submits billing information into the MAPP HHTS confirming that they have provided a billable service for December 2016
 - Payment for Health Home services in December with a 12/1/16 date of service will be processed by the Health Home using information from the CANS-NY and MAPP HHTS



Transitional Examples for Enrolling TCM Children in Health Homes

Example 2:

- TCM/Designated HH CMA for SED Provider obtains consent and conducts, signs and finalizes CANS-NY in December 2016 (should obtain Health Home consent to enroll at this time)
- In December 2016 child is enrolled in Health Home through MAPP HHTS Children's Referral Portal by TCM/Designated HH CMA for SED Provider, *ensuring enrolled Health Home matches to identified Health Home in the UAS-NY*
- Submit claim to State with 12/1/16 date of service for OMH TCM services conducted in November 2016
- TCM/Designated HH CMA for SED submits billing information into the MAPP HHTS confirming that they have provided a billable service for December 2016
 - Payment for Health Home services in December with a 12/1/16 date of service will be processed by the Health Home using information from the CANS-NY and MAPP HHTS



Transitional Examples for Enrolling TCM Children in Health Homes

Example 3:

- TCM/Designated HH CMA for SED Provider obtains consent and begins CANS- NY assessment in December 2016 or January 2017
- In January 2017 child is enrolled in Health Home through MAPP HHTS Children's Referral Portal by TCM/Designated HH CMA for SED Provider, *ensuring enrolled Health Home matches to identified Health Home in the UAS-NY*
- CANS-NY assessment is signed and finalized in January 2017
- Submit claim to State for OMH TCM services conducted in November (12/1/16 date of service) and December 2016 (1/1/17 date of service)
- TCM/Designated HH CMA for SED submits billing information into the MAPP HHTS confirming that they have provided a billable service for January 2017
 - Payment for Health Home services in January with a 1/1/17 date of service will be processed by the Health Home using information from the CANS-NY and MAPP HHTS



Transitional Examples for Enrolling TCM Children in Health Homes

- No later than January 31, 2017 all children enrolled in TCM should be transitioned to Health Home:
- All existing TCM children should be enrolled in Health Home within the MAPP HHTS, CANS-NY should be signed and finalized, and Health Home services should be billed
- OMH TCM services should not be billed for services provided after February 1, 2017 (2/1/17 for services provided in January 2017 is last service date that can be billed under OMH TCM rates)
- OMH TCM Legacy payment reconciliations will begin with Health Home claims paid in February 2017 (there will be no reconciliation during the December and January transition period)

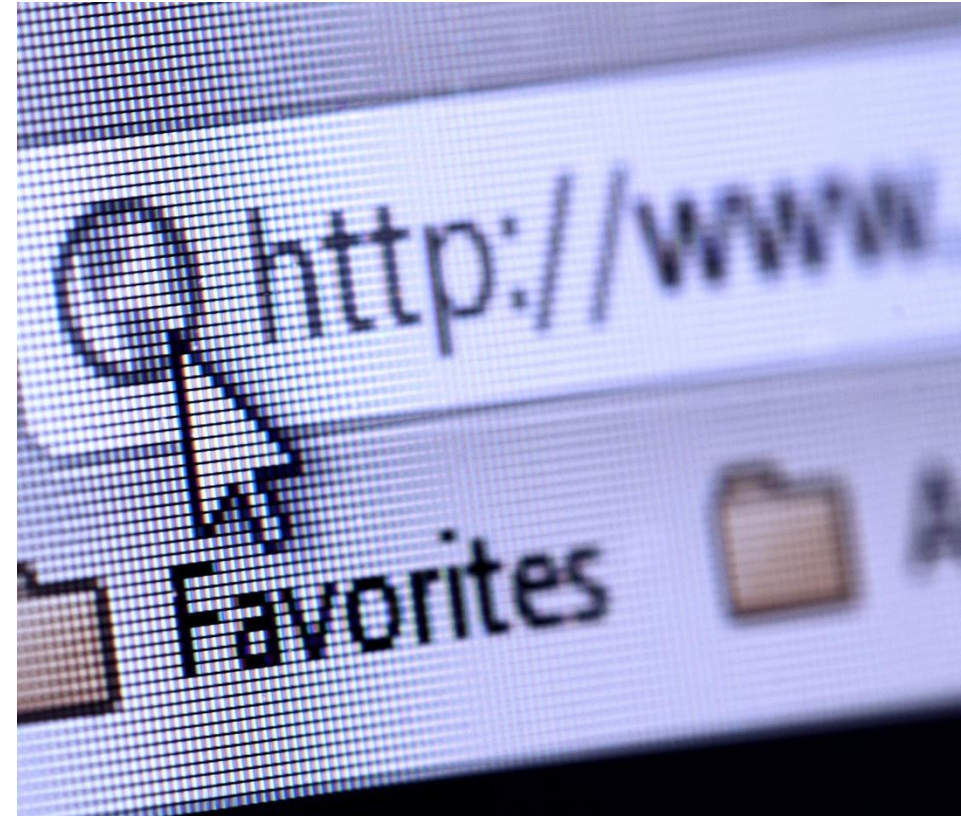


Questions and Discussion



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 Serving Children List of Acronyms

- ACS: NYC Administration of Children Services
- AI: AIDS Institute
- ALP: Assisted Living Program
- ASA: Administrative Service Agreement
- BAA: Business Associate Agreement
- BHO: Behavioral Health Organization
- CAH: Care at Home
- CBO: Community Based Organizations
- CMA: Care Management Agency
- DEAA: Data Exchange Agreement Application
- EI: Early Intervention
- Emedny: Electronic Medicaid system of New York
- FFS: Fee For Service
- HCBS: Home and Community Based Services
- HCS: Health Commerce System
- HH: Health Home
- HHSC: Health Home Serving Children
- HHTS: Health Home Tracking System
- HIT: Health Information Technology
- LDSS: Local Department of Social Services
- LGU: Local Government Unit



Health Homes Serving Children List of Acronyms

- MAPP: Medicaid Analytics Performance Portal (Health Home Tracking System HHTS)
- MCO/MCP: Managed Care Organization / Managed Care Plan
- MRT: Medicaid Redesign Team
- MMIS #: Medicaid Management Information Systems
- NPI #: National Provider Identifier
- OASAS: Office of Alcoholism and Substance Abuse Services
- OCFS: Office of Children and Family Services
- OMH: Office of Mental Health
- OMH-TCM: Office of Mental Health Targeted Case Management
- PMPM: Per Member Per Month
- SED: Serious Emotional Disturbance
- SMI: Serious Mental Illness
- SPA: State Plan Amendment
- SPOA: Single Point of Access
- SPOC: Single Point of Contact
- TCM: Targeted Case Management
- UAS-NY: Uniformed Assessment System
- VFCA: Voluntary Foster Care Agency

