ENCOMPASS FAMILY HEALTH HOME
Care Management
Policy & Procedure Manual

Care Management Policy #13 Managed Care Organizations

EFFECTIVE DATE: February 12, 2014
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POLICY: Encompass Health Home (HH) will contract with and provide Health Home services to participants/enrollees of Medicaid Managed Care Health Plans, consistent with New York State Department of Health Regulations, Managed Care Organization (MCO) agreements and provider manuals.

PROCEDURE:

COMMUNICATION:

A. The Health Home will partner with MCO and share Participant information needed for collaborative care coordination, engagement and successful outcomes, and will assure that services are not duplicated.
B. The Health Home will utilize the MCO as a resource for Participant information including demographics, claims data and resources for wellness, preventive and specific disease protocols.
C. The Health Home will involve the MCO in the development of the Plan of Care, and subsequent updates.
D. The MCO will communicate promptly information related to Participants admission/discharge from care, or when presenting at and receiving services from an emergency program, to assure appropriate transitional care is provided.
E. The MCO will regularly share performance information with the Health Home related to specific gaps in care.
    a. The Health Home will share related information with MCAs and will report follow-up activities back to the MCO.
    b. The MCO will provide needed guidance to assist the Health Home in quality improvement.
F. The MCO will share information regarding Participant complaints, and will work with the Health Home to resolve Participant issues.
G. The Health Home will utilize the MCO for educational information related to specific chronic disease progression and treatment.

PARTICIPANT ASSIGNMENT:

A. Encompass Health Home (HH) will provide current capacity availability to Managed Care Plans (MCP) at least monthly, to define new Participant assignment availability.
    1. HH will submit monthly, by the last business day of the month, the Provider Network Update file, identifying the monthly slot capacity to accept new assignments, through Secure File Transfer via the Health Commerce System (HCS).

i. Capacity will be reported to Excellus through secure/encrypted E-Mail: crc.snmm@excellus.com
ii. Capacity reporting will be specific to each County served.

B. MCP will review eligible members and will assign participants to the HH through the MAPP.
C. The MCP will send the Participant a welcome letter informing them of their Health Home enrollment and assignment.
D. Health Home will download the Assignment from the MAPP at least on a daily basis, and begin outreach and engagement services.
E. The HH will send a letter to the Participant (if address known), welcoming them to the HH, and informing them of their Care Management Contact information.
F. Candidate referrals received by the HH from other sources, will first be checked for assignment information via the MAPP.
    1. HH will review and verify MCP members for Medicaid and Health Home eligibility.
    2. If questions arise, HH may contact the MCP by phone to discuss the eligibility of MCP member referrals received from other sources.
G. HH will begin Outreach and Engagement activities within 3 business days of the Participant's assignment.
    1. Outreach and engagement will continue for a period of no more than 3 months.
    2. Outreach and engagement period will cease if Participant/Family refuses to sign consent to enroll.
H. HH will explain and obtain HH Consent from Participant/Family, and will forward forms to the MCP as requested through secure/encrypted messaging on a weekly basis.
    1. E-Mail Address: crc.snmm@excellus.com (Excellus)
    2. MCP will be included as a Core Partner on all member consents.
    3. Participant will transition to Active Care Management upon receipt of signed consent, and documentation verifying Health Home eligibility.
I. HH will notify DOH of enrollments, outreach and engagement status and assignment rejections by submitting member tracking files daily through the MAPP.
    1. MCP will monitor outside referrals, rejections and updates through the MAPP for their members.
J. HH will provide the MCP any updated/changed information required to track the status of each Participant within 3 business days of receipt.

DISENROLLMENT/OPT OUT:

A. During the intake process, HH will ensure that Participant/Family is made aware of the Opt Out and Consent Withdrawal forms and processes.

B. HH will forward Consent Withdrawals to the MCP through secure/encrypted messaging on a weekly basis, should Participants/Families decide against enrollment, or choose to disenroll.
    1. HH will notify all Providers involved in Participants plan of Care of their consent withdrawal.
C. Participants/Families will be informed that they may request the MCP to de-activate their HH status, or re-assign them to another HH.
D. If at any time the HH is unable to locate a Participant/Family enrolled in HH services for a 60 day period, they will be determined to be Lost to Services.
    1. Commencing the 1st of the following month after determination of Lost to Services, the HH may initiate Outreach and Engagement activities to locate the participant and re-engage in services.
        i. HH will submit a change record on the member tracking file, to indicate to indicate Lost to Services; and an add record to indicate that outreach and engagement has been initiated.
    2. If after 3 months outreach and engagement is unsuccessful, the Participant will be dis-enrolled, and the MCP notified.
E. HH will consult the MCP if Participant/Family does not engage in HH services or adhere to the plan of care, to determine appropriateness of placement.
F. HH will notify DOH/MCP of discharge/disenrollment, when Participant/Family is no longer in need of HH services through the MAPP.

PROVIDER NETWORK:

A. Encompass Health Home will establish and manage a list of Care Management Providers and Community Partners that will provide services within the Health Home network.
    1. HH will utilize service providers appropriately per written provider agreements in the delivery of HH services.
B. HH will submit via the HCS Application, a Provider Network Update file to the MCP monthly, by the last business day of the month.
    1. Provider Network Update file will be reported to Excellus through secure/encrypted E-Mail: crc.snmm@excellus.com
    2. HH will identify any changes to Lead HH information including:
        i. Tax ID numbers;
        ii. Name changes;
        iii. NPI number;
C. HH will update and submit via the HCS Application, a HH Network Partner Upload File to the MCP when Provider/Partner network changes occur.

1. HH will provide changes to the HH Network Partner Upload File no less than 15 days prior to the effective date of the change.

D. HH will utilize the MCP's network of providers when arranging for participant services.
   1. HH will communicate with MCP to expand network providers as needed.
   2. Care Managers will coordinate referrals for specialty providers through the participants Primary Care Physician.

RECIPIENT RESTRICTION PROGRAM (RRP)

A. All Health Home candidates will be screened for Medicaid eligibility through the MAPP.
   1. Those candidates that are enrolled in the RRP will be noted and the restrictions evaluated.
B. Candidates in the RRP that are not enrolled with a MCP will be assisted by the Care Manager, and Primary Care Provider if applicable, with choosing and enrolling into a plan that best meets their needs.
C. Care Managers will abide by the restrictions and selected providers when arranging for health care needs and services.
D. Care Managers will consult with the MCP and the Participants Primary Care Provider when additional non-emergency care needs are identified.
   1. The Primary Care Provider will determine if the needs can be met by the current providers.
   2. If not, upon approval from the MCP, the Primary Care Provider will complete a referral for needed services.'
      i. Excellus Provider Referral Requests: 1-800-919-8810

SCOPE OF SERVICES: MEMBER TRACKER UPDATES:

A. HH will provide Core Health Home Services to Participants enrolled in the MCP.
   1. Comprehensive Care Management;
   2. Care Coordination and health promotion;
   3. Comprehensive transitional care;
   4. Patient and family support;
   5. Referral to community and social support services.
B. After receiving the weekly referral/assignment list, HH will locate and provide outreach and enrollment services to MCP participants.
C. HH will update DOH daily regarding Participant's status of outreach and engagement activities; enrollments; active care management services; correction of reporting errors; rejections; disenrollment and new referrals, through uploading the member tracking files through the MAPP.
D. MCP will access member tracking files through the MAPP to monitor participant activity.

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QUALITY METRICS-CMART REPORTING:

A. HH will report Participant Care Management activities and acuity scores to DOH through the HCS Application, utilizing the Care Management Assessment Reporting Tool (CMART) on a quarterly basis.
B. MCP will monitor HH performance for Participants, by downloading the reported information from DOH.

BILLING:

A. Encompass Health Home will direct bill for HH services through the MAPP.
B. See Billing Procedure.

QUALITY OVERSIGHT:

A. MCP will monitor the performance of HH and provider network through oversight tools, quality measures and site visits.
B. HH will pro-actively audit and monitor services, to assure on-going, continuous improvement efforts.

BREACH & SECURITY INCIDENT NOTIFICATION:

A. CMA's will notify the Health Home, and respond to and investigate suspected or known privacy and security incidents according to the *Breach Notification and Risk Assessment Actions and Response,* and *Security Incident Reporting, Risk Assessment, & Response* policy and procedures.
B. Following the confirmation of any breach of a MCP's confidential or protected health information, they will be notified within 24 hours of discovery.
    1. If a reported security incident did not rise to the level of a breach, Health Home will inform the MCP of the incident within 5 days of discovery as it relates to implementing improvements to the security and handling of the MCP's information.
C. Within 5 days of the discovery, the Health Home will provide written notification to the MCP which shall include:
    1. A brief description of what happened, including the date of the breach and date of discovery if known, who made the non-permitted access, and who received the information;
    2. A description of types of unsecured protected health information involved in the breach (ie: full name, social security number, date of birth, diagnosis, etc);
    3. A description of what the CMA did to investigate the breach, what was done to mitigate the harm to individuals, and action taken to prevent further non-permitted access or disclosure;

D. The Health Home will cooperate with the MCP in any investigation into a privacy or security incident to meet the MCP's obligation under HITECH and any other security breach notification laws.

MANAGED LONG TERM CARE (MLTC):

A. Participants, who are engaged in a MLTC plan, may receive Health Home services to address needs not provided under the MLTC benefit.
B. The Health Home will contract with MLTC Plans in the service area by signing an Administrative Health Home Service Agreement (ASA), outlining in-plan services and respective responsibilities of the MLTC plan and the Health Home.
C. Once a referral is received and assigned, the Health Home Care Manager will provide Outreach and Engagement, and enroll the member into the Heath Home.
D. The Health Home Care Manager and MLTC will each conduct a Comprehensive Assessment, to assess appropriate needs for each service.
E. The Care Manager and MLTC Coordinator will discuss the collaborative approach for the Participant, and will document the collaboration on the "Care Planning and Coordination for MLTC and Health Homes" Form. (See attached)
    1. The "MLTC/Health Home Care Coordination Agreement" form will also be completed to outline services needed and provided by each entity. (See attached)
    2. The Plan of Care will be attached when completed to the "Care Planning and Coordination for MLTC and Health Homes" form, and will be filed in the Participant's record.
    3. The "Care Planning and Coordination for MLTC and Health Homes" Form will be completed during each reassessment of needs to ensure continuity of care and clear collaborative roles in providing Care Management.
F. The Health Home Care Manager and MLTC Plan will collaboratively develop the Plan of Care.
    1. Clear roles and responsibilities will be clearly outlined in the Plan of Care, and documented in Netsmart, including a determination of which party will serve as the lead Care Manager, and which party has service authorization responsibility.
    2. This decision will be based on the primary needs of the Participant, whether they be primarily behavioral health (Health Home) or long-term health care related (MLTC).
G. The Care Manager will provide Health Home services that fall outside the scope of the services provided by the MLTC plan, and will work collaboratively with the MLTC plan to prevent duplication of services.

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H. The Care Manager and MLTC Plan will communicate regularly to share needed information to update the Plan of Care as required.
    1. The MLTC Plan will be included in all Interdisciplinary Team Meetings.
    2. Any determinations to discharge from Health Home services will be made jointly, and discharge planning will include those services that would continue through the MLTC plan.
I. Care Manager and MLTC Coordinator will work together to assure outcomes and quality measures are met.