New York State Medicaid Health Homes

New York initiated a Health Home program for Medicaid members with chronic medical and behavioral conditions beginning in February 2012 when the Centers for Medicare and Medicaid Services (CMS) approved an amendment to New York's Medicaid State Plan with an effective date of January 1, 2012. The Health Home program is designed to increase quality and efficiency thereby improving patient health and reducing costs to the New York Medicaid program. An overview of the expectations and requirements for Health Homes was published in a *Medicaid Update Special Edition* in April 2012.

This article will provide an <u>update on the current status of the implementation of Health Homes in New York State with a focus on the conversion of Targeted Case Management (TCM) programs</u> and highlight some of the unique features and challenges of this transformative model for the delivery of fully integrated health care services. The current status (as of October 1, 2012) of Health Home implementation, assignment and billing by geographical phase is summarized in Table A on Page 2.

What are Health Homes?

Health Homes provide comprehensive care coordination and management services for people with complex combinations of chronic conditions. Health Homes provide a dedicated care manager to help eligible Medicaid members navigate the complex medical, behavioral and social service systems. They provide intensive care management and patient navigation services for high need/cost Medicaid members.

New York State designated Health Homes with diverse partner networks are connected <u>under a single point of accountability.</u> Such networks partners may include the following:

- o   One or more hospital systems;
- o   Multiple ambulatory care sites (physical and behavioral health);
- o   Community Based Organizations (CBOs), including existing care management and housing providers;
- o   Managed care plans.

Health Homes provide:

- o   Comprehensive care management;
- o   Care coordination and health promotion;
- o   Comprehensive transitional care (e.g., inpatient discharge, jail to community);
- o   Patient and family support;
- o   Referral to community and social support services (e.g., housing, legal, food); and
- o   Use of Health Information Technology to link services.

For a list of Health Homes, please visit the Health Home website at:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/prov_lead_designated_health_homes.htm.

TABLE A: HEALTH HOME ASSIGNMENT, IMPLEMENTATION AND BILLING BY PHASE		
PHASE	**IMPLEMENTATION STATUS**	**BILLING STATUS**
Phase 1: Effective January 1, 2012 Bronx, Clinton, Kings (Brooklyn), Essex, Franklin, Hamilton, Nassau, Schenectady, Warren, Washington.	Phase 1 Health Homes are enrolling eligible members and continue to execute MOUs/contracts with network partners and Managed Care Plans. Members in converting care management programs were assigned to Health Homes based on information provided by the member's case management agency. NYSDOH, Health Homes and Managed Care Plans (MCPs) are developing operational policies and procedures and are working together to improve the transmission of Health Home patient tracking file information between the Office of Health Insurance Programs (OHIP) Data Mart portal.	Phase 1 Health Homes, converting care management providers and MCPs may currently bill for Health Home services under the rate codes that are loaded on their provider rate files. Note that monthly average rate adjustments will end with the average rates loaded for September 2012. Claims with a date of service on or after October 1, 2012, will be calculated within the eMedNY system by multiplying the appropriate base rate by the members newly increased acuity scores (this calculation occurs automatically inside the claims payment system).
Phase 2: Effective April 1, 2012 (pending SPA approval by CMS) Dutchess, Erie, Manhattan, Monroe, Orange, Putnam, Queens, Richmond (Staten Island), Rockland, Suffolk, Sullivan, Ulster, Westchester.	Converting care management programs are working with Phase 2 Health Homes and MCPs to assign legacy members (those who were enrolled in/discharged from the converting programs on or after April 1, 2012) to Health Homes that best meet their needs. This will allow NYSDOH to exclude these legacy members from the Health Home assignment process. Phase 2 Health Homes should be working on their DEAAs (Data Exchange Application Agreements) and on executing MOU's/contracts with network partners and MCP's. Once DEAA's are in place, the Phase 2 Health Home eligible assignment lists can be made available to HHs and MCPs.	Billing for Health Home services in Phase 2 counties cannot begin until CMS has approved the Phase 2 SPA and providers have been advised to begin billing Medicaid under the Health Home services rate codes.
Phase 3: Effective July 1, 2012 (pending SPA approval by CMS) Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Columbia, Cortland, Delaware, Fulton, Genesee, Greene, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Niagara, Ontario, Oneida, Onondaga, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Wayne, Wyoming, Yates.	NYSDOH is in the final stages of designating Phase 3 Health Homes (five counties are pending). Phase 3 providers that have already been designated are working on addressing any contingencies identified in the review of their applications and formalizing network partnerships. As for Phase 2, above, converting care management programs in Phase 3 counties should start working with MCPs and Health Homes to identify legacy members (those who were enrolled in/discharged from converting programs on or after July 1, 2012). As for Phase 2, above, Phase 3 Health Homes should be working on their DEAAs (Data Exchange Application Agreements) and on executing MOU's/contracts with network partners and MCP's. Once DEAA's are in place, the Phase 3 Health Home eligible assignment lists can be made available to HHs and MCPs.	Billing for Health Home services in Phase 3 counties cannot begin until CMS has approved the Phase 3 SPA and providers have been advised to begin billing Medicaid under the Health Home services rate codes.

Health Home Assignment Process: Medicaid Members Currently Served by Case Management

The first group of members to receive Health Home services is those who are currently receiving services from one of the state's existing case management programs: OMH Targeted Case Management (TCM), HIV COBRA TCM, Office of Alcoholism and Substance Abuse Services (OASAS) Managed Addiction Treatment Services (MATS), and the Chronic Illness Demonstration Project (CIDP). These programs (described in Table B) are converting to Health Homes. Health Home eligible members that currently receive case management services under one of these converting case management programs are matched to a Health Home which includes the member's care manager. This match is performed to ensure that members will not need to change care managers.

TABLE B: TARGETED CASE MANAGEMENT (TCM) PROGRAMS CONVERTING TO HEALTH HOMES

TCM Program	Program Description
CIDP	The CIDP aimed to establish innovative, interdisciplinary models of care to improve health care quality, ensure appropriate use of services, improve clinical outcomes and reduce the cost of care for FFS Medicaid members with complex conditions.
COBRA TCM	An intensive, family-centered, community-based case management program that provides case management services to HIV-infected or high-risk persons identified as having had difficulty accessing medical care and/or other services. Upon implementation, all current COBRA enrollees will be assigned to a Health Home by their COBRA case management provider.
MATS	An OASAS targeted case management program administered at the county/NYC level that is aimed at high cost Medicaid members being treated for chemical dependency. During the transition to Health Homes, contracted funds will be available to assist with transition and implementation issues for MATS providers. Upon implementation of Health Homes, all current MATS enrollees will be assigned to a Health Home by the MATS provider.
OMH TCM	OMH TCM programs provide case management to individuals with mental health diagnoses at various intensity levels. Upon implementation of Health Homes, all current OMH TCM adult enrollees who are Medicaid eligible will be transitioned to Health Home services. Individuals receiving state operated OMH TCM services will be transitioned at a later date.

Health Home Assignment Process: Medicaid Members Not Already Engaged in Case Management

The NYSDOH assigns Health Home eligible members who are not already receiving case management services to a Health Home by matching Medicaid FFS claims and Managed Care Plan (MCP) encounters to providers in each Health Home's Provider Partner Network using the provider's National Provider Identifier (NPI). The member is assigned to the Health Home that includes the most providers from which the member receives services. FFS members are matched to a Health Home based on their hierarchical use of services (outpatient services, emergency department and inpatient). The NYSDOH Health Home matching information is provided to MCPs for their MCP members. Plans are encouraged to use this information to supplement their own data for use in assigning their members to a Health Home.

Billing Rules for Converting OMH and COBRA Case Management Programs

TCM programs converting to Health Home services will bill Medicaid directly for all members (both legacy members and new members) receiving active care management services or in outreach and engagement. Converting programs are billing the converting TCM Health Home (legacy) rate codes for TCM existing slots and the new Health Home rate codes (see Table C below) for new Health Home slots, for individuals in Phase 1 counties. Slots refer to the number of people the program has historically served.

Medicaid billing under the new Health Home rate codes and for the "legacy" TCM rate codes for individuals in converting programs in Phase 2 and 3 counties may not begin until CMS has approved the Phase 2 and Phase 3 SPAs for Health Home services. Once CMS has approved Phase 2 and Phase 3 SPAs for Health Home services, providers will be notified to begin using the "legacy" rate codes and the new Health Home rate codes listed below. In the meantime, Phase 2 and Phase 3 converting care management providers (except MATS) will continue to bill the pre-Health Home case management rate codes. MATS providers will continue to be reimbursed by state aid through local funding contracts.

Billing Rules for Converting MATS Providers

Since MATS providers did not bill Medicaid for care management services provided prior to Health Home implementation, they will not have any claims to reprocess for existing MATS patients. Phase 1 MATS providers will begin providing Health Home care management services and began billing for existing MATS patients using the applicable Health Home rate codes as of August 1, 2012. Phase 2 and 3 MATS providers will begin providing Health Home care management services and begin billing for existing MATS patients using the applicable Health Home rate codes when the SPAs are approved.

A matrix detailing the billing process for converting OMH TCM, COBRA and MATS providers is included on Page 5 as Table D.

TABLE C: HEALTH HOME SERVICES RATE CODES

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

TABLE D: BILLING MATRIX FOR CONVERTING OMH TCM, COBRA, AND MATS PROVIDERS

Source/ Member Type	TCM[2] Indicator (Y/N)	Slot Type (E-Existing) N-New)	Billing Provider	Outreach and Engagement or Active Enrollment (O or E)	Applicable Rate Codes
Legacy FFS or Managed Care Plan Member from TCM Provider _≤ Slot Allotment_	Y	E	TCM Provider	Legacy members are placed directly in Active Enrollment (E)	1851/1852 – OMH TCM 1880/1881 – COBRA TCM 1882/1883 – MATS
Legacy FFS or Managed Care Plan Member from TCM Provider to Health Home _> Slot Allotment_	Y	N	TCM Provider	Legacy members are placed directly in Active Enrollment (E)	1386/1387 – OMH TCM, MATS, and COBRA Providers
New FFS Member from Health Home to TCM Provider	Y	E (if legacy slot is available) N (if legacy slot is not available)	TCM Provider	New members are placed in (O) Outreach and Engagement if they have not yet engaged in care; or (E) Active Enrollment if applicable	**Slot Type E:** 1851/1852 – OMH TCM 1880/1881 – COBRA TCM 1882/1883 – MATS **Slot Type N:** 1386/1387 – OMH TCM, MATS, and COBRA Providers
New Managed Care Plan Member from Health Home to TCM Provider	Y	E (if legacy slot is available) N (if legacy slot is not available)	TCM Provider	New members are placed in (O) Outreach and Engagement if they have not yet engaged in care; or (E) Active Enrollment if applicable	**Slot Type E:** 1851/1852 – OMH TCM 1880/1881 – COBRA TCM 1882/1883 – MATS **Slot Type N:** 1386/1387 – OMH TCM, MATS, and COBRA Providers
New Referral (FFS or Managed Care Plan member) from TCM Provider to Health Home	Y	E (if legacy slot is available) N (if legacy slot is not available)	TCM Provider	New members are placed in (O) Outreach and Engagement if they have not yet engaged in care; or (E) Active Enrollment if applicable	**Slot Type E:** 1851/1852 – OMH TCM 1880/1881 – COBRA TCM 1882/1883 – MATS **Slot Type N:** 1386/1387 – OMH TCM, MATS, and COBRA Providers

Using the Health Home Member Tracking System

Health Home patient tracking information such as a member's Health Home status (enrolled and receiving active care management services vs. outreach and engagement status) is transmitted to NYSDOH in accordance with the requirements defined in the Health Home Patient Tracking System Specifications document available at:

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

Care management agencies transmit the patient tracking information to the appropriate designated lead Health Home Agency. The designated lead Health Home then transmits the patient tracking information to NYSDOH for FFS members and to the appropriate MCPs for managed care members. Each MCP transmits the patient tracking information to NYSDOH for their members. A matrix describing the specifications for converting OMH TCM, COBRA and MATS programs is included as Table D on Page 5.

Health Home Member Tracking System Impact on Medicaid Payment

The Health Home member tracking information will be used to add Health Home recipient exception (RE) codes to a member's profile in WMS. The addition of RE codes to WMS is anticipated to be implemented in February 2013. If the appropriate Health Home RE code is not on file, the Medicaid claim for the member's Health Home services will be denied. Therefore, it is critical that downstream care management agencies, Health Homes and MCPs compile and transmit member tracking information in a timely and accurate manner.

Increases to Health Home Payments

Beginning with dates of service on and after October 1, 2012, Health Home payments under rate codes 1386 and 1387 are member specific and based on the member's acuity. Acuity is a weighted average based on total Medicaid fee-for-service (FFS)and Managed Care encounter costs associated with the Clinical Risk Groups (CRG) for a Health Home eligible population for a given time period. The October 1, 2012, adjusted acuities include additional upward adjustments for mental illness and upward adjustments for predictive risk for adverse events. These adjustments will result in a significant increase in Health Home payments. The new rates are listed in Table E on Page 8.

Additional information on the new payments is available on the Health Home website at:

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

TABLE E: PROJECTED AVERAGE HEALTH HOME PAYMENTS BY BASE HEALTH STATUS AND SEVERITY OF ILLNESS
EXCLUDES LTC AND OPWDD POPULATIONS
EFFECTIVE OCTOBER 1, 2012

Base Health Status [1]	SMI	Severity of Illness[2]	Downstate			Upstate		
			Eligible Recipients	Average Acuity Score [3]	Average Monthly Payment [4]	Eligible Recipients	Average Acuity Score [3]	Average Monthly Payment [4]
Single SMI/SED	Yes	Low	15,989	6.6993	$155.89	7,231	6.6775	$124.93
		Mid	7,261	9.3623	$217.86	3,621	9.0329	$169.00
		High	292	22.1821	$516.18	68	21.9944	$411.52
Single SMI/SED Total			23,542	7.7127	$179.48	10,920	7.5539	$141.33
Pairs Chronic	No	Low	39,736	3.0966	$72.06	13,270	3.6602	$68.48
		Mid	20,983	7.2789	$169.38	7,804	7.6747	$143.59
		High	9,140	13.8438	$322.14	3,045	13.9366	$260.75
	Yes	Low	12,231	10.6780	$248.48	5,244	10.5974	$198.28
		Mid	14,357	15.8052	$367.79	6,771	15.4097	$288.32
		High	2,881	25.4821	$592.97	1,276	24.2513	$453.74
Pairs Chronic Total			99,328	8.3888	$195.21	37,410	9.1355	$170.92
Triples Chronic	No	Low	2,562	4.9587	$115.39	963	5.3808	$100.67
		Mid	7,762	7.8965	$183.75	3,053	8.2988	$155.27
		High	6,148	13.7811	$320.69	2,057	14.3990	$269.40
	Yes	Low	2,519	12.5158	$291.24	747	12.4206	$232.39
		Mid	4,266	17.4123	$405.18	1,649	17.4152	$325.84
		High	1,306	25.2165	$586.79	530	25.0789	$469.23
Triples Chronic Total			24,563	12.1102	$281.80	8,999	12.3819	$231.66
HIV/AIDS	No	Low	5,997	5.4996	$127.97	752	5.4517	$102.00
		Mid	5,160	10.5293	$245.02	815	9.5101	$177.93
		High	1,424	18.9814	$441.70	160	17.6933	$331.04
	Yes	Low	192	5.5550	$129.26	36	5.5029	$102.96
		Mid	3,713	10.4834	$243.95	450	9.6692	$180.91
		High	507	20.1222	$468.24	65	19.3610	$362.24
HIV/AIDS Total			16,993	9.6825	$225.31	2,278	8.9943	$168.28
Grand Total			164,426	8.9816	$209.00	59,607	9.3305	$174.57

[1] Mutually exclusive categories based on Clinical Risk Grouping.

[2] The clinical risk group software puts each patient into a severity group from 2 to 6 (level 6 being the highest severity). The six groups were collapsed down to low (1-2 severity), mid (3-4) and high (5-6) based on CRG severity ranking.

[3] While based on actual data, the acuity scores may be rescaled. This rescaling should not affect the average monthly payment.

[4] Average Health Home payment for members in the given rate/severity group - these groups are for illustration purposes - actual payments to Health Home providers will be based on a blend of a given provider's health home members from across all applicable rate/severity cells. These payments will eventually be recalculated (and any changes will be paid prospectively) based on service intensity and functional status data. DOH will closely review payment adequacy during health home implementation.

Claims Reprocessing for Converting OMH and COBRA TCM Providers

Claims submitted under old TCM rate codes will be reprocessed by NYSDOH under the new Health Home rate codes to ensure proper payment in accordance with the Health Home SPAs. At a future date, NYSDOH will adjust the pre-Health Home services rate code claims to the converting TCM Health Home rate codes. As a result, all pre-Health Home service rate code claims in the system with dates of service on or after the effective date of the Health Home services SPAs for OMH TCM and COBRA TCM will automatically be adjusted to the payment rate established for the converting TCM Health Home services rate codes. The automatic reprocessing for Phase 1 converting programs is expected to occur in December 2012.

Since the date of service of pre-Health Home OMH TCM rate code claims represents services that were provided in the previous month, OMH TCM service providers will need to submit new claims for the first month in which the Health Home services SPA is in effect for TCM clients for which the program already billed. For example, individuals in Phase 1 converting OMH TCM programs will need to submit a new claim with the Health Home Service rate code 1851 for January 2012 dates of service. Phase 1 OMH TCM claims with pre-Health Home service rate codes and dates of service on and after February 1, 2012, will be automatically reprocessed with the Health Home services rate code 1851. OMH TCM providers may need to adjust some claims for individuals that have subsequently enrolled/disenrolled from the OMH TCM program so that the date of service on the Health Home services claim represents the actual month in which OMH TCM services were provided to the member.

COBRA TCM programs were billing under the pre-Health Home rate codes using unit billing. In order to reprocess these claims, Phase 1 programs were instructed to submit a claim for one unit for each client who did not have a claim for the first of each month, January to June. Phase 2 providers have been instructed to perform the same process beginning with April 1 claims, and Phase 3 starting with July 1 claims. This will allow the system to automatically reprocess these claims with rate code 1880.

Providers who do not have a first of the month claim in the system for each individual, or who have some first of the month claims denied, will receive instructions on how to make adjustments so those claims may be reprocessed. Additional guidance will be provided through the Health Home listserv.

Community Referrals for Health Home Services

Real time client referrals are accepted into the Health Home program from community sources. Federal authority mandates that hospitals refer to Health Home services eligible individuals with chronic conditions who seek care or need treatment in a hospital emergency department. Referral for Health Home services may come from a variety of other sources, including but not limited to, the criminal justice system, state prisons, county and city jails, Mental Health Discharges/Referrals from State Operated Psychiatric Centers, Article 22 and 31 hospitals, managed care plans, designated Health Homes, converting case management programs, clinics, health care providers, HIV providers, social service providers, etc.*

Potential members do not have to be on NYSDOH assignment lists or be approved by NYSDOH in order to be accepted for Health Home referral. The referring entity should document that the individual presumptively meets Health Home services qualifications as outlined in the State Plan Amendment (HIV/AIDS or one serious, persistent mental health condition or two chronic conditions including substance use disorders, diabetes, asthma, heart disease, HIV/AIDS, overweight (BMI >25). The referral can be made based on the presumptive assessment and the individual will be enrolled in the Health Home for a comprehensive assessment. A fee for service member can be referred to the lead Health Home for this comprehensive assessment; a managed care member can be referred to either the lead Health Home or the appropriate managed care organization for assignment for the comprehensive assessment. If the comprehensive assessment reveals that the individual does not meet Health Home services criteria, the individual must be transitioned to an appropriate level of care.

Consideration should also be given to prioritizing members based on acuity and the risk of the individual experiencing an adverse event, (e.g., death or disability, or admission to nursing home or hospital) to focus initial Health Home resources to our neediest members. If NYSDOH has established the acuity score for the individual, that acuity score will determine the rate. If there is no acuity score on file for the individual, the rate will be based on the statewide average acuity score until a member-specific score can be established from claims and encounter data. A workgroup of Health Homes and MCPs are developing additional provider guidance for determining Health Home eligibility which will include a formula for quantifying acuity and risk.

This additional guidance will be published shortly. Factors that are being considered for quantifying acuity and risk include:

- o No primary care practitioner (PCP);
- o No connection to specialty doctor or other practitioner for their condition;
- o Poor compliance (does not keep appointments, etc);
- o Inappropriate Emergency Department use;
- o Repeated recent hospitalization for preventable conditions either medical or psychiatric;
- o Recent release from incarceration;
- o Cannot be effectively treated in an appropriately resourced patient centered medical home; and
- o Homelessness.

Table F on Page 10 provides an overview of the interim referral process.

*See page 10 for additional guidance on making priority referrals to converting case management programs.

TABLE F: INTERIM HEALTH HOME REFERRAL GUIDANCE

STEP 1 - ASSESS ELIGIBLITY: Must meet eligibility for Health Home services as described in the New York State Health Home State Plan Amendment (claims/encounter or other clinical data should be used whenever available to verify medical and psychiatric diagnoses).

- o Two chronic conditions (e.g., mental health condition, substance use disorder, asthma, diabetes, heart disease, BMI over 25, or other chronic conditions, <u>OR;</u>
- o One qualifying chronic condition (HIV/AIDS) and the risk of developing another, <u>OR;</u>
- o One serious mental illness.

STEP 2 - ASSESS APPROPRIATENESS FOR HEALTH HOME: Has significant behavioral, medical or social risk factors which can be addressed through care management.

- o Probable risk for adverse event, e.g., death, disability, inpatient or nursing home admission;
- o Lack of or inadequate social/family/housing support;
- o Lack of or inadequate connectivity with healthcare system;
- o Non-adherence to treatments or medication(s) or difficulty managing medications;
- o Recent release from incarceration or psychiatric hospitalization;
- o Deficits in activities of daily living such as dressing, eating, etc.;
- o Learning or cognition issues.

STEP 3 - INITIATE REFERRAL: If member meets criteria described in Steps 1 and 2, the referral can be made on the basis of this presumptive assessment.

- o Referrals for FFS members are made to the lead Health Home, referrals for plan members can be made directly to the MCP or to the lead Health Home to make the MCP connection.
- o Health Homes and MCPs have access to assignment information in the HCS portal and should check an individual's assignment status prior to making a referral. If the individual is already assigned to a Health Home, that Health Home should be contacted to discuss the appropriate course of action.
- o If a comprehensive assessment reveals that the individual does not meet Health Home services criteria, the individual must be transitioned to an appropriate level of care, such as a Patient Centered Medical Home (PCMH).
- o Detailed instructions on how to use the Health Home Member Tracking System to make a referral can be found in the Health Home Member Tracking System specifications document on the Health Home website.

Priority Referrals for Converting Care Management Services

New York's decision to convert OMH and COBRA TCMs and MATS programs requires that individuals found eligible by various sources including, Local Government Units (LGUs), Single Point of Access (SPOA), Local Department of Social Services (LDSS), NYC Human Resources Administration, NYC HIV AIDS Services Administration (HASA), New York City Department of Health and Mental Health (NYSDHMH), and health care facilities and other providers need to be referred for Health Home assignment on a priority basis.

OMH is developing guidance on the SPOAs and on the unique responsibilities that Health Homes will have for working with them. OMH is also developing guidance on referrals for Assertive Outpatient Treatment (AOT) services and the Assertive Community Treatment (ACT) program, which will be available on the OMH website at: http://www.omh.ny.gov/omhweb/adults/health_homes/.

Guidance from OASAS on the transition of MATS program services to Health Home services is available online at: http://www.oasas.ny.gov/admin/hcf/documents/MATSTransition.pdf.

The AIDS Institute has issued guidance on accepting referrals to transitioning COBRA case management programs through the bi-monthly Technical Assistance Group (TAG), conference calls, and e-mail memoranda outlining who is eligible for Health Home services at this time. A person with HIV is automatically eligible for Health Home services. This guidance will be available on the COBRA website at: www.cobracm.org.

Keeping Informed

There are several ways to keep informed and get questions addressed related to Health Homes.

o   Biweekly webinars are held every other Wednesday for Health Homes and their partners to obtain updates on Health Home implementation. Registration information is posted on the Health Home website or providers may join the listserv to receive announcements. Representatives from the NYSDOH Health Home program as well as other members of the implementation team (OMH, OASAS, and AIDS Institute) are available during these calls to answer questions specific to the converting TCM programs.

o   Weekly calls to provide technical assistance to Health Homes and MCPs on using the Health Home Member Tracking System are held on Tuesdays.

o   The NYSDOH has established a Health Home implementation provider support telephone line; (518) 473-5569. This support line is available Monday through Friday from 8:30 AM to 5:00 PM. Staff are available to answer questions from lead Health Homes on policy, provide implementation guidance and help to resolve implementation issues. Providers should contact the eMedNY Call Center at (800) 343-9000 for billing questions. Inquiries from the public and from Health Home members should continue to be directed to the Medicaid Call Center at (800) 541-2831.

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

Requests to join tracking calls or general questions about the Health Home program may be directed via e-mail to: hh2011@health.state.ny.us.