



New York State  
Office of Alcoholism & Substance Abuse Services  
Addiction Services for Prevention, Treatment, Recovery

**Transition from Managed Addiction Treatment  
Services (MATS) to Health Home Care Management**

**Interim Instruction:**

**March 8, 2012**

The NYS Office of Alcoholism and Substance Abuse Services (OASAS) MATS program will transition to Health Home Care Management (as each phase of Health Home (HH) implementation is implemented by the NYS Department of Health (DOH). The care management within HHs can be provided by transitioning MATS programs or other programs that contract with the HH. The following guidance is being provided by OASAS to assist MATS programs and their existing resources in its transition to Health Homes.

### **Transition from Managed Addiction Treatment Services (MATS) to Health Home Care Management:**

#### **Care coordination focus**

Health Homes are designed to help people manage chronic health conditions to improve health outcomes and reduce the use of inappropriate inpatient and emergency room care. The care management funded through Health Homes will assess the individual person's physical health, mental health, substance use, and social services needs. The care manager will work with the health home patient to develop an integrated care plan for all physical and behavioral health services. Access to appropriate care will be coordinated by the care manager who will work with an integrated treatment team.

Some Medicaid members assisted during the first wave to Health Homes will have significant behavioral health conditions, many also having co-occurring chronic physical health illnesses. A high percentage of this initial group will be unengaged in ambulatory care and have high usage of services in inpatient and emergency room settings. MATS case managers have worked with this difficult-to-engage patient over the past 5 years and will bring significant knowledge of substance use disorders (SUDs) and their impact on overall physical and mental health. To make the former MATS resource available to those most in need at critical points in their care, OASAS will expect an increased flow of individuals with SUD through the former MATS slots. This can be accomplished because the former MATS resource will now be embedded in a Health Home so people can be stepped down, as needed, to lower intensity care management creating increased availability of high intensity care management slots. With increased availability of high intensity care management slots, people will be able to benefit from rapid engagement with the care manager at the critical points in transition from inpatient to outpatient (key linkage in the continuum of care). They will also benefit from intensive care management to help with engagement in appropriate ambulatory care and social service supports, reducing reliance on detoxification and inpatient use and improving health outcomes. MATS care management slots should be included in Health Homes where current MATS programs exist. MATS providers should ensure that the health home leads identify SUD specifically and that skills and knowledge MATS providers bring to the Health Home are fully integrated.



### **Shifting from MATS to Care Management:**

The MATS model of care in OASAS focused on the plan of care for an individual's SUD barriers and linking to community services to prevent the high use of inpatient and detoxification resources. The model worked within a system that was built around silos of services that did not require case managers to become expert in other systems of care. MATS care managers worked across the silos of care and were responsible for facilitating linkages with a range of medical, mental health, and physical health providers. The Health Home model seeks to eliminate the silos and the care manager will work within an integrated treatment team. The care managers working in the Health Home will need to build and refine their:

- Outreach and engagement skills, motivational interviewing skills and skills to create recipient-centered and strength-based plans of care.
- Knowledge of the physical health care system and the mental health care system.
- Awareness of evidence-based practices and best practices and be able to identify quality providers, such as: integrated dual disorder treatment, individual placement and support, wellness self-management, family education, assertive community treatment, critical time intervention, and medication management.
- Access to the social services system and how to access resources and stay up to date with changing rules regarding benefits and entitlements, housing, employment supports, transportation, self-help groups – all of which may be essential to an individual and their recovery.

### **Assignment of Individuals from Former MATS Slots Who Are Medicaid Eligible:**

Upon implementation of Health Homes, all current MATS enrollees will be assigned to a Health Home by the MATS provider. The MATS care manager will make this assignment based on the Health Home the MATS care management is participating with and the MATS program the enrollee is currently participating in to make an appropriate assignment. The care management program will explain and work to secure the enrollees consent in the Health Home program and to allow patient information to be shared.<sup>1</sup> In NYC the Local Social Services District (LDSS), the Human Resources Administration (HRA) will retain the current referral process.

### **Health Home Services:**

Section 1945(h)(4) of the Affordable Care Act defines health home services as “comprehensive and timely high quality services,” and includes the following Health Home services to be provided by designated Health Home providers or health teams:

- Comprehensive care management;
- Care coordination and health promotion;

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<sup>1</sup> See <http://www.health.ny.gov/forms/doh-5055.pdf>



- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support, which includes authorized representatives;
- Referral to community and social support services, if relevant; and
- The use of health information technology to link services, as feasible and appropriate.

The following definitions are from the NYS Medicaid State Plan Amendment (SPA) recently approved by CMS entitled *Health Homes for Individuals with Chronic Conditions*. Each definition includes health information technology (HIT) expectations that are not included here but may be found on the DOH website:

### **Comprehensive Care Management:**

A comprehensive individualized patient-centered care plan will be required for all Health Home enrollees. The care plan will be developed based on the information obtained from a comprehensive health risk assessment used to identify the enrollee's physical, mental health, chemical dependency and social service needs. The individualized care plan will be required to include and integrate the individual's medical and behavioral health services, rehabilitative, long term care, and social service needs, as applicable. The care plan will be required to clearly identify the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager and other providers directly involved in the individual's care. The individual's plan of care must also identify community networks and supports that will be utilized to address their needs. Goals and timeframes for improving the patient's health, their overall health care status and the interventions that will produce this effect must also be included in the plan of care.

The care manager will be required to make sure that the individual (or their guardian) plays a central and active part in the development and execution of their plan of care, and that they are in agreement with the goals, interventions and time frames contained in the plan. Family members and other supports involved in the patient's care should be identified and included in the plan and execution of care as requested by the individual.

The care plan must also include outreach and engagement activities which will support engaging the patient in their own care and promote continuity of care. In addition, the plan of care will include periodic reassessment of the individual's needs and goals and clearly identify the patient's progress in meeting goals. Changes in the plan of care will be made based on changes in patient need.

### **Care Coordination:**

The Health Home provider will be accountable for engaging and retaining Health Home enrollees in care, as well as coordinating and arranging for the provision of services, supporting adherence to treatment recommendations, and monitoring and evaluating the enrollee's needs. The individualized plan of care will identify all the services necessary to meet goals needed for



care management of the enrollee such as prevention, wellness, medical treatment by specialists and behavioral health providers, transition of care from provider to provider, and social and community services where appropriate.

In order to fulfill the care coordination requirements, the Health Home provider will assign each individual enrollee one dedicated care manager who is responsible for overall management of the enrollee's plan of care. The enrollee's Health Home care manager will be clearly identified in the patient record and will have overall responsibility and accountability for coordinating all aspects of the individual's care. The Health Home provider will be responsible to assure that communication will be fostered between the dedicated care manager and treating clinicians to discuss as needed enrollee's care needs, conflicting treatments, change in condition, etc. which may necessitate treatment change (i.e., written orders and/or prescriptions).

The Health Home provider will be required to develop and have policies, procedures and accountabilities (contractual agreements) in place, to support and define the roles and responsibilities for effective collaboration between primary care, specialist, behavioral health providers and community-based organizations. The Health Home provider's policies and procedures will direct and incorporate successful collaboration through use of evidence-based referrals, follow-up consultations, and regular, scheduled case review meetings with all members of the interdisciplinary team. The Health Home provider will have the option of utilizing technology conferencing tools including audio, video and /or web deployed solutions when security protocols and precautions are in place to protect protected health information to support care management/coordination activities.

The Health Home provider will be required to develop and utilize a system to track and share patient information and care needs across providers, monitor patient outcomes, and initiate changes in care as necessary to address patient need.

#### **Health Promotion Service Definition:**

Health promotion begins for eligible health home enrollees with the commencement of outreach and engagement activities. NYS's Health Home plan for outreach and engagement will require a Health Home provider to actively seek to engage patients in care by phone, letter, health information technology (HIT) and community "in reach" and outreach. Each of these outreach and engagement functions will all include aspects of comprehensive care management, care coordination, and referral to community and social support services. All of the activities are built around the notion of linkages to care that address all of the clinical and non-clinical care needs of an individual and health promotion. The Health Home provider will support continuity of care and health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers. The Health Home provider will promote evidence-based wellness and prevention by linking Health Home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self- help recovery resources, and other services based on individual needs and preferences. Health promotion activities will be utilized to promote patient education and self management of their chronic condition(s).



**Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings) Service Definition:**

Comprehensive transitional care will be provided to prevent enrollee avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing or treatment facility) and to ensure proper and timely follow up care. To accomplish this, the Health Home provider will be required to develop and have a system in place with hospitals and residential/rehabilitation facilities in their network to provide the Health Home care manager prompt notification of an enrollee's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.

The Health Home provider will also have policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings, providers and community-based services to ensure coordinated and safe transition in care for its patients who require transfer to/from sites of care.

The Health Home provider will be required to develop and have a systematic follow-up protocol in place to assure timely access to follow-up care post discharge that includes at a minimum receipt of a summary care record from the discharging entity, medication reconciliation, and a plan for timely scheduled appointments at recommended outpatient providers.

The Health Home care manager will be an active participant in all phases of care transition: including: discharge planning and follow-up to assure that enrollees received follow up care and services and re-engagement of patients who have become lost to care.

**Individual and Family Support Services (including authorized representatives) Service Definition:**

The patient's individualized plan of care will reflect and incorporate the patient and family or caregiver preferences, education and support for self-management; self-help recovery, and other resources as appropriate. The provider will share and make assessable to the enrollee, their families or other caregivers (based on the individual's preferences), the individualized plan of care by presenting options for accessing the enrollee's clinical information.

Peer supports, support groups, and self-care programs will be utilized by the Health Home provider to increase patient and caregiver knowledge about the individual's disease(s), promote the enrollee's engagement and self management capabilities, and help the enrollee improve adherence to their prescribed treatment. The provider will discuss and provide the enrollee, the enrollee's family and care givers information on advance directives in order to allow them to make informed end-of-life decisions ahead of time.

The Health Home provider will ensure that all communication and information shared with the enrollee, the enrollee's family and caregivers is language, literacy and culturally appropriate so it can be understood.



### **Referral to Community and Social Support Services Service Definition:**

The Health Home provider will identify available community-based resources and actively manage appropriate referrals, access to care, engagement with other community and social supports, coordinate services and follow-up post engagement with services. To accomplish this, the Health Home provider will develop policies, procedures and accountabilities (through contractual agreements) to support effective collaboration with community-based resources, that clearly define the roles and responsibilities of the participants.

The plan of care will include community-based and other social support services, appropriate and ancillary healthcare services that address and respond to the patient's needs and preferences, and contribute to achieving the patient's goals.

### **Reimbursement for individuals assigned to Care Management:**

OASAS currently funds MATS CM slots through contracts with local government units (LGU) which in New York City is the Department of Health and Mental Hygiene (NYCDHMH). During the transition to Health Homes, contracted funds will be available to assist with transition and implementation issues for MATS providers. All current MATS clients will transition to Health Homes within the first month of implementation.

Upon conversion to Health Home services the MATS provider will bill NYS Medicaid directly through eMedNY for services provided in the previous month using the MATS Medicaid rate code. OASAS and DOH have established a Health Home MATS transition rate which will reimburse MATS providers a rate comparable to the current MATS reimbursement.

### **Definitions:**

- **Health Home MATS rate** – a Health Home rate code that may be billed for a portion (see calculation below) of the slots that were part of the former MATS provider's total average slot capacity. This rate has been calculated in an attempt to produce the same annual contracted amount collected by the provider under the former MATS program.
- **Health Home Services rate**– a Health Home rate code that may be billed for slots filled with Medicaid enrollees assigned to your care management program in excess of the number of slots authorized to be billed to the Health Home MATS rate. This will produce Medicaid revenue in addition to the annual Medicaid revenue previously collected by the provider under MATS contract. This is also the regular Health Home services rate.

### **Medicaid claims**

When a MATS provider replaces a current MATS enrollee with a new enrollee in a slot that may be billed at the Health Home MATS rate, they will have to submit claims to "eMedNY" using two rate codes:

1. The outreach and engagement rate (rate code 1883) will be available for up to three months by the local process or may be used to attempt to re-engage a MATS enrollee who chose to opt out of Health Home enrollment after the former MATS program is



converted to case management. This code is used until the person signs the “consent” agreement, by which the enrollee is agreeing to allow his/her health information to be shared among the Health Home partners, which can be a Regional Health Information Organization (RHIO). This code may be used up to three months. The outreach and engagement rate will be 80 percent of the full Health Home services rate. At the conclusion of this three month cycle, outreach and engagement claims are not permitted until another three months have passed. (The number of cycles of “outreach and engagement” reimbursement, i.e. three months of “O & E” claims and three months without claims, has not yet been determined.)

2. The Health Home MATS rate (rate code 1882) for care management is the Health Home/MATS rate discussed above for existing MATS enrollees who sign the “consent” within 3 months of the program’s conversion from MATS to Health Home care management, the existing MATS enrollees who do not sign the consent within 3 months and all new individuals assigned to these slots per the LGU/Health Home agreement.

Individuals that are not filling a Health Home MATS slot will be billed at the Health Home services rate will have claims submitted to eMedNY using two rate codes:

1. The outreach and engagement rate (rate code 1387) will be available for up to three months for individuals referred by the local process or may be used for a transitioning MATS enrollee who chooses to opt out of Health Home enrollment after the former TCM program is converted to care management. This code is used until the person signs the “consent” agreement, by which the enrollee is agreeing to allow his/her health information to be shared among the Health Home partners, which can be a Regional Health Information Organization (RHIO). This code may be used up to three months. The outreach and engagement rate will be 80 percent of the full Health Home service rate. At the conclusion of this three-month cycle, outreach and engagement claims are not permitted until another three months have passed. (It has not been determined the number of cycles that outreach and engagement may be billed by care management.)
2. The Health Home services rate (1386) care management. The rate code applies to all Health Home enrolled individuals assigned to the ex-MATS provider other than those claimed to Medicaid using the 1882/1883 rate codes. (The rate paid will be the same as paid to the Health Home for all other individuals, but only individuals assigned to the ex-MATS providers per the LGU-Health Home agreement and/or the ex-MATS-Health Home agreement regarding additional slots can be claimed directly to eMedNY.

The Date of Service for all claims will be the first day of the month based on “status” at the end of the claimed month (i.e., a client who signs a consent on March 28th will be claimable to eMedNY with the Date of Service of March 1).

The initial claims using any of the rate codes above must be held until the third week of the second month, i.e., in the example above, until about April 20, to allow the WMS registration process to be completed and the initial claim to be paid by eMedNY.



Care managers must provide at least one of the five care management Health Home services (not including the HIT service) per quarter. There must be evidence of activities that support billing, including:

- Contacts (face-to-face/no required minimum, mail, electronic, telephone)
- Patient assessment
- Development of a care management plan
- Active progress towards achieving goals

### **The Role of the State Agencies**

The state agencies are designating, not licensing, Health Homes. Similarly, NYS is providing guidance and not issuing regulations for its governance of Health Homes at this time. The relationship between the Health Home lead and members of the Health Home network, including the former MATS providers, will be indicated by the subcontract(s) with the Health Home and members of the Health Home network. NYS DOH will provide care management and Health Homes guidance regarding documentation and services to support a Medicaid claim. However, only the Health Homes and the care management providers (including MATS, TCM, COBRA CM, CIDP, etc.) will receive Health Home reimbursement either through eMedNY or from the Medicaid Managed Care Plans (CM providers will bill eMedNY directly as previously indicated). Therefore, the former MATS providers will have unique responsibility as part of the Health Home initiative to provide information (including care management metrics and patient functional status information) to the Health Home lead, the managed care plans and DOH, in addition to the information expectations of the LGU.

### **The Role of OASAS**

OASAS is providing this guidance to be followed by MATS providers (additional Health Home billing guidance will be distributed by NYS DOH in a Medicaid Update Article). OASAS will provide ongoing information and communication about billing and clinical transitional issues.

### **Role of the LDSS and LGU**

As part of MATS the local DSS and LGU may have in place referral processes that have worked to identify likely high utilizers of Medicaid services who have a significant SUD. This process can stay in place, at least during the first-year transition period. The eligibility for Health Homes should be utilized in determining whether a Health Home referral is needed.

- The former MATS slots must remain assigned to and available only to individuals with serious SUD. These resources were provided to serve the community of individuals with SUD who have a high level of care management needs.



- The LGU should expect that care management slots will turnover at a quicker pace than the former MATS program slots have traditionally and close management of the system will allow more people to be better served.
- There will be HIT requirements of each Health Home, the Health Home network members and most certainly for the care managers serving the high intensity need Health Home assignees.

