



Department  
of Health

Office of  
Mental Health

ANDREW M. CUOMO  
Governor

HOWARD A. ZUCKER, M.D., J.D.  
Commissioner of Health, DOH

Anne Marie T. Sullivan, M.D.  
Commissioner of Mental Health, OMH

October 11, 2016

Dear Health Home Provider,

In 2014, the New York State Office of Mental Health (OMH) and the New York State Department of Health (DOH) implemented an enhanced service and rate code package for Health Homes called Health Home Plus. Health Home Plus (HH+) is an intensive Health Home Care Management (HHCM) service established for defined populations with Serious Mental Illness (SMI) who are enrolled in a Health Home.

Health Home members receiving Assisted Outpatient Treatment (AOT) were identified as the first population eligible for HH+. On 12/1/16, as part of the expansion of HH+, two additional populations will now be defined HH+ eligible: releases from OMH's Central New York Psychiatric Center and its corrections-based mental health units, and OMH State Psychiatric Center discharges. The enclosed document entitled *Health Home Plus (HH+) Program Guidance: NYS OMH State Psychiatric Center ("State PC") and Central New York Psychiatric Center and its Corrections-Based Mental Health Units ("CNYPC") Adult Discharges* provides additional background and details regarding HH+; please review the guidance document carefully. Refer to separate guidance for updates to AOT HH+.

Attached to the guidance is the updated NYS DOH/OMH Health Home Plus Standard Attestation Form. The attestation form must be completed by all lead Health Homes to allow for billing the HH+ rate upon the elimination of direct billing by Care Management Agencies (CMA). The Health Home's attestation must include a list of all contracted downstream CMAs that will provide HH+ services to eligible members. By listing a CMA provider on the attestation form, the Health Home attests that the CMA meets all the HH+ requirements described in the HH+ guidance, and is therefore qualified to provide HH+ services and receive the HH+ rate. **Completed Attestation forms must be submitted to the NYS Department of Health no later than 12/1/16.** A completed form must be on record with DOH before any HH+ billing by the Health Home can occur.

Any questions regarding the HH+ program or rate code can be directed to Stacey Hale by email ([Stacey.Hale@omh.ny.gov](mailto:Stacey.Hale@omh.ny.gov)).

Sincerely,

Robert Myers, PhD  
Senior Deputy Commissioner  
Director, Division of Adult Services

Emil Slane  
Deputy Commissioner, Chief Fiscal Officer  
Office of Financial Management



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Attachment: Health Home Plus Program Guidance for Central New York Psychiatric Center Inpatient or Corrections-Based Mental Health Units AND New York State Office of Mental Health State Psychiatric Center Adult Discharges

Cc: County Mental Health Directors  
OMH Field Office Directors  
Moira Tashjian, OMH Associate Commissioner, Division of Adult Community Care Group  
Nicole Haggerty, OMH Director of Bureau of Rehabilitation Services and Care Coordination  
Peggy Elmer, DOH Office of Health Insurance Programs

**Health Home Plus Program Guidance**  
**New York State Office of Mental Health (OMH)**  
**State Psychiatric Center (“State PC”)**  
*and*  
**Central New York Psychiatric Center and its**  
**Corrections-Based Mental Health Units (Located within NYS DOCCS Prison System) (“CNYPC”)**  
**Adult Discharges**  
**October 2016**

## **Description**

Health Home Plus (HH+) is an intensive Health Home Care Management (HHCM) service established for defined populations with Serious Mental Illness (SMI) who are enrolled in a Health Home (HH) serving adults. In order to ensure their intensive needs are met, Health Homes must assure HH+ members receive a level of service intensity consistent with the requirements for caseload ratios, reporting, and minimum levels of staff experience and education outlined below. The differential monthly rate for HH+ is higher compared to the “high”, “medium” and “low” rates for HARP and non-HARP HHCM enrollees, and is intended to appropriately reimburse for the additional management and oversight standards for this population.

## **Population**

Individuals with SMI being discharged from NYS OMH State PCs, Central New York Psychiatric Center or its Corrections-Based Mental Health Units (located within designated NYS DOCCS facilities) - herein after “CNYPC” - often require a more intensive level of care management to help ensure a successful transition back into the community. This guidance applies only to adults with SMI who are being discharged or released from OMH State PCs or CNYPC. Individuals may benefit from this enhanced support for up to 12 consecutive months post-discharge.

Some individuals being discharged from State PCs or CNYPC may also be receiving Assisted Outpatient Treatment (AOT) upon discharge; these individuals are eligible for the HH+ rate for 12 months post-discharge and/or for as long as the active AOT order is in place. Please refer to the program requirements described in separate guidance for AOT Health Home Plus.

Individuals being discharged from State PCs or CNYPC into an OMH State-operated residence<sup>1</sup> located on Psychiatric Center (PC) campus grounds are eligible for health home services, but not reimbursable at the HH+ rate. These programs, by design, provide a high level of support reimbursed by existing residential rates.

Later when the individual is ready for discharge from the on-campus State-operated residence, the individual will then become eligible for HH+ for 12 consecutive months post-discharge from the residence.

The level of service provided under the HH+ rate will greatly benefit individuals who are transitioning into a more independent living situation and could use a high level of wrap-around supports. This guidance does not apply to individuals discharged from State PCs or CNYPC who are receiving Assertive Community Treatment (ACT), a program that by design includes an intensive level of care management.

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<sup>1</sup> OMH State-operated residence includes the following types: Transitional Living Residence (TLR), Transitional Placement Program (TPP), State Operated Community Residence (SOCR), and Residential Care Center for Adults (RCCA).

## Care Management Agencies (CMAs) eligible to serve people receiving HH+

Former OMH Targeted Care Management (TCM) providers, or OMH Legacy providers, are currently able to serve and bill the HH+ rate code for individuals being discharged from State PCs or CNYPC. Once program and training requirements are completed and verified by the State, Non-Legacy CMAs will also be able to serve and bill for the HH+ population. Further guidance will follow regarding specific training requirements for Non-Legacy CMAs.

ACT programs may also serve individuals being discharged from CNYPC or State PCs. However, ACT programs are not eligible for the HH+ rate code since these programs bill the ACT rate code, and therefore are not included in this guidance document.

### Attestation

It will be the responsibility of the lead Health Homes to attest that the HH+ program requirements described below are being met by all contracted Care Management Agencies (CMAs) providing HH+ services.

OMH and DOH will have joint oversight of HH+ compliance including the approval of attestation forms. Health Homes and CMA providers who are approved for the HH+ rate are subject to audit by the State. Agencies shall understand that failure to comply with HH+ requirements may jeopardize the agency's opportunity to bill the HH+ rate, and potentially affect a CMA's status as a downstream Health Home Care Management provider.

### Program Requirements

- Program requirements for HH+ enrollees are to be carried out consistent with the existing [“Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations”](#)  guidance distributed by the Department of Health.
- The preferred caseload ratio for HH+ enrollees shall be 1 staff to 12 HH+ recipients, but no greater than 1:15.
- For the purposes of case load stratification and resource management; a caseload mix of HH+ and non HH+ is allowable if and only if the HH+ ratio is less than 12 recipients to 1 Health Home Care Manager. Caseload sizes should always allow for adequate time providing care management as outlined in this guidance to individuals recently discharged from State PCs or CNYPC while allowing for thoughtful consideration of the care coordination needs of non HH+ recipients.
- Care management agencies shall provide a minimum of four (4) Health Home core services per month, two (2) of which must be face-to-face contacts, or more when the individual's immediate needs related to the transition out of a State PC or CNYPC requires additional contacts. **The HH+ rate code can be billed only when this requirement is met and clearly documented in the member's record.**
- If the minimum service requirements are not provided in a given month, but all other requirements as outlined in this guidance are met; and at least one (1) Health Home core service was provided by a qualified care manager:

- **While legacy billing is still allowed**, the CMA will bill the regular Health Home or legacy rate;
  - **After legacy billing is eliminated**, the HARP/non-HARP High Health Home rate code may be billed for that given month.
- HH+ shall always be delivered by a Health Home CMA with staff who have the experience, credentials, appropriate to serve the behavioral health population, specifically those with high needs. The following Minimum Qualifications<sup>2</sup> apply:

**Education**

1. A bachelor's degree in one of the fields listed below<sup>3</sup>; or
2. A NYS teacher's certificate for which a bachelor's degree is required; or
3. NYS licensure and registration as a Registered Nurse and a bachelor's degree; or
4. A Bachelor's level education or higher in any field with five years of experience working directly with persons with behavioral health diagnoses; or
5. A Credentialed Alcoholism and Substance Abuse Counselor (CASAC).

**and**

**Experience**

Two years of experience:

1. In providing direct services to people with Serious Mental Illness, developmental disabilities, or alcoholism or substance abuse; or
2. In linking individuals with Serious Mental Illness, developmental disabilities, or alcoholism or substance abuse to a broad range of services essential to successful living in a community setting (e.g. medical, psychiatric, social, educational, legal, housing and financial services). A master's degree in one of the listed Education fields may be substituted for one year of Experience.

**and**

**Supervision**

Supervision from a licensed level healthcare professional (e.g., RN, licensed clinician, psychologist) with prior experience in a behavioral health clinic or care management supervisory capacity; OR Master's level professional with 3 years prior experience supervising clinicians and/or CMs who are providing direct services to individuals with SMI/serious SUDs.

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<sup>2</sup> CMA Supervisors who requested a waiver of qualifications needed to supervise HCBS Assessors and were approved prior to 11/15/16, will be considered qualified Supervisors for HH+ for that CMA. The CMA has the option to arrange for a licensed or Master's level professional within the organization to provide regular clinical supervision to the CMs, jointly with the care managers' direct program supervisor

Care managers whose requests for HCBS Assessor qualification waivers were approved prior to 11/15/16 will be considered qualified to serve HH+ individuals (all HH+ populations) for that CMA.

*NOTE: If a Supervisor or CM currently permitted to serve HH+ individuals (as described above) later leaves the agency, the CMA is required to replace them with new staff that meet the HH+ Staff qualifications.*

<sup>3</sup> Qualifying education includes degrees featuring a major or concentration in social work, psychology, nursing, rehabilitation, education, occupational therapy, physical therapy, recreation or recreation therapy, counseling, community mental health, child and family studies, sociology, speech and hearing or other human services field.

- The HH+ rate code can be billed up to 12 consecutive months post-discharge from a State PC, CNYPC or OMH State-Operated on-campus residence.
  - This 12-month HH+ eligibility period is not affected by the individual's Health Home enrollment date. For example, for an individual discharged from CNYPC in March 2016 and enrolled into a Health Home in June 2016, the HH+ rate code can be billed for the period June 2016 through February 2016.
  - If a HH+ member is later readmitted into CNYPC, State PC, or State-Operated on-campus residential program, the 12-month HH+ eligibility period starts over again, effective the date of most recent discharge from CNYPC, State PC, or the residence.
  - If, at the time the 12-month period ends, the individual remains on an active AOT order that includes HHCM services, the HH+ rate code can continue to be billed through the month in which the AOT order expires.
- Communicating with Managed Care Plans regarding HH+ members:
  - The Care Management Agency (CMA) must inform the HH when a member meets criteria for HH+, and when they are no longer receiving HH+.
  - The HH must inform the Managed Care Plan of the members' HH+ status.

## Comprehensive Transitional Care

It is expected that State PC/CNYPC and HH/CMA staff will coordinate their efforts in a way that provides for a warm hand-off and immediate engagement with the HH care manager prior to discharge.

- State PC Discharge planning staff or CNYPC Pre-Release Services staff should, whenever possible, **initiate referrals to a Health Home prior to discharge**. State PC/CNYPC staff shall first obtain a signed Authorization for Release of Information from the individual, providing consent for a HH referral to be made.
- State PC/CNYPC staff shall verify and include the individual's Medicaid eligibility status in the referral, as well as the specific follow-up action needed post-discharge to help ensure the individual's Medicaid is activated as soon as possible.  
See Chart A "Discharge Scenarios for 21 – 64 Year Old Inpatients" below.  
For example, if the individual's Medicaid was suspended while inpatient or incarcerated, and determined that the individual will need to reinstate Medicaid through the local Department of Social Services upon discharge, State PC/CNYPC staff will indicate such status and the follow up needed in the referral being made to the HH.
- For most individuals age 18 - 21 (transition age youth) who are inpatients in a State PC, OMH (Medicaid District 97) will have opened a Medicaid case to cover the inpatient stay. If the youth had coverage prior to the inpatient admission and the case remained open, upon discharge the youth would have an OMH Medicaid case for the inpatient stay as well as an open local district or NYC HRA case. Following discharge, the OMH case would close and the local district/NYC HRA would be notified to resume the youth's coverage.

If the youth did not have Medicaid coverage prior to admission, or the Medicaid coverage was closed or expired during the inpatient stay, the OMH Medicaid coverage would transition to the new district of responsibility upon discharge.

Youth who have coverage through NYSoH may have to reapply for coverage upon discharge, or their coverage may also continue uninterrupted.

The OMH Medicaid case generally remains open for the month of the person's discharge and the following month during the transition process. Care managers should confirm that coverage is transitioned to the new Medicaid district.

- For most adults age 65 or older who are inpatients in a State PC, OMH (Medicaid District 97) will have opened a Medicaid case. Following discharge, that coverage is transitioned to a local district or NYC HRA. The OMH Medicaid case generally remains open for the month of the person's discharge and the following month during the transition process. Care managers should confirm that coverage is transitioned to the new Medicaid district.

#### Referral to a Health Home:

- To determine which Health Home to refer the individual to, State PC/CNYPC staff may:
  - Call the individual's Managed Care Plan to facilitate a referral,
  - Contact the HH affiliated with the State PC/CNYPC, or
  - Contact any HH in the region; a list of all Health Homes and contact information can be found on the [NYS Department of Health website](#). 
- In some counties, referrals to Health Home services for individuals being discharged from State PCs/CNYPC may go through SPOA, in which case, State PC/CNYPC staff can contact the local government unit (LGU) to facilitate a referral to SPOA.
  - It is imperative that State PC/CNYPC staff make referrals to SPOA in advance of discharge, in order to allow for a warm hand-off and more immediate care manager engagement, even prior to discharge.
  - The LGU is responsible to ensure that State PC and CNYPC referrals are coordinated in a timely and efficient way in order for this high risk population to benefit from the intensive services needed during their transition to the community. OMH asks that LGU's work with their own SPOA processes and Health Homes to develop a plan for the connecting referrals to a HH.
- For CNYPC discharges only: In NYC, most individuals being released from CNYPC will initially be referred to an OMH-dedicated forensic transitional case management team operated by Project Renewal, Education and Assistance Corporation (EAC), or OMH. The forensic care management team will later refer the individual to a Health Home for ongoing care management, and should work with the HHCM to ensure that a warm hand-off is coordinated. The HHCM will provide HH+ for the remainder of the 12-month period that the individual is eligible for HH+.

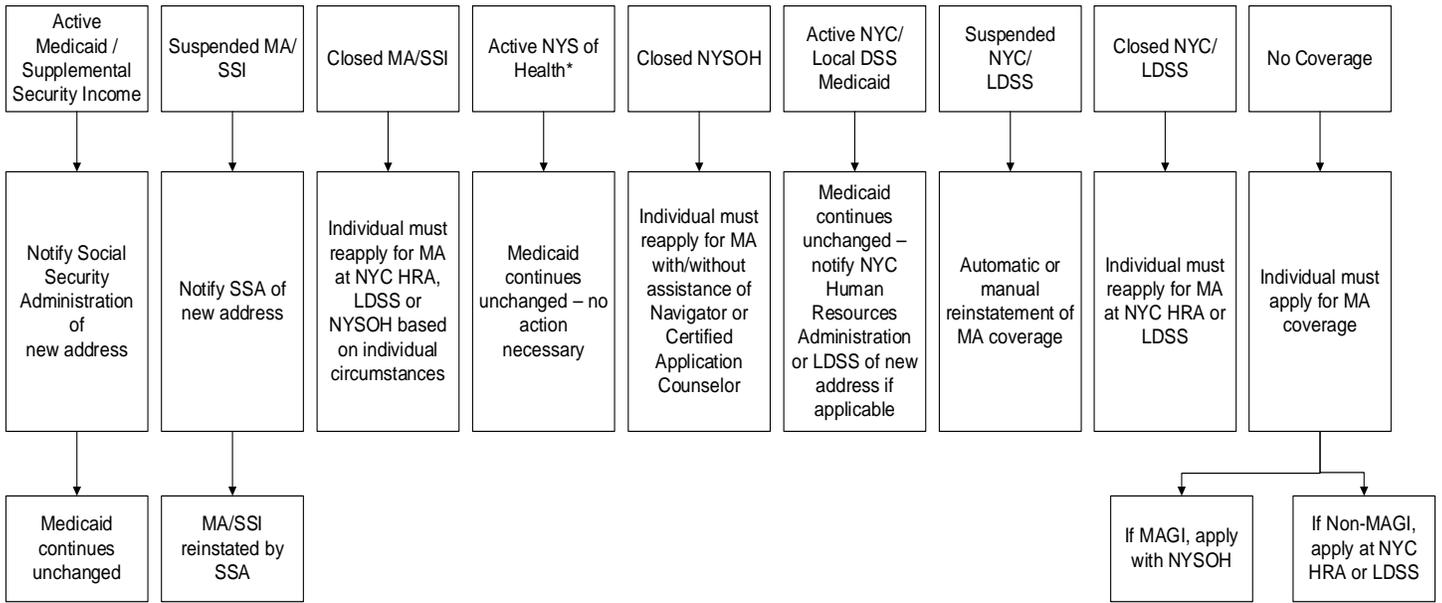
#### Receipt of Referral by Health Home / Warm Hand-Off:

- Upon receiving a new referral from a State PC, CNYPC, SPOA, and/or the OMH dedicated forensic transitional case management team, the Health Home must ensure that the individual is assigned to a CMA qualified to serve the HH+ population. The HH shall ensure prompt assignment is made to allow the CM the ability to participate in the planning process for continuity of care, whenever possible.

- Once assigned to a CMA, the CMA shall provide immediate delivery of HHCM services, including participation in the pre-release/discharge planning process whenever possible, to support a warm hand-off.
  - For individuals already enrolled in a HH and being discharged from a State PC or CNYPC, the CMA shall participate in the discharge planning process and have a face-to-face contact with the individual within 48 hours of discharge. Current best practice indicates that face to face contact with an individual within 24 hours of release from a forensic facility is pivotal to successful engagement for this population.
  - Coordination of care will likely include the reestablishment of Medicaid benefits for this population, so that individuals have immediate access to all services on their plan of care.
  - For individuals being released from prison with Parole, the health home care manager should establish contact as soon as possible with the Parole Officer to coordinate efforts for helping the individual follow their mental health discharge plan, which will include care management.

Chart A

Discharge Scenarios for 21 – 64 Year Old Inpatients



\*The automated suspension process is under development and not operational at this time

## Billing and Tracking Guidance

### Upcoming changes to Health Home Care Management reimbursement

Targeted to commence December 2016, Health Home Care Management Agencies (CMAs) will no longer bill Medicaid directly for either Health Home Care Management or HH+ Care Management. For reimbursable HHCM and HH+ services delivered on December 1, 2016 and thereafter, CMAs are to use either the MAPP HHTS or the Health Home's own system (which then feeds into MAPP HHTS) to attest that billable services were provided (minimum required HH+ services or HHCM core service) in a given month. The MCOs will use the MAPP HHTS billing support to pay the HH. HHs will bill eMedNY for HH enrollees not in mainstream MCOs (including mainstream plans, HIV-SNPs and HARPs). The HHs are to send the HH funds for a CMA, less the contracted administrative fee.

### Billing and Tracking System

- There is a unique rate code for HH+ services (1853).
- There is one HH+ payment rate for Downstate and one for Upstate.

Rate Code	Rate Description (OMH) HH+	Monthly HH+ Rate
1853	Downstate (applicable to Dutchess, Putnam, Rockland, Westchester, Nassau and Suffolk counties, and New York City.	\$800
	Upstate (applicable to all counties other than Downstate)	\$700

- The HH+ rates were added to OMH HHCM provider rate profiles in eMedNY for legacy providers under rate code 1853 (Health Home Plus/Care Management), with an effective date of April 1, 2014. Providers were notified with a letter from the Department of Health/CSC. HH+ rates will be added to lead HH rate profiles in eMedNY effective December 1, 2016 to allow lead HHs to bill on behalf of Care Management Agencies providing HH+ services.
- The Department of Health (DOH) Medicaid Analytics Performance Portal ("MAPP") will be used to identify individuals as HH+. In December 2016, MAPP users will be prompted in the monthly HML questionnaire with the question "Is the member in the expanded HH+ population?" If the user responds "Yes", the user is then prompted with "Were the minimum required HH+ services provided?" By responding "Yes", the CMA attests that the minimum service requirements for HH+ have been provided.

- CMAs are allowed to exceed the number of legacy slots originally allotted to them in order to accommodate HH+ members. CMAs will bill the HH+ rate code consistent with direct billing to eMedNY for legacy slots, until direct billing is eliminated. Until then, CMAs must ensure all HH+ members currently receiving Health Home services have a value of “Y” in the Direct Biller Indicator field in the Health Home Tracking System. Upon discontinuation of legacy rates, CMAs will attest that the HH+ services were provided and receive HH+ payment from the Health Home.

**NYS OMH Health Home Plus (HH+) Funding – Attestation  
October 2016**

**To be completed by Health Home programs prior to December 1, 2016.  
HH+ billing cannot begin until attestation forms are received.**

**Name of Health Home:** [Click here to enter text.](#)  
**Contact Person Phone:** [Click here to enter text.](#)

**Contact Person Name and Title:** [Click here to enter text.](#)  
**Contact Person E-Mail:** [Click here to enter text.](#)

**Instructions for completion or if you need assistance:**

- Complete the NYS OMH Health Home Plus Standard Attestation Form below.
- Submit form via mail no later than December 1, 2016, to:
  - NYS Department of Health, Attn: Peggy Elmer, 99 Washington Avenue, 7th floor, Suite 720, Albany, NY 12210
  - Or via the [Health Home BML](#) - Subject: Health Home Performance Targets
- Submit copies of Attestation Form to all of the following:
  - NYS Office of Mental Health - Attn: Stacey Hale, Director of Care Coordination. Email: [Stacey.Hale@omh.ny.gov](mailto:Stacey.Hale@omh.ny.gov);
  - Each Care Management Agency named in this attestation form; and
  - The Local Government Unit(s) having shared responsibility for monitoring AOT individuals enrolled in your Health Home.

Department of Health staff will review the information provided and contact your agency if further clarification is needed.

<b>Health Home Plus Standards</b>	
<b>To affirm Care Management Agency compliance with each standard, check box in left column.</b>	
<input type="checkbox"/>	Health Home Care Management program/manager informs partner Health Home regarding their member's HH+ status.
<input type="checkbox"/>	Upon assignment of a new HH+ eligible member to the Health Home, or notification of current HH member becoming HH+ eligible, Health Home Care Management program immediately assigns member to a care manager and/or begins providing HHCM services as outlined in the applicable HH+ program guidance.
<input type="checkbox"/>	Health Home Care Manager meets OMH staffing experience and qualification requirements to serve these individuals, including all qualifications as noted in the applicable HH+ program guidance.
<input type="checkbox"/>	Health Home Care Manager has a caseload size no greater than 12-15 HH+ recipients.
<input type="checkbox"/>	Health Home Care Managers shall meet the minimum service intensity requirements outlined in the applicable HH+ program guidance.
<input type="checkbox"/>	Additional requirements for Health Home Care Management programs serving individuals on AOT: <ul style="list-style-type: none"> <li><input type="checkbox"/> Health Home Care Management program/manager complies with all statutory reporting requirements under Kendra's Law. See OMH guidance regarding <a href="#">§9.60 of the Mental Hygiene Law</a>.</li> <li><input type="checkbox"/> Health Home Care Manager/program works with the LGUs AOT coordinator as per local policy and OMH Guidance for AOT Operation Reissued February 2014.</li> <li><input type="checkbox"/> Health Home Care Manager/program ensures that transitions and service engagement comply with the individuals' AOT court order.</li> </ul>

