

# Healthy Pathways Program

The Healthy Pathways program provides rapid engagement to members experiencing impaired emotional health because of a potential mental health or substance use disorder issue when: the member is ineligible for other case management services, eligibility for case management is unknown, or the member is currently receiving a higher level of services and needs step-down support.

## Eligible Providers

Healthy Pathways case management is provided by a qualified Mental Health Targeted Case Manager or ARMHS worker in the human services field and is employed in one of South Country's County partner, or behavioral health subcontractor agencies. In lieu of bachelor's degree a mental health practitioner or qualified county agency case manager may also provide case management.

## Eligible Members

The member must be:

- Enrolled with South Country Health Alliance;
- Age 17 or older;
- Residing in the community;
- Displaying a probable mental/chemical health concern at the time of the first encounter, which would include 1 or more of the following:
  - Connecting with providers or other Medicaid services
  - Transition – Step down (i.e. from MH-TCM)
  - Housing Support
  - Substance Use Disorder

A member with Care Coordination may be eligible for Healthy Pathways for up to six months to connect the member to mental/chemical health services, case management or care coordination.

## Duplicative Services

- MH-TCM/CMH-TCM
- ACT
- BHH
- Residential treatment
- Adult Day Treatment

\*If the member is transitioning to one or more of the above services, a one-month overlap is permitted.

## Case Manager Role

The Case Manager connects the member to ongoing treatment services, care coordination services, Medicaid benefits, and available supports, based on the member's priorities, needs and goals.

*\*Requires monthly contact either face to face or telephonic. An actual face to face contact must occur every three months.*

## Case Manager Services

### Intake & Assessment

- Determine member's needs, preferences, and current functioning to set a primary goal.
- Complete release of information forms with member.
- Review any discharge summary or recommendations from previous service to guide future goals and activities.
- Identify triggers/signs of distress and identify positive coping skills the member can access in the future.
- Assess housing barriers to determine housing and service needs.
  - i.e.: legal problems, mental health and substance use disorder issues, previous evictions, etc.
- Assess the member's living arrangement for safety concerns.
- Identify natural supports to assist member in remaining housed and support independent living, mental health, and sobriety (includes communication with supports on behalf of member).
- Determine what other engagement staff are involved.
  - i.e.: care coordinator, mobile crisis team, certified peer specialist, regional crisis center, and other community providers.
- Assess member's preferences for SUD treatment.
  - i.e.: inpatient, outpatient, dual diagnosis program, AA, sober living, virtual support group, peer support, MAT, etc.

### Implementation of Support Plan

- Calling agencies to determine availability.
  - i.e.: mental health agencies, clinics, and residential providers.
- Identifying community supports member might use to address their current situation.
  - Schedule times to access these resources.
- Completing paperwork, applications and referrals to member's chosen providers.
- Completing rental or housing applications with the member present or on their behalf.
- Finding temporary housing until more permanent housing can be accessed.
- Calls, referrals, and forms for mental health and SUD services.
- Meeting with member to discuss the results of their comprehensive assessment and

refer member to identified/preferred provider.

- Referring member to an agency to apply for Social Security Disability.
- Accompanying member to community resources, such as a food shelf, Salvation Army or essential appointments.
- Assist member in creating reminder system of upcoming appointments.
- Calling possible housing options without member present.
- Identifying resources to pay for deposits, moving expenses or home goods.
- Connecting the member to MA reimbursable services.
- Assisting member to implement aftercare plan upon completion of SUD program.
- Coordinating care including communicating with providers, transitioning member to assigned care coordinator and making plans to address gaps in care.
- Creating a long-term budget system with member to pay rent, utilities, food, and other necessities.

## Case Aide Role

The case aide will assist the case manager with delegated administrative duties related to the Health Pathways Program services. The case aide must be employed by an agency that provides the Health Pathways Program, and have at a minimum, a high school diploma (GED). Case Aide duties require telephonic or face to face contact with the member.

*\*These are not exclusive to the case aide and may be completed by case manager.*

## Case Aide Services

### Resource Identification and Appointments

- Accompanying a member to community resources such as a food shelf or Salvation Army.
- Communicating with the member to remind them of upcoming appointments and any reminder systems already in place.
- Calls to possible housing options without member present.
- Identifying resources to pay for deposits, moving expenses or home goods.

### Paperwork

- Assisting the member to complete paperwork to establish or maintain eligibility for health care benefits.
- Assisting the member to obtain required legal documents to access housing.

### Transportation

- Scheduling transportation for appointments.
- Identifying transportation resources (public transit, friends/family, medical transportation etc.).
- Transporting the member to needed appointments.

### Money Management

- Assisting the member with shopping for food and clothing, paying bills, and other activities of daily living.
- Assisting the member to utilize the budget created with the Healthy Pathways Case Manager to make payments for rent, utilities, food and other necessities.

## Expected Milestones & Outcomes

The following are expectations for the Healthy Pathways Program

1. Rapid engagement in the Healthy Pathways Program.
2. Establishing connection of resources within the first three months of the program.
3. Improvement of the members' overall mental/chemical health functioning.
4. Connection to other mental/chemical health services, case management or care coordination.
5. Member will graduate from Healthy Pathways within 12 rolling months from the initiation of services.
6. Upon completion of goals the end assessment is due as soon as possible and no more than 30 days

## Monitoring and Evaluation of Outcomes

### Assessment

An assessment and member questionnaire will be conducted at the start of services and before proceeding to the next tier via the authorization process and at the end of the program.

### Care Plan

Within the first month of member engagement, a plan of care must be established to address no more than three goals. Each goal should be anchored to one of the following areas:

- Connecting with providers or other Medicaid services
- Transition – Step down (i.e. from MH-TCM)
- Housing Support
- Substance Use Disorder

### Documentation

All contacts with the member and a brief summary of work completed with and for the member are required to be documented in narrative form in the member's case file.

## Authorization Procedure

- The member will progress through tiers one through four corresponding to the length of time open to Healthy Pathways.
- A reassessment and member questionnaire is required with every authorization submission.

- a. Tier one through three: every three months
- b. Tier four: every six months
- c. Timely authorization requests are required within 30 days for each tier.
- On tier four, the authorization request will require submission of the member's care plan and case notes with the authorization request. Case Manager will need to display a clear rationale to continue Healthy Pathways including care plan and clear objectives and progress notes.
- If there is a break in service, the Case Manager and South Country will communicate to determine the appropriate tier to re-engage the member.
- Members stepping down from MH-TCM into HP will start at tier three.

### Billing

- Submit claim with the facility NPI as the billing and rendering provider.
- Case Manager billing code: **G9006 XX** (with the appropriate tier modifier).
- Case Aide billing code: **G9006**
- If a claim is not received within ninety days of the last authorization or claim, South Country presumes the program has ended and will reach out to the Case Manager if no end of program assessment was completed.

### Program Benefits Grid

- Providers are only allowed to submit one claim per month for either Case Management or Case Aide.
- In the event of a billing error, the payment will default to the case aide.

| Tier | Length - by month | Code  | Modifier | Rate per month |
|------|-------------------|-------|----------|----------------|
| 1    | 1 – 3 (3)         | G9006 | U1       | \$350          |
| 2    | 4 – 6 (3)         | G9006 | U2       | \$300          |
| 3    | 7 – 9 (3)         | G9006 | U3       | \$250          |
|      | 10-12 (3)         |       |          |                |
| 4    | 13 + (6)          | G9006 | U4       | \$150          |
|      | Case Aide         | G9006 |          | \$100          |

*\*Based on the case manager assessment South Country may assign a repeat higher tier 1 x in a rolling 12 months.*