

Health Home Frequently Asked Questions

1. When will we have access to eligibility reports for HH? **Medicaid eligibility can be checked on OHCA website. Auto-attribution reports will be available by 1/16/15.**
2. If we have already sent in our dates for the readiness review, when will we know when it has been scheduled? **1/9/15**
3. What was the decision on a letter being sent out to eligible individuals/guardians? Can we get a copy so that we can help explain? **There will be a state template letter available for providers to send out.**
4. Have PCMH's been informed that this has been finalized? Will they have any idea what we are talking about when we go to partner with them? **OHCA will be contacting PCMH's, as well as notifying hospitals.**
5. Do we have billing codes? **Yes, codes will be available at the meeting on 1/7/15.**
6. When is the next Wellness Coach training? **January 8 & 9, then monthly after that.**
7. Will we have to use the ODMHSAS supplied consent form as well as ODMHSAS privacy practices? Will legal be drafting a new set of these for health home? **There will be a Health Home Consent for Services, available 1/7/15. HHs will use their current release of information form for now.**
8. If a client gets one level of HH but it's decided that they need to be in different level, do they do a PA change request like they do now? **Yes, request a new PA.**
9. If a client is receiving FFS and then on the last day of the month, they enroll in HH and the G code is billed, will the FFS payments for that month be recouped? **No, the G code goes along with PA.**
10. Why is the treatment plan review included as a bundled rate if a therapist has to do it? **A therapist does not have to a HH treatment plan review. The HH team completes the treatment plan with the care coordinator ensuring every team member is involved. LBHP is involved in a supervisory role.**
11. If we bring a location online at a later date, can we have those clients grandfathered in? **Yes.**
12. How many of the bundled services do we have to provide before we can bill the child G code for kids? **The G code can be billed after one bundled service is provided; however, it is advised that**

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the G code is not billed until the minimum 12 hours per month high intensity, and 6 hours per month moderate intensity have been met to avoid recoupment.

13. What is the HH denial code? **Codes will be available at the meeting on 1/7/15.**
14. Is rehab included in the bundled rate? **No.**
15. If there are services that Medicaid doesn't pay for can we bill DMHSAS like we do now? **Yes.**
16. Are the RSS services included in the bundled rate as the wellness coaching? **No.**
17. Are the SPA's on the website the most recent versions? **We are waiting for the most recent version from OHCA; it is anticipated to have minimal changes.**
18. As individuals lose and regain Medicaid eligibility will they be re-enrolled in the same health home? **As long as there is an active PA, consumer will remain in the HH.**
19. Many children have dual eligibility with Medicaid being secondary. Are they eligible for HH's? **Yes.**
20. Will dual Medicaid and Medicare adults be enrolled? **Yes.**
21. How and when will consumers be notified of their enrollment? **That will be up to each HH provider to notify its existing clients that are eligible. A list of clients to be auto enrolled will be sent to the providers shortly.**
22. Once the consumers in these sites are converted will we get a list of all those that were converted to Health Home? **Yes.**
23. How will billing on these consumers work until we get our Health Home teams in place? For services like Case Management, Peer Support, and Service Plan Review, since they are part of the bundled PMPM, will we start getting reimbursement at that PMPM rate? **Fee for service rates will remain in effect until consumer is enrolled in HH.**
24. Is the state plan amendment approved by CMS? **No, the plan is pending final follow up questions.**
25. Are approved standards available for HH providers? **Standards are in place as of January 1, 2015.**
26. If two providers are both seeing a Medicaid client in the same service area, and they are both HHs, which one gets to enroll the client? **The consumer will be on both providers' lists, but the consumer will have choice of where to enroll.**

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27. Will a provider have to offer HH with no Medicaid funding? **No, although it would be a good thing if a HH has an alternative way to fund those services.**
28. Can ODMHSAS generate a list of all who have received a Medicaid service and are designated SMI, SED? **No.**
29. What is the date that the new HH rules will be in place? **They were in place as of January 1.**
30. If I start outreach on the 5th but my readiness review is not till the 16th, can I still bill the outreach once I pass my readiness review? **Yes.**
31. Please explain how we bill HH services and the bundled rate. There will be **training at the meeting on Jan 7th.**
32. How will we determine what level someone is on? How will you keep consistency across providers? Who determines level? Will there be technical assistance available? By who? When? **There will be training on this on January 7. There is a set of criteria which HHs will follow. There will be ongoing training and technical assistance by the ODMHSAS, and for utilizing Ohio Scales for children, by the eTEAM of the University of Oklahoma. There will be quality monitoring for all aspects of HH on a regular, ongoing basis.**
33. It looks as though the PMPM rate is only triggered by a service each month, will any and all services be included? **All the bundled services will be included. There will be further training on this on January 7.**
34. Is there any scenario in which we would not receive the PMPM rate on an enrolled member who has received the required amount of services? **There is not one that is anticipated at this time.**
35. Will there be a service that does NOT trigger a billing each month? **Will be covered at training.**
36. Will there be PICIS reports that provide the health outcomes required for clinical outcomes? **The chart for quality measures indicates that claims data will be used to track this. A request for proposals is being developed for HH patient registry that will track clinical outcomes.**
37. What are the expectations for outcome tracking physical health concerns? **HH will be required to collect and submit to patient registry additional data fields for physical health monitoring.**
38. Will there be a PICIS report that provides us with the names of Health Home clients assigned to us? **The report will provide the list of your current customers that are eligible for HH. That is the only list you will receive.**

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39. Is there a CAR level score requirement for initial attribution, and what is it? No, CAR score is not a requirement for initial attribution. Initially everyone will be attributed at level 3 for medium intensity, if higher intensity is warranted a new PA will need to be done. The expectation is a high level intensity adult would be level 4, any level for moderate intensity. For high intensity children is level 4, for moderate intensity children level 3. It is our expectation that a level 1 or 2 child would not need intensive care coordination.

1/13/15

40. Is there going to be an auto-enrollment of consumers into HH? Consumers who are currently receiving services at the HH and meet criteria will be auto-attributed to that HH.

41. Is the Wellness Coach Certification training the same as the Well Power training? Yes

42. Is the consent form given out yesterday mandatory or can we develop our own with the required components? Please use the Consent form we handed out at the HH meeting as your core content for consent. You may make minimal changes for your agency (fillable form, logo, etc) but please send to Malissa for approval. We will approve quickly, knowing you need to be outreaching right now. Please keep the additions as simple and short as possible, in language understandable at a sixth grade reading level.

43. Does Out Reach and Engagement have to be a face-to-face service? Or can it be billed for mailing out the letters or telephone service, etc? Group or mass education is not billable per CMS guidelines. O/E may be by telephone. The reimbursable unit of service is a code that can be billed monthly for performing required Health Home activities. A Health Home may bill up to three months for outreach and engagement **to a member attributed to the Health Home**. The reimbursement for outreach and engagement is limited to once per month.

a. (Initial Health Home Screening, Outreach and Engagement) - Billing Criteria

The member is identified as meeting CMHCSMI-HH or IMPACT-HH qualifying diagnosis eligibility criteria for a care coordination payment using a screening method, patient registry, or supporting tools made available by ODMHSAS;

The member is informed about: HH enrollment, what it means to the member, privacy, the potential benefits, selecting a PCP, and has reviewed recommendations from the HH team member and payment eligibility;

The HH documents the decision of whether the member agrees to participate in care coordination and the agreed upon start date in the medical record system where all team members can access the information;

The HH team member should seek the member's input during the discussion that results in shared decision making about the member's engagement and participation in care coordination.

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44. Can we bill Out Reach and Engagement before the Readiness Review? **Yes, once the system is ready.**
45. Will HH services/members qualify for Sooner Ride? **ODMHSAS will double check with OHCA member services regarding this. The current thought is; if it is an eligible medical appointment SoonerRide would be available as usual. However, it is the expectation that a HH would be providing enhanced care coordination and would go to the consumer as needed and/or providing transportation and assistance with medical appointments as necessary.**
46. What type of permission do HH providers need for the Ohio Scales? **There is a nominal charge to use Ohio Scales. The ODMHSAS pays that fee for statewide usage in our Systems of Care, so individual agencies will not have to pay in order to use. Training will be available within the next 30 days.**
47. After the auto enrollment period, what is the process for new enrollments? **You will submit the CDC and use the referral code '60 Moderate HH Opt In' or '61 High Intensity HH Opt In' in the secondary referral field so we know the correct PA level and cap to assign to the member. Only locations that are health home locations can report these referrals. There is no additional documentation that has to be submitted from the information system side.**
48. What will be required in addition to the single page application distributed at this week's meeting? **Consent for HH services and OHIO Scales. Sample comprehensive care plans will be made available.**
49. If we do not have an active PACT team but do have enough HH High adults to start a PACT team, can we start a PACT team? Would we bill eligible to bill PACT services following chapter 55 Temporary Permit? If so, is PACT HH High billing consist of HH High plus PACT billable services? **Title 43A prohibits provision of PACT services without Certification. There are no additional PACT funds at this time.**
50. Shadow Billing. We are under the impression that for each Health Home service we will bill the appropriate 900x code for the team. The first would pay and the rest would kick back a denial code. It is the body of the note attached to an event that distinguishes the services: Care Management, Care Coordination, Health Promotion, etc. We are not billing traditional codes that are covered in the bundle after billing the initial 900x code to count for the month. Correct? **No, The G900x code will only be billed once a month. The traditional codes included in the bundled rate will still be billed but will be denied using a HH denial code.**

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51. The \$53 outreach code is only for persons who do not have a current PA? So these are not active CREOKS clients or clients whose PA has expired. So we can outreach to clients who are still with CREOKS but do not have an active PA? Or is this only for clients who have no relationship with CREOKS? **Yes, you can outreach to clients that do not have an active PA, which includes CREOK clients without a PA.**
52. Will consumers be grandfathered to HH at their current level (1, 2, 3, and 4) or to level 1, 2, and 3; and any level 4's must be justified. **Adult clients meeting the high intensity will be attributed to this level, all other adults meeting HH criteria will be attributed to the medium intensity. For children, those meeting the high intensity will be attributed to the high intensity and those meeting the medium intensity will be attributed to the medium level.**
53. Does grandfathering include persons affiliated with CREOKS (not discharged) but their PA has expired? Or only clients who have an active PA? **Only clients that have an active PA will be attributed.**
54. We understand grandfathering as only marking the client as eligible for HH and does not mean that we have to begin offering HH services the same month as grandfathering. So if we enroll them in Health Home a month after grandfathering this is okay. Or does grandfathering mean we must get an opt in or opt out that month? If grandfathering means they are marked in the system as being able to convert to HH without a treatment plan update done beforehand, we would want all of our clients grandfathering agency wide. If we have to initiate HH for all clients grandfathered in the same month, we want to know if grandfathering can be staged. We may wish to pilot HH with our current enrolled SOC children and gradually increase the number of teams. We need to staff up in terms of Care Coordinators and would not have the staff to operate all the children's HH teams in a given area for all those children grandfathered. We also might want to stage by geographical site. We have some outlying clinics where we may delay implementation. **Once a client is attributed, the bundled services cannot be billed fee for service so you would not want a client attributed until you are ready to start providing him or her with HH services. You can stagger sites in and the clients there would not be attributed until you are ready to begin providing HH services. You will not need to do a new treatment plan on every consumer at the beginning; treatment plans can be updated as they come due.**
55. For Health Home High adult- is there a required number of contacts, billed hours, face to face contacts per month? **This high level of care coordination is intended for the most chronically ill, and highest cost consumers; typically for adults that exhibit problems that are indicators of a need for continuous high level of services (i.e., greater than eight hours per month) by multiple members of the multi-disciplinary health home team.**

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56. We are verifying that the adult HH rates are \$127.35 (urban) and \$146.76 (rural). There have been conflicting rates sent in documents

		Urban		Rural	
		Adult	Child	Adult	Child
level 3		\$127.35	\$297.08	\$146.76	\$345.34
level 4		\$453.96	\$864.82	\$453.96	\$1,009.60

57. In previous emails and meetings over the last year PACT was to be considered high intensity with high intensity rate, which would be around \$450. I don't recall any conversation about CAR score affecting the high intensity PACT rate. From the ppt last Wednesday, it appeared that the high intensity rate is directly related to CAR scores and not related to being a PACT team. Has this changed? **There has been discussion over this point. PACT consumers will be High Intensity HH regardless of CAR scores.**

- ---- as a PACT team, we have always been encouraged to show a reduction in CAR scores. This lowering of scores is directly related to the
- intense services provided by a PACT team and would probably dramatically change if this level of care was not given. I think this is what feels
- confusing because all PACT clients truly are high intensity, just by the nature of them being eligible for a PACT team.

I also understood that the 25% cut in FFS rate was directly related to receiving \$453 pppm. If I misunderstood does this mean that, if receiving the moderate rate, we will still receive only 24.08 for FFS?

58. The CAR level 4 with a medical score of over 30 is very hard to meet. It was my understanding that the \$453.96 rate was for SMI-PACT as stated on the rate sheet. Structuring the criteria needed to meet this level in this way greatly minimizes the amount of PACT clients eligible for this rate. This results in PACT utilizing the 127.35 rate *plus* having a 25% cut in all other services. I am concerned that this is not financially viable. **See 19**

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59. PACT doesn't utilize the PG038 authorization for initial services. Outpatient will utilize this and get intake and initial treatment plan paid for at normal rate. Will PACT be able to get paid for our intake and initial treatment plan outside of the bundle?
60. Is the requirement to see high level consumers at minimum 3 x's a week gone? **No, PACT services remain, with the addition of Health Home Services.**
61. If a PACT consumer opts-out, do they remain at our current H0039 rate? **Yes**
62. If all PACT consumers are being grandfathered in (per David M's presentation) does that mean we cannot bill Outreach and Engagement on our current consumers? His presentation also states anyone grandfathered in will not be allowed to bill Outreach and Engagement. **No, outreach, engagement and education about HH is encouraged. O/E, may be provided by face to face, by phone, any time frame, by any staff person.**
63. Will *all* H0039 services be paid for at the 25% reduced rate? For example, we are running a Wellness group-will we bill group rehab and be paid H0039 rate minus 25%? **Wellness is in the bundled Health Home rate.**
64. Can we get the requirements for billing the Outreach and Engagement Code? Such as the minimum staffing level, time requirements, can service be non-face-to-face, is mailing a letter considered outreach? **O/E, may be provided by face to face, by phone, any time frame, by any staff person, see #24.**
65. What type of assessment/documentation is required upon admission to a Health Home? **Consent for HH services and OHIO Scales. Sample comprehensive care plans will be made available.**
66. If a consumer is already enrolled in a Health Home and we receive a referral on them for PACT, will we be able to utilize the Outreach and Engagement code while we are going through our screening process with them? **No**