

## Enrollment/Transfers/Discharges

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- 1. Can an ACT client be enrolled in a Healthcare Home?**  
Yes. Please see document titled "Nurse Care Manager Responsibilities with ACT clients" for additional information.
- 2. Can consumers be enrolled in both a CMHC HCH and a Primary Care HCH at the same time?**  
No.
- 3. Can an agency choose to enroll non-Medicaid clients in HCH?**  
No.
- 4. Is there an age limit for Healthcare Home clients?**  
No.
- 5. Can clients that are in institutional facilities such as a boy's home remain in the Healthcare Home?**  
Yes.
- 6. What are the specific eligibility criteria for youth and HCH?**
  1. A serious and persistent mental illness
    - o CPR eligible adults and kids with SED (CPR eligible diagnosis or mental health diagnosis and DLA-20 CGAS of  $\leq 50$ )
  2. A mental health condition and substance use disorder
  3. A mental health condition and/or substance use disorder and one other chronic health condition
- 7. Can consumers who are enrolled in a Managed Care plan also be enrolled in a CMHC Healthcare Home?**  
Yes.
- 8. Is an agency required to enroll everyone who asks to be in Healthcare Home?**  
No. It is the agency's decision which clients to enroll in its Healthcare Home.
- 9. Regarding presumptive eligibility, does an agency have to enroll all HCH clients into CPR?**  
No, but you should investigate why they would not need CPR services.
- 10. Should agencies be focusing on certain diseases when enrolling consumers into HCH?**  
A: All consumers must meet the basic diagnostic criteria. The HCH should prioritize those individuals it thinks would benefit most from HCH services.
- 11. If a consumer chooses a Primary Care HH in another area, can he/she continue to receive CPRC services from his/her current CMHC?**  
Yes.
- 12. Is there a process for transferring between CMHC and Primary Care HH or would one discharge so the other can enroll?**  
The Primary Care HH would discharge and then the CMHC would enroll.
- 13. If a consumer transfers to another CMHC HCH, will his/her funding "slot" go to the other CMHC HCH?**  
No.
- 14. When transferring a client to a new CMHC, who submits the transfer form?**  
The agency transferring must fill out and submit the transfer request form.
- 15. Will transfer requests be given priority for agencies, that have waiting lists for services, or is this decision up to the agency?**  
This is an individual agency's decision.
- 16. If a client is discharged from all other clinical treatment programs at our CMHC, can he/she still be enrolled in the HCH and receive just Nurse Care Manager's services?**  
No.

**17. Is there any paperwork, like the discharge form, needed for consumers who have passed away?**

The agency will need to complete a discharge form.

**18. If an agency has a few DM3700 clients who originally accepted services but who have since dropped out of care, how should the agency handle this situation?**

The agency should try to outreach the clients again, but if the clients cannot be located or refuse service, then the agency should request they be discharged, citing this as the reason for discharge.

### *Healthcare Home Team*

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**1. What specialty must an APN have to supplement the Primary Care Physician Consultation?**

A list of approved specialties is posted to the DMH CMHC HCH website.

**2. Can an agency use its Medical Director for the Primary Care Physician Consultant role? Can this person be a psychiatrist?**

The Medical Director may serve as a Physician Leader within the agency, but the Primary Care Physician Consultant role cannot be filled by a psychiatrist.

**3. Are there outlined requirements for the Primary Care Physician Consultant role?**

The PCPC should be board certified in family practice or internal medicine and be current in the practice.

**4. Does the NCM position require experience in pediatrics if assigned a children/youth caseload?**

If a NCM has a caseload that is significantly or predominantly children/youth, the Department would expect to see experience in pediatrics.

**5. Can an agency staff a full time nurse using the .5 FTE for CMHC Healthcare Home and match it with the .5 FTE for the Primary Care Healthcare Home?**

Yes, agencies that are operating both Primary Care Health Homes and CMHC Healthcare Homes may choose this approach in order to meet the staffing requirements.

**6. If an agency's enrollment exceeds caseload requirements, when will the agency have to add staff FTE?**

The agency should be monitoring its caseload sizes and FTE requirements. Overall the agency will have to meet its 85% staffing requirements over the course of the year. NCMs should not exceed their caseload requirements. For other staff, the agency may inquire with the Department on how it can distribute the additional FTE need.

### *Provider Practices & HCH Responsibilities*

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**1. Is there a draft letter for agencies to send out to Primary Care Physicians?**

Yes. It's on the DMH website.

**2. How should an agency communicate to the hospitals the importance of noting who is in a HCH? Will the hospitals have access to this information in Cyber Access?**

The hospitals have access to Cyber Access, and there is an identifier that the client is in a Health Home. There are no guidelines/requirements set. It is up to the agency how it will develop contacts and rapport with hospital staff.

**3. Can NCMs do health related activities with non-HCH enrollees and still count the time as a HCH service?**

It is acceptable to do health related activities with non-HCH consumers and agency staff. However, agencies should ensure that the NCM's time is not compromised. The NCM's time should be primarily with HCH consumers.

4. **Can an agency include non-Healthcare Home clients in the same educational classes or groups as Healthcare Home clients?**

Yes.

### *Treatment Planning*

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1. **What is the expectation of the Physician Consultant reviewing and signing the treatment plan?**

The Primary Care Physician Consultant is not required to sign treatment plans.

2. **How often is the Nurse Care Manager required to review the Healthcare Home ITP goals?**

Treatment plan reviews for Healthcare Home clients should adhere to rules already established for the treatment program the client is enrolled (i.e. quarterly for CPR rehabilitation level, annually for CPR maintenance level and for non-CPR clients). Nurse Care Managers should participate in the annual treatment plan review for consumers on their caseload and should be consulted, as appropriate, in quarterly reviews.

3. **Is it acceptable for the caseworker to create an ITP and the nurse to have a separate ITP document, or should the nurse ask the caseworker to put NCM goals on the current ITP forms?**

There should only be one ITP.

4. **Does the Health Screening qualify as a treatment plan for non-CPRC clients?**

No. The health screen only helps to identify potential issues to be addressed in a treatment plan.

5. **If the caseworker already has physical health interventions, can the NCM work in partnership with this, or will the RN need separate goals identified with the addition of Healthcare Home services?**

The consumer's ITP should address whatever health and/or wellness goals are appropriate for the consumer. If a consumer already has health and/or wellness goals and no additional goals are appropriate, then the Nurse Care Manager should provide whatever assistance is appropriate to help the consumer achieve those goals.

6. **Should health conditions (e.g. STDs) that are not explicitly included as targeted Healthcare Home diagnoses be addressed by the Nurse Care Manager and included in the consumer's ITP?**

Any and all relevant health conditions should be addressed by the Healthcare Home team.

7. **Will outpatient consumers who are not in CPRC or maintenance require a partial assessment and new treatment plan when being enrolled in Healthcare Home?**

The treatment plan should be updated as needed in accordance with existing standards.

8. **Is Smoking Cessation mandatory for consumers who smoke?**

No. All goals on treatment plans must be kept person-centered.

9. **For medication only clients, can the agency add an addendum to their existing treatment plan? Also, does the client have to sign the addendum?**

Yes. The agency can add an addendum to the treatment plan and should have the client sign the addendum to show he/she participated and was involved in the development of the plan.

### *Health Screening*

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1. **Agencies already complete a Health screen annually for all consumers. Do agencies have to complete another Health Screen once a consumer is enrolled in HCH, or can the NCM review the Health Screen that was completed for the year?**

Using an existing Health Screen tool is acceptable if it meets the minimum requirements outlined in the guidelines.

**2. Should substance abuse be included in the Health Screen?**

If substance abuse is not addressed in an individual's initial assessment, it should be included in the health screening.

**3. Is the same Health Screen used for children and youth?**

At this time, the same Health Screen is used for both adults and children/youth; however, providers are welcome to add/develop their own screenings so long as it meets the minimum required components.

**4. Can the CSS complete the Health Screen?**

The CSS can gather information for the Health Screen, but the NCM or trained individual should be available to discuss any health screen questions. Furthermore, the NCM should review, sign, and assist in the development of health related goals.

**5. Who does the Department define as qualified staff for Health Screenings other than Nurse Care Managers?**

Each CMHC has the authority to determine who is qualified to complete the required Health Screens.

**6. Does the Nurse Care Manager have to meet face-to-face with the client when he/she signs the Health Screening forms?**

The Nurse Care Manager should be face-to-face with the client to discuss the results of the Health Screening as well as the development of health care goals. Telephone consultation can be utilized if necessary, but the need must be documented.

**7. Do agencies need to do a health screen and metabolic screening on admission with an established CPRC client who had a metabolic screening completed in past 12 months?**

The Health Screening is due no later than the time of the next annual evaluation and treatment plan. The Metabolic Screening can continue to be done on the annual schedule.

### *Hospitalization Follow Up*

**1. Regarding hospital discharge follow-up, does it matter if the NCM or CSS completes the follow-up?**

The CSS can gather information, but the NCM should complete the medication reconciliation.

**2. Regarding psychiatric versus medical hospitalizations, does the NCM follow-up on both?**

Yes.

**3. Is the 72-hour follow-up for hospital discharges based on calendar or working days? Would the Department consider starting the 72-hour timeframe when the agency is actually notified versus actual discharge date?**

The 72-hour follow-up for hospital discharges is based on calendar days, and that time begins when the individual is discharged; however, notification of the discharge is taken into account.

**4. If a consumer is discharged from the hospital to medical rehab, does the hospital still need to complete the follow-up and medication reconciliation?**

Yes.

**5. If a consumer is discharged from the hospital to an SNF, does the hospital still complete a follow-up and medication reconciliation?**

Yes.

**6. If a consumer is discharged from one hospital to another, does the hospital still complete a follow-up and medication reconciliation?**

A follow-up still needs to occur, but the medication reconciliation is not required.

**7. Can a face-to-face hospital discharge follow-up be via tele-health?**

Yes.

**8. When a client is discharged from the hospital, the NCM is working very hard to arrange a face-to-face meeting within 72-hours. However, sometimes the NCM can't reach the client, or the client doesn't want to be seen right away. Is it acceptable to contact the client (or at least try to) within the 72-hours and see him/her later?**

Yes. A phone contact is appropriate until a face-to-face can be made.

**9. What happens if the hospital has a consumer who was admitted and was seen but he/she is not on the Hospitalization Follow-Up Report?**

The hospital can add the consumer to the self-reported hospital follow-up included in the MIR.

**10. Does the Hospitalization Follow-Up Report include only Healthcare Home enrollees?**

The notifications include any CIMOR EOC; however, the monthly HH report will only include those HH enrollees.

**11. On the lines with multiple admissions, what does the Department want on the lines? Should the agency enter information on every line?**

The hospital only needs to enter the last record for that hospitalization and add a comment on the duplicate records.

**12. The medication reconciliation is completed within 72-hours. Should community support contacts still be completed within 5 days?**

Yes. CSS contact is a separate requirement in the CPRC state regulations.

**13. Are ER visits documented on the Hospitalization Follow-up reports? Some hospitals have consumers who went to the ER and then went inpatient but are not listed on the hospital report.**

Pure ER visits are not listed, but the inpatient portion will appear.

**14. Regarding hospital admission alerts, are the alerts for both medical and psychiatric?**

Yes.

**15. Will hospitals get notifications for consumers who are dual Medicaid/Medicare?**

If it is a Medicaid Prior Authorization (PA), a notification will be sent.

**16. Are hospitals expected to follow-up on hospital notifications from several months ago?**

No. Hospital notifications are available once the pre-certification has been approved for payment by MHN or shortly after. The Department does expect these to appear on reports from time to time, but hospitals are not expected to follow-up on an old admission.

**17. Can an alert be tagged to a prior authorization that a consumer is a HCH enrollee?**

This edit has been requested, and a ticket has been made.

**18. Regarding the Hospital Prior-Authorizations list, some clients were hospitalized that were not on the list. What are some possible reasons why they were not on the list?**

Examples may include: the hospital hasn't requested inpatient days; the client wasn't Medicaid eligible; or more likely, the client was dual-eligible. There are some situations that Medicaid doesn't require a prior-authorization, e.g. child birth.

**19. Some clients are not being carried forward on the hospital alert report from one day to the next until their certification end date has expired. For example, one client had an admit date of 2/21 and end date of 2/25. The client was listed on the 2/22 report but not on the report received for 2/24. Is there any way to carry those clients forward on the reports through their end date to help with tracking and recording the follow-up?**

Clients are not carried forward. A client is only listed multiple times if there are multiple certifications on subsequent days. This happens often but not always. When a client appears again the next day, this means a new certification went through -- for example, hospital

requested an additional day be certified.

### **Billing Questions**

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**1. Will the PMPM still be paid if spend down is not met?**

No.

**2. What is the process to determine if someone has met spend down?**

MHN will determine if spend down is met and will initiate the payments.

**3. Does the consumer only have to be eligible one day in the month in order to attest and receive the payment for the month?**

The individual must be eligible on the last day of the month.

**4. Some FSD offices do not get spend down claims approved by the end of the month. Is there a grace period?**

Yes. There will be an approximate 3 week delay before PMPM payments for the prior month will be calculated, giving additional time for incurred expenses to be reported to the local FSD office.

**5. Can agencies use DMH allocations to cover PMPM for those on spend down?**

No.

**6. Is it appropriate to discharge a consumer from HCH who has a very large spend down that is never met?**

Providers are allowed to discharge clients if the client has not met spend down for three consecutive months.

**7. Can the CSS bill for a team review/consultation?**

Yes. As long as the review/consultation is independent of a normal agency staffing, it is billable. The documentation should clarify this.

**8. Can the CSS bill for a team review if participating via tele-conference?**

Yes. However, the CSS must ensure he/she is not billing any other services (e.g. travel time for another consumer).

**9. Is the PMPM affected by a consumer being in the hospital?**

As long as the consumer is still enrolled in HCH, the PMPM will continue. The only exceptions to this are for those hospitalized in Skilled Nursing Facilities, Intermediate Care Facilities and those at Cottonwood or Hawthorne. If a consumer is in a skilled nursing facility, the PMPM is not reimbursable. If a youth is in one of the mentioned facilities on the last day of the month, the agency should not attest to them.

**10. If a payment was rejected because of LOC, who should the agency contact?**

The agency should work with its local DFS office. If the agency has continued difficulties, contact the HCH Director Liaison.

**11. If a payment is rejected but it later shows the consumer was eligible for payment, will the agency be reimbursed?**

Yes. If the consumer later meets the eligibility requirements, the agency will see these in the retro payments. There is at least a six month lag for retro payments, and this information is distributed via email.

**12. Is there a way to add what the invalid ME codes are on the payment reject report?**

To clarify the "invalid/ineligible ME code" could mean that the consumer's Medicaid is no longer active OR it could mean that the type of coverage he/she has (ME code) is not valid for health home.

**13. Will payments be rejected if the consumer is in hospice?**

No.

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**Miscellaneous**

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- 1. Will consumers be identified as enrolled in “HCH” in CIMOR?**  
Yes. The agency can view the CIMOR HCH Registry Report in CIMOR, and there is an identifier in the top right hand corner of CIMOR for specific consumers.
- 2. How do Healthcare Home staff who need to have access to the FTP site gain access?**  
Each agency determines who within their organization has access to the FTP site. The agency should check with its administration in order to receive approval and instructions for accessing this site. Access request and additional information about the FTP site can be found at:  
<https://portal.dmh.missouri.gov/>
- 3. Will agencies be able to see HCH claims in Cyber Access?**  
No.
- 4. APN names are not visible under pharmacy claims as the prescriber. Usually the name of the collaborating physician is shown. Can the APN names be shown?**  
No. The collaborating physician name will continue to be shown.
- 5. Can a CSS bill to review Cyber Access?**  
Only if the consumer is present and involved in the review. If a CSS introduces accessing Direct Inform to a consumer, this is also billable.
- 6. Will the agency collect Performance Data for individuals who do not meet their spend down in a given month?**  
Yes. Just as CPR consumers who do not meet spend down remain in CPR and continue to receive services, the same goes for HCH.
- 7. Regarding reports for consumers not in HCH who will be monitoring their reports?**  
It is expected that agencies will monitor all reports for their active consumers, regardless of program enrollment.
- 8. Will the Client Status Report information carry forward each month?**  
Yes, until a PCP is established and contacted.
- 9. How is a partial month’s vacancy reported?**  
All staff will report actual hours worked each month on the Team Log. Filled positions should also include sick, holiday, and annual leave in their hours.
- 10. When the agency submits new enrollment/discharge/transfer requests, does DMH update the client status report in real time or once per month?**  
The client status report is updated once per month. Approved/processed enrollments, discharges and transfers will appear on the following month’s client status report.
- 11. On the client status report, when a consumer declines or is transferred or discharged, does the PCP information need to be completed?**  
Yes, make a note in the comment field.
- 12. When a NCM is providing individual or group interventions, can clients utilize Medicaid transportation (NEMT)?**  
NEMT will not transport clients to appointments with the NCM or other HCH staff such as the PCPC.
- 13. How will Primary Care HCHs affect agencies if there is several in one area?**  
If a client is already in the one of the health homes (whether CMHC or PCHH), the other health home should not try to recruit that client. The client makes the decision of where he/she would like to receive health homes services. If there is discussion about which health home is most appropriate, the Directors from both health homes should provide care coordination to determine which health home is most appropriate.

**14. Can MC+ consumers be enrolled in HCH?**

Yes, those consumers are eligible.