

Health Home Provider Manual - Policy and Billing

State of New York
Department of Health

APPROVED

NOTE: The Provider Policy Guidance and Manual for *Care Coordination Organization/Health Homes (CCO/HH)* serving individuals with intellectual and developmental disabilities (I/DD) can be accessed via eMedNY at: <https://www.emedny.org/ProviderManuals/HealthHomes/index.aspx>

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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 policy statements and requirements governing the Health Home program, and instructions related to the completion and submission of various forms and documents to support Health Home care management practices.

Before rendering services 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.

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 must be familiar with current and past issues of the Medicaid Update to be current on policy and procedures.

Additional information concerning the Medicaid Health Home program for adults and children including policies and procedures, guidance documents, resources and references can be found via the following:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/ - *Medicaid Health Homes - Comprehensive Care Management*

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/index.htm - *Health Homes Serving Children (HHSC)*

Disclaimer

Although every effort is made to keep this manual updated, information provided is subject to change. This manual is formatted to incorporate needed changes including links to the many pertinent documents and resources. Additional information concerning the Medicaid Health Home program, and references to policies and documents within this manual, can be found on the Department of Health's Medicaid Health Homes - Comprehensive Care Management website noted above.

The History of Health Home Designation

New York State's Medicaid program serves individuals (adults and children) with a broad array of health care needs and challenges, including those with complex medical, behavioral, and long-term care needs that drive a high volume of high cost services including inpatient and long-term institutional care.

Patient Protection and Affordable Care Act

The goal of the Health Home program 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 to implement Health Homes effective January 1, 2011. The purpose of Health Homes is to provide States the opportunity 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 Home 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 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>

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.” The authority to implement Health Homes 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 are included in Section 1945 of the Social Security Act and in NYS Social Services Law Section 365-l.

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

The Health Home program was one of 79 recommendations endorsed by Governor Andrew Cuomo’s Medicaid Redesign Team (MRT), which was charged with identifying ways to reduce costs and improve the quality and efficiency of care within the New York Medicaid program. The 2011 New York State (NYS) budget provided for the establishment of a model for person-centered integrated care coordination and care management services called Health Homes.

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 HH program.

A listing of all State Plan Amendments for the Medicaid Health Home program can be found on the Department’s *Medicaid Health Homes - State Plan Amendments* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/med_spa.htm

1 Introduction to Health Home Service Model

1.1 Overview of the Health Home Model

The Health Home (HH) program is a care management service model where all of the professionals involved in a member's care communicate with one another to address the member's medical, behavioral health and social service needs in a comprehensive manner. A dedicated care manager (HHCM) oversees and coordinates access to all of the services a member requires. Appropriate care management is intended to 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.

HH services are provided through a *Health Home*, defined as a partnership of health care providers and community-based organizations. HHs facilitate linkages to long-term community care services and supports, social services, and family support services. For Medicaid managed care members, HH services are provided through partnerships between the member's Medicaid Managed Care Plan (Plan) and an assigned HH.

The HH model of care differs from a Patient-Centered Medical Home (PCMH). 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 (ACA) anticipates that the HH 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 HH member may be enrolled in a HH and also receive services at a PCMH. A PCMH may also be a HH. Provider reimbursement will be allowed for a beneficiary who is in receipt of services from both a PCMH and a HH.

1.2 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 HH members receive appropriate and timely access to medical, behavioral, and social services in a coordinated and integrated manner. HHs are closely monitored to assure that HH standards are met.

HH provider qualification standards can be found on the Department's *NYS Health Home Provider Qualification Standards for Chronic Medical and Behavioral Health Patient Populations* webpage at:

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

2 Requirements for Health Home Participation and Provider Enrollment

The HH program is a Medicaid program. As a New York State Medicaid program, it is necessary that the applicant agrees to comply with all Medicaid program requirements. HH providers can either directly provide, or subcontract for the provision of HH services.

2.1 Requirement for Obtaining a National Provider Identifier (NPI)

The National Provider Identifier (NPI) is a unique identification number issued to health care providers by the Centers for Medicare and Medicaid Services (CMS). An NPI is required before submitting a Medicaid provider enrollment application. The application for the NPI is found on the National Plan and Provider Enumeration (NPPES) website at the following link:

<https://nppes.cms.hhs.gov/#/>

2.2 Obtaining a Medicaid Management Information System (MMIS) Provider Identification number and Category of Service (COS) 0265

HHs and CMAs will be required to obtain a Medicaid Management Information System (MMIS) provider identification number. That MMIS ID must have a Category of Service (COS) 0265, for Case Management. Enrollment applications for MMIS and COS 0265 can be obtained at:

<https://www.emedny.org/info/providerenrollment/cmcm/Option1.aspx>.

Completed applications should be sent to eMedNY at the address listed under the “Mailing Instructions” section of the application. Questions regarding provider enrollment applications should be directed to the eMedNY call center at 1-800-343-9000.

Information on system access and data sharing via the HH program’s MAPP Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) and member assessments tools are discussed in more detail under Section VI: Health Home Program Information Systems Access and Support.

2.3 Designated Health Homes

The HH provider is responsible for all HH program requirements, including services performed by subcontractor(s). HHs must be a New York State Medicaid enrolled provider.

HH providers 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. Therefore, they may have additional requirements established by the respective governing bodies. Additional information, including agency contacts can be found on the Department’s *Find a Health Home* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_map/index.htm

2.4 Use of Medicaid Enrolled Providers for the Provision of Care Management Services

Network partners providing care management services, referred to as a Health Home Care Management Agency (CMA), will also need a NPI and be a New York State (NYS) Medicaid enrolled provider with a MMIS provider ID and Category of Service (COS) 0265 (refer to subsections 2.1 and 2.2).

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

HHs and their network CMAs are encouraged to use Medicaid enrolled providers, but the Department understands that HHs may not always have the option to do so. In those instances, HHs may contract with non-Medicaid providers to deliver HH services. The contracted services may include, but are not limited to: care management, peer counseling, outreach and engagement, nutrition, vocational or housing supports. In these cases, it is up to the entities involved to form partnership and payment agreements to reimburse providers commensurate with the level of services provided. The Department expects that HHs 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 HH per member per month (PMPM) fee, HHs 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 HH any incidents, suspected fraud, waste, or abuse or criminal acts;
- The non-Medicaid provider agrees to be bound by confidentiality provisions (2.9 of the Administrative Health Home 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 HHs and Plans to use for the delivery of HH services. It is available via the following link:

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

2.6 Medicaid Confidential Data Use Agreement (DUA)

The Department requires that all HHs submit and receive acceptance of the Medicaid Confidential Data Use Agreement (DUA) from the Department's Office of Health Insurance Programs, Division of Operations and Systems, Security and Privacy Bureau in order to access Medicaid Confidential Data (MCD). Completed DUAs should be sent to:

doh.sm.Medicaid.Data.Exchange@health.ny.gov

The purpose of the DUA is to assure the Department that the HH will maintain the security and privacy of MCD that the Department releases to the HH.

The DUA, once accepted by the Department, establishes a legally binding agreement between the HH and the Department by defining the terms and conditions of the MCD release. *The sensitivity of MCD cannot be over-emphasized. MCD includes all personal information about Medicaid members, including Protected Health Information (PHI).*

A DUA must be completed and accepted prior to the Department granting a HH access to the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS), which contains MCD and PHI.

HHs who work with subcontractors/business associates that will also access MCD and the MAPP HHTS are required to complete and submit a DUA Addendum along with the Business Associate Agreement (BAA). The BAA is an agreement between the HH and their subcontractors/business associates regarding the release of MCD/PHI. BAAs must be sent to and acknowledged by the Security and Privacy Bureau before any MCD/PHI can be shared with the HH's business partners. The Department must acknowledge security requirements imposed by the HH on subcontractors/business associates which should take into account the risk presented by the type and volume of the data being shared by the HH with the subcontractor/business associates in the DUA Addendum and BAA before the subcontractor/business associate may access MCD.

The HH is responsible for complying with all federal and state laws and regulations regarding the privacy, protection and security of MCD. The HH must ensure that any BAA with a subcontractor/business associate reasonably protects the HH from liability in the event of a breach attributable to the subcontractor/business associate.

All questions regarding the DUA and/or BAA should be directed to the *New York State Department of Health, Office of Health Insurance Programs, Division of Operations and Systems, Security and Privacy Bureau* at:

doh.sm.Medicaid.Data.Exchange@health.ny.gov

2.7 Managed Care Contracts

HHs will provide services to eligible Plan members through contractual agreements between the Plan and the HH. Plans will assign their members to HH utilizing Department issued HH 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 HH services to a HH. Plans will pay for their members upon receiving a claim from the HH. HHs should utilize the Plan's contracted network of providers for direct care services that are included in the benefit package when arranging for care for HH members. Plans may opt to expand their provider networks based on HH member need.

In the event the contract between the Plan and HH is terminated, certain rules identified in the contract regarding the retention of HH member records after contract termination must be followed.

This and other information related to Managed Care Contracts with Health Homes can be found on the Department's *Managed Care Organization* webpage at:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/managed_care.htm - under: *Health Home Contracting*

2.8 Health Home Health Home Network Changes and Use of the Notification of Change (NOC) form

HHs are responsible to adhere to the HH 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 Homes for Enrollees with Chronic Conditions*.

If a HH intends on making changes in their structure and/or network, certain steps must be taken to manage them. This may include use of the Health Home *Notification of Change (NOC)* form attesting to the applicable revision(s). When used, the NOC must be completed, signed by the HH's Executive Director, and submitted to the Department for review. HHs must follow instructions for completing structure/network changes provided in the *Requirements and Instructions For Using the Notification of Change Form*, which can be found on the Department's *Lead Health Home Resource Center* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/lead_hhc.htm - under: *Administrative Requirements for Health Homes (see: Notification of Change Instructions)*

HH records must be retained even in the case of contract termination between HH and service provider or Plan (refer to Section IX: Record Keeping Requirements).

If additional assistance is needed to manage a network change that is not identified within the NOC form or in the *Requirements and Instructions For Using the Notification of Change Form document*, HHs should contact the Department either through the Medicaid Health Home Provider Line at (518) 473-5569, or the Department's Health Home Bureau Mailbox (BML) on the *Email Health Homes* webpage at:

https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action - Subject: *Organizational Changes*

2.9 Background Checks

The 2018-19 Enacted Budget includes new statutory requirements (Chapter 57 Laws of 2018) related to criminal history record checks, mandated reporter requirements, Statewide Central Register Database checks, and Staff Exclusion List checks for certain Health Home care managers and children's (Home and Community Based Services (HCBS) providers as outlined below:

Effective April 1, 2018, the statute requires:

- Health Homes and those that subcontract with Health Homes (e.g., care management agencies) that provide Health Home care management to:
 - Health Home enrollees under age 21 – includes members enrolled in Health Homes designated to serve children and adults

- Individuals enrolled in Health Homes that have a diagnosis of developmental disability as defined in Section 1.03(22) of the New York State Mental Hygiene law, i.e., all members enrolled in designated CCO/HHs that began operations on July 1, 2018
- Providers of HCBS to children under 21 years of age authorized under the Children's 1915 (c) Waiver amendment listed below:
 - OMH SED 1915(c) waiver (NY.0296)
 - DOH Care at Home (CAH) I/II 1915(c) waiver (NY.4125)
 - OPWDD Care at Home 1915(c) waiver (NY.40176)
 - OCFS Bridges to Health (B2H) SED 1915(c) waiver (NY.0469)
 - OCFS B2H Medically Fragile 1915(c) waiver (NY.0471)
 - OCFS B2H DD 1915(c) waiver (NY.0470)

To conduct:

- Criminal History Record Checks (CHRC), including finger printing, on prospective employees and
- Statewide Central Register (SCR) Database Checks and Staff Exclusion List (SEL) checks on prospective employees.

Such providers must also be mandated reporters.

Information related to this requirement can be found on the Department's *Health Home Policy and Updates* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/greater6.htm#bchecks - under: *Background checks*

3 Member Enrollment

3.1 Member Eligibility Requirements

To determine eligibility for HH program enrollment for adults and children, appropriate steps must be taken to ensure individuals meet eligibility requirements as follows:

- Medicaid enrolled
- Two chronic conditions or one single qualifying condition (specific for adults and children)
- Meet appropriateness for HH services (determinants of medical, behavioral, and/or social risk)

Information on *Eligibility Requirements: Identifying Potential Members for Health Home Services* can be found on the Department's *Health Home Policy and Updates* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/greater6.htm#outreach - under: *Eligibility (see: Health Home Eligibility Policy)*

3.2 Medicaid Enrollment

One of the required steps in determining HH eligibility is obtaining confirmation of Medicaid eligibility and coverage type prior to HH enrollment. When determining whether an individual's Medicaid coverage supports HH enrollment, the type of Medicaid coverage must be considered. Programs such as Assertive Community Treatment (ACT) and certain coverage and Plan codes are not compatible with HH services and therefore, an individual would not be eligible for HH enrollment (e.g. **FIDA**; **FIDA-IDD**; **PACE**). In addition, certain Recipient Restriction/Exemptions (RRE) codes are not compatible with HH services therefore, providers need to identify any restrictions that may exist.

Once enrolled, a member's Medicaid eligibility and coverage must be confirmed each month. If the provider does not verify eligibility prior to rendering services, the provider will be at risk for non-payment for services provided. The State will not

compensate a provider for a service rendered to an individual who is not enrolled with the appropriate Medicaid coverage.

If the person is not enrolled in 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 deemed not eligible for Medicaid by the LDSS should be provided with assistance in finding other appropriate health care options.

Guidance documents related to Medicaid eligibility and HH enrollment, coverage and/or restriction exception codes, e.g., FIDA, FIDA-IDD, Pace, etc. are available on the Department's *Health Home Policy and Updates* webpage as follows:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/greater6.htm#eligibility

Billing:

- *Coverage Codes*
- *Restriction Exception (R/E) Codes*

Eligibility:

- *Health Home Eligibility Policy*
- *Updated Guidance for FIDA and Health Home*
- *Desk Aid for Identifying FIDA, PACE, and FIDA IDD Members*

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 or enrollment verification may be addressed to the eMedNY Call Center at (800)-343-9000.

3.2.1 The Recipient Restriction Program (RRP)

RRP is a medical review and administrative mechanism whereby selected enrollees with a demonstrated pattern of abusing or misusing the Medicaid program may be restricted to one or more health care providers (e.g., primary care physician, clinic, hospital, dentist and/or pharmacy). Individuals in the RRP program are eligible for HH enrollment. HHCMs must work with Plans to coordinate care and services for members under the RRP.

More information about the *Recipient Restriction Program* (RRP) can be found on the Department's *Health Home Policy and Updates* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/greater6.htm#eligibility
– under: *General Health Home*

3.2.2 Special Populations

Special populations are a defined population of individuals who meet certain indicators for high risk/high needs, requiring a more intensive level of HHCM to address barriers and support engagement in care that lead to better stabilization and health outcomes.

Health Homes must have policies and procedures in place that address the unique requirements for serving special populations such as the following:

3.2.3 Health Home Plus (HH+)

Health Home Plus (HH+) is an intensive Health Home Care Management HHCM service established for defined adult populations with Serious Mental Illness (SMI) and for individuals who are HIV+ and virally unsuppressed and enrolled in a Health Home.

To ensure the intensive needs of these individuals are met, Health Homes must assure HH+ individuals receive a level of service consistent with the requirements for caseload ratios, face-to-face visits, and minimum levels of staff experience and education. The monthly HH+ rate is higher compared to the Health Home High Risk/Need Care Management and Health Home Care Management rates and is intended to appropriately reimburse for the intense and consistent support needed for these populations.

Information about *Health Home Plus*, can be found on the Department's *Health Home Plus (HH+)* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/special_populations/hh_plus.htm

(see):

- Health Home Plus (HH+) Guidance for Serious Mental Illness (SMI)
- Health Home Plus Program Guidance for Individuals with HIV

3.2.4 Adult Home Plus (AH+)

Adult Home Plus (AH+) provides individuals with Serious Mental Illness, living in Adult Homes in regions of New York City, the opportunity to transition to the community to live in the most integrated setting possible. AH+ is a result of the stipulation and order of settlement, *United States v. State of New York*, Civil Action No. 13-CV-4165 (NGG) *O'Toole et al. v. Cuomo et al.*, Civil Action No. 13-CV-4166 (NGG). *Class members*, individuals living in Adult Homes that meet the eligibility requirements for AH+, must chose to transition to the community and therefore, be enrolled in a Health Home.

AH+ has specific rules and program requirements related to: AH+ eligibility; caseload and qualifications of AH+ care managers; billing; class members in Licensed Assisted Living Program (ALP) Beds, the provision of services by the AH+ care manager (e.g. face to face visits, documentation), etc.

Information about Adult Home Plus can be found on the Department's *Adult Home Plus (AH+)* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/special_populations/ah_plus.htm

3.3 Referrals

Referral for HH services may come from a variety of sources such as: Local Government Units (LGU), Single Point of Access (SPOA), Local Departments of Social Services (LDSS), Human Resources Administration (HRA), HIV/AIDS Service Administration (HASA), healthcare facilities, and other providers.

Federal authority to conduct HHs mandates that *hospitals refer individual with chronic conditions who seek care or need treatment in a hospital emergency department to designated Health Home providers*. Other referral sources may include: criminal justice system, court ordered patients for Assertive Outpatient Therapy (AOT), State prisons, county and city jails; mental health discharges/referrals from State operated psychiatric centers, Article 28 and 31 Hospitals; Plans; designated HHs; health clinics, family members, health care practitioners, social service providers, and so forth.

The referring entity should first identify if the client receives their health care services from a Plan or through FFS. Referrals for HH enrollment can be made to the individual's Plan or directly to a HH. Providers with access to ePACES and/or eMedNY

should check for connectivity to a HH or CMA (A1 and A2 codes), or for those with access, through the Medicaid Analytics Performance Portal (MAPP) Health Home Member Tracking System (HHTS).

NOTE: A FFS member may be referred to a HH based on the referred client's county of residence, or county where services are received, or the need for a specific CMA. A Plan member can be referred to either the HH or the appropriate Plan for assignment.

Referred individuals meeting HH eligibility criteria that are enrolled in HHs will be reported to the Department using the MAPP HHTS.

3.3.1 Health Home Referral Requirement of Hospitals

As required by Section 1945(3)(d) of the Social Security Act, all NYS 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. Language related to this requirement can be found in Medicaid Health Home SPA #NY-13-0018 and SPA #NY-15-0020 at the following link:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/med_spa.htm

The Department issued written notification to hospitals describing the requirement and providing guidance for referring eligible individuals to HHs. This notification letter and associated frequently asked questions (FAQs), posted on the Department's HH website, is as follows:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/dal_1704.pdf - *Letter to Hospital CEOs DHDTc DAL 17-04*

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/dal_1704_qa.pdf - *Questions and Answers for DHDTc DAL 17-04*

HHs must establish and maintain connectivity with hospitals to receive referrals of potentially eligible individuals.

3.4 Outreach

Individuals identified as HH eligible must be contacted and advised of the HH program, including their right to decline enrollment. Specific procedures related to conducting outreach to potential HH members by HHs, CMAs and Plans must be followed to support engagement and the potential for enrollment, including relevant activities to support billing. Required procedures for conducting *outreach* can be found on the Department's *Health Home Policy and Updates* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/greater6.htm#outreach - under: *Outreach* (see):

- *Interim Guidance Addressing Outreach Modifications* – October 2017
- *Health Home Outreach Reprogramming* – October 2017

3.5 Optimization Plans for Medicaid Managed Care Plans

In 2018, the Department issued notification to Plans, HIV Special Needs Plans (HIV/SNP), and Health and Recovery Plans (HARP) who are contracted with HHs of a requirement to participate in an optimization program focusing on improving the engagement and enrollment (outreach) of high-risk individuals (adults and children) into HHs. Through a collaborative effort between the Department, Plans, and HHs, three optimization models were developed giving Plans the option to submit a

proposal for at least one, but up to all three models identified. Plans were also provided with the option to submit one additional model (Other) for consideration. Upon approval by the Department, Plans were able to put their Optimization Plan into effect with the expectation that Plans and HHs would work together to meet program goals.

Information regarding the Optimization Program (e.g., the application, the Department's definition of High Risk, etc.), can be found on the Department's *Managed Care Organizations* webpage, as follows:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/managed_care.htm - under: *Health Home Healthy Rewards and Enrollment of High Risk Members to Health Homes*

3.6 Transition and Access to other Medicaid services

HHs are responsible for ensuring that their members receive all medically necessary care, including primary, specialty and behavioral health services. HH members needing long term care services, i.e., greater than 120 days, may be transitioned into other long-term care (LTC) management programs. HHs are responsible for ensuring that the appropriate program is contacted to initiate the transition. HHs may continue to serve members requiring long term care services and work with appropriate providers in the HH network to assure the member's needs can be met in areas where no Managed Long Term Care (MLTC) plans are available. HHs are allowed to contract with MLTC plans for care management services (refer to subsection 3.2 for programs/products that are not HH compatible).

Additional information related to MLTC Plans and HHs can be found on the Department's *Managed Care Organizations* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/managed_care.htm - under: *Health Home and Managed Long Term Care (MLTC) Plan Guidelines for Administrative Service Agreements (ASAs)*

4 Health Home Standards for the Provision of Care Management Services

HHs and CMAs have vital roles and responsibilities in the provision of HH services to enrolled members. As specified in the SPA, HHs are required to provide the following six HH core services:

1. Comprehensive Care Management
2. Care Coordination and Health Promotion
3. Comprehensive Transitional Care
4. Enrollee and Family Support
5. Referral to Community and Social Supports
6. Use of Health Information Technology (HIT) to Link Services

HH SPAs can be found on the Department's *Medicaid Health Homes – State Plan Amendments* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/med_spa.htm

Information related to *Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations* can be found on the Department's *Policy and Standards* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/index.htm - under: *Health Home Standards and Requirements*

HHs must have policies and procedures in place to ensure care management services meet the above requirements. Such policies must include, but are not limited to, the following:

4.1 Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents #HH0009

Enrollment in the HH program is *voluntary*. An individual's decision to/not to enroll is documented through completion of applicable HH consent(s). Consent form(s) document the member's approval for accessing and sharing Protected Health Information (PHI) between specified entities named in the consent (e.g., HH, CMA, Medicaid Managed Care Plan (MMCP), healthcare providers, family and other supports, etc.). Consents also provide a method for documenting member choice related to continued enrollment and the member's approval of changes in healthcare providers, non-healthcare services, personal supports and others throughout the member's enrollment in the HH program.

HHs must ensure that policies and procedures are in place to direct CMAs on appropriate practices related to the use of HH consents and address protections related to Protected Health Information (PHI). This policy, in its entirety can be found on the Department's *Policy and Standards* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/index.htm - under: *Health Home Policy and Updates* (see: *Consent*)

Information about Health Home consents for children can be found on the Department's *Health Home Serving Children (HHSC)* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/index.htm - under: *HHSC Consent Forms and Templates*

Information about Health Home consents for adults can be found on the Department's *Lead Health Home Resource Center* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/lead_hhc.htm - under: *Forms and Templates*

The letter issued by OASAS (November 1, 2012) supporting the use of the DOH 5055 *Health Home Patient Information Sharing Consent* under 42 CFR Part 2 can be accessed as follows:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/forms/docs/2012-11-21_oasas_ltr_support_hh_consent.pdf

4.2 Health Home Notices of Determination and Fair Hearing Process #HH0004

HHs must have policies and procedures in place related to notifying members/potential members of their Fair Hearing rights, and participation in the Fair Hearing process if an individual requests a Fair Hearing challenging their enrollment, denial of enrollment, or disenrollment from the Health Home Program.

This policy, in its entirety can be found on the Department's *Policy and Standards* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/index.htm - under: *Health Home Policy and Updates* (see: *Eligibility*)

4.3 Health Home Comprehensive Assessment Policy (Adult and Children) #HH0002

HHs must have policies and procedures in place related to the provision of comprehensive care management, including the completion of a comprehensive assessment for consented HH members and required components for adults and children.

This policy, in its entirety can be found on the Department's *Policy and Standards* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/index.htm - under: *Health Home Policy and Updates* (see: *General Health Home*)

4.4 Continuity of Care and Re-engagement for Enrolled Health Home Members #HH0006

HHs must establish and maintain policies and procedures that address how a member is identified as disengaged from care management services; steps that must be taken to search for and re-engage disengaged members; specific timeframes associated with location and re-engagement efforts; acceptable billing practices; and quality monitoring activities.

This policy, in its entirety can be found on the Department's *Policy and Standards* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/index.htm - under: *Health Home Policy and Updates* (see: *General Health Home*)

4.5 Health Home Monitoring: Reportable Incidents Policies and Procedures #HH0005

HHs must establish and maintain policies and procedures that address the handling of reportable incidents in compliance with the *Health Home Standards* outlined in the SPA. This includes required timeframes, documentation, and notification procedures (e.g. between CMA and HH, and HH and Department, where applicable).

This policy, in its entirety can be found on the Department's *Health Home Policy and Updates* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/index.htm - under: *Reportable Incidents*

4.6 Member Disenrollment From the Health Home Program Policy #HH0007

Discharge Planning for the disenrollment of a member should be a collective process consisting of the member, member's Plan, member's care team and supports. Disenrollment must include steps to assure: member choice; member notification; provision of essential post disenrollment care and service information; protection of member PHI; following timelines and billing procedures; etc. Disenrollment activities should be monitored to include identification of high-risk populations (e.g., HARP, HIV SNP, etc.) and the potential for member re-engagement following disenrollment, if necessary.

HHs must have policies and procedures in place that outline the necessary steps to be taken by CMAs and HHCMs when disenrollment is indicated, and for ensuring safe and appropriate discharge planning. Procedures must include actions to be taken to minimize the potential for untimely member disenrollment whenever possible.

This policy, in its entirety can be found on the Department's *Health Home Policy and Updates* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/greater6.htm - under: *General Health Home*

Certain codes must be used when ending a segment for a member upon disenrollment from the HH program. Information regarding these codes can be found on the Department's *Medicaid Analytics Performance Portal (MAPP)* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/index.htm - under: *Member Assignment and Enrollment*

- MAPP Segment End Date Reason Codes Crosswalk
- MAPP Segment End Date Reason Codes Guidance Chart

4.7 Member Changing Health Home/CMA

Upon HH enrollment, members must be provided with information on how to request a change in their HH and/or CMA. If a member chooses to be in a different HH, they should notify their Plan **and** HH immediately. The request for transfer must be acted upon timely. This includes obtaining the reason for the member's decision to transfer and discussing any potential resolutions with the member.

The HH involved needs to discuss the timing of the transfer. The transfer would be effective the first day of the next month as only one HH may bill for a member in a given month.

In addition, certain rules apply when updating or obtaining new consent as it relates to a member's change of HH and/or CMA. Information can be found in the Health Home policy, *Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents # HH0009* on the Department's *Health Home Policy and Updates* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/greater6.htm#consent - under: *Consent*

Instructions on how to transfer a member's HH can be found on the Department's *Medicaid Analytics Performance Portal (MAPP)* webpage at:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_information.htm - under: *Tracking System File Formats (see: MAPP HHTS File Specifications Document)*

5 Billing

In order to be reimbursed for a billable unit of service, HH providers must, at a minimum, provide one of the required Core HH services in a given month, complete the Clinical and Functional Questionnaire in the MAPP-HHTS, and ensure appropriate supporting documentation is completed. HH services are billed on a monthly basis, with a date of service for the first day of the month in which the service was provided. Claims for HH members not enrolled in a Mainstream Managed Care Plan (e.g., FFS, MLTC) are submitted by the HH to Medicaid (eMedNY). HHs must have policies and procedures in place to ensure requirements related to proper billing activities are followed (refer to: **Section IX Record Keeping Requirements**).

Information about *Billing* can be found on the Department's *Health Home Billing* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/index.htm

(see:)

- *Billing and Documentation Guidance for Health Home Adult Rates with Clinical and Functional Adjustments Effective May 1, 2018 - Revised March 2019*
- *Medicaid Managed Care Plan Billing and Payment Protocol for Health Home Services – Effective July 1, 2018 - Revised: March 2019*

Detailed information on Medicaid claiming can be found on eMedNY's *Information For All Providers* webpage at:

<https://www.emedny.org/ProviderManuals/AllProviders/index.aspx> - under: *General Billing Guidelines - INSTITUTIONAL*

For Billing and remittance questions:

For FFS: contact eMedNY Call Center (Computer Science Corporation) at 1-800-343- 9000 or visit eMedNY at:

www.emedny.org

For Managed Care: contact the appropriate Plan

5.1 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>

6 HH Program Information Systems Access and Support

6.1 Health Commerce System (HCS)

The Health Commerce System (HCS) is an electronic information exchange tool used by the Department to communicate with NYS 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. The Department's program area that is responsible for collection and maintenance of specific data, shall authorize access to that data, via the HCS. Therefore, the Department's HH Team is responsible for authorizing HCS access for HHs, participating Plans, and CMAs.

6.1.1 Organization Access to HCS

The HCS account for your organization is set up using your organization's MMIS provider ID. This organization account and/or account users from your organization, can then be granted access to other systems needed for the HH program. Many HH program related applications, such as the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS), Secure File Transfer (SFT), Criminal History Record Check (CHRC) and the Uniform Assessment System (UAS) are currently housed in HCS. This access is needed to communicate HH member billing support information and collect quality metrics between the Department and Plans, HHs and CMAs.

6.1.2 End User Access to HCS

Once an organization is given access to HCS, an HCS Director and HCS Coordinator from that organization are provisioned using a two-step authentication process. When that is complete, the HCS Director and HCS Coordinator can add their organization's users. All HCS users are assigned an HCS user ID, a Personal Identification Number (PIN), and a password by the Department. These codes are unique for every user and must be saved securely for future reference. The PIN and HCS account password should never be shared with others. The consequences of sharing an HCS access account are severe and can include revocation of the account. Multiple instances of violations that compromise the security of account usage may result in the inability of your organization to do business on the HCS.

6.1.3 HCS Account Assistance for Health Home Providers

If a HH or CMA does not have a HCS account or a HCS role update is needed for the HCS Director or Coordinator(s), the HH program team should be contacted by visiting the HH website found at the following link:

https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action Select, "Health Commerce Accounts for Health Homes" as the subject from the drop-down menu. You can also call the Health Home Provider Line at 518-473-5569.

Note: Organizational changes including changes in organization name, MMIS provider ID or NPI number, affect the HCS account. Therefore, this can also affect any applications or data that is transferred via the HCS. (see:

Requirements and Instructions For Using the Notification of Change Form found on the Department's *Lead Health Home Resource Center* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/lead_hhc.htm - under: *Notification of Change Instructions*

HCS Authorized Accounts – Support and Password Resets

Once an active HCS account is obtained or identified, the following support unit may be contacted for relevant HCS application questions:

Commerce Accounts Management Unit (CAMU) may be reached at 1-866- 529-1890 or electronically at:

camu@health.ny.gov with questions regarding

- HCS Account Status
- HCS Account Passwords
- HCS Secure File Transfer 2.0 application

6.2 Access to Uniform Assessment System

The Uniform Assessment System (UAS) application is also housed in the HCS. The UAS–NY contains reporting functionality for information on individuals assessed, as well as aggregate or agency–wide information, which will be immediately available to users during and upon completion of the assessment. The UAS–NY also includes an ad hoc reporting function that will enable users to create customized reports and to download information from the UAS–NY. This data can then be uploaded to an organization's local management system.

Information on the UAS NY can be found at:

https://www.health.ny.gov/health_care/medicaid/redesign/uniform_assessment_system/

The UAS support team may be reached at 518-408-1021, or electronically at:

uasny@health.ny.gov

6.3 Medicaid Analytics Performance Portal (MAPP)

The Medicaid Analytics Performance Portal (MAPP) supports both the Health Home program and Delivery System Reform Incentive Payment (DSRIP) program's performance management organizations, through separate access points. MAPP serves as a retail front-end to the Medicaid Data Warehouse for both Performing Provider Systems (PPS) and Health Home organizations.

Health Homes, CMAs and Managed Care Plans are required to have an active Health Commerce System (HCS) account to access HCS. LGU-SPOAs and LDSS offices are also granted access to MAPP Health Home Tracking System (HHTS) by the Department. LGU-SPOAs and LDSS staff will use MAPP HHTS for Client Identification Number (CIN) searches and to submit children's referrals for Medicaid members that are Health Home eligible, through the Children's Referral Portal. The MAPP application, accessed through HCS, is a secure electronic application that supports the HHTS.

Health Homes, CMAs, and Managed Care Plans can submit and access member tracking files in MAPP HHTS every day. The portal will process these files immediately, outside of the scheduled system black out period. The current scheduled blackout period is daily from 12:00 AM to 6:00 AM.

The MAPP HHTS is updated regularly with new or improved functionality on an ongoing basis. Therefore, additional detailed information about the MAPP HHTS, such as released communications, file formats, upcoming and past webinars, a complete system issues list, and frequently asked questions can be found at the following link:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/index.htm

6.4 MAPP HHTS Application Support

The MAPP HHTS is supported by MAPP Customer Care Center (CCC). All MAPP HHTS issues, access, training for MAPP user roles, adding or removing your organization's MAPP Gatekeeper, MMIS ID changes, adding or removing MAPP relationships and all other MAPP questions or concerns, should be sent to the Department's HH team through MAPP CCC by sending an email to MAPP-customercenter@cma.com or calling 518-649-4335.

6.5 Health Commerce System (HCS) Secure File Transfer

Files containing PHI data may also be transferred among providers, Plans and the Department using the Health Commerce System (HCS) Secure File Transfer (SFT) application. Secure File Transfer 2.0 is a utility that provides solutions for the handling of sensitive information, including financial files, medical records, legal documents, personal data, etc. SFT securely collects, stores, manages, and distributes information between the HCS users. The utility will securely and easily transfer files and folders of up to 2GB in size between two or more users. It uses email addresses from the HCS Communications Directory to send and receive packages. This utility functions like an email system, with an Inbox, Drafts, Sent, Templates and Trash mailboxes. For more information, please view the Secure File Transfer 2.0 Quick Reference Guide.

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

7 Health Information Technology (HIT)

7.1 Statewide Health Information Network of New York (SHIN-NY)

The Statewide Health Information Network for New York (SHIN-NY), allows the electronic exchange of clinical information and connects healthcare professionals statewide. This enables coordination of care needed to improve patient outcomes and the quality and efficiency of care while protecting patient privacy. The SHIN-NY is overseen by the Department and provides rules for the securing and the exchange of patient health information.

The SHIN-NY is comprised of seven Regional Health Information Organizations (RHIO), or Qualified Entity (QE). RHIO/QEs support HIPAA-compliant clinical data exchange and use between their participating data providers and consumers. The RHIO/QEs are supported by shared technology, governance, and policy standards led by NYSDOH and facilitated by the New York eHealth Collaborative (NYeC) that oversees the SHIN-NY. Over the past decade, New York State has made major investments in the SHIN-NY and RHIO/QEs to facilitate data exchange between clinicians and Care Managers to support the delivery of high-quality coordinated, preventive, and person-centered care, resulting in improved patient outcomes, reduction of avoidable tests and procedures, lowered costs, and support of new models of care delivery.

Information on the SHIN-NY, the seven regional RHIO/QEs, and NYeC, can be found on the NYeC website at:

<https://www.nyehealth.org/shin-ny/what-is-the-shin-ny/>

7.2 Health Information Exchange via NYS RHIO/QE

Health information in New York State is exchanged between providers, hospitals, payers and other authorized stakeholders, via

the SHIN-NY, and its component RHIO/QE networks. Providers, hospitals, HHs and other stakeholders sign a data sharing agreement to become a participant with a RHIO/QE so they can access and exchange electronic health information with participants in their region, and throughout New York State. With limited exceptions, a HH participating with a RHIO/QE can access individual's information via the RHIO/QE's interface only if the individual signs a written consent form authorizing such access.

Individuals can provide this written consent in a variety of ways. The current *Health Home Patient Information Sharing Consent form* (DOH-5055) is a single entity RHIO/QE consent, in that it allows the HH to access the individual's health information through the RHIO/QE named on the consent form (provided the HH is a participant with that RHIO/QE). It is important to note that some RHIO/QE's do not accept the DOH-5055 as an alternate form of consent to access health information of HH members in their system. Each RHIO/QE has their own specific consent form on their respective website. HHs should discuss with the RHIO/QE(s) they participate with which form should be used to document affirmative consent to access their member's PHI. If the RHIO/QE can support the use of a multi-entity consent form, such form is permitted. The individual must give the HH permission to directly access their health information at each RHIO/QE. In other words, a HH can access the individual's information via more than one RHIO/QE interface, provided each RHIO/QE is named on the signed HH consent form (and the HH has a data sharing agreement to participate with each RHIO/QE).

The HH is required to participate with at least one RHIO/QE to meet the final HIT requirements. There may be financial considerations to joining a RHIO/QE or using their interface for data exchange. Ultimately, the HH must be able to transmit and receive data electronically with its associated organizations and providers.

If a HH Withdrawal of Consent form (DOH-5058) is signed, permission to share new data among HH partners is negated and the HH cannot access the individual's health information via the RHIO/QE(s) named on that form.

Information related the use of HH consents can be found on the Department's *Health Home Policy and Updates* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/greater6.htm#general - under: *Consent (see: Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents #HH0009)*

7.3 Single Care Management Record

HHs 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, HHs must access and contribute 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.

7.4 CMART

The Health Home Care Management Assessment Reporting Tool (HH-CMART) is a case management reporting utility for HHs that was developed by the Department based on a reporting tool used by Plans. This customized reporting module is used by HHs to report all HH process metrics, including numbers and dates of contacts and HH services delivered. This process data

will provide the Department 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 HH care management programs during the reporting period. Additional information on HH-CMART, refer the webinar at following link:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/performance/index.htm - under: *Performance Management (see: Health Home CMART)*

8 PERFORMANCE MANAGEMENT

The Health Home Performance Management (PM) program provides a formal framework for Health Homes, CMAs, Plans, and the Department to work together to improve health outcomes for HH members.

A successful PM program requires concerted and tactical efforts by HHs to actively monitor performance measures and manage practices, processes and providers to ensure HH care management is providing value and improving health outcomes.

The PM program includes specific measures that lead to short term and long-term performance outcomes to achieve the vision of health, wellbeing, and recovery for HH members. All Quality Measures are reported to CMS on an annual basis. All Process Measures are utilized to assess quality of care provided by HHs and CMAs. The PM program includes but is not limited to individualized technical assistance, learning collaboratives, re-designation support and quality/performance improvement webinars and activities.

A full array of topics related to HH quality management can be found on the Department's *Performance Management* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/performance/index.htm

8.1 Quality Management Program #HH0003

HHs must provide timely, comprehensive, high quality HH services using the 'person-centered' approach to care. To meet these requirements, HHs must maintain an environment that fosters continuous quality improvement strategies. This is achieved through implementation of a Quality Management Program (QMP), a system to monitor and objectively evaluate HH quality, efficiency, and effectiveness.

HHs must develop and maintain a Quality Management Program in alignment with HH Standards and Requirements that objectively, systematically, and continuously assess, assure, monitor, evaluate, and improve the quality of processes, activities, and services provided to HH members.

HHs must have policies and procedures that outline the components of an effective Quality Management Program.

This policy, in its entirety can be found on the Department's *Policy and Standards* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/index.htm - under: *HH Policy and Updates (see: Performance and Quality Management)*

8.2 Health Home Designation #HH0012

The Department is responsible to review performance to determine whether HHs are in compliance with Federal and State standards and requirements. Working collaboratively with its State Agency Partners (Office of Mental Health (OMH), AIDS Institute (AI), and Office of Alcoholism and Substance Abuse Services (OASAS)), the Department conducts a review of all HHs

across the State. This is done through a three-part process to include on-site visits and pre and post site visit activities. This policy provides specific information on the redesignation process.

This policy, in its entirety and access to the *Health Home Re-Designation Site Visit Standards and Chart Review Tools*, can be found on the Department's *Health Home Performance Management* webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/performance/index.htm - under: *Redesignation Process and Tools*

9 Record Keeping Requirements

9.1 Documentation of Health Home Services Supporting Minimum Billing Standards

HHs must provide at least one of five Core (exclusive of HIT) HH 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 that are reciprocal in nature, 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. HHs must be aware and include in policy any exceptions that exist regarding member contacts and face to face visits (e.g. HHSC, AOT, etc.).

New York State retains the right to review HHCM records as required to assure that services were provided in each month for which a Medicaid payment was made for HH 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.

9.1.1 Health Home Minimum Billing Standards

This chart provides the 5 core services (excluding HIT) and examples of activities for each core services that must be provided monthly to meet minimum billing requirements. Documentation must be in place to support each activity performed as follows:

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.

Care Coordination & Health Promotion	<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.
Comprehensive Transitional Care	<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.
Member & Family Support	<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.
Referral and Community & Social Support Services	<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.

9.2 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 at a minimum, but not limited to the following components:

- Local claiming forms
- All completed and signed HH consents
- Records of eligibility determination and evaluations
- Copy of Notice of Determinations issued to the member
- Initial assessments (e.g. comprehensive) and reassessments (annual or significant change)
- Initial and subsequently updated Plan of Care containing goals, objectives, timeframes, and other required components, per policy
- Copies of any releases of information signed by the member (or member's representative)

- Medical, behavioral health, social services or any other referrals made for the member
- Progress notes
- Additional assessments
- Safety plan
- Discharge plans
- Copy of medical records
- Pertinent correspondence with member or member representative
- Any additional documentation as identified by applicable State and Federal regulations

9.3 Record Retention

Member records must be kept for a period of six years after the date of service, and in the case of a minor three years after the age of majority or six years after the date of service, whichever is later, in accordance with all applicable State and Federal laws and regulations, or the contract between Plans and the Department. HH records must be retained even in the case of contract termination between HH and service provider or Plan.

10 Glossary of Terms

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

A1/A2 codes: These codes are used to identify an individual in active outreach or enrolled in the Health Home Program. A1 will display as HHP-CMA and identify the Care Management Agency's (CMA) name; and A2 will display as HHP-HH and identify the Health Home's (HH) name.

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/restriction_exception_codes.pdf

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.

Computer Science Corporation (CSC): CSC is the Medicaid fiscal agent for eMedNY.

Data Use Agreement (DUA): 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.

Delivery System Reform Incentive Payment Program (DSRIP): DSRIP's focus is to restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over 5 years.

Designated HH Provider: a provider approved and designated by the Department as a Lead provider of HH services.

Department of Health (Department): New York State agency responsible for the administration of the Medicaid program at the state level.

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

Electronic Medicaid of New York (eMedNY): an access system that allows NY Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible members.

Electronic Provider Assisted Claim Entry System (ePaces): ePaces is a web-based program, developed by eMedNY on behalf of the NYS Department of Health, that allows enrolled New York Medicaid providers to submit and receive responses for HIPAA-compliant claims, eligibility requests, prior approval requests and claim status requests.

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.

Fully Integrated Duals Advantage (FIDA): Administered by CMS and NYSDOH, FIDA is a joint Medicare and Medicaid demonstration designed to integrate care for New Yorkers who have both Medicare and Medicaid and who reside in the targeted geographic area. Beneficiaries who choose to participate will receive both Medicare and Medicaid coverage, including Part D prescription drugs, from a single, integrated FIDA managed care plan.

https://www.health.ny.gov/health_care/medicaid/redesign/fida/

Fully Integrated Duals Advantage for individuals with Intellectual and Developmental Disabilities (FIDA-IDD): Care management program focuses on individuals who receive long-term care and intellectual and developmental disabilities service needs. https://opwdd.ny.gov/opwdd_services_supports/people_first_waiver/care_management/FIDA_IDD

Home and Community-Based Services (HCBS): Federal category of Medicaid services and waiver programs, established by Section 2176 of the Social Security Act, that includes adult day care, respite care, homemaker services, training in activities of daily living skills, and services not normally covered by Medicaid; these services are provided to disabled and aged recipients to allow them to live in the community and avoid being placed in an institution

Health and Recovery Plans (HARP): HARP is a managed care product that manages physical health, mental health, and substance use services in an integrated way for adults with significant behavioral health needs (mental health or substance use). HARPs must be qualified by NYS and must have specialized expertise, tools and protocols that are not part of most medical plans. HARPs must be qualified by NYS and must have specialized expertise, tools and protocols that are not part of most medical plans.

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 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.

HH Care Manager (HHCM): employed by care management agency under agree with a HH(s) with the qualifications to serve HH enrolled members as defined by the HH requirements and standards. The HHCM works with members to identify their needs and connect with healthcare and service providers approved by the member to develop a plan of care. The HHCM oversees and coordinates access to all of the services a member requires to achieve optimum level of health and independence possible,

HH Eligible: an individual identified as meeting eligibility criteria required for enrollment in the HH program.

HH Member: An individual who has been deemed to meet all HH eligibility criteria and has been enrolled in the HH program.

HH 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.

HH Service Organizations: the collective list of HH Service Providers

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

Health Insurance Portability and Accountability Act of 1996 (HIPAA): is legislation that provides data privacy and security provisions for safeguarding medical information.

HIV/AIDS Services Administration (HASA): administered by the New York City Human Resources Administration (HRA) provides services to individuals diagnosed with HIV/AIDS. <https://www1.nyc.gov/site/hra/help/hiv-aids-services.page>

HIV Special Needs Plan (SNP): SNP (or HIV SNP) is a health plan that covers all the same services as other Medicaid health plans, but also provides additional specialty services important to people living with or at risk for HIV/AIDS. <https://www.health.ny.gov/diseases/aids/general/resources/snps/>

Human Resources Administration (HRA): The New York City Human Resources Administration/Department of Social Services (HRA/DSS) <https://www1.nyc.gov/>

Ineligible Person: 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.

Local Departments of Social Services (LDSS): Local district entities responsible for Medicaid eligibility determination and for performing a number of Medicaid functions

Local Governmental Unit (LGU): The LGUs have a statutory responsibility under NYS Mental Hygiene Law to oversee and manage the local mental hygiene system and develop, implement and plan for services and supports for adults and children with mental illness, substance use disorder and developmental disabilities. http://law.onecle.com/new-york/mental-hygiene/MHY041.03_41.03.html

Managed Care Organization/Plan (Plan): 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).

Medicaid Management Information System (MMIS): MMIS is a mechanized claims processing and information retrieval system that State Medicaid programs must have to be eligible for Federal funding. The system controls Medicaid business functions, such as: Administrative program and cost control; Beneficiary and provider inquiries and services; Operations of claims control and computer capabilities; and Management reporting for planning and control.

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

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

Programs of All-Inclusive Care for the Elderly (Pace): is a Medicare and Medicaid program that helps people meet their health care needs in the community instead of going to a nursing home or other care facility. PACE stands for Programs of All-Inclusive Care for the Elderly. Serves 55 and older; need a nursing home level of care; be able to live safely in the community with Pace services.

Personally Identifiable Information (PII): PII is information that can be used to distinguish a person's identity, such as their name, social security number or date of birth, when standing alone or when combined with other personal information, such as mother's maiden name.

Protected Health Information (PHI): The Office for Civil Rights enforces the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, which protects the privacy of individually identifiable health information; the HIPAA Security Rule, which sets national standards for the security of electronic protected health information; the HIPAA Breach Notification Rule, which requires covered entities and business associates to provide notification following a breach of unsecured protected health information; and, the confidentiality provisions of the Patient Safety Rule, which protect identifiable information being used to analyze patient safety events and improve patient safety. For information related to HIPAA Privacy Rules, refer to The Office for Civil Rights at: <http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html>

RHIO (Regional Health Information Organization): 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.

SPOA (Single Point of Access): 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.

11 HEALTH HOME CONTACT INFORMATION

eMedNY Call Center (Billing, Remittance and Training)	Phone: (800) 343-9000 E-mail: emednyproviderrelations@csc.com
MAPP Customer Care Center	Phone: (518) 649-4335 Email: mapp-customercenter@cma.com
Health Home Program - New York State Department of Health Office of Health Insurance Programs (OHIP) Division of Program Development and Management (DPDM)	Phone: (518) 473-5569 (Health Home Provider Line) Email: (refer to: Section X, 10.1)
Office of Alcoholism and Substance Abuse Services (OASAS)	Albany Office: 1450 Western Avenue Albany, NY 12203-3526 Phone: (518) 485-2317

	E-Mail: legal@oasas.ny.gov
AIDS Institute (AI) - New York State Department of Health	Empire State Plaza, Corning Tower Albany, NY 12237 (800) 541-AIDS (English) (800) 233-SIDA (Español) Website: www.cobracm.org
New York State Office of Mental Health (OMH)	44 Holland Avenue Albany, New York 12229 Phone: (800) 597-8481 Website: https://www.omh.ny.gov/ Website (Health Homes) http://www.omh.ny.gov/omhweb/adults/health_homes/
Health Commerce System (HCS)	Informatics Unit, BHNSM, NYSDOH 800 North Pearl Street, Room 236 Albany NY 12204 Phone: (518) 473-1809 (General Inquiries)
	Commerce Account Management Unit (CAMU) Phone: (866) 529-1890 Email: camu@its.ny.gov Website: https://commerce.health.state.ny.us/public/hcs_login.html
Health Home Member Information	NY Health Options Medicaid Helpline Phone: (800)-541-2831
Early Intervention Program	New York State Department of Health, Bureau of Early Intervention Corning Tower, Room 208 Empire State Plaza Albany, NY 12237-0660 Phone: (518) 473-7016 Email: beipub@health.ny.gov
NYSDOH Security and Privacy Bureau	Email: doh.sm.Medicaid.Data.Exchange@health.ny.gov

11.1 Email the Health Home Program

To email the Health Home program, visit the Department's *Email Health Homes* webpage at:
https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action

In order to submit a question, four fields marked with * **must** be filled out:

- Subject
- Question or Comment
- Name
- Email Address

If you have multiple questions which relate to multiple topics found in the *Subject* drop-down list, **submit them separately**, to allow for a timelier response.

Appendix - Acronyms and Abbreviations

ACA	Affordable Care Act
AOT	Assertive Outpatient Therapy
ASA	Administrative Service Agreement
BAA	Business Associate Agreement
BHO	Behavioral Health Organization
BML	Health Home Bureau Mail Log
CCO/HH	Care Coordination Organization/Health Home
CHP	Child Health Plus
CIN	Client Identification Number
CMA	Care Management Agency
CMS	Center for Medicare and Medicaid Services
GDIT	General Dynamics Information Technology (CSRA/GDIT)
Department	New York State Department of Health
DSRIP	Delivery System Reform Incentive Payment
DUA	Data Use Agreement
EIP	Early Intervention Program
FFS	Fee-for-Service
FIDA	Fully Integrated Duals Advantage
FIDA-IDD	Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities
FQHC	Federally Qualified Health Center
HARP	Health and Recovery Plan
HASA	HIV/AIDS Service Administration
HCBS	Home and Community Based Services
HCS	Health Commerce System
HH	Health Home
HHCM	Health Home Care Manager
HHTS	Health Home Tracking System
HIE	Health Information Exchange
HRA	Human Resources Administration
HIV	Human Immunodeficiency Virus
HIV SNP	HIV Special Needs Plan
LDSS	Local Department of Social Services
LGU	Local Government Unit
MAPP	Medicaid Analytics Performance Portal
MEVS	Medicaid Eligibility Verification System
MMIS	Medicaid Management Information System
NPI	National Provider Identifier
OIG	Office of Inspector General
PACE	Programs of All-Inclusive Care for the Elderly
PCMH	Person Centered Medical Home
PHI	Protected Health Information
PII	Personally Identifiable Information
Plan	Medicaid Managed Care Plan/Organization (MCP/MCO)
POC	Plan of Care
PMPM	Per Member Per Month
PSYCKES	Psychiatric Services and Clinical Knowledge Enhancement System
RHIO	Regional Health Information Organization
SPA	State Plan Amendment
SPOA	Single Point of Access