NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

Guidance for Adult Home Plus Program (AH+)

I. Background

The State has established more intensive care management requirements for Adult Home (AH) class members, otherwise known as class members, who are transitioning to the community under 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). This intensive care management will be known as Adult Home Plus (AH+). Health Homes (and while direct billing is in effect, Care Management Agencies) will be reimbursed for the more intensive care management, lower caseloads and program requirements as described in this guidance document for the transitioning Adult Home population. Effective December, 31, 2015 all class members desiring transition, who are enrolled in a Health Home, must be provided AH+ level of care management.

II. AH+ Population Eligibility

In order for a class member to be eligible for AH+ the class member must:

- Be identified as a class member on the class member list;
- Be enrolled in a Health Home;
- Desire and be eligible to transition to the community under the stipulation and order of settlement.

III. Caseload and Qualifications of an AH+ Care Manager

Beginning September 1, 2015, in order to be eligible for the AH+ rates described in Section V, Health Homes/Care Management Agencies must:

1. Show demonstrated progress towards achieving a dedicated, e.g., "non-blended" caseload ratio of 1 care manager to 12 class members by December 31, 2015.

2. By December 31, 2015, an AH+ a care manager must have the following experience and credentials:
    a. Education
        i. A bachelor's degree in one of the below listed fields*, or
        ii. A NYS teacher's certificate, or
        iii. NYS licensure and registration as a Registered Nurse and a bachelor's degree
    b. Experience
        i. Four years of experience in:

- Providing direct services to persons with Serious Mental Illness, or
- Linking individuals with Serious Mental Illness to a broad range of services essential to successful living in a community setting (e.g., medical, psychiatric, social, educational, legal, housing and/or financial services)

ii. A master's degree in one of the below listed fields* may be substituted for two years of experience.

* social work, psychology, nursing, rehabilitation, education, occupational therapy, physical therapy, creative arts therapy, recreation or recreation therapy, counseling, community mental health, child and family studies, sociology, speech and hearing

IV. Program Requirements

Beginning September 1, 2015, in addition to providing Health Home services as outlined in the Health Home Provider Manual, AH+ care managers must (and each claim for reimbursement is an attestation that the following have been provided as applicable):

- Establish regular direct communication with Managed Care Plans (MCP) and Managed Long Term Care (MLTC) Plans, and serve as single point of contact for class members enrolled in MLTC Plans pursuant to the terms of the Administrative Services Agreements (ASAs) executed between Health Homes and these Plans;
- Refer class members who desire transition to the assigned housing contractor for in-reach;
- Review the class member's need for securing identification and benefits (including, but not limited to: Medicaid, food stamps, appointment of representative payee) and assist the class member or directly undertake any necessary applications/renewal processes;
- Provide face-to-face contact with the class member AT LEAST four times per month (more frequently as necessary). This includes months in which the class member resides for all or part of the month in a hospital or nursing facility;
- For enrollees who are temporarily hospitalized or in a nursing facility, participate in the discharge planning process and have a face-to-face contact with the class member within two days after discharge;
- Have at least monthly phone contact with the class member's housing provider; and
- For class members residing in the community, conduct assessments every six months (or if there is a significant change) following transition to determine if the class member still requires the AH+ level of care management.

All class members enrolled in Health Homes who indicate an interest in moving to the community, whether or not in-reach has occurred, must be assigned to care managers with AH+ dedicated caseloads. Class members newly enrolled in Health Homes who do not indicate an interest in moving will be assigned to regular Health Home care management. Codes 1860 and 1861 (as listed in Section V below) can be billed prior to the class member receiving in-reach. When in-reach is conducted and it is determined that the class member wants to move to the community, or if the class member otherwise indicates an interest in moving, the class member must be reassigned to an AH+ care manager.

If a class member is enrolled in the Health Home and has expressed an interest in moving to the community and has not received in-reach, the Health Home and care management agency will have two months to bill the AH+ rate code (1861) until in-reach is completed by the Housing Contractor. During this two month period, it is expected that the Health Home care manager will meet with the class member at least once per week to educate them on the benefits of transitioning. The Health Home care manager is also expected to link the class member to the Housing Contractor for in-reach as soon as the class member expresses an interest in moving. The Housing Contractor will have up to two months to complete in-reach with the referred class member. If the class member is not interested in moving after the two month period is complete, the regular Health Home rate code (1386) will be billed for subsequent months.

If at the time of in-reach the class member no longer desires to transition, billing codes 1860 and 1861 can be billed for the month in-reach was received. Billing must return to standard Health Home rates the following month.

V. Billing Requirements for AH+

The following are the Adult Home Plus (AH+) rate codes:

Rate Code	Rate Code Description	Medicaid Payment Amount
1860	Health Home Services- Adult Home Transition	$800.00
1861	Adult Home Assessment and Management Fee	$200.00

The Health Home Care Management Services – AH+ rates may be claimed by the Health Home or Care Management Agency (CMA) if all of the following statements apply:

- The Health Home and CMA signed the required attestation form and returned to the Department of Health;
- The class member enrolled in the Health Home and signed the Health Home consent form(s);
- The class member indicated an interest in transitioning from the adult home to the community;

- A care manager was assigned and the care plan was initiated within 7 business days of enrollment;
- Care management is provided as described in Section IV.

If the caseload and care manager qualification requirements described in Section III are not met by December 31, 2015, the Health Home must submit a corrective action plan to be implemented by March 1, 2016. As of March 1, 2016, Health Homes will be subject to a retroactive adjustment of AH+ amounts claimed for any enrollees who are not at the required 1:12 caseload ratio with a care manager meeting the AH+ qualification requirements.

The Adult Home Assessment and Management Fee (1861) is intended to support the lead Health Home for the management of class members and may be claimed by the lead Health Home for class members who are provided AH+ care management. It is the Health Home's responsibility to ensure that all AH+ requirements are met as indicated in this document. This fee may be claimed by the lead Health Home for each month that a Health Home Services – Adult Home Transition (1860) may be claimed (including months that four contacts were not made; see below).

If the care manager does not fulfill the requirement that each AH+ class member is provided four face-to-face contacts per month, the code 1860 cannot be claimed for that month and standard Health Home rates would apply, unless there is documentation supporting attempts to reach the class member. It is imperative that the AH+ care manager/care management agency document the explanation for the failure to have four face-to-face contacts in the class member's care management record. This information may be requested by the State or the court's independent reviewer at any time.

Class members enrolled in Managed Long Term Care (MLTC) Plans who enroll in Health Homes may be AH+ or regular Health Home enrollees. MLTC Plans must enter into an Administrative Services Agreement (ASA) with the Health Home delineating their respective roles and will continue to bill their premiums directly. For class members in AH+, the Health Home care manager will be the single point of contact for the class member. The MLTC Plan will continue to conduct the UAS-NY assessments for transition purposes, authorize long term services and supports and collaborate with the Health Home care manager to determine the class member's needs.