

## **Questions from the July 18, 2012 Health Home Bi-weekly Implementation Webinar**

Below are the questions and answers covered during the Health Home Biweekly Implementation webinar held on July 18, 2012. These questions and answers, which were collected from emails sent to the Health Home Bureau Mail Log, will be posted on the Health Home website shortly.

### **Contracts with Managed Care Plans**

**Question:** Will the health homes be receiving contact information on who we should be reaching out to at the MCO plans, once we are ready to begin receiving rosters? OR is the expectation that the plans have to initiate outreach to us?

**Answer:** Health Homes can certainly approach Plans to let them know of their readiness and their interest in pursuing contracts to work with their members. A list of contacts for each of the MCOS will be posted on the Health Home website shortly.

### **Assignment List**

**Question:** Can you give us an idea as to when the Phase 2 counties will be receiving the list of eligible Members?

**Answer:** Several items must be completed before Phase 2 Health Homes can get their member lists. Phase 2 Lead Health Homes must provide their latest partnership lists to the Health Home program. Lead Health Homes must complete their DEAA (Data Exchange Application and Agreement) and their partners must complete the DEAA subcontractor packet. The DEAA allows DOH to release to the Lead Health Home the Medicaid confidential data and protected health information that is on the patient tracking sheets and the subcontractor packet allows Lead Health Homes to share this information with their network partners. Once the DEAA is approved by DOH, a loyalty analysis will be run to appropriately match Medicaid members who are eligible for Health Home services to the appropriate Health Home. Once this is completed the Health Homes will receive their FFS lists. Phase 2 Health Homes that have completed the steps outlined above can expect to get FFS lists by late summer. Managed Care Plans can share lists of Managed Care members with Health Homes once they have a contract.

### **Start Dates**

**Question:** When will the decision be made on applications for the Phase 3 Health Homes and what is the expected start date?

**Answer:** Phase 3 begins July 1<sup>st</sup> which is aligned with the effective date of Phase 3 State Plan Amendment (SPA) . SPA's for Phases 2 and 3 are still under review by CMS. Contingently designated Health Homes in Phase 3 will be announced starting in late July-August. Once the SPA for Phase 3 is approved, converting case management programs may bill retroactive to July 1, <sup>for</sup> members already engaged in targeted case management.

**Question:** The implementation date for Phase 2 is listed on the website as April 1. Has the date been revised since it is past that date?

**Answer:** The implementation date for Phase 2 is April 1. This date corresponds to the effective date of the Phase 2 State Plan Amendment (SPA), which is still under review by CMS. OMH (and COBRA) converting case management programs for Phase 2 may bill retroactive to April 1, for members already engaged in targeted case management. Guidance will be issued for OASAS MATS programs as to the effective date for Phase 2 billing. Converting case management programs will receive additional guidance on billing the Health Home rate codes for legacy slots and information on the retroactive reprocessing that will adjust post-April 1 date of service claims from the pre-Health Home rate code to the new Health Home rate code.

## **Referrals**

**Question:** How does an entity refer a Medicaid member for Health Home services?

**Answer:** Community referral guidance is still under development. In the interim lead Health Homes can add Fee-for-service (FFS) members meeting Health Home criteria to their tracking file as outlined in the Health Home Member Tracking System Specifications. If the member is in Managed Care then the Managed Care Plan should be contacted to make the referral.

## **Populations Served**

**Question:** Can we transition (and get paid for) 18 year olds in our TCM programs to our Adult Health Home?

**Answer:** Health Homes are not age specific, although the current model is not transitioning children in OMH TCM programs or children with an SED diagnosis. Any individual being served in a current adult TCM program can be served in Health Homes.

**Question:** May individuals of all ages be served by a Health Home?

**Answer:** Yes, there is no age requirement for Health Homes, however, OMH is not transitioning their TCM programs that serve children right now and the State is prioritizing adults for initial assignments. There are two multi-agency State workgroups developing recommendations on how children in Health Home should be served. More information on serving children in Health Homes will be forthcoming

**Question:** There is a federal mandate for hospital ER's that treat people with chronic issues to connect individuals to designated health homes. Who is educating the hospitals about this requirement?

**Answer:** Referral guidance is under development for use by hospitals and other providers. Once guidance is developed we will be working with the Hospital Associations for input and assistance in communicating this requirement to hospitals.

**Question:** If individuals are to have choice of health homes in their area, and a choice of MCO, is it implied that therefore health homes are required to be a network provider with ALL Managed Medicaid Providers in their community?

**Answer:** There is no requirement for all MCOs to contract with all Health Homes or vice versa. The State is obligated to provide members with a choice of Health Home as practicable which is being accomplished by designating more than one Health Home in each region. In addition, members have a choice of care managers in their Health Home.

## **TCM**

**Question:** If a Health Home assigns a non- TCM member to a TCM provider can the Health Home bill?

**Answer:** No, TCMs bill for both TCM legacy slots and non-TCM slots (new Health Home slots).

**Question:** How will TCM provider expand the number of Health Home clients they are eligible to serve and maintain the previous care management relations with their converting TCM clients they currently serve?

**Answer:** It is the State's intention to not disrupt care management relationships that are working; therefore the State is allowing converting TCM programs to keep their members. It will be up to transitioning TCM programs and Health Homes how best to balance their case loads. At least initially many case managers' caseloads will not change until the members who are being served require different levels of services. Ultimately decisions about how to balance case loads and assign members to case managers will be left to the care management agencies and the Health Home, acting in partnership with their local government unit.

**Question:** ACT teams provide case management services as do PROS service providers. Are these service providers included as members of Health Homes provider networks or are their functions being carried out by the Health Home? Is there a potential for duplicate billing for case management services by ACT teams, PROS, and Health Homes? If so, how will this be addressed under the current model?

**Answer:** Guidance is under development by OMH.

## **Managed Care**

**Question:** Is there managed care related eligibility information available, similar to the information provide by county for FFS Health Home eligible recipients?

**Answer:** At this point in time we do not have any Managed Care Health Home recipient eligibility information, but we will look in to posting this in the future.

**Question:** Is it still the expectation that MCOs participating in the Health Home program align themselves (contract with) a RHIO as a condition of the Health Home program within the next 18 months? Or, is it the requirement for the Provider Lead Health Homes to obtain a contract with a RHIO? .

**Answer:** There has never been a requirement for Managed Care Plans to work with RHIOs. Provider Led Health Home and their partners have 18 months to meet final HIT requirements which include working with a RHIO/qualified entity (QE).

**Question:** Do Medicaid Members with HIV/AIDS need to also have a BMI of 25 and above to receive HH services?

**Answer:** Medicaid members with HIV/AIDS diagnosis do not need any other chronic condition to qualify for Health Home services.

## **Training**

**Question:** Will DOH provide training for Health Home staff?

**Answer:** DOH is not offering Training for staff of Health Homes at this time. Please check under the *Partner Resources* section of the Health Home Website for training resources, including OHITT sponsored presentations for HIT Adoption Training and a list of organizations that have received funding for workforce retraining. The State is pursuing an enhanced 1115 waiver to provide funds for Health Home Development, which would include additional resources for workforce training and retraining.

## **Detention**

**Question:** Are Detention/Correctional facilities and Housing Agencies included under Health Homes?

**Answer:** These entities are encouraged to partner with Health Homes and should reach out to designated Health Homes they would like to work with. Mechanisms are being explored to provide priority access to Health Homes for homeless individuals and those being released from detention and correctional facilities. OMH is encouraging all funded housing providers to network with one or all of the Health Homes in their area.

**Question:** If a Health Home eligible individual is incarcerated when located during Outreach and Engagement, is it possible to enroll the client?

**Answer:** Individuals who are incarcerated may not qualify for Health Home services until they are no longer incarcerated. However, the Health Home that is assigned that individual may work with county or city jail and/or DOCs transitional services unit to make sure they are aware of the Health Home that will be willing to provide services after the individual's term.

## **Sign Language/ Translations**

**Question:** Do the Health Home eligibility lists provided include the language the client speaks?

**Answer:** The Medicaid tracking system does not have information on the language the member speaks.. Health Homes need to work with their partners (who may have a relationship with the member) to help answer some of these questions. Usually it won't be until the care manager is able to locate the member that their language may be identified

**Question:** Are any resources being developed for the hearing impaired? Are there any DVDs or videos for Deaf individuals, in American Sign Language? They will not be able to understand the written consent.

**Answer:** Not at this time although the Health Home program is exploring resources that could be developed, including an ASL video.

## **Consent (includes questions moved from Page 12)**

**Question:** Clarifying consent: Some clients are concerned and will not sign the consent because the consent includes a list of several partners, many of which do not apply to them. Is it possible for the client to give consent for only their providers and place a line through those providers that the client does not wish to consent? What happens if the person refuses to sign the HH consent form? Is there a time frame established in which the person must sign by? (Note: *This question has already been answered under Q and A #3 on the Health Home website*)

**Answer:** Members are enrolled upon assignment, but Health Homes must decide when the member is receiving Health Home services and active care management. Health Homes must decide if and how they can deliver quality Health Home services and care coordination without a member's consent to share information, and for how long without their consent.

**Question:** What if the individual is only comfortable with signing a consent that includes current service providers that are part of their Plan of Care, is that sufficient?

**Answer:** Health Homes must decide if and how they can deliver quality Health Home services and care coordination without a member's consent to share information, and for how long without their consent. We are refining the process for how Health Homes will work with the RHIOs.

## **Administrative Issues**

**Question:** Does the Health Home have a Catalog of Federal Domestic Assistance (CFDA) number?

**Answer:** Medical Assistance Program CDFA # 93.778. The Catalog of Federal Domestic Assistance (CFDA) provides a full listing of all Federal programs available to State and local governments (including the District of Columbia); federally-recognized Indian tribal governments; Territories (and possessions) of the United States; domestic public, quasi- public, and private profit and nonprofit organizations and institutions; specialized groups; and individuals.

**Question:** Why are the Health Home leads so involved in the process of care coordination when they should be focused on an administrative role? Is it true that NYS has stated that Health Home Leads should be focused on outcomes rather than process?

**Answer:** Lead Health Homes are not only responsible for an administrative role, they are also delivering Health Home services directly and with network partners making decisions about how the Health Home should operate. Although the State has posted several required forms and assessments, the State anticipates that Health Homes may have other forms and assessments they will want to use to better the provision of care. The State has stayed away from proscribing process and will be holding Health Homes responsible for meeting quality measures. Health Homes have the flexibility to decide the processes and policies the Health Home may or may not need to meet quality measures.

## **FMAP**

**Question:** What is the FMAP rate for costs NYS incurs in administering, overseeing, and assessing/reporting quality measures? Would states be able to claim the enhanced match for these activities, or the state's regular FMAP?

**Answer:** Only costs connected to the provision of Health Home services are eligible for the enhanced match.

## **Assessment**

**Question:** Do we have to use the FACT-GP Assessment posted on the HH Site?

**Answer:** Yes, all Health Homes must use the FACT-GP functional assessment but are also able to use other assessment tools the Health Home finds useful.

## **Spend-down**

**Question:** Will Medicaid Spend Down, Buy-in and individuals-in the Special Needs Trust be eligible for Health Home services?

**Answer:** Medicaid spend down individuals can be included in the Health Home program for chronic behavioral and medical conditions, provided their Medicaid eligibility can be sustained. LDSS and OMH regional offices can work with members to ensure they meet any spend down requirements, pursuant to published ADMs. Person's Living With HIV/AIDS (PLWHA's) who have Medicaid spend-down can contact ADAP for assistance with their spend down requirements. Individuals participating in the Medicaid Buy-in program and those with an Exception Trust (a Supplemental Needs Trust that provides for Medicaid reimbursement upon the death of the recipient) who are fully eligible for Medicaid are eligible for Health Homes. PLWHA's can be served in a grant-funded program.

## **Transportation**

**Question:** Health Home Care Plans will include activities like smoking cessation, wellness groups, peer run services etc. Will those services that are identified on the Care Plan now be approved for Medicaid Transportation?

**Answer:** Currently Medicaid transportation will only cover transportation for medically necessary services such as medical or behavioral health visits. Smoking cessation is a Medicaid covered service so transportation to smoking cessation services would be covered, but not transportation to wellness groups or peer run services, unless these services are part of a medically necessary service, e.g. OMH's Personalized Recovery Oriented Services (PROS).

**Question:** Can Medicaid dollars be use to pay for client travel to and from social service providers office, PCP, specialist, public assistance office, housing appointment etc? Due to limited income a number of our clients are unable to attend vital appointments which affect their health. Medicaid transportation reimburse for care plan development and review meetings?

**Answer:** Medicaid transportation will only reimburse for transportation to medically necessary services such as medical or behavioral health visits.

## **PSYKES Data**

**Question:** There had been some preliminary discussions about granting Health Home access to PSYCKES data, but we haven't heard anything further about it for a while. We hope this is still under consideration because it could be such a valuable tool for Health Home Care Managers. We'd appreciate any information you can provide about the status of this request.

**Answer:** OMH is currently working with Health Home care managers to allow them to access PSYKES. Some of the Health Home network providers such as clinics may already have access to PSYKES.

## **Billing**

**Question:** What HCPCS code should be used by Health Homes?

**Answer:** HCPCS codes are not required on Health Home claims. In general, Health Homes are responsible for making decisions on coding; DOH cannot make billing or coding recommendations.

## **Payments**

**Question:** If the payment made by the Lead Health Home to the down stream provider happens to go to an Article 28 provider, is the payment subject to the HCRA surcharge?

**Answer:** We are consulting with our HCRA program leads on this issue and will post an answer shortly.

**Question:** How much of the health home PMPM may be retained for administrative services such as HIT?

**Answer:** The state has provided guidance that no more than 6% of the Health Home payment should be retained for administrative purposes some of which may go to Managed Care Plans. Health Homes may also be investing in HIT and have other infrastructure costs and the State has not restricted the amount the Health Home may retain but have encouraged as much of the PMPM as possible should be used for direct Health Home services.

## **Metrics**

**Question:** The Inpatient Utilization General Hospital Quality Measure Specification includes the rate of utilization of acute inpatient care per 1,000 member months. Data is reported by age for categories: Medicine, Surgery, *Maternity* (emphasis added) and Total Inpatient” Since Pregnancy is not one of the medical conditions in the HH program, how are we to interpret this?

**Answer:** While pregnancy is not a qualifying condition for Health Homes, if members have maternity stays, the stays are included in the inpatient utilization measure. Inpatient utilization is not limited to specific conditions; it is inclusive of all stays just like the HEDIS measure for the Medicaid membership.

## **Funding**

**Question:** Health Homes will bill NYS Medicaid for their care/case management services once operational, is there any funding available for implementation?

**Answer:** At this point in time there is no source for implementation funding. The State is pursuing an enhanced 1115 waiver to provide funds for Health Home Development.

## **Care Managers**

**Question:** Are there specific qualifications required to become a care manager?

**Answer:** Each Health Home determines and defines the qualifications required for care managers.

## **Hotline/Call Center**

**Question:** The answer to Question 9 of the Q&A's posted on the Health Home website refers to a Medicaid Call Center being available for members. We understood that the Health Home was expected to provide a call-center service 24/7. Is that correct or has there been a change in this expectation?

**Answer:** Health Homes are still responsible to establish a 24-hour, 7 days a week call center service to assist their members. The Medicaid Call Center operates only during business hours and will address general questions or concerns. A process for handling complaints about Health Homes through the Medicaid Call Center is under development. .

## **Assessment**

**Question:** If someone is already in case management through another mechanism with a Health Home entity, can we use an existing baseline risk assessment or are we required to complete a new Health Home baseline risk assessment?

**Answer:** For a member entering a Health Home, a FACT-GP and HH Functional Assessment must be completed at enrollment, annually and at disenrollment. These will be reported to the State through the HH-CMART tool that will be released shortly. The results of these assessments will be used to adjust the risk scoring for members and, through that, the applicable rates. These are limited tools and do not take the place of the comprehensive assessment needed to develop a care management plan for the member. The care manager should use all resources that are available for that member to ensure the most appropriate care management plan is formulated including information from previous care management. We would also expect care managers to use validated assessment tools most appropriate to the member's situation.

**Question:** Is the FACT- GP functional assessment final? Page 3 still indicates draft.

**Answer:** The FACT-GP and HH Functional Assessment with scoring guidelines in their final form were posted on the Health Home website on July 18, 2012.

**Question:** Does the assessment have to be conducted only face-to-face or can it be conducted telephonically as well? Face-to-face requirement is a potential obstacle to expeditious enrollment. Also it is unlikely that someone who self disenrolls from a Health Home will be available/willing to complete a functional assessment.

**Answer:** It is our expectation that the FACT-GP and HH Functional Assessment as well as the comprehensive assessment will be conducted face to face. If at disenrollment it is not possible to do these face to face, telephonically could be allowed.

**Question:** Is there a proposed standardized risk assessment for Health Homes to use with members upon enrollment into a health home? If there is not a standardized risk assessment tool, is there guidance for what Health Homes should include in their assessment?

**Answer:** For a member entering a Health Home, a FACT-GP and HH Functional Assessment must be completed at enrollment, annually and at disenrollment. These will be reported to the State through the HH-CMART tool that will be released shortly. The results of these assessments will be used to adjust the risk scoring for members and, through that, the applicable rates. These are limited tools and do not take the place of the comprehensive assessment needed to develop a care management plan for the member. The care manager should use all resources that are available for that member to ensure the most appropriate care management plan is formulated including information from previous care management. We would also expect care managers to use validated assessment tools most appropriate to the member's situation. There are a number of tools such as the DLA Assessment and SBIRT that are available for use.

**Question:** Currently SPOAs only provide status updates to the individual who lodged the application. This is a significant issue for the SPMI population who need case management services. Can NYSDOH HH address SPOA's prevention of ACMs from pursuing status of applications made to them by another individual/agency

**Answer:** Please contact OMH directly with your concerns as additional information is needed to understand this question.

### **State Plan Amendments (SPA)**

**Question:** Will Health Homes for subsequent phases have to wait for SPA approval before we can implement services? I think we must resolve the contract issue, does the TCM program have a contract with the HH? If not can the program bill for any HH CM services?

**Answer:** Yes, for new members. Existing TCM members may continue to be served, once SPAs are approved OMH TCM providers may bill retroactive to the effective date of the SPA. SPAs for Phases 2 and 3 have been submitted to CMS for approval. TCM providers will continue to bill with the current TCM rate codes and once SPAs are approved TCM providers will be notified of the new Health Home rate codes and amounts. Guidance will be issued to OASAS MATS providers as to the effective date for Phase 2 billing and whether billing will be adjusted back retroactively to a particular date. For COBRA TCM programs, all unit billing will be reconciled back to the effective date of each SPA once all Phases have been implemented. COBRA TCM programs will continue to serve all existing clients and will continue to take "bottom up" referrals during this time. Additional guidance on the reprocessing of claims to adjust the TCM rate code to the new HH rate code will be provided after SPA approval.

**Question:** The State Plan Amendment #11-56 only indicates approval in a small number of counties (Bronx, Brooklyn, Nassau, Warren, Washington, Essex, Hamilton, Clinton, Franklin, and Schenectady). Now that the Phase 2 Health Homes have been announced, does the State need to obtain another SPA?

**Answer:** Yes, SPAs for Phases 2 and 3 (which are identical to SPA #11-56 with the exception of the list of specific counties for each Phase) have been submitted to CMS for approval.

**Question:** Will SPA approval delay implementation?

**Answer:** TCM agencies will implement Health Home billing for current members as of the approval date for each SPA. Billing will be ADJUSTED BACK retroactively to the effective date for each Phase, for current OMH TCM and COBRA Members. Guidance will be issued to OASAS MATS providers as to the effective date for Phase 2 billing and whether billing will be adjusted back retroactively to a particular date.

### **Intensive Case Management (ICM)**

**Question:** Are OMH Intensive Case Management (ICM) programs being carved into Health Homes?

**Answer:** OMH ICMs are included in Health Homes

### **LTHHCP**

**Question:** Can individuals in a waiver program with care coordination, like the Long Term Home Health Care Program, enroll in a Health Home without jeopardizing their LTHHCP services?

**Answer:** At this point in time individuals enrolled in the LTHHCP are not eligible for Health Home services. These individuals may be included in future Health Home waves.

### **OUTREACH**

**Question:** Please clarify Outreach:

- 1) Minimum activity needed in a month to report on tracking sheet / bill
- 2) Documentation needed to support
- 3) Is the combination of using data to match list and sending letters to members sufficient to claim Outreach for month one for any member, assuming Outreach continues to be active and progressive going forward?
- 4) Is documentation required in the clients care management record required to support billing for Outreach and Engagement?

**Answer:** Yes, all client contact must be recorded in the case management record. All Health Home Outreach and Engagement activities are billable under the monthly PMPM as long as active outreach is occurring each month and at least one of the five core services (excluding HIT) described on page 13 of the Medicaid Update are provided in each billed month. There will be no requirement for minimum face-to-face contacts; however, there must be evidence of activities each month that support billing, including:

- Active Outreach
- Contacts (face-to-face, mail, electronic, telephone)
- Health promotion activities
- Patient assessment
- Development of a care management plan; and/or
- Active work towards achieving care management plan goals

## **FFS Definition**

**Question:** Does the Fee-for-service (FFS) definition exclude all eligibles with managed care coverage or does FFS also include the persons whose services are provided on a FFS basis and not covered by the managed care benefit plan?

**Answer:** The FFS definition excludes all eligibles with managed care coverage (even if the Managed Care individual receives carved out services through FFS)

## **TCM/COBRA**

**Question:** We have heard that NYS is working on some of the financing structures for Health Homes. Is the following accurate?

- a. MCO's will get a separate payment so no money will be taken from the Health Home rate.
- b. There will be an additional Health Home administrative rate added, intended for Lead Health Home payment with a 3% cap, with the result that 100% of the initial rates DOH has published for Health Home services will go to the Care Management Agency.

**Answer:** As of now there is no change in how Managed Care Plans will receive support for administrative services. DOH is in discussions with CMS to add administrative support to the Plan capitation rate for the support of Health Homes. If that is approved we will revise our billing guidelines and instructions.

**Question:** It is understood that converting TCM and COBRA TCM organizations are to bill eMedNY directly for both FFS and MCP members for both their legacy slots as well as new Health Home Slots. When does the Lead HH and the MCP begin billing for converting TCM agencies?

**Answer:** No final decisions have been made about when Health Homes and Plans will bill for converted TCM programs.

**Question:** During at least the 1st year, if a converted TCM/HH receives a referral to serve a Medicaid-eligible enrollee that is seriously and persistently mentally ill (SPMI), can the converted TCM/HH place the individual in one of their converted TCM/HH slots (if available) and bill Medicaid directly for HH services at the TCM rate? Can we continue to fill our TCM converted Health Home slots with people who are Health Home participants and bill Medicaid directly at the present TCM rates for one year or two years?

**Answer:** Yes, converted TCM/HHs can place Health Home members into available converted TCM/HH slots and bill eMedNY directly. Payment will be at the TCM rate for up to one year (based on the SPA approval date).

**Question:** In the newest Health Home Member Patient Tracking System Guide (6-26-12) on Pg 18; Outreach / Enrollment Code. It states; specifies whether the segment is outreach or enrollment. If both outreach and enrollment occurred in the same month, only the enrollment event should be submitted. Please clarify as we understand this is to be an 'opt-out' program and that members are automatically enrolled. DOH has not described an 'enrollment event'.

**Answer:** When the individual/legal representative can be considered to be in active care management the segment would be changed from Outreach to Enrollment. See also Q and A #2 on the Health Home website:

2. Since the guidance gives latitude to the Health Home to determine what constitutes enrollment, what triggers billing at 100% PMPM? Below are proposed triggers for billing/payment of 100% PMPM:

- a. Initiation of baseline risk assessment;
- b. Completion of baseline risk assessment; and/or

Note: Baseline risk assessment typically requires two hours to complete.

Health Home is an opt-out program; therefore, the member is enrolled upon assignment but the Health Home must decide when the member is **under active case management (receiving Health Home services)** or if the Health Home is doing outreach and engagement. The examples above could all be used to determine if the member is enrolled in their Health Home, and when they would switch from outreach and engagement to active care management at 100% PMPM.

See the Health Homes Special Edition of the Medicaid Update for further information on Outreach and Engagement and Consent

**Question:** Who establishes acuity for legacy slots?

**Answer:** DOH calculates acuity based on an algorithm that looks at member claim data. Legacy rates are based on the converting provider's pre-Health Home payments, not on member's acuity scores.

**Question:** Currently there are limits to providing billable services for clients who are either inpatients or incarcerated. In what instances can Health Home services be provided, and billed for, if someone is receiving inpatient services or is incarcerated.

**Answer:** Health Homes cannot bill for Health Home services when members are either admitted to an Institute for Mental Disease (IMD) inpatient facility or incarcerated. Inpatient facilities should have discharge planners to assist with transitions to a Health Home. Incarcerated individuals will have case management provided through the NYS Department of Corrections. There may be some situations in which care management can be provided subject to Olmsted Laws, further guidance will be provided when the applicability of these laws to Health Home services is has been determined.

**Question:** Is the state working on developing specific documentation forms beyond the Matrix and Tracking forms? Can the MCO's require specific documentation in addition? Is the lead Health Home responsible for developing any additional documentation forms?

**Answer:** Listed on the Health Home website under Forms and Templates are various forms, including the Health Home Patient Information Sharing Consent Form, the Health Home Patient Information Sharing Withdrawal of Consent and the Health Home Opt-out Form. It is at the discretion of the Health Home to develop any additional forms they may need.

**Question:** How frequently will the individual's acuity be adjusted?

**Answer:** During the implementation phase, acuity will be adjusted on a quarterly basis. As rates stabilize acuity may be adjusted less frequently (semi-annually or annually).

**Question:** What information will be used to inform the acuity adjustment?

**Answer:** Claims data will be used, as well as the FACT-GP Functional Assessment.

**Question:** Is there a mechanism for a care manager to request an acuity adjustment?

**Answer:** No. Claims and encounter data will impact the acuity. In the future, the functional assessment information may also impact acuity.

**Question:** Will OMH TCM programs be expected to provide only Health Home care management, or will OMH TCM programs continue to need to meet OMH requirements (e.g., four face-to-face encounters per month per ICM, array of services from regulations, etc.).

**Answer:** Once an OMH TCM program converts to Health Home services (is billing Health Home/OMH/TCM rates) they are no longer subject to TCM rules and regulations. COBRA programs converted to Health Home services once they engaged with a lead Health Home and signed DEAA's and accepted Health Home assigned clients. This conversion is taking place by Phases in each county. Phase 3 counties are just beginning the conversion. The unit billing will be retroactively reconciled with the PMPM legacy rates once all Phases are implemented.

**Question:** Is it true that services provided to consumers in legacy slots paid for by OMH/TCM rates must meet the current ICM guidelines and the Health Home slots are the only ones exempt from ICM regulations? If that is true then do the care coordinators have to meet current qualifications?

**Answer:** Once an OMH TCM program converts to Health Homes (is billing Health Home Service rates/OMH/TCM rates) they are no longer subject to OMH TCM rules and regulations. Each Health Home determines and defines the qualifications required for their care managers.