

Health Home Provider FAQ

*Questions in bold are new additions since the last draft of this document.

Staffing

Q: What does the role of the Physician/Nurse Practitioner Consultant look like?

A: The Physician/NP Consultant should be available to provide consultation regarding somatic care to the Health Home staff, including participating in treatment planning and staff meetings, providing referrals, leading trainings, and coordinating care with outside providers as necessary. While a Physician or NP must sign off on the initial intake assessment, they are not required to complete the assessment single-handedly—this should be a collaborative effort involving assorted PRP/MTS/OTP staff and Health Home staff, and a primary care provider (PCP) or PCP records as appropriate.

Q: What should a provider do if the Physician or Nurse Practitioner Consultant they hire is not working out?

A: The Department will not play a role in the internal staffing decisions of Health Homes beyond ensuring the staffing requirements are met. Therefore, if a Health Home decides to terminate a contract with a staff member, they are expected to fill the position as soon as possible. If the position is not filled within a period of 60 days, they must notify the Department and demonstrate they are actively attempting to fill the position. The Department maintains the right to stop Health Home payment if required staffing levels are not maintained.

Q: How does the Health Home need to document the Physician/NP Consultant's role, considering they must be employed at a rate of 1.5 hours per participant, per year?

A: The 1.5 hour requirement is for the purpose of calculating an overall employment level, rather than as a strict requirement of time to be dedicated to each participant. While the Physician/NP Consultant should be employed at this level, they need not dedicate exactly 1.5 hours to each participant, or to document these specific times. Their activities should be noted, however, such as through documentation of attendance at staff meetings or in treatment planning sessions.

Q: Do you have any suggestions for how to meet the staffing requirement with the per member, per month rate of \$98.87?

A: The Health Homes program includes several provisions designed to enable cost-effective staffing and service delivery for providers. For example, smaller providers may form a consortium to share staff and therefore costs, and Health Home staff may play dual roles, serving half time as a Health Home Director and half time as a Health Home Care Manager. Please refer to the provider manual for additional details.

Q: Can a psychiatrist be used in the MD/NP Consultant role? This might be a staffing issue in rural areas.

A: Yes, a psychiatrist may serve in the physician consultant role, although the Department encourages providers to hire or to bring medical staff on board who have experience in family practice, internal medicine, or a related field. Those serving as a MD/NP Consultant in a Health Home for children must be trained in an appropriate field such as pediatrics or family practice.

Accreditation

Q: If we are already accredited by either CARF or The Joint Commission, do we have to obtain an additional accreditation?

A: Health Homes must obtain the Health Home specific accreditation or certification from the appropriate accrediting body. While some providers may already be accredited for their mental health or opioid

treatment programs, and others may elect to pursue this accreditation simultaneously with the Health Home accreditation, **only** the Health Home accreditation is required.

Q: The Department has stated provider must obtain Health Home accreditation within 18 months of initiating the accreditation process (e.g. date of CARF's Letter of Intent to Survey). Will funds be taken back if this deadline is not met?

A: The Department will review these instances on a case by case basis. The provider would need to demonstrate that meaningful steps have been taken towards obtaining accreditation, and provide a clear plan for moving forward. If the Department determines that these efforts have not been made in good faith, we reserve the right to halt payment or enact sanctions.

Q: Where can we access the Health Home certification standards from The Joint Commission?

A: The final Health Home standards will be posted on The Joint Commission's website (<http://www.jointcommission.org/>) on August 1st.

Consortiums

Q: Are Health Home consortiums limited to 2 providers?

A: Generally, yes, they are limited to 2. However, some rural or underserved locations may be allowed 3, and the Department will review this on a case-by-case basis.

Q: Do consortiums have to be with like providers, i.e. only PRPs with PRPs?

A: Providers of different types may join together in a Health Home Consortium agreement. However, they must demonstrate that staff is appropriate to the population served.

Billing

Q: If a practice has a physician on staff that works 20 hours a week, could this be counted towards the required Health Home Physician Consultant hours?

A: In this case, the physician could serve as the Health Home Physician Consultant, but their hours would need to be **in addition** to the 20 hours per week already dedicated to existing services.

Q: Are there minimum service expectations for billing?

A: A minimum of two Health Home services must be delivered and reported in eMedicaid each month in order to bill for that month's rate.

Q: Are there minimum service duration expectations?

A: No. However, it is expected that services will be substantive, appropriate for the participant, and delivered by a qualified staff member.

Q: Is the initial intake billed separately and at the same rate as the PMPM?

A: Yes, there are separate billing codes for the intake and the monthly service provision, but both are reimbursed at the same rate.

Q: Can a provider bill two Health Home services for a participant in the same day?

A: Yes, as long as they are two clearly distinct services and all other requirements are met.

Q: Can a health home service and a PRP service be provided on the same day but clearly at different times on that same day? If a Health Home service is provided during PRP hours, may this be reported as a Health Home service?

A: A Health Home service may be delivered on the same day as a PRP service, as long as it is NOT during the time in which the individual is receiving PRP services. The single exception to this rule is in the case of non face-to-face services delivered by a Health Home staff member not involved in the delivery of PRP services. For example, a Health Home Care Manager may have a telephone conversation with a participant's PCP regarding the individual's diabetes treatment while that participant is receiving PRP services from other staff members. Both services must be appropriately documented.

In cases where, for example, an individual received PRP services in the morning, and then met with their Health Home Care Manager for a Health promotion activity in the afternoon, the afternoon encounter could be reported as a Health Home service.

Q: Does the Physician/Nurse Practitioner Consultant have to spend 1.5 hours per year in face-to-face encounters with each participant? How is this time documented?

A: The Physician/NP Consultant must be under contract with the Health Home for the equivalent of 1.5 hours per participant, per year. However, this is intended to be an average in practice, with the amount of time dedicated to each participant varying depending on their needs. The Consultant's role will rarely be fulfilled through face to face participant interactions; more often they will participate in treatment planning or case review sessions with other staff, provide training or education to staff related to a somatic health topic, or outreach to other providers. Their participation in such activities should be documented (through meeting minutes, in participant charts, etc), but need not specify the duration.

Q: If our agency includes both a PRP and OMHC, can an OMHC doctor deliver a Health Home service for a participant enrolled in the PRP Health Home, assuming they do not bill this service elsewhere? Can this happen if the doc is not employed by the PRP but works in the agency OMHC?

A: No, only services delivered by the PRP, MT/ACT, or OTP provider may be counted as Health Home services. However, if for example, the agency wished to employ a part-time clinic doctor as their Health Homes Physician Consultant at the level required for the Health Home, a service such as smoking cessation counseling would be permissible, although it would not be typical of the role we expect the Physician/NP consultant to play.

Services

Q: What are the services that qualify as Health Home services?

A: All Health Home services must fit within one of the six broad categories of core services mandated by the federal guidelines, which are listed in the provider manual. However, there are multiple qualifying services under each of these categories, as well as an "other" option as appropriate for cases where a provider does not feel that the existing options accurately describe the services delivered. These options are listed under each service category in the provider manual.

Q: Can Health Home services be delivered in a group setting?

A: Group services are allowable, with the following limitations:

- Only one group service per month may count towards the 2 service monthly minimum
- Group services must be provided with a minimum staff to participant ratio of 1:10.
- Only services falling within the categories of Individual & Family Services and Health Promotion may be delivered in a group setting.
- Group Health Home services must be entirely independent of any existing PRP, mobile treatment, or OTP services offered, and must be delivered by the Health Home Director, Health Home Care Manager, or Health Home Physician/Nurse Practitioner Consultant.

Q: Is it possible to use an already existing treatment/care plan during intake?

A: Yes, we encourage providers to meet the care plan requirement of the Health Home by incorporating Health Home-specific goals into the participant's existing treatment, rehabilitation, or care plan, rather than creating a separate document.

Q: For providers with multiple sites, can one Health Home serve all participants across sites, or will each site serve as its own Health Home?

A: A provider with multiple sites will submit a single application, on which they will indicate whether they have multiple sites that will offer Health Home services. In such cases, a provider may use the same protocols at all sites, and may share staff between sites, but participants must be served at the location where they regularly receive services.

Q: Will hospitals have some sort of requirement to refer to HHs?

A: There will not be a requirement in place to conduct such referrals, but the Department will perform outreach to educate hospitals regarding the Health Homes option and how to identify and refer a potentially-eligible individual. Additionally, Core Service Agencies, Local Health Departments, and other entities will act as additional referral sources.

Q: Often when we request records or communication from PCPs, we do not receive a timely response or sometimes any response at all. How can this be combated in the Health Home program, where collaboration with the PCP is such a central factor?

A: The Department will perform outreach to PCPs to ensure they're aware of the Health Homes program and familiar with the expectation of collaboration. Additionally, a care management tool can be valuable in communicating with outside providers and tracking these communications. If a health Home participant is unhappy with the care they are receiving from their PCP, the Health Home may assist them in reviewing their options and potentially switching to a new PCP.

Participant Eligibility

Q: Are Medicare and Medicaid dual-eligible individuals eligible for Health Homes? Which eligibility groups does this include?

A: Only dually-eligible individuals with full Medicaid coverage are eligible for participation in the Health Home. This does not include individuals in the Qualified Medicare Beneficiary (QMB) or Service Limited Medicare Beneficiary (SLMB) groups, as appears in the "Benefits Description" portion of the recipient eligibility verification system message.

Q: Are all full Medicaid recipients eligible for Health Homes, regardless of which type of Medicaid they have?

A: Yes, assuming they meet all other eligibility requirements of the program.

Q: Are Primary Adult Care (PAC) recipients eligible for the Health Home?

A: No, Medicaid is not currently able to reimburse providers for PAC recipients' participation in the Health Home. However, PAC recipients will become eligible for full Medical Assistance benefits in January 2014, at which point they may be enrolled in the Health Home.

Q: Can individuals disenroll from the health home for any reason at any time? Can they do so mid-month? What happens if individuals want to go in and out of health homes?

A: Yes, an individual may disenroll from the Health Home at any time for any reason, revoking their consent to participate. If this occurs mid-month, and the minimum of two services delivered has already

been met, the provider may submit a claim for that individual's monthly rate. If the disenrollment involves substantive discharge planning, this may count towards the service minimum for the month. Providers may not bill the monthly rate if the service minimum has not been met. If an individual later wishes to re-enroll in the Health Home, they may do so and the provider would re-enroll them in eMedicaid accordingly. If there the period between discharge and re-enrollment is less than 6 months, the Health Home is not required to conduct another intake assessment, and may not bill for this service.

Participant Enrollment

Q: Will people be auto-enrolled?

A: No, participants may not be auto-enrolled due to the requirement for consent and in the initial intake process.

Q: If an individual is already receiving PRP, MT, or OTP services prior to enrollment in the Health Home, does the provider need to complete the full intake process?

A: Yes, because certain data is required to complete the intake process in eMedicaid. However, if the individual has a prior relationship with the provider, it is expected that this intake will be less time-consuming than with an entirely new participant, as staff will already be familiar with much of the information that must be gathered for intake.,

Q: Guidance states that Physician or Nurse Practitioner sign-off is required for the initial intake of a new participant. Providers are expected to pre-enroll as many participants as possible prior to the go-live date of the program, yet are given a grace period of 30 days following go-live to hire all Health Home staff, and therefore may not have their Physician/NP Consultant in place during this pre-enrollment stage. How are they expected to complete the enrollments before go-live without the required Physician/NP?

A: To accommodate the unique challenges of starting a new program, the Department will allow Health Homes to pre-enroll participants without Physician/NP Consultant sign-off, contingent upon Physician/NP review and sign-off within 90 days of the beginning of service provision. Any participants enrolled with a Health Home more than 30 days after the program's go-live date must have Physician/NP sign-off on their intake, as stated in the regulations. Please refer to the Provider Update email sent on August 19, 2013 for additional details.

Implementation Timeline

Q: The Department states that they would like all providers to be enrolled as Health Homes, and to then pre-enroll all participants prior to the implementation date for the program. Is there flexibility with this?

A: The Department would like as many providers and participants to be enrolled in the Health Home program as possible upon go-live, so that we are able to fully maximize the two years of enhanced federal funding for the program. However, we understand that not all providers will be fully prepared to complete their application and pre-enroll their participants by go-live, and **we will continue to accept applications on an ongoing basis**. Likewise, participants may be enrolled on an ongoing basis.

Q: Can we do the assessment before go-live and still be paid for it?

A: Yes, but claims may not be submitted for reimbursement until the first day of go-live. Any assessments and subsequent enrollments that occur prior to official implementation of the program may be billed immediately on day one of the program implementation date. **In such cases, the date of service on the claim submitted should be listed as October 1, 2013.** As of day one of the program implementation, regular Health Home service provision may begin with claims for the monthly rate submitted at the end of the first month of service provision. On an ongoing basis following

implementation of the program, intake assessments may be billed as they are completed, and regular Health Home services will be billed on a monthly basis.

Provider Application

Q: Can you give us more information about and possibly examples of the job descriptions required?

A: Please see the “Health Home Staffing Roles” document posted on the Health Homes website for additional details which may be helpful in drafting your job descriptions.

Q: When can we expect to hear that our application is accepted?

A: The Department will process applications in the order in which they are received, as quickly as possible while allowing for close review. Until we know the volume of applications to be submitted, it is difficult to estimate how long the review process will take.

Q: Can C&A PRP clients be included in the overall health homes numbers along with adults for purposes of staffing or must they be counted separately and served in a separate health home?

A: Yes, a PRP that serves both adults and youth may include both populations in their enrollment to calculate the staff levels required, and staff may be shared between the two populations.

Other

Q: Which outcomes will the Department track? Will continuation of the program be contingent upon these outcomes?

A: The Department will draw from a variety of sources to evaluate program outcomes, including claims and encounter data, participant surveys, and eMedicaid reports. Outcomes will include avoidable hospital readmissions, emergency department encounters, participant experience of care, health and social indicators, and others. Continuation of the program beyond the two years of enhanced federal match will be dependent on cost-savings and outcomes achieved during the program’s operation.

Q: Does only the facility applying to be a Health Home register with CRISP's ENS or is there also a registration process that each individual provider within that facility has to complete?

A: For ENS, just the facility needs to complete the “registration” steps (i.e. complete all of the documents). CRISP is able to provide the facility with a single Direct account that users in the practice can share (or CRISP can provide multiple – individual users or groups of users – if so desired). Only access to the CRISP portal required each individual to register with CRISP.

Q: Are the consent forms in the provider manual an example of what we should use or are we expected to use those exact forms?

A: Although providers are free to reformat the consent form included in the manual, the text must remain the same for consistency and to ensure that the unique data-sharing elements of the Health Home are addressed.