Health Home Implementation Webinars

Session #43– August 20, 2014

ACT Transition to Health Home and Implementation of Health Home Plus for AOT

NEW YORK state department of **HEALTH**

Agenda

- MAPP Update
- ACT Transition to Health Home
- Health Home Plus for AOT

Medicaid Analytic Performance Portal (MAPP) Update

▶ Information regarding the MAPP and survey summaries is located on the Health Home website, Medicaid Analytics Performance Portal section located here: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_mapp.htm

◦ Survey # 1

• *Purpose:* the survey is designed to focus on existing tracking system process flows and assist in understanding current business processes in order to inform development of the Medicaid Analytics Performance Portal (MAPP).

◦ Survey#2 –to be posted soon

• *Purpose:* Focuses on exchanging billing information for Managed Care Plan and Health Home only

Medicaid Analytic Performance Portal (MAPP) Update

- Upcoming surveys:
  - ◦ 360 Degree Patient View & Analytics for Care Management questionnaire:
    - *Purpose:* provide a complete and accurate view of member information to help a member's care team understand the health/wellness of their HH members
  - ◦ NYHH Interoperability questionnaire:
    - *Purpose* obtain more background information on providers existing system's and the current state of interoperability- what interoperability means to you and where to focus the interoperability efforts for MAPP project.
- *Distribution:* Notices will be sent out through HH listserv soon when these surveys are available.

ACT PROGRAMS AND HEALTH HOMES

ASSERTIVE COMMUNITY TREATMENT PROGRAM (ACT) JOINING HEALTH HOME (HH) NETWORKS

AUGUST 20TH, 2014

Assertive Community Treatment (ACT)

<u>Definition:</u>

- Integrated set of evidence-based treatment, rehabilitation and support services delivered by mobile, multi-disciplinary mental health treatment team.

- ACT's recovery oriented, individualized services provide recipients with tools needed to obtain and keep housing, employment, relationships, and relief from symptoms and medication side effects.

- ACT serves a small population of individuals with serious mental illness not engaged with traditional treatment services, and who often have significant inpatient and emergency psychiatric histories, involvement with the criminal justice system, and alcohol / substance abuse histories. The ACT plan of care evolves over time as the needs and goals of the individual change.

What are the Goals and Benefits of the ACT Programs Joining HH Networks?

- Health Home, a DOH initiative, is a care management model that provides individuals with access to a wide network of physical and behavioral health providers and community services.

- All of the individual's service providers communicate, monitor and provide linkages with one another to address his or her unique social, physical and behavioral health needs in a comprehensive way.

What are the Goals and Benefits of the ACT Programs Joining HH Networks? Cont'd

Health Homes:

• Reduce emergency room, inpatient hospital and long term care facility use;

• Improve health outcomes for populations;

• Reduce Medicaid costs;

• Promote continuity of care within the Health Home environment; and

• Provide ACT teams easier accessibility for step down care management at discharge.

ACT Programs Joining Health Homes

Data Exchange Application Agreement (DEAA):

• Health Homes must execute a DEAA Subcontractor Packet agreement with ACT programs and submit to DOH for approval

• DEAAs allow the ACT program and the Health Home to share information on ACT recipients prior to obtaining the ACT recipient's consent.

ACT Programs Joining Health Homes Cont'd

- The Office of Mental Health provided statewide guidance to all ACT programs on December 12th, 2013 to become part of Health Home networks.

- In order for ACT recipients to be in a Health Home, the ACT program and Health Homes must enter into a contract.

- ACT programs may contract with more than one Health Home. Each Health Home has its own contract template.

- The contract is needed so that:
  - Administrative fees for Health Homes can flow from the ACT Program; and
  - The Health Homes can make its provider network available to ACT recipients who have signed a Health Home consent form (DOH 5055)

ACT Program Joining Health Homes Cont'd

Health Home Responsibilities:

- It is the responsibility of the Health Home to ensure that ACT programs joining Health Homes:

  - Are familiar with a Health Home procedures and reporting requirements;

  - Execute DEAAs and contracts;

  - Assign members to the Health Home using the Health Home member tracking system.

Reimbursement and ACT Claims

- ACT teams must assign Medicaid eligible ACT recipients into Health Homes using the Health Home's Member Tracking System.

- For ACT recipients enrolled in a Health Homes, the ACT team provides reimbursement to the Health Home as an administrative fee.

- ACT programs were notified of an increase to the ACT rate on December 6, 2013.

- Programs received a retroactive increase in the monthly reimbursement as of July 1, 2013. The increase was to be used for costs of preparing infrastructure, new IT and recordkeeping requirements, etc.

Reimbursement and ACT Claims Cont'd

• When ACT recipients are enrolled in Health Homes, ACT teams will forward $30 of their $50 rate increase to the Health Home as an administrative fee.

•The ACT program will retain the $20 balance for the new responsibilities and additional costs associated with being part of a Health Home.

• If in any month an ACT participant is in a setting where Medicaid may not be claimed, the ACT program will not be responsible for remitting the administrative fee to the Health Home.

Reimbursement and ACT Claims Cont'd

- In the case of an OMH State PC run ACT Team, OMH will provide monthly administrative fees funds directly to the Health Home.

- If an individual is in an inpatient facility that does not allow for Health Home care management billing, the ACT program is not reimbursed and therefore no administrative fee is provided by the ACT team to the Health Home.

Assignment & Enrollment

- The ACT Program will work with the Health Home(s) with which they have agreements and contracts to identify any ACT participants that already have Health Home assignment or enrollment.

- If an ACT recipient is already enrolled in the Health Home, the ACT program must contact the Health Home and inform them that the ACT program is providing the care management.

- The ACT Program must work with ACT recipients to secure consent (DOH 5055) for participation in the Health Home program, including assurance that ACT recipients fully understand the form upon signing.

- The Health Home DOH 5055 Consent Form allows the Health Home network partners listed on the form to share appropriate information to assist the member.

Assignment & Enrollment, Cont'd

- To **assign** ACT recipients with active Medicaid to a Health Home, the ACT program must complete and submit Member Tracking information to the Health Home(s) in the format the Health Home requires. *Only demographic information may be shared prior to obtaining a signed DOH 5055 consent form.*

- The ACT program populates the Direct Biller field of the Health Home Patient Tracking Form with the value of "Y." This indicates to the Health Home that the downstream care management agency—in this case the ACT Program—bills eMedNY directly for services.

- The ACT program must indicate on the Health Home's Member Tracking that the individual is in active care management. When the individual signs the Health Home DOH 5055 consent form, the ACT program updates the field with the date the consent form was signed.

Reporting

- Health Homes require a single plan of care documenting the care management activities. Health Homes and ACT Programs can negotiate whether the ACT plan of care can be used and the extent to which information is integrated.

- ACT Programs will continue to report in CAIRS, consistent with OMH guidance.

- Health Home members enrolled in ACT programs will not be included in the Health Home CMART data documentation. ACT Programs are not responsible for submitting CMART data to the Health Home or for completing the FACT-GP functional assessment, as information on care management activity and functional status is reported via the CAIRS system.

- ACT programs and Health Homes must develop a system of communication and information sharing.

Reporting Cont'd

• When ACT services are no longer needed and participants transition to Health Home Care Management, ACT Programs may complete a FACT-GP and the HH Functional Assessment, and submit them to the Health Home, or the Health Home can assign a new care manager to complete these requirements.

• In addition to the member tracking information, Health Homes require a single plan of care documenting the care management activities for individuals who have signed a Health Home consent.

• ACT teams must document care management activities as negotiated with the the Health Home and provide at least one Health Home Care Management service per month.

Specific Guidance for ACT Members Living in Certain NYC Adult Homes

- Agencies involved in the stipulated settlement in NYC to transition Adult Home class members to the community were provided with specific guidance related to the transition.

- When a class member is enrolled in an ACT Program, participating Health Homes will be notified on their Community Transition List (CTL), which is distributed by the Department of Health.

- The Health Home will conduct a UAS-NY assessment for all adult home residents who have indicated an interest in moving to community housing. If the assessment indicates that ACT services are no longer required, the ACT Program will facilitate the participant's transition to Health Home Care Management.

Specific Guidance for ACT Members Living in Certain NYC Adult Homes

• New admissions to ACT are no longer permitted for adult home residents, except when so ordered in an Assisted Outpatient Treatment (AOT) procedure.

• Current adult home residents who are receiving ACT services must be reviewed by the Health Home and ACT to determine the appropriate level of care.

Summary: Next Steps, ACT and Health Homes

- Execute DEAA and contract between ACT program and Health Home(s)

- The ACT Programs should complete assigning ACT recipients into Health Homes by completing and transmitting Member Tracking information in whatever format the Health Home requires. Only demographic information may be shared prior to obtaining a signed DOH 5055 consent form.

- Indicate that the recipient is in active care management in the Health Home's Member Tracking System. When the ACT recipient signs the Health Home consent form (DOH 5055), the Health Home program updates that field with the date the consent was signed.

Questions?

For questions concerning ACT:

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HEALTH HOME PLUS

Health Home Plus for Assisted Outpatient Treatment (AOT)

Health Home Plus

- The New York State Office of Mental Health (OMH) and the New York State Department of Health (DOH) have created a new service and rate code package for Health Homes.

- Health Home Plus (HH+) is an intensive Health Home Care Management (HHCM) service being established for defined populations with Serious Mental Illness (SMI) who are enrolled in a Health Home.

Population

- HH+ applies only to people with AOT court orders not being served by Assertive Community Treatment (ACT) teams.

- In the future this rate may expand to include individuals with serious mental illness who are:

  ➤ discharged from state psychiatric hospitals, nursing homes, and adult homes;

  ➤ released from jails and prisons; and

  ➤ receiving enhanced service plans (informal AOT status).

Program and Caseload Requirements

- See detailed list of all program requirements in the guidance documents.

- Programs must send in signed attestation yearly.

- A caseload ratio no greater than 1 staff to 12 HH+ recipients – that is, each AOT/HH+ will represent 8.5% of a full-time HHCMs available care management time if the caseload includes other than HH+ clients.

Providers

- Due to their familiarity with the AOT status recipient, Health Home Plus services shall be provided only by legacy OMH TCM providers.

- In the case of clients with AOT court orders, the Health Home Care Management agency must ensure the care managers providing HH+ services meet all the qualifications formerly required in the Intensive Case Management program.

LGU Requirements

- The LGU is responsible to operate, direct, and supervise an AOT program and to provide or arrange for all categories of AOT services.

- See guidance document for detailed list of LGU responsibilities.

Billing and Tracking

- There will be unique rate codes for HH+ services. This arrangement will be superseded for Medicaid Managed Care/HARP enrollees when all behavioral health services are added to Medicaid Managed Care rates: January 2015 in NYC and July 2015 in the rest of the state.

- These rate codes will be billed directly to eMedNY by legacy TCM providers, as are all other care management rate codes.

Billing and Tracking

- HH+ clients will be included in the total number allowed to bill under the 1800 series rate codes:

  ➢ Example: Prior to HH+ a provider has 100 slots that it may bill at the 1800 series rate codes each month. If 10 individuals are identified at this provider as HH+ eligible, and are billed using the HH+ rate code, 90 slots will remain that may be claimed for individuals using the 1800 series rate codes.

Billing and Tracking

- As with all members receiving Health Home services from a converting OMH TCM provider, HH+ members must have a value of "Y" in the Direct Biller Indicator field in the Tracking System.

- Only those individuals reported in TACT as on active AOT status will be eligible to be claimed at the HH+ rate.

Billing and Tracking

- Only those individuals reported in TACT as on active AOT status will be eligible to be claimed at the HH+ rate.

- If the individual is on active AOT status at any time during the month the HH+ rate code may be billed.

- Guidance on billing effective dates, retroactive billing, and detailed instructions on how to bill will be forthcoming from the DOH.

OMH Contact Information

For questions concerning Health Home Plus:

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Useful Health Home 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