HCH Q & A

HCH and CCBHC

1. **How will the CCBHC PPS affect communication between NCMs and CSSs?**

   There should be no changes in communication once the PPS goes into effect. Care coordination activities are a requirement of CCBHC although they will not generate a PPS payment. Care coordination costs were built into each agency's PPS rate.

2. **How will CCBHC impact HCH?**

   HCHs participating in the CCBHC demonstration will continue to operate as usual. The same staffing ratios apply and we will continue to monitor staffing compliance. HCH will continue to attest to enrollees in Cyber Access each month, however the attestations will no longer generate a PMPM. The cost of HCH is included in the PPS rate. All HCH policies still apply.

3. **Will we continue to receive the payment reject report if there is no PMPM payment?**
   MHD believes this report will continue whether or not a PMPM is generated.

Enrollment/Transfers/Discharges

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 HCH clients?**
   No.
5. **Can clients that are in institutional facilities such as a boy's home remain in the HCH?**

   Yes.
6. **What are the specific eligibility criteria for youth and HCH?**

   A serious and persistent mental illness

   - CPR eligible adults and kids with SED (CPR eligible diagnosis or mental health diagnosis and DLA-20 CGAS of ≤ 50)
   - A mental health condition and substance use disorder
   - A mental health condition and/or substance use disorder and one other chronic health condition
7. **Can individuals who are enrolled in a Managed Care plan also be enrolled in a CMHC HCH?**
   Yes.
8. **Are we required to enroll everyone who *asks* to be in HCH?**

   No. It is your decision which clients to enroll in your Healthcare Home.
9. **Regarding presumptive eligibility, do we have to enroll all HCH clients into CPR?**
   No, but you should investigate why they would <u>not</u> need CPR services.
10. **Should agencies be focusing on certain diseases when enrolling consumers into HCH?**
    All consumers must meet the basic diagnostic criteria. The HCH should prioritize those individuals they think would benefit most from HCH services.

11. **What do we do when someone has moved out of our area? Do we contact the provider in the new area and let them know the client has moved there?**

Yes. You would contact the HCH director in the other service area and initiate a transfer from your HCH to their HCH by completing a transfer form and submitting it to DMH.

12. **If a consumer chooses a Primary Care HH in another area, can they continue to receive their CPRC services from their current CMHC?**

Yes.

13. **Is there a process for transferring between CMHC and Primary Care Health Home (HH) or would they just discharge so we can enroll?**

The Primary Care HH would discharge and then the CMHC would enroll.

14. **If a consumer transfers to another CMHC HCH, will their funding "slot" go with them to the other CMHC HCH?**

No.

15. **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.

16. **Will transfer requests be given priority for agencies that have waiting lists for services? Or will this be up to each agency to decide?**

This is an individual agency decision.

17. **If a client is discharged from all other clinical treatment programs at our CMHC, can they still be enrolled in the HCH and receive just Nurse Care Manager's (NCM) services?**

No.

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

You will need to complete a discharge form.

19. **We have a few DM3700 clients who originally accepted services, but who have since dropped out of care. How should we handle them?**

You should try to outreach to them again, but if you cannot locate them or they refuse service, then you should request they be discharged, citing this as the reason for discharge. Agency staff should document any and all outreach attempts.

20. **Should DM consumers be enrolled in HCH?**

Yes. The expectation is that consumers enrolled in DM 3700 should also be given an opportunity to be enrolled in HCH.

21. **When we submit 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.

HCH Team

1. **What is the staff to caseload ratio expectation?**

   HCH Director- 1 FTE:500 Enrollees; PCPC- 1 Hr Per Enrollee Per Year; NCM- 1 FTE:250; Clerical/Care Coordinator- 1 FTE:500 Enrollees.

2. **What specialty must an APN have to supplement the PCPC?**
   A list of approved specialties is posted to the DMH CMHC HCH website.
3. **Can we use our Medical Director for the PCPC role? Can that person be a psychiatrist?**
   The Medical Director may serve as a Physician Leader within the agency, but the PCPC role cannot be filled by a psychiatrist.
4. **Are there outlined requirements for the PCPC role?**

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

5. **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, we would expect to see experience in pediatrics.
6. **Can we 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.
7. **If an agency's enrollment exceeds caseload requirements, where is the line drawn to when we have to add staff FTE?**
   You should be watching your caseload sizes and FTE requirements. NCMs cannot exceed the caseload maximum of 1:250. For other staff, you may inquire with the Department on how you can distribute that additional FTE need.
8. **Can the PCPC provide their consultation via telehealth?**

   Yes.

Provider Practices & HCH Responsibilities

1. **Is there a draft letter for agencies to send out to Primary Care Physicians?**
   Yes. It is on the DMH website.
2. **How do we communicate with the hospitals that it is important for them to note that a consumer is in a HCH? Will they have access to that 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 for this. It is up to the agency how they will develop contacts and rapport with hospital staff, but it may be a good idea to identify the hospital social worker with whom to coordinate.
3. **Can NCMs do health related activities with non-HCH enrollees and still count that time as a HCH service?**
   It is okay 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 we include non-Healthcare Home clients in the same educational classes or groups as Healthcare Home clients?**
   Yes.
5. **We are having difficulty getting clients to come to the office to meet, but even then we have had some resistance. I had a staff member ask if she could have the client Skype in with the nurse to meet the face-to-face requirement. I'm not sure the client will really do this, but would it be allowed?**

Skype is not a HIPAA compliant form of communication and should not be used.

Treatment Planning

1. **What is the expectation in regards to the Physician Consultant reviewing and signing off on the treatment plan?**
   The PCPC is not required to sign treatment plans.
2. **Is it ok for the case worker to create an ITP and the nurse to have a separate ITP document they work from? Or will we need to ask case workers to put NCM goals on to current ITP Forms?**
   There should only be one ITP.
3. **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.
4. **When a client has an annual treatment plan review, is there any regulation about when the HCH health screen and goal setting takes place? Can the HCH assessment be completed before or after the caseworkers complete the ITP?**

   The health screen should be done in conjunction with the annual assessment and ITP. The HCH goals should be on the completed ITP.
5. **If the case worker already has physical health interventions, can the NCM work in partnership with this or will the NCM need separate goals identified with the addition of HCH 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 such goals are appropriate, then the NCM should provide education, assistance, etc. to the case worker in order for them to help the consumer achieve those goals.
6. **Should health conditions (e.g. STDs) that are not explicitly included as targeted HCH 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 CPRP require a partial assessment and new treatment plan when being enrolled in Healthcare Home?**
   Their 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 we add an addendum to their existing treatment plan? Also, does the client have to sign the addendum?**

   Yes, you can add an addendum to the treatment plan, and you should have the client sign-off on that addendum to show they participated and were involved in the development of their plan.

Health Screening

1. **We already do a health screen annually for all consumers. Do we have to complete another health screen once a consumer is enrolled in HCH or can the NCM review the one that was already done for the year?**

Using an existing Health Screen tool is acceptable if it meets the minimum requirements outlined in the guidelines. The NCM should review and sign the existing health screen and if necessary, meet with the consumer to formulate a treatment goal(s) on the treatment plan.

2. **Should substance use be included in the Health Screen?**
   It depends on if substance use is addressed in the initial assessment.
   Like any other condition, if it is addressed in the assessment, it should be included in the Health Screen.
3. **Is the same Health Screen used for children and youth?**
   Children and youth in HCH now have their own health screen requirements.
4. **Can the caseworker/CSS fill out 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. The NCM should review, sign, and assist in the development of health related goals.
5. **Who do you define as qualified staff for Health Screenings other than NCMs?**
   Each CMHC has the authority to determine who is qualified to complete the required Health Screens.
6. **Does the NCM have to meet face-to-face with the client when she/he signs off on the Health Screening forms?**
   The NCM should meet 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 we need to do a Health Screen and Metabolic screening on admission with an established CPRP client who had a metabolic screening done 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.

8. **Will there be a youth health screen template?**
   No. Providers now develop their health screen templates within their EMR so DMH will not issue one.
9. **What is the age limit for the youth health assessment? 17 and under?**

   It should coincide with their CPR enrollment. If they are in youth CPR, then use the youth health screen. If they are in adult CPR, use the adult screen. Some agencies have programs for transition age youth. Those programs should use the youth screen.

Hospitalization Follow Up

1. **Regarding hospital discharge follow-up, does it matter if it is the NCM or CSS completes the follow-up?**
   CSSs can gather information, but the NCM must 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 calendar or working days? Would you consider starting the 72-hour time frame to begin when the agency is actually notified versus actual discharge date?**
   The 72-hour follow-up for hospital discharges is based on calendar days. The 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, do we still need to complete the follow up and medication reconciliation?**
   Yes.
5. **If a consumer is discharged from the hospital to an SNF, do we still do a follow up and medication reconciliation?**
   Yes.
6. **If a consumer is discharged from one hospital to another, do we still do 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. **The NCM works very hard to arrange a face-to-face meeting within 72 hours when a consumer is discharged from the hospital. Sometimes the NCM cannot reach the consumer, or the consumer doesn't want to be seen right away. Is it okay to reach the consumer by phone until a face-to-face can be made?**
   Yes. Phone contact is appropriate until a face-to-face can be made.
9. **What happens if we have a consumer who was in the hospital and we see them but they are not on the Hospitalization Follow-Up Report?**
   You can add them to the self-reported hospital follow-up included in the Monthly Implementation Report (MIR).
10. **Does the Hospitalization Follow-Up Report include only Healthcare Home enrollees?**
    The notifications include any CIMOR EOC; however, the monthly HCH report will only include those HCH enrollees.
11. **On the lines with multiple admissions, what do you want on the lines? Do you enter on every line?**

    You only need to enter the last record for that hospitalization; you can add a comment on the duplicate records.

12. **The medication reconciliation is done within 72 hours. Are community support contacts still to be done within 5 days?**

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

13. **Do ER visits show on our report? We have consumers who went to the ER and then went inpatient that did not show on our hospital report.**

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

14. **Regarding hospital admission alerts, is that for both medical and psychiatric?**
    Yes.
15. **Will we get notifications for consumers who are dual Medicaid/Medicare?**
    If it is a Medicaid Prior Authorization (PA).
16. **Are we expected to follow up on hospital notifications from several months ago?**

    No. These show up once the pre-certification has been approved for payment by MHD. Sometimes that doesn't happen until after-the-fact. We do expect these to show up on reports from time to time, but you are not expected to follow up on an old admission.

17. **Regarding the Hospital Prior-Authorizations list, we have had at least 2 clients this week that were hospitalized that were not on the list. What are some possible reasons why they were not on the list?**

    Examples may include: If the hospital hasn't requested inpatient days; if the client wasn't Medicaid eligible, or more likely, if they were dual-eligible. There are some situations that Medicaid doesn't require a prior-auth, i.e. child birth. There is an edit of how long the hospital has to send in a prior-auth.

18. **We are finding that 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 showed up on the 2/22 report, but not on the report received for 2/24. We would like to know if there is any way to carry those clients forward on the reports through their end date – it would help with tracking and recording the follow-up.**

    Nothing is carried forward. A client only shows up multiple times if there are multiple certifications on subsequent days. That happens often but not always. When a client shows up again the next day that means a new certification went through -- for example, hospital requested an additional day be certified.

Billing Questions

1. **Will the PMPM still be paid even if spend down is not met?**
   No.
2. **What is the process to determine if someone has met their spend down?**
   MHD will determine that and trigger the payment.
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 for this?**
   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 we 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. The documentation should clarify this.

8. **Can the CSS bill for a team review if participating via conference phone.**

   Yes; however, the CSS must ensure they are 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 person is still enrolled in HCH, the PMPM will continue. The only exceptions to this are for those in Skilled Nursing Facilities, Intermediate Care Facilities and those at Hawthorne Children's Hospital. If they are in skilled nursing facilities, the PMPM is not reimbursable. If a youth is at Hawthorne on the last day of the month, you should not attest to them.

10. **If a payment was rejected because of LOC, who do we talk to?**

    You should talk with someone at your local DFS office. If you have continued difficulty, you may contact DMH.

11. **If a payment is rejected, but it later shows the person was eligible for payment will we still get reimbursed?**

    Yes if they later met the eligibility requirements, you 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 person's Medicaid is no longer active OR it could mean that the type of coverage they have (ME code) is not valid for health home.

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

    No.

MISCELLANEOUS

1. **Will consumers be identified as enrolled in "HCH" in CIMOR?**
   Yes, you can view the CIMOR HCH Registry Report in CIMOR and there is an identifier in the top right hand corner of CIMOR when you look up a specific individual.
2. **How do HCH 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. You should check with your 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 CSSs 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 we 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. **Who will monitor reports for consumers not in HCH?**
   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. **On the client status report, when a consumer declines, or is transferred or discharged, does the PCP information need to be filled out?**

    Yes, make a note in the comment field.

11. **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.
12. **How will Primary Care HHs affect us if there are 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 or 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.

13. **Can MC+ consumers be enrolled in HCH?**
    Yes, those consumers are eligible.
14. **Some of our HCH enrollees only receive "outpatient services" (i.e. not CPRP). Why do we have to have an open episode of care (EOC) in CIMOR for these clients?**

    Our data systems pull information from CIMOR for individuals identified as HCH. If they do not have an open EOC, they will not be included in the data.