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Transitioning Office of Mental Health Children's Targeted Case Management (TCM) Program to Health Homes

Webinar #4 :

Transitional Rate Provisions for OMH TCM Legacy Providers and Enrolling TCM Children in Health Homes Serving Children

September 20, 2016

Introductions

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Today's Discussion

- Webinar #4 in a series of Webinars for OMH TCM Providers that will transition to the Health Home Program
 - See OMH TCM section located at http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hhsc_webinars.htm
- Health Home Serving Children Implementation Updates
 - Health Home Eligibility Criteria – Including Definition of Serious Emotional Disturbance
- Transitional Rate Provisions for OMH TCM providers
 - PMPM Health Home for Children's Rates and Methodology for Reconciliation
 - Legacy Slots, Legacy Rates
- Pre-Populating CANS-NY and Enrolling Current OMH TCM Children in Health Home
- SPOA referral to Health Home Serving Children through the MAPP Children's HH Referral Portal
- Care Coordination for the non-Medicaid Population



Health Home Serving Children Implementation Updates



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Health Home Implementation Updates – Approvals and Timeline

- State Plan Amendment approved in April 2016 – includes Health Home rates for children (including TCM rate reconciliation discussed later in the presentation) and CANS-NY assessment, expanded eligibility criteria (i.e. complex trauma),
- Health Homes Designated to Serve Children will begin to enroll children on ***December 2016***
- October 2016 enrollment date was recently changed to December 2016 to align the timeframe for amending capitated rates to Managed Care Plan to include Health Home payments with start date for enrolling children in Health Homes (change will reduce time it takes for payments to flow from Plans to Health Home to Care Managers (including OMH TCM providers))
- The change in the enrollment date for children will also provide Health Homes and Plans with more time to address readiness activities



Health Home Implementation Updates – Timelines

- In December 2016 there will be access to MAPP HHTS Referral Portal to refer and enroll children
- Health Home payments will begin for dates of service on and after December 1, 2016
- ***To facilitate transition for OMH TCM Providers beginning October 2016, OMH TCM providers will have access to UAS to begin pre-populating CANS-NY for their members***
- All other providers will have access to UAS in December 2016



Health Home Implementation Updates – Readiness Activities

- Key Readiness Activities that Remain Outstanding:
 - ✓ Administrative Services Agreements (ASAs) with HHSC and Managed Care Plans – January 2016 ASA or Customized
 - ✓ Access to HCS and UAS for Care Managers – ***Including OMH TCM Providers***
 - HCS account needed for UAS access for the CANS-NY
 - HCS account needed for MAPP access for the Referral Portal
 - ✓ Health Homes are Establishing/Documenting Network Provider Relationships
 - ***100% Alignment with OMH TCM Providers is required for Health Home network adequacy***
 - ***2 OMH TCM Providers do not have Business Associate Agreement with at least one Health Home***



Health Home Implementation Updates – Readiness Activities

- The State continues to conduct at least monthly calls with HHSC to assess progress made in addressing contingencies and overall readiness
 - ✓ State has scheduled a site visit in September for the three new Health Homes Serving Children that currently do not serve adults – three CMAs will be asked by the Lead Health Home to present at the site visit and an OMH TCM provider will be reviewed at each site visit
- For most HHSC, outstanding readiness activities primarily revolve around:
 - ✓ Entering into Administrative Services Agreements (ASAs) with Managed Care Plans
 - ✓ HIT Compliance – Updated written HIT policies, care management software
 - ✓ Billing Readiness – Billing software, Billing Certifications (adult and children Health Homes must submit separate attestations)
 - ✓ BAAs – Network Adequacy being reviewed now by State Partners, including alignment of existing waiver, OMH TCM and voluntary foster care agencies with Health Homes
- Additionally, the State has been conducting a series of readiness webinars – they will continue through December 1, 2016 launch date – State will also hold “State of Implementation” Webinars to get back feedback from stakeholders during the first several months of implementation
- See Website for readiness Webinars
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hhsc_webinars.htm



Health Home Chronic Condition Eligibility Criteria

- The individual **must** be enrolled in Medicaid
- Medicaid members eligible to be enroll in a Health Home must have:
 - Two or more chronic conditions (e.g., Substance Use Disorder, Asthma, Diabetes*) OR
 - One single qualifying chronic condition:
 - ✓ HIV/AIDS or
 - ✓ Serious Mental Illness (SMI) (Adults) or
 - ✓ Serious Emotional Disturbance (SED) or Complex Trauma (Children)

Chronic Condition Criteria is NOT population specific (e.g., being in foster care, under 21, in juvenile justice etc. does not alone/automatically make a child eligible for Health Home)



Health Home Appropriateness Criteria

Individuals must meet the Chronic Condition Criteria AND be Appropriate for Health Home Care Management

Appropriateness Criteria: Individuals meeting the Health Home eligibility criteria must be appropriate for the intensive level of care management provided by Health Homes. Assessing whether an individual is appropriate for Health Homes includes determining if the person is:

- ✓ At risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)
- ✓ Has inadequate social/family/housing support, or serious disruptions in family relationships;
- ✓ Has inadequate connectivity with healthcare system;
- ✓ Does not adhere to treatments or has difficulty managing medications;
- ✓ Has recently been released from incarceration, placement, detention, or psychiatric hospitalization;
- ✓ Has deficits in activities of daily living, learning or cognition issues, or
- ✓ Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home.



Serious Emotional Disturbance (SED) as a Single Qualifying Condition for Health Homes

- The DSM categories include in the definition of SED used to determine Health Home eligibility is different than the SED definition used to determine eligibility for other Medicaid services (e.g., OMH clinic, inpatient, etc.)
- Gender Dysphoria is included in the Health Home Serving Children SED definition
- The following slide outlines the specific Health Home Serving Children definition of SED



Serious Emotional Disturbance (SED), as Defined Below, is Single Qualifying Chronic Condition for Health Home Eligibility

SED Definition for Health Home – *SED, as defined, is a single qualifying chronic condition for Health Home* and is defined as a child or adolescent (under the age of 21) that has a designated mental illness diagnosis in the following Diagnostic and Statistical Manual (DSM) categories* as defined by the most recent version of the DSM of Mental Health Disorders **AND** has experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis

SED Definition for Health Home - DSM Qualifying Mental Health Categories*

- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma- and Stressor-Related Disorders
- Dissociative Disorders
- Somatic Symptom and Related Disorders
- Feeding and Eating Disorders
- Gender Dysphoria
- Disruptive, Impulse-Control, and Conduct Disorders
- Personality Disorders
- Paraphilic Disorders
- Gender Dysphoria
- ADHD for children who have utilized any of the following services in the past three years:
 - Psychiatric inpatient
 - Residential Treatment Facility
 - Day treatment
 - Community residence
 - Mental Health HCBS & OCFS B2H Waiver
 - OMH Targeted Case Management

Functional Limitations Requirements for SED Definition of Health Home

To meet definition of SED for Health Home the child must have experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis. The functional limitations must be **moderate in at least two** of the following areas or **severe in at least one** of the following areas:

- Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
- Family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
- Social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
- Self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
- Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

❖ *Note: the DSM categories include in the definition of SED used to determine Health Home eligibility is different than the SED definition used to determine eligibility for other Medicaid services (e.g., OMH clinic, inpatient, etc.)*

*Any diagnosis in these categories can be used when evaluating a child for SED. However, any diagnosis that is secondary to another medical condition is excluded.

Transitional Rate Provisions for OMH TCM Legacy Providers



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General Framework: Transitional Health Home for Children Per Member Per Month (PMPM) Rate Provisions for Legacy OMH TCM Providers

- OMH TCM Providers will be subject to Children's Health Home (HH) Per Member Per Month (PMPM) Rates
 - For many OMH TCM providers, the proposed HH PMPM for children are higher than current OMH TCM rates
- Payments received under the HH PMPM rate structure will be reconciled by comparing what an OMH TCM provider would have received under an OMH TCM Legacy Rate to what it received from the HH PMPM rates
 - Providers that received less under the HH PMPM payment than they would have received under legacy rates will receive a legacy payment
- The reconciliation process allows for consistent billing and payment procedures across Health Homes, while also ensuring children's OMH TCM providers receive a level of funding that is comparable to what was received prior to the implementation of Health Homes



Health Home Serving Children Per Member Per Month (PMPM) Rates

Per Member Per Month HH Care Management Rates for Children under 21		
Acuity for Determining PMPM (CANS-NY Algorithm*)	Upstate	Downstate
High	\$750	\$799
Medium	450	479
Low	225	240
Outreach	135	135
Assessment**	185	185

*The State is working to finalize programming of CANS-NY Algorithms and will make them public shortly

*State will monitor acuity determinations against supporting documentation and services included in care plan

** Unlike the adult CMHA assessment fee (which is an HCBS fee) the CANS-NY Assessment fee is a Health Home fee authorized under SPA



OMH Health Home Care Management Legacy Slots

- OMH TCM Providers will be subject to Children's Health Home (HH) Per Member Per Month (PMPM) Rates - they will not bill Legacy Rates. As discussed later in this presentation there will be a rate reconciliation process to help ensure cash flow stability of OMH TCM providers as they transition to Health Home
- The number of legacy slots represent Children's TCM Medicaid claims based upon calendar year 2013 data.
- Unlike in the adult TCM HH transition there is no differentiation between Legacy Slots and Health Home slots within a program-all slots will be billed using the Children's Health Home PMPM Rates
- Legacy slots are a mechanism used during the reconciliation process



OMH Health Home Care Management Legacy Rates

- Legacy rates are based on the rates in effect as of April 1, 2016.
- For TCM providers of only one type of case management service, the rate is simply the rate in effect for that service type (ICM, SCM or BCM).
- For TCM providers of more than one type of case management services, the rate is total billable dollars divided by total Medicaid claims paid.
- Legacy rates are a mechanism used during the reconciliation process



Reconciliation of HH PMPM Rate and Legacy Rates

- Initially, DOH will begin the reconciliation process ten days following the close of a calendar quarter. If it is determined that insufficient data is in the system ten days following the close of a quarter, DOH/OMH will determine the appropriate timeframe to complete the reconciliation within the close of a future quarter
- DOH/OMH will monitor and reconcile HH payments for two years. DOH/OMH reserve the right to suspend legacy reconciliation earlier if the legacy TCM conversion is fiscally stable. Providers will be given at least one quarter's notice in the event of early suspension.
- Monthly monitoring will occur by the State of each providers' billing revenue; individual outreach to TCM agencies on cash flow and fiscal standing will occur.



Health Home Payment Flow

On December 1, 2016 the statewide process for all Health Home payments (children and adults) will be as follows:

- Health Home Payments will be included in Managed Care Plan capitation rates (for both children and adults)
- For Children enrolled in Plans (nearly all Health Home eligible children): the Plan will use billing information provided in MAPP HHTS to make payments to the Health Home, who will make payments to its downstream care managers (including OMH TCM providers)
- For Children enrolled in Fee-for-Service Medicaid: the Health Home will use billing information provided in the MAPP HHTS to bill the State; Health Home then pays the downstream care managers (including OMH TCM providers)
- All Health Homes were required to submit an updated billing readiness attestation to the Department of Health by July 15, 2016 stating they have systems in place to make timely payments received from the Plan or directly from the State to downstream providers and these systems have been tested with the Downstream Service Providers (DSPs). The HH also had to acknowledge receipt of further guidance and clarification that was sent out on July 27, 2016.



Pre-Populating CANS- NY and Enrolling Current OMH TCM Children into HHSC



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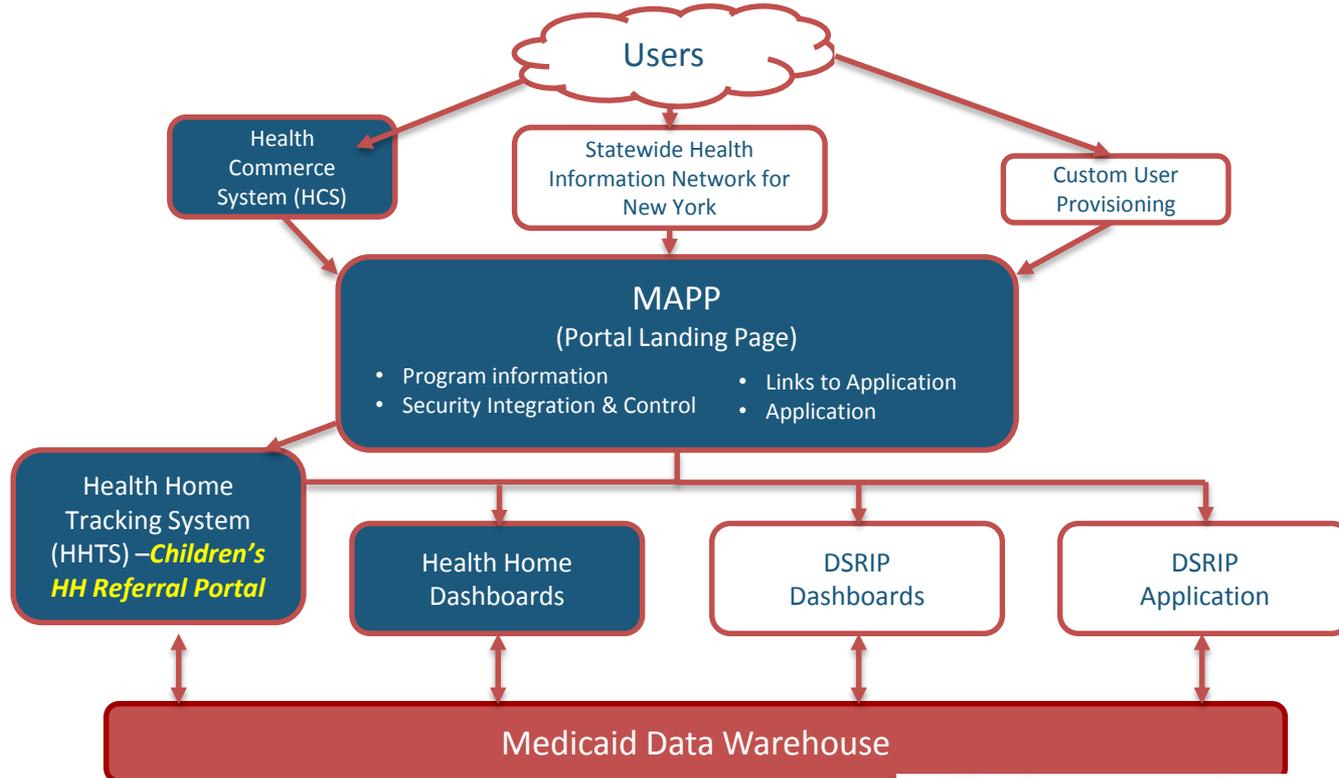
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Medicaid Analytics Performance Portal Health Home Tracking System (MAPP HHTS) Functionality for Children

- MAPP HHTS - performance management system to support providing care management for the Health Home population
- MAPP Features for Children Include:
 - Children's Health Home Referral Portal - All referrals of children for Health Homes will be "ground up" – unlike adults there is no assignment list for enrolling children in Health Home
 - Member tracking - identification, assignment, consent management
 - MAPP will interface with CANS-NY assessment and algorithm housed in Uniform Assessment System (UAS)



Medicaid Analytics Performance Portal (MAPP)



MAPP Children's Health Home Referral Portal

- MAPP Children's HH Referral Portal must be used to refer (create an assignment with a referral record type), and enroll children in Health Homes
- The following entities will have access to the MAPP Children's HH Referral Portal on Day 1:
 - ✓ Managed Care Plans
 - ✓ Health Homes
 - ✓ Care Management Agencies (e.g., OMH TCM Providers Transitioning to Health Home)
 - ✓ LGU/SPOA
 - ✓ LDSS (In NYC, VFCA that contract with ACS will make Referrals on behalf of ACS)

Future Phases: Over time, the State will expand access to the MAPP Children's HH Referral portal by identifying and authorizing other entities that are natural points of contact in the systems of care that impact children to make referrals through the MAPP Referral portal (School Districts, county probation departments, pediatricians, emergency rooms, Early Intervention initial care coordinators, etc.)



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CANS-NY and Health Home

(CANS-NY Child and Adolescent Needs and Strengths Assessment-NY)

- The CANS-NY assessment (as modified for New York) will be used:
 - ✓ To assist in the development of the person centered care plan
 - ✓ Determine acuity for Health Home rate tiers
 - ✓ CANS-NY by itself will not determine Health Home eligibility
 - ✓ CANS-NY will be housed in the Uniform Assessment System (UAS) and will interface with MAPP to provide billing information
- The CANS-NY tools for Health Home:
 - For Children and Youth ages 0-5
 - For Children and Youth ages 6-21
 - http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm



CANS-NY and Health Home

- OMH TCM Providers must have access to the Health Commerce System (HCS) to access the UAS
 - http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hhsc_webinar_hcs_7_9_2015.pdf
- OMH TCM providers must be trained and certified annually in the CANS-NY (CANS-NY assessments cannot be completed by a care manager that has not satisfied training and certification process)
 - ✓ Care Manager must keep their CANS-NY certification current by annual renewal
 - ✓ Supervisors must be CANS-NY certified- and must achieve at least a score of 80% or higher on exam
 - ✓ Care Managers must be CANS-NY certified and must achieve at least a score of 70% or higher on exam
 - <https://canstraining.com/login>



OMH TCM Providers May “Pre-populate” CANS-NY Assessment

- To ensure a smooth and seamless transition for OMH TCM providers, the following transitional procedures will be put in place for OMH TCM providers and their clients
- OMH TCM providers that have access to the HCS, UAS-NY and are properly trained and certified in CANS-NY will be able to begin to pre-populate CANS-NY for their current clients in October 2016
 - Reference guidance that was issued to OMH TCM providers on August 24, 2016
- 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 should be obtained from the member (if appropriate), parent, guardian or legally authorized representative to **enroll** the child in Health Homes

http://devweb.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children_forms.htm



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Enrolling Children Currently Served in OMH TCM Program in Health Home Transitional Billing Rules for OMH TCM Providers

- For CANS-NY assessments completed in October and November OMH TCM programs will continue to bill OMH TCM rates for care management services provided in October and November
- In December 2016, MAPP will become available for OMH TCM providers to complete a referral using the MAPP Referral Portal (with verbal consent) and then enroll members for which you have consent into Health Home with an enrollment segment
- In MAPP, the OMH TCM will enroll the child 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
- For services provided in December you will:
 - 1) Enter in MAPP that you have provided billable service – UAS-NY MAPP interface will apply algorithm to determine and indicate Health Home PMPM rate (i.e., High, Medium, Low)
 - 2) Submit your last claim for OMH TCM services provided in November



December Billing if a CANS-NY is not completed

- Currently served OMH TCM children without a completed CANS-NY in December
 - Verbal Consent to make a Health Home referral should be obtain along with a consent to enroll
 - A referral should be made by the OMH TCM provider within the MAPP Referral Portal along with an enrollment segment
 - Low acuity will be billed for the month of December 2016 and January 2017 until a CANS-NY is completed and the acuity algorithm determines the appropriate rate (high, medium or low)
- If the CANS-NY is not completed by the end of the January 2017, OMH TCM provider will no longer be able to bill for any service until the month in which the CANS-NY is completed.
- Please Note: This aligns with the billing guidance

http://devweb.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/june_29_2016_billing_guidance_final.pdf



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Children's MAPP Referral Process for OMH TCM Providers (and HH, other CMA/VFCAs for Children NOT in Foster Care

HH or CMA/VFCA users making a referral for a child that is **NOT** in Foster Care to a Health Home will be required to provide the following information:

1. Accept Terms and Conditions [provides brief overview of Health Home program and eligibility requirements (Medicaid member and two chronic conditions, Serious Emotional Disturbance (SED), Complex Trauma, HIV/AIDS)]
2. Identify that the child is NOT in Foster Care
3. Affirm and indicate they have obtained consent to make the referral from the child's parent, guardian, legally authorized representative, or self (individual's 18 -21 years of age or minors that are married, pregnant, or a parent may provide consent on their own behalf)
4. Provide the Medicaid CIN # for the individual being referred
5. Identify all chronic conditions that the referrer believes make the child eligible for Health Home and appropriateness meeting Health Home eligibility



Children's MAPP Referral Process for OMH TCM Providers (and HH, other CMA/VFCAs for Children NOT in Foster Care

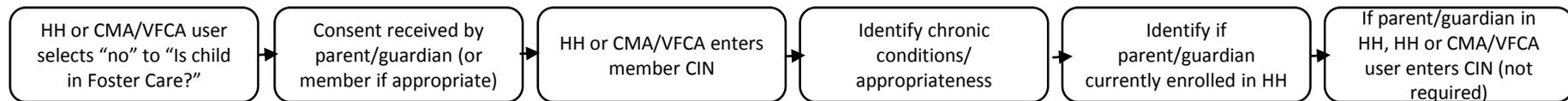
6. Indicate whether the parent/guardian is currently enrolled in a Health Home (if yes, may provide CIN number of parent/guardian)
7. Provide consenter's contact information
8. ***HH or CMA/VFCA user indicates they have been engaged and in communication with the child and wants to enroll the child in the Health Home or has already obtained consent to enroll***
9. HH or CMA/VFCA enters the child in an outreach segment (i.e., consent to enroll has not yet been obtained) or in an enrollment segment (i.e., consent to enroll in Health Home has been obtained)
 - If the HH or CMA/VFCA is not engaged and in communication with the child and will not be serving as the HH CMA, the referral will be submitted to either the Managed Care Plan for members in Managed Care, or for FFS members, the appropriate Health Home based on loyalty match
10. MCP or HH receives an assignment with a referral record type

* If the member is enrolled in a MCP, the member will be reflected in the Plan's list of Health Home assigned members

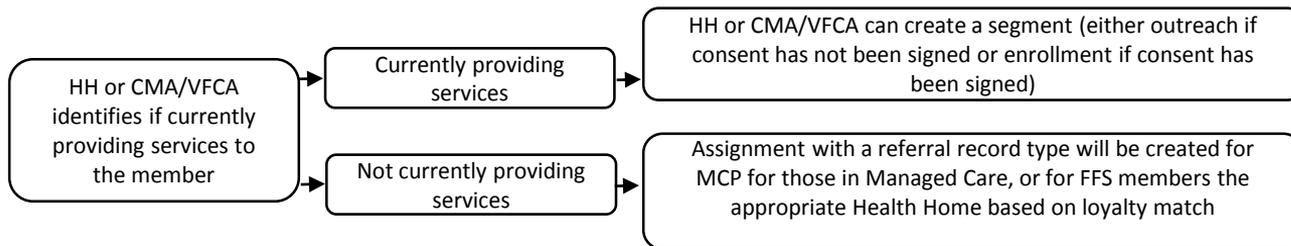


Children's MAPP Referral Process for OMH TCM Providers (and HH, other CMA/VFCAs for Children NOT in Foster Care)

Non-Foster Care Flow



Referral Received/Processed



Process for SPOA to Make Referral to Health Home Using MAPP Children's Health Home Referral Portal



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Process for SPOA or LGU Using MAPP Children's Referral Portal to Make a Referral for Children NOT in Foster Care

LGU/SPOA users making a referral for a child that is **NOT** in Foster Care to a Health Home will be required to provide the following information:

1. Accept Terms and Conditions [provides brief overview of Health Home program and eligibility requirements (Medicaid member and two chronic conditions, Serious Emotional Disturbance (SED), Complex Trauma, HIV/AIDS)]
2. Identify that the child is NOT in Foster Care
3. Affirm and indicate they have obtained consent to make the referral from the child's parent, guardian, legally authorized representative, or self (individual's 18 -21 years of age or minors that are married, pregnant, or a parent may provide consent on their own behalf)
4. Provide the Medicaid CIN # for the individual being referred
5. Identify all chronic conditions that the referrer believes make the child eligible for Health Home and appropriateness meeting Health Home eligibility



Process for SPOA or LGU Using MAPP Children's Referral Portal to Make a Referral for Children NOT in Foster Care

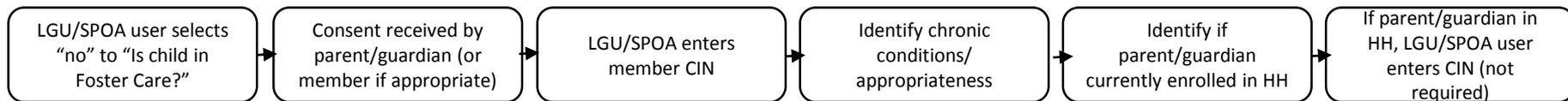
6. Indicate whether the parent/guardian is currently enrolled in a Health Home (if yes, may provide CIN number of parent/guardian)
7. Provide consenter's contact information
8. Referrer receives notification referral submitted
9. MCP or HH receives an assignment with a referral record type

* If the member is enrolled in a MCP, the member will be reflected in the Plan's list of Health Home assigned members

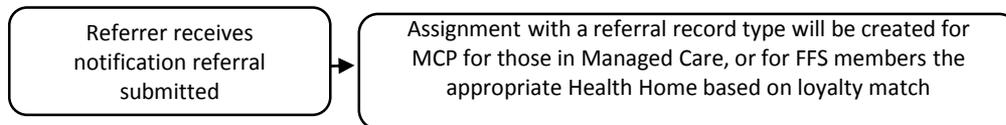


Process for SPOA or LGU Using MAPP Children's Referral Portal to Make a Referral for Children NOT in Foster Care

Non-Foster Care Flow



Referral Received/Processed



SPOA Referral: MAPP HHTS Children's HH Referral Portal-

- SPOA will continue to manage and triage the most needy children being referred in the County.
- SPOA does not submit a completed CANS-NY as part of the MAPP HHTS Children's Referral Portal as is done currently
- SPOA will have the capability to make a recommendation to a OMH TCM Legacy Provider as the CMA
- MAPP HHTS will make the HHSC assignment based on the individuals Medicaid service utilization for FFS members, and the MCP for individuals in a MCP



Care Coordination for Children w/SED without Medicaid



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Care Coordination for Children without Medicaid

- OMH will continue to provide LGUs with State Aid for the TCM Legacy program to be used towards providing care coordination to children with **SED** that are not Medicaid eligible, and thus cannot be enrolled in Health Home.
- SPOA continues to be the referral source
- Reporting in CAIRS will continue to be required
- CANS-NY will be completed to identify needs and strengths and guide the plan of care, will be entered into CAIRS

Guidance document currently being drafted



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Service Dollars

- OMH will continue to provide LGUs with the same amount of service dollar funding previously given for the TCM Legacy provider. These service dollars may be expended only for children with **SED (Medicaid and Non-Medicaid)**, not the general HH population a TCM program may serve .
- The amount of State Aid each provider receives will continue to be at the discretion of the LGU.



Action Steps for TCM Providers

- If not already CANS-NY certified, become certified:
 - <https://canstraining.com/login>
- Care Managers should ensure they have the necessary paperwork to complete a CANS-NY during the “pre-population” period(October and November) in UAS for current TCM clients. If care managers do not have the necessary paperwork, they should begin to gather.
- Care Managers should begin discussing Health Homes Serving Children with the children/youth and families that are currently on their caseload.
 - DOH FAQ:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hhsc_children_faq.pdf
 - HHSC PR materials- websites, brochures, etc.



Action Steps for TCM Providers

- Reach out to Health Homes Serving Children that you have contracts with to discuss program capacity and enrollment into Health Home
- In October/November 2016 as OMH TCM care managers add and complete the CANS-NY tool within the UAS for existing OMH TCM clients, they will need to identify which Health Home they are completing the CANS-NY on behalf of.
- Begin to assess alignment of contracts with the Health Home and Health Homes with the Managed Care Plans for currently enrolled TCM clients. Taking into account this alignment, and family choice, start to identify which Health Homes current TCM clients will enroll in.



Questions?



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Resources for Updates

- DOH Health Homes and Children Website

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

- DOH Medicaid Health Homes Listserv

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

- OMH TCM Listserv

Email Michelle Wagner- Michelle.Wagner@omh.ny.gov



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