

Health Homes Provider Manual

Billing Policy and Guidance



State of New York

Department of Health

The purpose of this Manual is to provide Medicaid policy and billing guidance to providers participating in the New York State Medicaid Health Home Program.

Note: Although every effort has been made to keep this policy manual updated, the information provided is subject to change.

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Preface

The purpose of this Manual is to provide Medicaid policy and billing guidance to providers participating in the New York State Medicaid Health Home Program. It is designed to provide instructions to complete and submit forms and documents relating to billing procedures and to provide links to additional information.

Policy statements and requirements governing the Health Home Program are included. The Manual is formatted to incorporate changes as additional information and periodic clarifications are necessary.

Before rendering service to a client, providers are responsible for familiarizing themselves with all Medicaid procedures and regulations, currently in effect and those issued going forward, for the Health Home Program. The Health Home Program is an optional service under the New York State Medicaid State Plan.

Be advised that the Department of Health publishes a monthly newsletter, the *Medicaid Update*, which contains information on Medicaid programs, policy and billing. It is sent to all active enrolled providers. New providers should be familiar with current and past issues of the *Medicaid Update* to be current on policy and procedures.

Note: Although every effort has been made to keep this policy manual updated, the information provided is subject to change. Medicaid program policy concerning this Health Home initiative may be found at the Department of Health's website listed below.

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

Statutory Authority and Overview of Health Homes

Patient Protection and Affordable Care Act

The goal of Health Homes is to improve care and health outcomes, lower Medicaid costs and reduce preventable hospitalizations, emergency room visits and unnecessary care for Medicaid members.

Health Homes is an option afforded to States under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703, allows states under the state plan option or through a waiver, the authority to implement health homes effective January 1, 2011. The purpose of Health Homes is to provide the opportunity to States to address and receive additional federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons with chronic illness. States approved to implement Health Homes will be eligible for 90 percent Federal match for health home services for the first eight (8) fiscal quarters that a health home state plan amendment is in effect.

State Medicaid Director Letter: Health Homes for Members with Chronic Conditions

State Medicaid Director Letter (SMDL), #10-024, Health Homes for Members with Chronic Conditions, provides preliminary guidance to States on the implementation of Section 2703 of the Affordable Care Act, entitled “State Option to Provide Health Homes for Members with Chronic Conditions.” A link to the State Medicaid Director’s letter has been provided below for additional information:

<http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf>

The authority to implement Health Homes is included in Section 1945 of the Social Security Act and in NYS Social Services Law Section 365-I and all other applicable State and Federal responsibilities for those Health Home providers that may hold specific license(s) and/or certificate(s) apart from their Health Home provider

designation. Upon issuance of final federal regulations, NYS will need to comply with regulatory requirements, which may include amending the Health Home SPAs.

The Health Home Program was one of seventy-nine (79) recommendations endorsed by Governor Andrew Cuomo's Medicaid Redesign Team (MRT) which was charged to find ways to reduce costs and improve the quality and efficiency of care within the New York Medicaid program.

The 2011 New York State (NYS) Executive budget provided for the establishment of a model for person-centered integrated care coordination and care management services called Health Homes. Authorization for the establishment of Health Homes was included in the Affordable Care Act (P.L. 111-148 & P.L.111-152), Section 2703 (SSA 1945b) and the NYS Social Services Law Section 365-l entitled "State option to provide Health Homes for members with chronic conditions under the Medicaid State Plan."

On February 3, 2012 the US Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) approved New York State's first State Plan Amendment (SPA) #11-56, Health Home SPA for Individuals with Chronic Conditions, Phase 1 of the Health Home Program with an effective date of January 1, 2012. On December 4, 2012 CMS approved two additional Health Home SPAs for Phase 2 (SPA #12-10) and Phase 3 (SPA #12-11) with effective dates of April 1, 2012 and July 1, 2012 respectively. The combined approval of these three SPAs allows for statewide implementation of the Health Home Program.

http://www.ssa.gov/OP_Home/ssact/title19/1945.htm#ftn490

Conversion of Care Management Programs to Health Homes

As of the effective date of each Health Home SPA, the State converted a subset of existing case management programs into Health Homes. The case management programs converted to Health Homes include: a portion of OMH Targeted Case Management (TCM), HIV COBRA TCM, and the OASAS Managed Addiction Treatment Services (MATS) program.

For additional information concerning Health Home partner resources refer to the link below.

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/partner_resources.htm

New York State Office of Mental Health (OMH):

http://www.omh.ny.gov/omhweb/adults/health_homes/

New York State Office of Alcoholism and Substance Abuse Services (OASAS):
<http://www.oasas.ny.gov/admin/hcf/documents/MATSTransition.pdf>.

New York State Department of Health, AIDS Institute: www.cobracm.org

Section I: Introduction to Health Home Service Model

1.1 Overview of the Health Home Model for Members with Behavioral Health and/or Chronic Medical Conditions

Health Home is a care management service model where all of the professionals involved in a member's care communicate with one another so that the member's medical, behavioral health and social service needs are addressed in a comprehensive manner. The coordination of a member's care is done through a dedicated care manager who oversees and coordinates access to all of the services a member requires in order to facilitate optimum member health status. It is anticipated that the provision of appropriate care management will reduce avoidable emergency department visits and inpatient stays, and improve health outcomes. With the member's consent, health records will be shared among providers to ensure that the member receives needed unduplicated services.

Health Home services will be provided through a State Designated Health Home, defined as partnership of health care providers and community based organizations. Health Homes are responsible to facilitate linkages to long-term community care services and supports, social services, and family support services. For Medicaid managed care members, Health Home services are provided through partnerships between the member's Managed Care Plan and an assigned Health Home through contractual arrangements.

The Health Home model of care differs from a Patient-Centered Medical Home (PCMH). The PCMH is a model of care provided by physician-led practices. The physician-led care team is responsible for coordinating all of the individual's health care needs, and arranging for appropriate care with other qualified physicians and support service providers. The Federal Patient Protection and Affordable Care Act anticipates that the Health Home model of service delivery will expand on the traditional medical home model to build linkages to other community and social supports and to enhance coordination of medical and behavioral health care, with the main focus on the needs of persons with multiple chronic illnesses.

A Health Home member may be enrolled in a Health Home and also receive services at a PCMH. A PCMH may also choose to apply to become a Health Home. Provider reimbursement will be allowed for a beneficiary who is in receipt of services from both a PCMH and a Health Home.

1.2 Federal Health Home Population Criteria

Health Home services are provided to a subset of the Medicaid population with complex chronic health and/or behavioral health needs whose care is often fragmented, uncoordinated and duplicative.

This population includes categorically and medically needy beneficiaries served by Medicaid managed care or fee-for-service and Medicare/Medicaid dually eligible beneficiaries who meet Health Home criteria. Individuals served in a Health Home must have at least two chronic conditions; or one qualifying chronic condition and be at risk of developing another; or one serious mental illness. The chronic conditions described in Section 1945(h)(2) of the Social Security Act include, but are not limited to, the following:

- Mental Health Condition
- Substance Use Disorder
- Asthma
- Diabetes
- Heart Disease
- Overweight as evidenced by a body mass index (BMI) of 25
- HIV/AIDS
- Other Chronic Conditions

Note: As of November 2012, Health and Human Services (HHS) announced HIV/AIDS as an additional diagnosis to the list of qualifying chronic conditions.

Additional information on Health Homes for individuals with chronic conditions is contained in (approved) Health Home SPA, #11-56, which may be viewed by visiting the link below.

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/chronic_conditons_spa_11-56_phase.pdf

1.3 Federal Core Health Home Services

The Health Home service delivery model is designed to provide cost-effective services that facilitate access to a multidisciplinary array of medical care, behavioral health care and community-based social services and supports for individuals with chronic medical and/or behavioral health conditions. Health Home services support the provision of coordinated, comprehensive medical and behavioral health services through care coordination and integration. The goal of these core services is to ensure access to appropriate services, improve health outcomes, reduce preventable hospitalizations and

emergency room visits, promote use of Health Information Technology (HIT), and avoid unnecessary care.

Section 1945(h)(4) of the Social Security Act defines Health Home services as "comprehensive and timely high quality services" and includes six Health Home services to be provided by designated Health Home providers.

Health Home Services include:

1. Comprehensive care management;
2. Care coordination and health promotion;
3. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
4. Individual and family support, which includes authorized representatives;
5. Referral to community and social support services if relevant; and
6. The use of HIT to link services, as feasible and appropriate.

Health Home providers will be required to maintain written documentation that clearly demonstrates how these core requirements are being met. Further information concerning the six core services is available at this link:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/provider_qualification_standards.htm

1.4 Federal Health Home Provider Functional Requirements

The Health Home model of service delivery supports the provision of timely, comprehensive, high-quality health homes services that operate under a whole person approach to care. The whole-person approach to care addresses all of the clinical and non-clinical care needs of the individual. Section 1945(b) of the Social Security Act requires providers of Health Home services to address/provide the following functional components.

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
4. Coordinate and provide access to mental health and substance abuse services;
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes

- appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
 7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
 8. Coordinate and provide access to long-term care supports and services;
 9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;
 10. Demonstrate a capacity to use Health Information Technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
 11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Additional information regarding Federal Health Home Functional Requirements may be found at:

<http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf>

1.5 New York State Provider Qualification Standards for Health Homes

To assure that New York Medicaid Health Homes meet the proposed Federal Health Home model of service delivery standards and State standards, “Health Home Provider Qualification Standards for Chronic Medical and Behavioral Health Patient Populations” were developed. These standards set the ground work for assuring that Health Home members will receive appropriate and timely access to medical, behavioral, and social services in a coordinated and integrated manner. Health Homes will be closely monitored to assure that Health Home standards are being met.

Information on Health Home provider qualification standards may be found at the following links:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/provider_qualification_standards.htm

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/federal_requirements.htm

Section II: Requirements for Health Home Participation

2.1 Health Home Application

During specific designated application periods, and as directed by the New York State Department of Health (NYSDOH), organizations may apply to participate in the Health Home Program. Enrollment periods for additional Health Homes will be determined by the State as needed. If the State determines that there is a need for additional Health Homes, specific instructions for completing a Medicaid Health Home provider application will be posted to the Health Home website.

The State also reserves the right to allow previously designated Health Homes to apply to meet supplemental standards for the provision of Health Home services to other populations as authorized under the State Plan Amendment.

The State has designated Health Homes statewide in three geographic phases. These Health Homes are designated for an initial period of three years from the effective date of the respective State Plan Amendment for the Phase in which the Health Home is operated.

- Phase 1 effective date is January 1, 2012;
- Phase 2 effective date is April 1, 2012; and
- Phase 3 effective date is July 1, 2012.

A list of the designated Health Homes can be found at:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/prov_lead_designated_health_homes.htm.

For a phase-in schedule of Health Homes by county, refer to Figure 2, located in **Section 12**, *Summary of Charts and Tables*.

After the initial three year period of designation, the DOH, OMH and OASAS will collaboratively review each Health Home's performance to determine if the program will be redesignated. State redesignation of Health Homes will be determined based on the needs of the State, compliance with Federal and State program requirements designed to meet Health Home goals of decreased inappropriate inpatient admissions and emergency department visits, and improved health outcomes of members.

Performance on process and quality metrics, effective engagement, and retention rates and member satisfaction of enrolled Health Home members will be considered.

New York's Health Home infrastructure includes Designated Health Homes working with multidisciplinary teams of providers. Medicaid providers eligible to become Health Homes include:

- Hospitals;
- Medical, mental health and chemical dependency treatment providers and/or clinics;
- Primary care practitioner practices;
- Patient Centered Medical Homes;
- Federally Qualified Health Centers;
- Targeted Case Management providers;
- Certified Home Health Care Agencies; and
- Any other Medicaid enrolled provider(s) that meet Health Home provider qualification standards

2.2 Provider Enrollment Instructions for Health Homes

Once a Health Home application has been reviewed and approved by the State, the Health Home provider will receive a letter of notification from the Department of Health indicating their status as a Designated Health Home. Any contingencies to the designation will be identified and described in this letter. The contingently designated Health Home is required to respond within an appropriate timeframe with an acceptable plan that addresses any contingencies to the satisfaction of the State in order to become officially designated.

2.3 Designated Health Home Disenrollment

If a Health Home elects to discontinue provision of Health Home services, six month advance notice is required to the Department of Health (DOH). Health Home services may not be discontinued without a DOH approved closure/services cessation plan, which includes proper procedures for clinically appropriate member transition.

2.4 Health Home Provider Eligibility and Enrollment of the NYS Medicaid Program

Designated Health Home providers must be or apply to become a New York State Medicaid enrolled provider with a Category of Service (COS) 0265 (Case Management).

In order to be enrolled (or be eligible for enrollment) in the State's Medicaid program the applicant must agree to comply with all Medicaid program requirements. Health Home providers can either directly provide, or subcontract for the provision of, Health Home services. The Health Home provider is responsible for all Health Home program requirements, including services performed by the subcontractor(s). A Medicaid provider enrollment application for Health Homes can be obtained at:

<http://www.emedny.org/info/providerenrollment/index.aspx>.

Once located, scroll to the bottom of the page and select the "Case Management Provider (CMCM)" link.

Completed applications should be sent to Computer Science Corporation (CSC) at the address provided in the application instructions. Questions regarding the provider enrollment applications should be directed to CSC at 1-800-343-9000.

Note: Designated Health Home providers that may hold specific license(s) and/or certificate(s), such as Article 28 of the Public Health Law, and/or Article(s) 31 and 32 of the Mental Hygiene Law may have additional requirements established by the respective governing bodies. For additional information, including agency contacts, refer to the Department's Health Home website at the link below:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/medicaid_enroll_prov-led_hh_rev.htm

2.5 Health Home Partner Network Development

Designated Health Homes provide the Department of Health (DOH) an updated organizational partner list upon initial designation and on an ongoing basis as needed in order to facilitate member assignments. Health Homes are required to complete a Medicaid Data Exchange Application and Agreement (DEAA) and their network partners are required to complete a DEAA subcontractor packet in order to receive and share member assignment lists. For additional information, refer to **Section 2.9 Medicaid Data Exchange Application and Agreement (DEAA)**.

2.6 Health Home Referral Requirement of Hospitals

As required by Section 1945(3)(d) of the Social Security Act, all hospitals must have procedures in place for referring any eligible individual with chronic conditions who seek or needs treatment in a hospital emergency department to a Department of Health Designated Health Home.

2.7 Use of Medicaid Enrolled Providers for Provision of Care Management Services

Network partners providing care management services should be NYS Medicaid enrolled providers with a Medicaid Management Information System (MMIS) provider identification number. A MMIS number is required to communicate Health Home member billing, and process and quality metrics between the Department of Health, MCPs, and Health Homes.

2.8 Use of Network Partners that are Non-Medicaid Enrolled Providers

Designated Health Homes and contracted network care management agencies are encouraged to use Medicaid enrolled providers but the State understands that Health Homes may not always have the option to do so, in those instances Health Homes may contract with non-Medicaid providers to deliver Health Home services. The contracted services may include but are not limited to care management, peer counseling, outreach and engagement, nutrition, vocational or housing supports, in which case it is up to the entities involved to form partnership and payment agreements to reimburse providers commensurate with the level of services provided. The State expects that Designated Health Homes will be responsible to monitor the appropriateness, timeliness and quality of services provided by these non-Medicaid providers. If these providers are paid from the Health Home per member per month (PMPM) fee, Designated Health Homes must ensure that all payment agreements include the following:

- The non-Medicaid provider must certify that information submitted in support of services is accurate, complete and truthful and certify that they will not submit false claims for payment;
- The non-Medicaid provider must agree to comply with laws designed to prevent fraud and abuse;
- The non-Medicaid provider must agree to report to the Health Home any incidents, suspected fraud, waste, or abuse or criminal acts;
- The non-Medicaid provider agrees to be bound by the confidentiality provisions (2.9 of the Administrative Health Homes Services Agreement); and
- The non-Medicaid provider must certify that none of its owners, employees or contractors is an Ineligible Person. “Ineligible Person” means an individual or entity who (1) is ineligible to participate in Federal health care programs, (2) has been convicted of a criminal offense subject to OIG’s mandatory exclusion authority described in Section 1128(a) of the Social Security Act, or (3) is

currently ineligible to participate in State medical assistance programs, including Medicaid or CHIP, or State procurement or non-procurement programs as determined by a State governmental authority.

Model language for these agreements and references to the applicable laws and statutes can be found in Sections 6.18, 6.19, and 6.20 of the Administrative Health Home Services Agreement being used for Health Homes and Managed Care Plans to use for the delivery of Health Home services. It is available on the Health Home website at:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/administrative_health_home_services_agreement.pdf

2.9 Medicaid Data Exchange Application and Agreement (DEAA)

All Designated Health Homes must complete and submit the DEAA to the Medicaid Privacy Coordinator and receive approval, in order to obtain the Health Home Member Tracking File for initial member assignment. DEAA's must be updated as network partnerships evolve, to continue to share demographic data with the Designated Health Home and facilitate outreach and engagement. Completed DEAA applications should be sent to:

Privacy Coordinator
New York State Department of Health
Office of Health Insurance Programs
Division of Program Development and Management
Empire State Plaza
Corning Tower, OCP-720
Albany, New York 12237

The purpose of the DEAA is to provide information supporting the Health Home request for the release of Medicaid Confidential Data (MCD) and to serve as the basis for assessing the appropriateness of releasing MCD. A DEAA must be completed and approved prior to the State's release of member lists, which are considered MCD and Protected Health Information (PHI). In addition, the DEAA, when approved by the NYSDOH, forms an agreement between the applicant and NYSDOH as to the terms and conditions under which the release of member data will be made.

Medicaid Confidential Data/Protected Health Information includes all information about a protected recipient or applicant as well as enrollment information and eligibility data. Health Home partners that will receive member lists prior to members consenting to Health Home services are required to complete a DEAA subcontractor packet.

Subcontractor packets must be approved in order for the Health Home to share member information with the Health Home network partners.

The subcontractor packet requires sections to be completed by both the Designated Health Home and the subcontractor. Medicaid providers that may be involved in the treatment of their members who are NOT providing care management services to members prior to consent for health home services (e.g. outreach and engagement) are NOT required to complete the DEAA packet as their privacy and confidentiality issues are covered under their regular provider packet with Medicaid.

Behavioral Health Organizations (BHOs) have contracts with the Office of Mental Health (OMH), as well as DEAAs with the NYSDOH, which allow them to receive data from OMH. The State has entered into contracts and DEAAs with five regional (BHOs). The BHOs are monitoring fee-for-service Medicaid admissions for inpatient psychiatric care and detoxification services and reviewing discharge planning.

Health Homes are encouraged to execute a Confidentiality Agreement with their regional BHO that would allow the Health Home to receive alerts if a member is admitted for these services. NYSDOH requests that a copy of this Agreement be sent to the Privacy Coordinator. The Health Home and BHO can work together on discharge planning and the BHO also may include the Health Home as part of the discharge planning process.

2.10 Health Home Changes to Originally Approved Health Home Application

Health Homes are responsible to adhere to the Health Home provider qualification and standards, functional requirements, and guidelines as outlined by the Centers for Medicare and Medicaid Services (CMS), in the State Medicaid Director Letter (SMDL) #10-024, Health Home for Enrollees with Chronic Conditions. If a Health Home intends on making changes to their originally approved Health Home application and designation letter then a *Health Home Notification Letter* attesting to the applicable revision(s) must be completed, signed by the Health Home CEO/Executive Director, and submitted to the Department of Health for review. Submitting a completed *Health Home Notification Letter* will allow the DOH to update the Health Home file, provide any needed guidance regarding provider enrollment and advise on any requirements that may result from changes in the partner network (i.e. including amendments to Data Exchange Agreement Applications (DEAAs) and Health Home Consent Forms). Changes to the Health Home infrastructure/organization may include, but are not limited to, the following:

- Health Home Name,
- National Provider Identifier (NPI),

- Billing Agent,
- DEAA, and
- Partner Network.

Changes to the Health Home partner network need to be reported by using the *Health Home Notification Letter* outlined above only if the change:

- (a) will result in the Health Home's inability to offer the full range of Health Home services as submitted in the initial application, or
- (b) will impact the Health Home's ability to remain in compliance with Health Home standards and guidelines as outlined by the CMS, in the State Medicaid Director Letter (SMDL) #10-024, Health Homes for Enrollees with Chronic Conditions, or
- (c) was a result of a failure of a partner to meet expectations, or
- (d) includes changes or additions of care management agencies, or other partners receiving member demographic data prior to obtaining the Health Home consent; this may require either an application to amend the existing DEAA or the need to file a new DEAA.

A copy of the *Health Home Notification Letter* can be found on the following link:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/medicaid_enroll_prov-led_hh_rev.htm

The *Health Home Notification Letter* and questions concerning it may be submitted electronically to the Health Home mailbox at this link:

HealthHome2013@health.state.ny.us

The subject "Provider Enrollment/Network Changes" should be used in the subject line of your email. Questions may also be directed to the DOH Health Home program at (518)-473-5569.

Section III: Claims Submission and Billing for Health Home Services

3.1 General Requirements for Health Home Claim Submission

There are three types of providers that may bill Health Home Rate codes. The three types of providers include:

- Converting Case Management providers, (Includes Chronic Illness Demonstration Project (CIDP), the Office of Mental Health Targeted Case Management (OMH TCM), the AIDS Institute's COBRA TCM, and the Office of Alcoholism and Substance Abuse Services (OASAS) Managed Addiction Treatment Services (MATS) providers),
- Health Homes, and
- Managed Care Plans.

The provider types bill Medicaid claims for Health Home services as follows:

- During the two year transition period, converting Case Management providers (OMH TCM, COBRA TCM and MATS providers) bill eMedNY directly for all their patients including fee-for-service and managed care members receiving Health Home services from the converting case management provider.
- Health Homes bill eMedNY directly for fee-for-service members receiving Health Home services from a care management provider that is not a converting care management provider. Health Homes then distribute payments to any downstream partners and care management agencies commensurate with their effort.
- Managed Care Plans bill eMedNY directly for plan members receiving Health Home services from a care management provider which is not a converting CM provider. Managed Care Plans then distribute payments to Health Homes who in turn distribute payments to their downstream partners and care management agencies.

This section provides guidance to Health Homes billing for fee-for-service members. Refer to **Section 3.3** for information on billing for converting case management programs and **Section 3.6** for information on rate sharing between Health Homes and Managed Care Plans.

The care management fee will be paid in two increments based on whether a member is in the: 1) case finding (referred to as outreach and engagement) group, or 2) active

care management group. The outreach and engagement group will receive a PMPM that is a reduced percentage (80%) of the active care management PMPM. The outreach and engagement PMPM will be available for three consecutive months after the Health Home begins to provide outreach and engagement services to the member. If the member is not engaged in active care management during this period, then the Health Home cannot bill for case finding for that member for the next three months. Following this interval, outreach and engagement can be billed for another three months while case finding is attempted once again. This PMPM is intended to cover the cost of activities related to outreach and engagement for the purpose of engaging members in active care management.

Health Home services are billed on a monthly basis. In order to be reimbursed for a billable unit of service, Health Home providers must, at a minimum, provide one of the core Health Home services in a given month. The monthly payment will be paid via the outreach and engagement and active care management PMPM. Once a member has been assigned a care manager and is enrolled in the Health Home program the active care management PMPM may be billed.

Providers should submit one PMPM claim using the first of the month as the date of service, regardless of when the service was provided during the month. As an example, for a member enrolled in a Health Home on October 14th; the corresponding claim would have a date of service of October 1st. At least one of the five (5) core services (excluding HIT) must be provided in a given month in order to bill for Health Home services in that month. Refer to **Section 9** *Health Home Record Keeping Requirements*, for additional information.

Claims are submitted electronically using the 837-I institutional claim type format or paper UB04. In addition to diagnosis code and revenue code, providers must provide the appropriate rate code on the Medicaid claim. The rate code on the Medicaid claim identifies the type of Health Home services provided to the member.

Monthly payments to Managed Care Plans (plan members), Health Homes (fee-for-service members) and on a transitional basis converting TCM programs (both plan and fee-for-service members) will all be made through eMedNY. After the transition period, for converting care management providers, Health Homes will receive payment for fee-for service members and Managed Care Plans will receive payment for their plan members.

Billing and remittance questions should be directed to the eMedNY Call Center (Computer Science Corporation) at 1-800-343-9000 or visit eMedNY at:

www.emedny.org.

For information on electronic remittance advice guidelines refer to:

https://www.emedny.org/providermanuals/allproviders/general_remittance_guidelines.pdf

3.2 Health Home Locator Code

Upon designation, the Health Home will be asked to complete information to assist the State in ensuring accurate payment for Health Home services, such as their National Provider Identifier (NPI) number and Medicaid Management Information System (MMIS) provider identification number. MMIS is a computerized system for claims processing. Each Health Home must submit the NPI and an address that the Health Home would like to have linked to a new locator code that will be associated with its NPI. Health Homes serving individuals in both upstate and downstate regions must identify two distinct addresses and will receive two locator codes, one associated with the upstate region and another locator code associated with the downstate region.

3.3 Converting Targeted Case Management (TCM)

For the first two years following the effective date of the Health Home State Plan Amendment (SPA) for the county being served, the converting case management providers (OMH TCM, COBRA TCM and MATS) will bill Medicaid directly for Health Home Services for all members (both legacy and new members) whether they are receiving active care management services or in outreach and engagement. Converting case management providers are approved to treat a specified number of members (also known as slots) based on their historical capacity and may bill the converting TCM Health Home legacy rate codes up to the level of these previously approved or legacy slots and the new Health Home rate codes (rate codes 1386 or 1387) for new members. Converting programs are to bill the converting TCM Health Home legacy rate codes for existing slots and the new Health Home rate codes (1386 or 1387) for new Health Home slots (see Table A, below) as of the effective date of the SPA for each phase. Note that Health Homes can negotiate with TCM and MATS programs for a portion of their payment for administrative services and other support.

After the two year period, Health Home billing for OMH TCM, COBRA TCM and MATS services will transition to the Health Home for fee-for-service members and to Managed Care Plans for managed care members. The CIDP programs were required to convert to being a Health Home service provider as of March 29, 2012. Effective April 1, 2012, converting CIDP programs billed their legacy rate for one year. For dates of service on and after April 1, 2013, Health Home billing transitioned to the Health Home or MCP.

Information on the transition of converting case management programs to Health Home billing for CIDP can be found at:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_to_m_legacy_rates_extended.htm

Determination of whether to bill the outreach and engagement or the active care management rate code for Health Home members is based on the services provided to the Health Home member. The type of service is also identified in the information reported in the Health Home member tracking system described **Section 6.2 Health Home Member Tracking System**. Since the tracking system information documents the Health Home services, the Health Home rate code on the Medicaid claim should correspond to the Health Home service provided to the member. The appropriate rate code must be on the Medicaid claim for Health Home services. Below is a listing of the Health Home rate codes and the corresponding billing entity.

Table A: Health Home Services Rate Codes

Health Home Services Rate Codes		
Rate Code	Rate Code Description	Rate Codes Billed By
Health Home Services Rate Codes		
1386	HEALTH HOME SERVICES	Health Homes, MCPs, converting TCM providers
1387	HEALTH HOME SERVICES – OUTREACH	Health Homes, MCPs, converting TCM providers
Health Home Services Rate Codes Applicable to Converting TCM Providers		
1851	HEALTH HOME/OMH-TCM	Converting OMH TCM providers only
1852	HEALTH HOME OUTREACH/OMH-TCM	Converting OMH TCM providers only
1880	HEALTH HOME/AIDS/HIV CASE MANAGEMENT	Converting COBRA TCM providers only
1881	HEALTH HOME OUTREACH/AIDS/HIV CASE MANAGEMENT	Converting COBRA TCM providers only
1882	HEALTH HOME/MATS	Converting MATS providers only
1883	HEALTH HOME OUTREACH/MATS	Converting MATS providers only
1885	HEALTH HOME/CIDP CASE MANAGEMENT	Converting CIDP providers only

3.4 Targeted Case Management Regulation and Policy Relief

Regulations and policies governing frequency, number of interventions and required program documentation for COBRA and OMH TCM programs will no longer apply once a converted TCM program begins billing for Health Home services. Once a provider is billing for health home services, Health Home rules for documentation apply. The OMH and COBRA Targeted Case Management Regulation relief letter may be found at the following links:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/partner_resources.htm

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_tcm_reg_chng_ltr.pdf

For further information and guidance on the conversion of these programs to Health Home services, refer to the links below.

Rate Information:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_tcm_legacy_rates_extended.htm

Office of Mental Health (OMH):

http://www.omh.ny.gov/omhweb/adults/health_homes/

Office of Alcoholism and Substance Abuse Services (OASAS):

<http://www.oasas.ny.gov/admin/hcf/documents/MATSTransition.pdf>.

Department of Health AIDS Institute:

www.cobracm.org

3.5 Claim Submission

If a problem arises with a claim submission, the biller (TCM provider, Health Home, or MCP) should first contact Computer Sciences Corporation (CSC) to assist in understanding the denial reason; as the denial explanation will help determine the next course of action. For instance, in some cases a claim may have been denied because action is required by the member's Local Department of Social Services (LDSS) or the

NYC Human Resources Administration (HRA) (eligibility issues) in which case the provider should contact the (LDSS or NYC HRA) for resolution.

For additional information concerning how to contact CSC, refer to **Section 2.4 Health Home Provider Eligibility and Enrollment of the NYS Medicaid Program** and **Section 6.1 Medicaid Eligibility Determination for Health Home Members**.

3.6. Rate Sharing Between Managed Care Plans and Health Homes

Plans are paid for Health Home services outside of regional premiums using a monthly care management fee paid under the Health Home rate code. The plan bills eMedNY for Health Home payments using the rate codes 1386 and 1387 as appropriate. Plans may retain a portion of this payment for administrative services, as negotiated in individual contracts between the Plan and the Health Home. Plans need to contract with Designated Health Homes to assign their plan members to Health Homes. Plan payments should be shared commensurate with the Health Home services being delivered. Health Homes receive those payments from the Plans and then distribute payments to network partners comparable to relative effort.

3.7. Payment for Health Home Members During an Extended Inpatient Stay

Health Home care management services can continue for Medicaid beneficiaries who are admitted for treatment in an inpatient facility, whose discharge is anticipated within 180 days, for the following inpatient settings:

1. Hospital or other medical facility licensed under article 28 of Public Health Law; or
2. An inpatient psychiatric unit of a hospital licensed under article 28 of Public Health Law; or
3. Residential treatment facility for children and youth; or a State operated psychiatric hospital or a free standing psychiatric hospital licensed under article 31 of Mental Hygiene Law; or
4. Hospital based or freestanding inpatient detoxification programs and chemical dependence inpatient rehabilitation programs, licensed under article 32 of Mental Hygiene Law; or
5. Chemical dependence residential rehabilitation programs for youth licensed under article 32 of Mental Hygiene law.

In the month of admission and/or discharge, Health Homes services can be billed at the active care management rate, provided at least one of the Health Home core services is provided. Care management services must be provided for the purposes of discharge planning and must be translated into the patient care management plan. The care manager must share the member's care plan and coordinate with all of the member's providers to make sure that all needed services are in place to ensure a safe, timely discharge. The care management agency must keep the member actively engaged during the process. Health Home Minimum Billing Standards are located in Figure 1 in **Section 12**, titled *Summary of Charts and Tables*, at the end of this manual

In the interim months of the admission, payment will be made at the outreach and engagement rate, provided a three month period has lapsed since the Health Home last billed for outreach and engagement for that member with appropriate delivery of Health Home related services, as previously mentioned. Pursuant to the limitations of outreach and engagement billing rules, one of these four intervening months will not be billable.

Section 6.2, *The Health Home Member Tracking System*, details the reporting requirements for Health Home members with an extended Inpatient Stay.

3.8 Health Home Member Lost to Services, Outreach for Re-engagement, or Disenrollment

A Health Home member is considered Lost to Services when the Health Home is no longer able to locate the member to provide Health Home services. Lost to Services will be determined pursuant to policies and standards established by each Designated Health Home. Once a member is determined Lost to Services, the Health Home or care management agency may begin to bill for outreach and engagement for the purposes of locating the member and then re-engaging the member into care. Commencing the 1st of the following month of the Lost to Services determination, the Health Home may bill for outreach and engagement for three consecutive months, for activities related to locating and re-engaging the member provided that a three month period has lapsed since the Health Home last billed for outreach and engagement for that member. The details on how to report this in the File Specification Document are located in **Section 6.2**, *Health Home Member Tracking System*.

Health Homes must document in the member's care management record the date of determination of Lost to Services and follow-up attempts to contact while billing for outreach and engagement. If the Lost to Service member is not found after three months of outreach and engagement, the member should be disenrolled from the program.

3.9 The Use of Per Member Per Month (PMPM) Payments for Incentives, Gifts or Inducements

Gifts and incentives to beneficiaries are allowable but subject to the requirements outlined in a *Special Advisory Bulletin* issued by the NYS Office of the Inspector General, Federal Register, Vol. 67, No. 169, Friday, August 30, 2002. The bulletin provides a "bright line" on gift giving. Any provider that wants to offer gifts should consult their own legal counsel for a complete analysis of the facts and circumstances. The bulletin can be found at:

<https://oig.hhs.gov/authorities/docs/FRversionofSABonOfferingGifts.pdf>

Section IV: Rate Calculation and Methodology

4.1 Health Home Base Rate and Acuity Score (Rate Codes 1386 and 1387)

The Health Home payment is comprised of two components: the member's adjusted acuity and the Health Home per member per month (PMPM) regional base rate. Acuity is a weighted average based on total Medicaid fee-for-service and managed care encounter costs associated with the Clinical Risk Groups™ (CRG) for a Health Home eligible population for a given time period. DOH adjusted acuity includes additional upward adjustments for mental illness, predictive risk for adverse events and severity of illness. The acuity scores are typically recalculated based on quarterly changes in a member's CRG.

The Health Home PMPM regional base rate is resource-based to include an average cost per case manager salary, fringe benefits, non-personal service, agency and program administration (direct supervision) and capital. To adjust for regional salary and other differences, the regional base rate pays 24% more for the downstate region as compared to the upstate region. The base rate for Health Home outreach and engagement services (rate code 1387) is established at 80% of the Health Home active care management rate (rate code 1386). The current Health Home PMPM base rates are located in at a link provided here:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/rate_codes.pdf

Prior to October 1, 2012, Medicaid payments for Health Home services under rate codes 1386 and 1387 were paid an average monthly rate based on the enrolled members for that month as reported on the monthly tracking files. For dates of service on and after October 1, 2012, Medicaid payments for Health Home services under rate codes 1386 and 1387 are member specific; the Health Home base rate is multiplied by the member's acuity. Additional information on the Health Home base rates, rate codes and rate calculation are available on the Health Home website below:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_information.htm

4.2 Health Home Payment Calculation

Health Home payments are calculated within the eMedNY payment system by multiplying the member specific acuity score by the provider's regional PMPM base rate. Claims for members without a pre-calculated acuity score will be placed in pend

status for up to 60 days. The Department of Health (DOH) will receive notification of the pended claims and will then submit an average acuity score for that member to the payment system. This submission of the acuity score to the payment system will trigger payment of the pended claim. The automatic notification to DOH of pended claims is under development. Until the automatic notification of pended claims is implemented, DOH will use Health Home Member Tracking System information to identify members that do not have an acuity score. Once identified, an average acuity will be loaded to the payment system so that the Medicaid claim will pay.

Health Home rate information questions and answers:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_chart_q_and_a.htm

Health Home Rate summary table:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/2012-10-01_hh_payment_calculations.xls

Health Home Rate Code Definitions:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/rate_code_definitions.pdf

4.3 The FACT-GP[®] + Health Home Functional Assessment Tool

Health Homes are required to administer a functional assessment tool called the FACT-GP[®] and Health Home Functional Assessment Questionnaire and report results to the Department of Health (DOH). This will enable DOH and other State partner agencies to evaluate each Health Home participant on a range of measures obtained from the member's point of view. Face-to-face administration of the tool will be required at initial assessment, annually, and at disenrollment. The FACT-GP[®] + Health Home Assessment outcomes will be reported to the DOH by the Designated Health Homes using the Health Home Care Management Assessment Reporting Tool (HH-CMART). (Refer to **Section 4.4**, *Health Home Care Management Assessment Reporting Tool (HH-CMART)*).

The FACT-GP[®] is a validated tool that measures a person's status for the most recent seven days based upon the member's own assessment. The State has added to this the Health Home Functional Assessment that is a proxy for the member's ability to meet their activities of daily living (ADL) and functional ADL as self reported for the most recent seven days. By using this combination of tools, the FACT-GP[®] and the Health

Home Functional Assessment, the DOH will be able to collect more timely data on member status than available through the claims and encounter database. While this information will not adjust member risk or acuity on an individual basis, this information may be used in the future to adjust the accuracy of the acuity and risk scoring on a population basis.

The FACT-GP[®] and the Health Home Functional Assessment do not take the place of a comprehensive assessment that should be performed on members subject to individual Health Home policies and procedures, however, this assessment tool allows the DOH to collect basic information about members in each Health Home to measure longitudinal changes in this population.

For additional information on assessment and quality measures refer to the following link:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/index.htm

4.4 Health Home Care Management Assessment Reporting Tool (HH-CMART)

The Health Home Care Management Assessment Reporting Tool (HH-CMART) is a case management reporting utility for Health Homes that was developed by the Department of Health (DOH), based on a reporting tool used by Managed Care Plans. This customized reporting module will be used by Health Homes to report all Health Home process metrics, including numbers and dates of contacts, health home services delivered, and member scores on the FACT-GP[®]+Health Home Functional Assessment Questionnaire. This process data will provide the DOH with information about care management services to evaluate the volume and type of interventions and the impact of care management services have on outcomes for people receiving these services. The submission file will include information for all Medicaid members involved in Health Home care management programs during the reporting period. For additional information on HH-CMART refer the webinar at following link:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/meetings_webinars.htm

4.5 Care Management and Quality Metrics

Measurement of the process and outcome of the Health Home Program will be necessary to understand the value of the overall program and the efficacy of any one component. Measurements also will guide any improvement process. Care

management metrics will be assessed in two ways: process metrics collected using the HH-CMART described above, and quality outcome metrics.

The New York State outcome metrics are provided in the SPA and will generally be derived by the Department of Health (DOH) using the Medicaid claims and encounter database. CMS has also issued Health Home Core Quality Measures for assessing the health home service delivery model. Other metrics including a member satisfaction survey may be conducted in the future.

Information on Health Home quality measures refer to the following link:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/index.htm

CMS guidance and final Health Home core measures refer to the following link:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/quality_measures.pdf

For additional information on the proposed outcome metrics, refer to the following link:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/nys_implementation.htm

Section V: Managed Care Contracts with Health Homes

Health Homes will provide services to eligible Medicaid Managed Care Plan members through contractual agreements between the Plan and the Designated Health Home. Managed Care plans will assign their members to Designated Health Homes utilizing Department of Health (DOH) assignment lists and any other information the plan may have about their plan member. Plans may also refer members they determine are eligible and in need of Health Home services to a Health Home. Plans will bill eMedNY for their members and pass through payment, minus an administration fee and/or other contracted costs, to the Designated Health Home. Health Homes should utilize the Managed Care Plans contracted network of providers for direct care services that are included in the benefit package when arranging for care for Health Home members. Managed Care Plans may opt to expand their provider networks based on Health Home member need.

Refer to the links below for additional information on the following topics:

- Managed Care Information
- Managed Care Roles and Responsibilities
- Health Home and Managed Care Contracting
- Managed Care and Health Home Questions and Answers
- Policy for Sharing Protected Health Information of Members between the MCP and the Health Home Prior to the Member Signing A health Home Consent

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/managed_care.htm

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/forms/policy_for_sharing_personal_health_information.htm

Section VI: Member Assignment, Enrollment and Disenrollment

6.1 Medicaid Eligibility Determination for Health Home Members

It is important to determine Medicaid eligibility prior to providing Health Home services as clients entering Health Homes must be enrolled in Medicaid, and Medicaid is date specific. A member's Medicaid eligibility may change frequently and it is incumbent on the provider to assure that they are providing services to a Medicaid member prior to rendering services. If the provider does not verify eligibility and the extent of coverage of each member each time services are requested, then the provider may be at risk for non-reimbursement for services provided, as the State cannot compensate a provider for a service rendered to individual who is not an eligible Medicaid member. In determining member Medicaid eligibility, the provider is responsible to review the type of Medicaid coverage authorized, as well as any restrictions that may exist.

If the person is not eligible for Medicaid or Medicaid coverage has lapsed, then the referring entity should work with the Local Department of Social Services (LDSS) or New York City Human Resources Administration (HRA) as appropriate to apply for or reactivate Medicaid coverage. Persons not eligible for Medicaid should be provided with assistance in finding appropriate health care options.

Member Medicaid eligibility information, including covered services, is identified in the Medicaid eligibility verification process. For more information, consult the Medicaid Eligibility Verification System (MEVS) Manual, online at:

<http://www.emedny.org/ProviderManuals/AllProviders/index.html>

Questions concerning member Medicaid eligibility verification may be addressed to the eMedNY Call Center at (800)-343-9000.

6.2 Health Home Member Tracking System

The Health Home Member Tracking System is housed in the Health Commerce System (HCS). The HCS allows for a HIPAA compliant automated file exchange process between the Department of Health (DOH), Health Home and their network partners providing care management services, and MCPs. Health Home member tracking information such as a member's Health Home status (enrolled and receiving active care management services vs. outreach and engagement status) is transmitted to the DOH in accordance with the requirements defined in the Health Home Member Tracking System Specifications Document available at the following link:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_information.htm.

Care management agencies transmit the member tracking information to the appropriate Health Home agency. The Health Home then transmits the member tracking information to DOH. MCPs will have access to the member tracking information from DOH for their members.

6.21 Tracking System for Reporting Requirements for Health Home Members with an Extended Inpatient Stay (as described in Section 3.7)

In order to bill for three of the four interim months of the inpatient admission, the Health Home or Care Management Agency will be required to submit a change record on the Member Tracking File, end dating the enrollment segment using the Segment End Date Reason Code 13 (Patient of Inpatient Facility) to indicate to DOH that the segment is ending. The end date must be later than the begin date and must always be the last day of the month. An add record will also be required to begin the service segment for outreach and engagement.

For the month of discharge from the inpatient facility, the Health Home or Care Management Agency must again initiate a change record and an add record to the Health Home Member Tracking System.

Health Homes must document in the member's care management record the date of admission (and discharge) to an inpatient facility and document all health home services provided during the inpatient admission. If the inpatient stay is beyond the initial six months the member must be disenrolled from the Health Home. Upon discharge from the inpatient facility the member may return to the Health Home.

6.22 Tracking System Reporting Requirements for Health Home Members Lost to Services (as described in Section 3.8)

The Health Home or care management agency will be required to submit a change record on the Member Tracking System, end dating the enrollment segment using the Segment End Date Reason Code 14 (Enrolled in Health Home Patient Lost to Services) to indicate to DOH that the segment is ending. The end date must be later than the begin date and must always be the last day of the month. An add record will also be required to begin the service segment for outreach and engagement.

Note: Member data should never be emailed to DOH. All member tracking files must be submitted to DOH through the HCS which is a secure, HIPAA compliant portal.

6.3 Member Assignment

The Department of Health (DOH) will release a member tracking file containing assigned Health Home members to designated Health Homes and Managed Care Plans (MCPs). The file will contain each member's current demographic information and be shared through a secure portal accessed through the Health Commerce System (HCS) (Refer to **Section 6.2**, *Health Home Member Tracking System*).

Assignments of Medicaid members who qualify for Health Home services will be made by DOH by matching Medicaid fee-for-service claims and Managed Care Plan (MCP) encounters to providers in each Health Home Provider Partner Network using the appropriate provider National Provider Identifier (NPI). The member is assigned to the Health Home which includes the providers from which the member receives the most services. Fee-for-service members are matched to a Health Home based on their hierarchical use of services (outpatient services, emergency department and inpatient). Health Home members may also be accepted as referrals. For additional information concerning the referral process refer to **Section 7**, *Member Referral Process*.

DOH will prioritize and assign fee-for-service members directly to Health Homes. DOH will provide MCPs with a suggested Health Home assignment for MCP members. The DOH Health Home matching information is provided to MCPs for their MCP members. MCPs are encouraged to use this information to supplement their own data for use in assigning their members to a Health Home. DOH will identify the Health Home eligible population and release the newly identified population to Health Homes and MCPs on a quarterly basis.

Health Homes and MCPs will submit the member tracking information in the format outlined in the Health Home Member Tracking Systems Specification Document:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_information.htm

6.4 Outreach and Engagement

A completed DEAA and network partner DEAA subcontracts enable Health Homes to access Health Home member tracking assignment files. These files include newly

assigned, Health Home eligible Medicaid members. The newly assigned Health Home eligible members should be contacted and advised of the Health Home services program. The outreach and engagement per member per month (PMPM) payment will be available for three (3) months.

Note: The care management agency determines when the member is in active case management, according to its own policies and procedures.

If outreach and engagement is unsuccessful (defined as neither locating nor engaging the member during or after the three month period), the provider may continue outreach and engagement, but is not eligible to bill again for these activities until an interval of at least three months has elapsed since billing for outreach and engagement.

6.5 Health Home Patient Information Sharing Consent Form (DOH-5055)

Health Homes are responsible for securing the completed member consent forms. New York State expects care managers to assist members in Health Homes in completing the Health Home Patient Information Sharing Consent Form, DOH-5055. Care managers should ensure members understand the form, read the form to the member, if necessary, and answer any questions. By completing the consent form, a member is agreeing to allow his/her health information to be shared among the consented Health Home partners and the Designated Health Home to access the Regional Health Information Organization (RHIO) for information available within the community.

Note: For new Health Home members, the consent does not have to be signed immediately for care management activities to begin in the Health Home. However, without consent the Health Home care manager cannot share Protected Health Information (PHI). The Health Home care manager can work one-on-one with the member on some care management activities that do not require sharing of PHI until the consent is completed. Because many of the Health Home eligible members may be disenfranchised from the health care system, they may not immediately be comfortable signing a consent form. The goal is to have the member sign the consent so all providers involved in the member's care has access to the same information to better serve the member. Members who continuously refuse to sign the consent form will eventually need to be disenrolled as the Health Home Program requires coordination between providers.

Outreach and engagement activities are supported by the limited information NYSDOH can provide to the Health Home without a patient consent.

In keeping with State requirements, the form being used will be translated into seven additional languages including: Chinese, French, Haitian Creole, Italian, Korean, Russian and Spanish. It is available in English at the link below:

www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/forms/http://www.health.ny.gov/forms/doh-5055.pdf

The Health Home Consent form in the additional seven languages will be available on the Department of Health website in the near future.

Converting OMH TCM, HIV COBRA TCM, CIDP and MATS programs are responsible for obtaining the member signature on the DOH Health Home Patient Information Sharing Consent Form in order to allow data sharing. These programs may continue to work with existing members while they obtain the Health Home consent.

Note: The Health Homes that will be sharing data with their network partners prior to obtaining member consent, e.g. with care management entities to do outreach and engagement with members, must first have an approved business associate subcontractor Data Exchange Application and Agreement (DEAA) packet on file for these network partners. DEAA requirements are described in the **Section 2.9** titled *Data Exchange Application and Agreement*.

6.6 Regional Health Information Organizations (RHIO)

A signed RHIO consent form will allow access to the RHIO's Health Information Exchange (HIE) if the organization is a member of or has a data sharing relationship with that local RHIO. The current DOH-5055 Health Home consent is single entity consent for RHIO purposes. It allows the Designated Health Home to access member health information through the HIE. If the RHIO can support the use of a multi-entity consent form, such a form is permitted. The Health Home can either use the RHIO's multi-entity consent in addition to the DOH-5055 or contact the Department of Health to discuss use of the original Health Home consent form.

A signed Health Home consent allows a Designated Health Home to access more than one RHIO's HIE if each of the RHIOs that will be directly accessed is named on the consent form. Health Homes must also have a data sharing agreement with each of the RHIOs. The member must give permission, for each of the RHIOs that the Health Home is directly accessing, for his/her health information. The Health Home is encouraged to join a RHIO to meet the final HIT requirements. There may be financial considerations to joining a RHIO or using their HIE for data exchange. There may be other ways to meet these requirements and Health Homes are encouraged to seek input from the DOH if they choose not to join a RHIO. Ultimately, the Designated Health

Home must be able to transmit and receive data electronically with its associated organizations and providers.

If a Health Home withdrawal of consent form (DOH-5058) is signed, permission to share new data among Health Home partners is negated and the Designated Health Home loses RHIO access for that member.

6.7 Health Commerce System

The Health Commerce System (HCS) is an electronic information exchange tool used by DOH to communicate with New York State healthcare providers, employees, and partner agencies and collect provider information to help conduct business involving public health. It is a comprehensive web-based technology that supports, integrates and secures the electronic exchange of health data and information among partners.

6.71 Health Commerce System Account Access

If an organization does not have a HCS account or if information is needed regarding the name of the HCS Director or Coordinators for the organization, contact the Health Home program either electronically by sending an email to HealthHome2013@health.state.ny.us with the subject "Assistance with HCS Account" or by calling the Health Home Provider Line at 518-473-5569.

Note: Organizational changes including changes in Health Home name or NPI number affect the Health Commerce System account status for the staff person submitting data to the Health Home portal.

Once an active HCS account is identified or obtained the following offices/units may be contacted for relevant questions:

Informatics Unit may be contacted at 518-473-1809 or electronically at: hcsoutreach@health.state.ny.us with questions regarding:

- Communications Directory
- Coordinator Training
- Roles

Commerce Accounts Management Unit (CAMU) may be reached at 1-866-529-1890 or electronically at: hinhpn@health.state.ny.us with questions regarding:

- Account Status
- Passwords

6.72 Health Commerce System and the Member Tracking System

Health Homes and Managed Care Plans are required to have an active HCS account and the ability to access the New York State Health Commerce System to submit or access member tracking files in the Member Tracking System Portal.

- The Member Tracking System Portal, housed in the HCS, is the secure electronic application that supports the Health Home Member Tracking System.
- Health Homes and Managed Care Plans are to identify the HCS Coordinator within their organization to obtain access to a HCS Account.
- Health Homes and Managed Care Plans need to identify two or three HCS contacts that will be responsible for submitting and accessing Health Home Member Tracking System information through the Portal.
- Health Homes and Managed Care Plans can submit and access member tracking files in the portal 24 hours a day, 7 days a week. The portal processes files daily at midnight.
- Files may be transferred using the Health Commerce System Secure File Transfer application between providers that have active HCS accounts.

Note: Member data should never be e-mailed to DOH. All member data and tracking files must be submitted to DOH through the HCS. Member data must always be exchanged in a secure, HIPAA compliant manner.

Health Homes and Managed Care Plans are required to have HCS accounts in order to access the Health Home portal on the HCS. If Health Home or Managed Care Plan staff who will access data on the Health Home portal already have an existing HCS account, no action is needed. If the Health Home or Managed Care Plan staff accessing Health Home data through the Health Home portal, need an HCS account, the organization's HCS Director or Coordinator should be contacted.

6.8 Health Home Member Disenrollment/Opt Out

Members who want to disenroll from a Health Home program prior to signing a patient consent need to sign an Opt Out Form (DOH-5059). Members who want to disenroll and have already signed a patient consent need to sign a Withdrawal of Consent Form (DOH-5058). In keeping with NYS and DOH protocols, all forms are in English and translated into seven additional languages including: Chinese, French, Haitian Creole, Italian, Korean, Russian and Spanish. These forms and additional information can be found at:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/forms/

In addition to the forms completed and signed by the member, the assigned care management agency is required to report member disenrollment to the lead Health Home through the Member Tracking System. Refer to **Section 6.2**, *The Health Home Member Tracking System*, for additional information.

6.9 Member Changing Health Homes

If a member chooses to be in a different Health Home, they should notify their MCP or assigned Designated Health Home immediately. The transfer would be effective the first day of the next month. The Health Homes involved needs to discuss the timing of the transfer. Only one Health Home may bill for a member in a given month. Please refer to the Member Tracking Specifications Document for instructions on how to report a member's Health Home transfer see the Health Home Member Tracking System Specifications Document available at the following link:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_information.htm

The three month outreach and engagement consecutive billing maximum is still in effect if a Health Home passes along a member's information to another Health Home to continue outreach and engagement services. In order to bill for outreach and engagement again after the initial three month period of payment for this service, a lapse of three months must occur before outreach and engagement can be billed again.

Section VII: Member Referral Process

7.1 Member Referral Process

In addition to the members assigned to Health Homes through the process described in **Section 6**, *Health Home Member Assignment, Enrollment & Disenrollment*, real time client referrals will be accepted by Health Homes. Client referral for Health Home services may come from a variety of sources. New York's decision to convert the Targeted Case Management programs (OMH and AIDS Institute), and the Managed Addiction Treatment Services program (OASAS) into Health Homes requires that individuals be referred for Health Home assignment on a priority basis. These referrals are expected from OMH Local Government Units (LGUs), including Director of Community Services Single Point of Access (SPOA), Local Department of Social Services (LDSS), New York City Human Resources Administration (HRA), NYC HIV/AIDS Services Administration (HASA), NYC Department of Health and Mental Health (DHMH) and health care facilities and other providers.

Individuals identified by local government agencies and by the nature of their diagnosis will, in the majority of cases, meet Health Home criteria. For those clients in need of care management, the referring entity will first need to identify if the client receives their health care services from a Managed Care Plan or through fee-for-service.

New referrals meeting Health Home criteria that are enrolled in Health Homes will be reported to DOH using the Health Home Member Tracking System.

7.2 Other Referral Sources

Federal authority to conduct Health Homes mandates that hospitals refer individuals with chronic conditions who seek care or need treatment in a hospital emergency department to Designated Health Home providers. Other referral sources may include the criminal justice system, court ordered patients for Assisted Outpatient Therapy (AOT), State prisons, county and city jails, mental health discharges/referrals from State operated psychiatric centers, Article 28 and 31 Hospitals, Managed Care Plans, Designated Health Homes, clinics, family members, health care providers, HIV providers, social service providers etc.

Note: A fee-for-service member may be referred to a Designated Health Home based on the referred client's county of residence, or county where services are received, or the need for a specific care management agency. A managed care member can be referred to either the Designated Health Home or the appropriate Medicaid Managed Care Plan for assignment.

For information and guidance on the Single Point of Access (SPOA) and Assisted Outpatient Therapy (AOT), refer to the following link:

http://www.omh.ny.gov/omhweb/adults/health_homes/

7.3 Transition and Access to Other Medicaid Services

Health Homes are responsible for assuring that their members receive all medically necessary care, including primary, specialty and behavioral health care. Health Home members needing long term care services, i.e., greater than 120 days, may be transitioned into other long term care (LTC) management programs, such as a Managed Long Term Care Plan (MLTC) (if available in the geographic region). Health Homes would be responsible for contacting the appropriate program and initiate the transition. Health Homes may also continue to serve members requiring long term care services and work with appropriate providers in the Health Homes network to assure the members' needs can be met in areas where no MLTC plans are available. Health Homes are allowed to contract with MLTC plans for care management services.

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Section VIII: Health Information Technology

8.1 Office of Health Information Technology Transformation

Established within the Department of Health (DOH) in 2007, the Office of Health Information Technology Transformation (OHITT) is charged with coordinating health IT programs and policies across the public and private health care sectors. Its goal is to enable improvements in health care quality, increase affordability and improve health care outcomes for New Yorkers. These programs and policies are designed to be HIPAA compliant and facilitate the transmission of medical information to clinicians and care managers to support the delivery of high-quality coordinated, preventive, and patient-centered care. The initiatives also support clinicians in new prevention and quality-based reimbursement programs and new models of care delivery.

Questions regarding HIT issues should be directed to the Office of Health Information Technology Transformation (OHITT) at (518)-474-4987.

For more information see visit the OHITT website at the link:

<http://www.health.ny.gov/technology/>

8.2 Use of Health Information Technology to Link Services

To facilitate Health Home use of Health Information Technology (HIT) to improve service delivery and coordination across the care continuum, initial and final HIT standards were included in the NYS Health Home Provider Qualification Standards for Chronic Medicaid and Behavioral Health Patient Populations, available electronically at:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/provider_qualification_standards (refer to **Section 6**, *Health Home Member Assignment, Enrollment & Disenrollment*).

It is anticipated that a portion of Health Home providers may not utilize HIT in their current programs. Health Home applicants will be required to provide DOH with a plan to achieve all nine HIT standards within 18 months of the effective date of the State Plan Amendment for their Phase. By the end of 18 months, it is expected that all HIT standards will be met. This includes all designated Health Homes having a participation agreement with their local Regional Health Information Organization (RHIO) or a Qualified Entity (QE). In addition, Health Home partners should be encouraged to sign a participation agreement with their local RHIO/QE.

8.3 Single Care Management Record

Health Homes are responsible for assuring there is a single care management record that can be used and shared with members of the interdisciplinary team. Care collaboration and coordination will be supported by case reviews conducted on a regular basis and attended by all members of the interdisciplinary team as appropriate. The care manager will be responsible for overall management and coordination of the member care plan which will include both medical/behavioral health and social service needs. The goal is to have the care management record available electronically at every point of care. While some of this may occur utilizing the electronic care management record itself, it is anticipated that the Health Homes will be accessing and contributing data to the local Regional Health Information Organizations (RHIO) health information exchanges (HIE) covering New York State.

New York State is served by RHIOs that have operating HIE platforms. These RHIOs and HIEs were developed by a combination of State and regional partners. The goal of New York's HIE initiatives is to improve the safety, effectiveness, quality, and affordability of health care delivery through the widespread adoption of an interoperable health information infrastructure. New York State is implementing the Statewide Health Information Network of New York (SHIN-NY). The SHIN-NY is a secure network for sharing clinical patient data across New York State via the RHIOs.

Section IX: Health Home Record Keeping Requirements

9.1 Health Home Services and Minimum Billing Standards

Health Homes must provide at least one of five core (exclusive of HIT) Health Home services per month to meet minimum billing requirements. The mode of contact may include, but is not limited to: face to face meeting(s) (no minimum requirement), mailings, electronic media and telephone calls, and case conferences. Active, ongoing and progressive engagement with the member must be documented in the care management record to demonstrate active progress towards outreach, and engagement, care planning and/or the member achieving their personal goals. Except for member interviews to make assessments and plans, case contacts do not need to be all face-to-face encounters. They may include contacts with collaterals or service providers in fulfillment of the member's plan.

New York State retains the right to review Health Home care management records as required to assure that services were provided in each month for which a Medicaid payment was made for Health Home services. It is the Department's expectation that the written documentation in the care management record will clearly demonstrate how all of the core services, with the exception of the use of HIT are being met. The Health Home Minimum Billing Standards are provided in the **Section 12, Summary of Charts and Tables**, Figure 1.

9.2 Health Home Record Keeping Requirements

A separate care management record must be maintained for each member served and for whom reimbursement is claimed. In addition to the record requirements, the care record must contain:

- A copy of the member's signed consent form (DOH-5055);
- An initial comprehensive assessment will be required. Reassessment will be required annually and/or if there is a significant change in the member's health/behavioral health or social needs status;
- The FACT-GP[®] and the Health Home Functional Assessment is also required and should be administered at time of enrollment, annually and upon discharge from the Health;
- The initial care management plan and subsequent updates, containing goals, objectives, timeframes, etc. as agreed to by the member and the care manager;
- Copies of any releases of information signed by the member; and
- Medical/behavioral health and social service referrals made.

Documentation required for COBRA and OMH TCM programs will cease when a converted TCM program begins billing for Health Home services. Health Home regulations for documentation will then begin. The OMH, COBRA Targeted Case Management Regulation relief letter may be found using the following link:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/partner_resources.htm

Documentation requirements set forth in contracts with MATS providers will cease once a former MATS patient is enrolled in a Health Home. Contracts with MATS providers have been terminated in Phase I counties. Contracts in Phase II counties will be terminated when MATS providers have filled all legacy slots.

Section X: Shared Savings Pool

Subject to the approval of CMS, if the State achieves overall savings from the implementation of this program, Health Home providers will be eligible to participate in a shared savings pool. New York State is committed to share 30% of the State share of the savings pool with qualified Health Homes and the Department is working with CMS on a Federal match. Once an agreement is reached with CMS, a methodology to distribute shared savings will be established.

Section XI: Glossary of Terms

Glossary of Terms

For the purposes of the Medicaid program and as used in this Manual, the following terms are defined.

Assertive Community Treatment (ACT): ACT Teams provide mobile intensive treatment and support to people with psychiatric disabilities. The focus is on improving an individual's quality of life in the community and reducing the need for inpatient care by providing intense, community-based treatment services by an interdisciplinary team of mental health professionals. Treatment is focused on individuals who have been unsuccessful in traditional forms of treatment.

Assisted Outpatient Treatment (AOT): On August 9, 1999, the Governor signed Kendra's Law (Chapter 408 of the Laws of 1999), creating a statutory framework for court-ordered AOT to ensure that individuals with mental illness and a history of hospitalizations or violence participate in community-based services appropriate to their needs. Under Section 9.60 of the Mental Hygiene Law, any AOT order must include either care management services or ACT services as part of a court-ordered treatment plan.

Business Associate Agreement (BAA): an agreement not to use or further disclose Protected Health Information other than is permitted or required by the agreement or as required by law. This includes using the appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by the agreement. The agreement includes implementing administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any electronic Protected Health Information that it creates receives, maintains or transmits on behalf of the covered entity.

Behavioral Health Organization (BHO): an organization that will help to manage behavioral health benefits of Medicaid members, advocate to meet behavioral health needs and secure appropriate care management/transition plans.

Care Management: a process of coordinating and arranging for the provision of needed services in accordance with goals contained in a written care plan.

Client Identification Number (CIN): Medicaid Client Identification Number that is unique to each Medicaid beneficiary.

Claims Payment: a process within eMedNY that generates a payment of all approved claims and prepares a Remittance Statement with each payment cycle which lists the status of all paid, denied, and pending claims.

Computer Science Corporation (CSC): Computer Sciences Corporation, the fiscal agent for eMedNY.

Data Exchange Agreement Application (DEAA): an agreement to provide information supporting an applicant's request for the release of Medicaid Confidential Data (MCD) and to serve as the basis for assessing the appropriateness of releasing MCD.

Designated Health Home Provider: a provider approved and designated by NYSDOH as a Lead provider of Health Home services.

Dually Eligible Individual: an individual that qualifies and receives both Medicare and Medicaid.

eMedNY: Electronic Medicaid System of NY. Allows NY Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible members.

Existing (TCM) Targeted Case Management Member: a member already receiving specific case management services before the implementation of Health Home (can be fee-for-service members or Managed Care Members).

Federally Qualified Health Centers (FQHCs): Federally qualified health centers (FQHCs) include all organizations receiving grants under Section 330 of the Public Health Service Act (PHS). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

Fee-for-Service (FFS) Member: members that do not belong to a Medicaid Managed Care Plan and receive services from providers who are contracted with the State based on an agreed upon rate for services.

Functional Assessment of Cancer Therapy for General Populations (FACT-GP®): a generic CORE questionnaire that includes a 27-item compilation of general questions divided into four primary quality of life domains: physical well-being, social/family well-being, emotional well-being and functional well-being.

Health Commerce System (HCS): an electronic resource designed to protect the confidentiality of data by requiring that organizations adhere to NYSDOH health data security standards. This secure website can be used to send/request data and reports. The HCS is maintained by the NYSDOH Bureau of HEALTHCOM Network Systems Management.

Health Home Service Provider: a provider of Health Home Services that has a contractual relationship with a Health Home.

Health Home Services: services as defined in Section 1945(h)(4) of the Social Security Act including: comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings; individual and family support; referral to community and social support services; and the use of health information technology to link services as feasible.

Health Home Service Organizations: the collective list of Health Home Service Providers.

Health Home Participant: a Medicaid eligible candidate who agrees to receive Health Home services.

Health Home Eligible: a member who is assigned by the MCP or NYSDOH to a Health Home.

Health Information Exchange (HIE): the process of reliable and interoperable electronic health information sharing managed such that confidentiality, privacy and security of the information is maintained. A health information exchange is the platform that is used to manage this process and that has a number of functionalities to allow this secure management and exchange of data.

Legacy Slots: an approved number of slots that can be billed at the OMH TCM, COBRA TCM, or MATS program legacy rates that were established prior to implementation of Health Homes.

LGU: a Local Government Unit means a county, except a county within the city of New York, and the city of New York. The unit of local government is given authority by the government to provide local services.
http://law.onecle.com/new-york/mental-hygiene/MHY041.03_41.03.html

Managed Addiction Treatment Services (MATS): initiative designed to improve the delivery of health care and other related services to Medicaid recipients requiring treatment for chemical dependence to move toward recovery and self-sufficiency through substance use treatment.

Managed Care Organization/Plan (MCO or MCP): a health maintenance organization/plan or prepaid health service plan, certified under the Public Health Law, that contracts with health care providers and medical facilities to provide care for members at reduced cost(s).

National Provider Identifier (NPI): an identification number assigned by the National Plan and Provider Enumeration System (NPPES).

Outreach and Engagement: case management that locates Health Home eligible members with the goal of engaging them in active Health Home services.

Regional Health Information Organization (RHIO): organizations of regional partners that may include hospitals, physicians, and Managed Care Organizations and others that oversee the infrastructure for the secure electronic exchange of clinical information.

Single Point of Access (SPOA): is a process led by a SPOA Coordinator that helps local governments achieve community-based mental health services that are cohesive and well-coordinated in order to serve individuals most in need. The SPOA manages access and utilization.

Targeted Case Management (TCM): a State Plan Service to assist eligible individuals (targeted by population and/or geographic region) to gain access to needed medical, social, educational and other services and include assessment, service plan development, referrals to services, monitoring and follow up.

Section XII: Summary of Charts and Tables

Figure 1

Health Home Minimum Billing Standards

<p>Health Homes must provide documentation of carrying out at least one of the five core (exclusive of HIT) Health Home services per service month to meet minimum billing requirements. The mode of contact may include, but is not limited to: face to face meeting(s) (no minimum requirement), mailings, electronic media and telephone calls, case conferences.</p> <p>Active, ongoing and progressive engagement with the client must be documented in the care management record to demonstrate active progress toward outreach and engagement, care planning and/or the client achieving their personal goals. The State retains the right to review Health Home care records as required to assure that active services were being provided in each month for which a Medicaid payment was made for Health Home services</p>	
Core Health Home Services	Examples of Core Health Home Services/Interventions/Activities
Comprehensive Care Management	<ul style="list-style-type: none"> • Complete a comprehensive health assessment/reassessment inclusive of medical/behavioral/rehabilitative and long term care and social service needs. • Complete/revise an individualized patient-centered plan of care with the member to identify member's needs/goals and include family members and other social supports as appropriate. • Consult with multidisciplinary team on client care plan/needs/goals. • Consult with primary care physician and/or any specialists involved in the treatment plan. • Conduct client outreach and engagement activities to assess on-going emerging needs and to promote continuity of care and improve health outcomes. • Prepare client crisis intervention plan.

<p>Care Coordination & Health Promotion</p>	<ul style="list-style-type: none"> • Coordinate with service providers and health plans as appropriate to secure necessary care, share crisis intervention (provider) and emergency info. • Link/refer client to needed services to support care services to support care plan/treatment goals, including medical/behavioral health care; patient education and self help/recovery and self management. • Conduct case reviews with interdisciplinary team to monitor/evaluate client status/service needs. • Advocate for services and assist with scheduling of needed services. • Coordinate with treating clinicians to assure that services are provided and to assure changes in treatment or medical conditions are addressed. • Monitor/support/accompany the client to scheduled medical appointments. • Crisis intervention, revise care plan/goals required.
<p>Comprehensive Transitional Care</p>	<ul style="list-style-type: none"> • Follow up with hospitals/ER upon notification of a client's admission and/or discharge to/from an ER, hospital/residential/rehabilitative setting. • Facilitate discharge planning from an ER, hospital/residential/rehabilitative setting to a safe transition/discharge where care needs are in place. • Notify/consult with treating clinicians, schedule follow up appointments and assist with medication reconciliation. • Link client with community supports to assure that needed services are provided. • Follow up post discharge with client/family to assist client care plan needs/goals.
<p>Member & Family Support</p>	<ul style="list-style-type: none"> • Develop/review/revise the individual's plan of care with the client/family to ensure that the plan reflects individual's preferences, education and support for self management. • Consult with client/family/caretaker on advanced directives and educate on client rights and health care issues, as needed. • Meet with client and family, inviting any other providers to facilitate needed interpretation services. • Refer client/family to peer supports, support groups, social services, entitlement programs as needed. • Collaborate/coordinate with community based providers to support effective utilization of services based on client/family need.
<p>Referral and community & social Support Services</p>	<ul style="list-style-type: none"> • Identify resources and link client with community supports as needed. • Collaborate/coordinate with community base providers to support utilization of services based on client/family need.

Figure 2

Health Home Phase-In Schedule

Phase	Counties	Effective Date
Phase 1	Bronx, Clinton, Kings (Brooklyn), Essex, Franklin, Hamilton, Nassau, Schenectady, Warren and Washington	January 1, 2012
Phase 2	Dutchess, Erie, Manhattan, Monroe, Orange, Putnam, Queens, Richmond (Staten Island), Rockland, Suffolk, Sullivan, Ulster and Westchester	April 1, 2012
Phase 3	Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Columbia, Cortland, Delaware, Fulton, Genesee, Greene, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Niagara, Ontario, Oneida, Onondaga, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Wayne, Wyoming and Yates	July 1, 2012

Section XIII: Health Home Contact Information

Billing, Remittance, And Training	<p>Computer Sciences Corporation eMedNY Call Center (800) 343-9000 E-mail: emednyproviderrelations@csc.com</p>
Health Home Policy - Office of Health Insurance Programs (DOH)	<p>NYS Department of Health Office of Health Insurance Programs (OHIP) Division of Program Development and Management (518) 473-5569 E-mail: HealthHome2013@health.state.ny.us</p>
Office of Alcoholism and Substance Abuse Services (OASAS)	<p>Albany Office 1450 Western Avenue Albany, NY 12203-3526</p> <p>General Information: Phone: (518) 485-2317 E-Mail: legal@oasas.ny.gov</p>
New York State Department of Health AIDS Institute (AI)	<p>Empire State Plaza Corning Tower Albany, NY 12237 (800) 541-AIDS (English) (800) 233-SIDA (Español) Website: www.cobracm.org</p>
Office of Mental Health (OMH)	<p>44 Holland Avenue Albany, New York 12229. (800) 597-8481 http://www.omh.ny.gov/omhweb/adults/health_homes/ E-mail: clinicrestructuring@omh.state.ny.us</p>
Office of Health Information Technology Transformation (OHITT-DOH)	<p>New York State Department of Health Empire State Plaza Corning Tower Albany, NY 12237 Office: (518) 474-4987 Website: http://www.health.state.ny.us/technology</p>

Health Commerce System (HCS)	Informatics Unit, BHNSM, NYSDOH 800 North Pearl Street Room 236 Albany NY 12204 General Inquiries (518) 473-1809 Commerce Accounts Management Unit (CAMU) (866) 529-1890 Website: https://commerce.health.state.ny.us/hcsportal/hcs_home.portal
Health Home Member Information	NY Health Options Medicaid Helpline 1- (800)-541-2831

Keeping Informed Concerning the Health Home Program

The NYSDOH has established a Health Home implementation provider support telephone line: (518) 473-5569. This support line is available Monday through Friday from 8:30 AM to 5:00 PM for Designated Health Homes and Managed Care Organizations to ask questions concerning Health Home policy and/or implementation guidance. Providers should contact the eMedNY Call Center at (800) 343-9000 for Medicaid billing questions. Inquiries from the public and from Health Home members should be directed to the Medicaid Call Center at (800) 541-2831.

Sign up to receive information from the Health Home listserv at:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/listserv.htm

Important Health Home Links

Health Home Website:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

Health Home Member Assignment, Tracking System, Billing and Rates
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_information.htm

Health Home Member Tracking System Specifications Document:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_information.htm

Health Home Meetings and Webinars:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/meetings_webinars.htm

Health Home Frequently Asked Questions and Answers:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/questions_and_answers.htm

Health Home Rate Information Questions and Answers

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_chart_q_and_a.htm