

Health Home change for 2/2/2018

Starting 2/2/2018, clients currently enrolled as a high intensity Health Home member will be subject to review. This review is based on reported time of service based on the shadow-billed services reported along with the corresponding G codes for payment. Clients currently enrolled as moderate intensity are not part of this process.

Overview:

- The process will run the first Friday of each month.
- Three months will be evaluated by using the end date of the PA line for which a G code is paid.
 - For example, if the end date of a PA line is 10/15/2017, a month will cover service dates from 9/16/2017 to 10/15/2017.
- A three-month average will be reviewed, not counting the closest month, due to claim lag.
 - For example, the process in February 2018 will look at PA lines ending in October, November and December 2017. Data for January 2018 will NOT be reviewed until the following month.
- For adults, the minimum to remain in Health Home High is an average of three hours.
- For children, the minimum to remain in Health Home High is an average of 12 hours.
- Service times are calculated using the time of service allowed from the Health Home manual.
 - For example, only one hour of travel a month is counted, even if shadow billing shows 20 hours.
- Clients must have at least one paid high intensity G code paid in the timeframe and only paid months are counted.
 - For example, if in Oct/Nov/Dec 2017, only two months have a paid G code, only those two months will be evaluated.
- Any month where the client spent more than 7 days in crisis, inpatient, or residential treatment for the month will not be counted.
 - Note: This is dependent upon data available in the Medicaid Management Information System (MMIS). If the client spent time in inpatient, crisis, or a residential treatment facility that does not report to the MMIS (i.e. a non-contracted provider) an exception will have to be requested.
- Any month which was excluded from the client average because of number of days in a higher level of care, will automatically be included if the excluded month will bring the three-month average up to the minimum hours.
 - For example, a client who was in inpatient for 10 days during the month will be excluded. However, if the agency provided 15 hours of Health Home services to the client during that month, the process will add that back in to help the average.
- Children not meeting a 12-hour average and adults not meeting a three-hour average will be moved to moderate intensity. The PA is changed (if applicable) and the provider is notified.
- Clients will not be eligible for high intensity at that Health Home until the average for their age group is met. Clients are reexamined each month in the following runs.
- Clients found eligible by meeting the hourly average for their age group in the following months are unlocked, allowing for Health Home High requests/billing. The PA will be changed to high intensity (if applicable) and the provider is notified. The PA is changed only if it has been less than six months since the client was first locked AND the agency has an active PA with lines that start after that date.
 - For example, if the client does not meet the minimum average for the process in February 2018, the PA is changed to moderate for any PA lines starting after 2/2/2018. In March 2018, the client will be evaluated again. If the client at that time does meet the minimum average, the PA will be changed back to Health Home High for any PA lines starting after 3/2/2018 (if applicable – see 2b) and the provider will be notified.

- Clients must have been opted into the Health Home at least one month prior to the timeframe used for the average. This will look for the first date of opt-in at the agency, not the opt-in from the current episode.
- Clients that transition to adult Health Home will have to have three continuous months at adult level before being counted in the average.
- If moved to Health Home High during timeframe, only months with Health Home High will be evaluated.

System Changes:

1. If the client does not meet the high intensity:
 - a. The current PA will have all lines that start after the process date changed to their corresponding moderate intensity.
 - i. For children only the procedure code will change. The modifier will stay the same (if the PA line had the TN modifier that will remain the same).
 - ii. For adults, the high intensity does not have a TN modifier, but after the drop to moderate, the PA could. The addition of the TN modifier indicates that the Health Home is in a rural area and will depend on the location of the Health Home the client is at for that record.
 - b. If the client is on their last PA line (i.e. last month) of the PA currently, the PA will not be altered.
 - c. Customer will be locked in PICIS, disabling high intensity
 - i. If high intensity is submitted on any subsequent requests while client is locked, the record will be rejected.
 - ii. Client will stay locked until a three-month average is met. If client is discharged, client will be unlocked after six months.
 - iii. Discharges will not automatically unlock clients.
 - d. Notification is created alerting provider of change.
 - i. New notification type 22 will be created and sent through the ongoing Notifications operation using the current web service.
 - ii. Notification type will send the PA detail, but only for the Health Home lines.
 - iii. Modifier1 and Modifier2 will be added to the notification response in the second table that returns the detail line information, but only for this notification and the notification 23 (below). This is so vendors can identify if the Health Home lines were moved to moderate or not.
 - iv. If no lines were altered, the notification and the PA information will still be sent. This will still alert the vendor that the client is locked.
 - v. Notification will also be sent by email to provider, unless the provider has opted out of email notifications.
2. If a client has met high intensity and is unlocked:
 - a. Locked clients are reviewed on every subsequent run and those now meeting the three-month average for high intensity will be unlocked as of that process date.
 - i. The locking will be date based so providers will receive rejections if attempting to back date into an ineligible period for the recipient.
 - b. If client is unlocked within six months of being locked initially and still has an active level PA with moderate intensity, that PA will be moved to high intensity even if the PA is not the same PA as the one that was lowered. This is because providers will be submitting extensions while the client is locked and can only request the moderate intensity. If client is unlocked after six months, provider will be responsible for changing the client to high intensity if needed.
 - i. Only PA lines that start after the process date will be altered.
 - c. Notification is created alerting provider of change.

- i. New notification type 23 and 24 will be created and sent through the ongoing Notifications operation using the current web service. The 23 notification will notify a provider that ODMHSAS unlocked the client and moved the client back to high intensity. The 24 notification will notify the provider that ODMHSAS unlocked the provider, but the provider will have to determine if the client meets criteria and needs to be enrolled back in health home high intensity. If the client does, the provider will have to submit an update to PICIS.
- ii. Notification type 23 will return the same information as notification type 22 (detail PA information). The notification 24 will only return the recipient ID with no other identifying information.
- iii. These notifications will also be sent by email to provider, unless the provider has opted out of email notifications.