NEW YORK STATE HEALTH HOMES: AN OVERVIEW

Deirdre Astin
Program Manager
New York State Department of Health
Office of Health Insurance Programs
Health Home Program

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What is a Health Home?

- Section 2703 of the Affordable Care Act (ACA) authorized an optional Medicaid State Plan benefit to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions

- Health Homes provide comprehensive, integrated, person-centered care management and coordination to Medicaid enrollees with complex needs through a network of medical, behavioral health, and social service providers

Health Home Care Management Services

Health home providers will be required to provide the following Health Home services in accordance with federal and State requirements:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care
- Patient and family support
- Referral to Community and Social Support Services
- Use of Health Information Technology to Link Services

Who is Eligible to be Enrolled in Health Home?

- Persons enrolled in Medicaid with:
  - At least two chronic conditions
  - One qualifying chronic condition: HIV/AIDS or one serious mental illness
- Chronic Conditions include (but are not limited to):
  - Mental Health condition
  - Substance Use Disorder
  - Asthma
  - Diabetes
  - Heart Disease
  - Obesity (BMI>25)

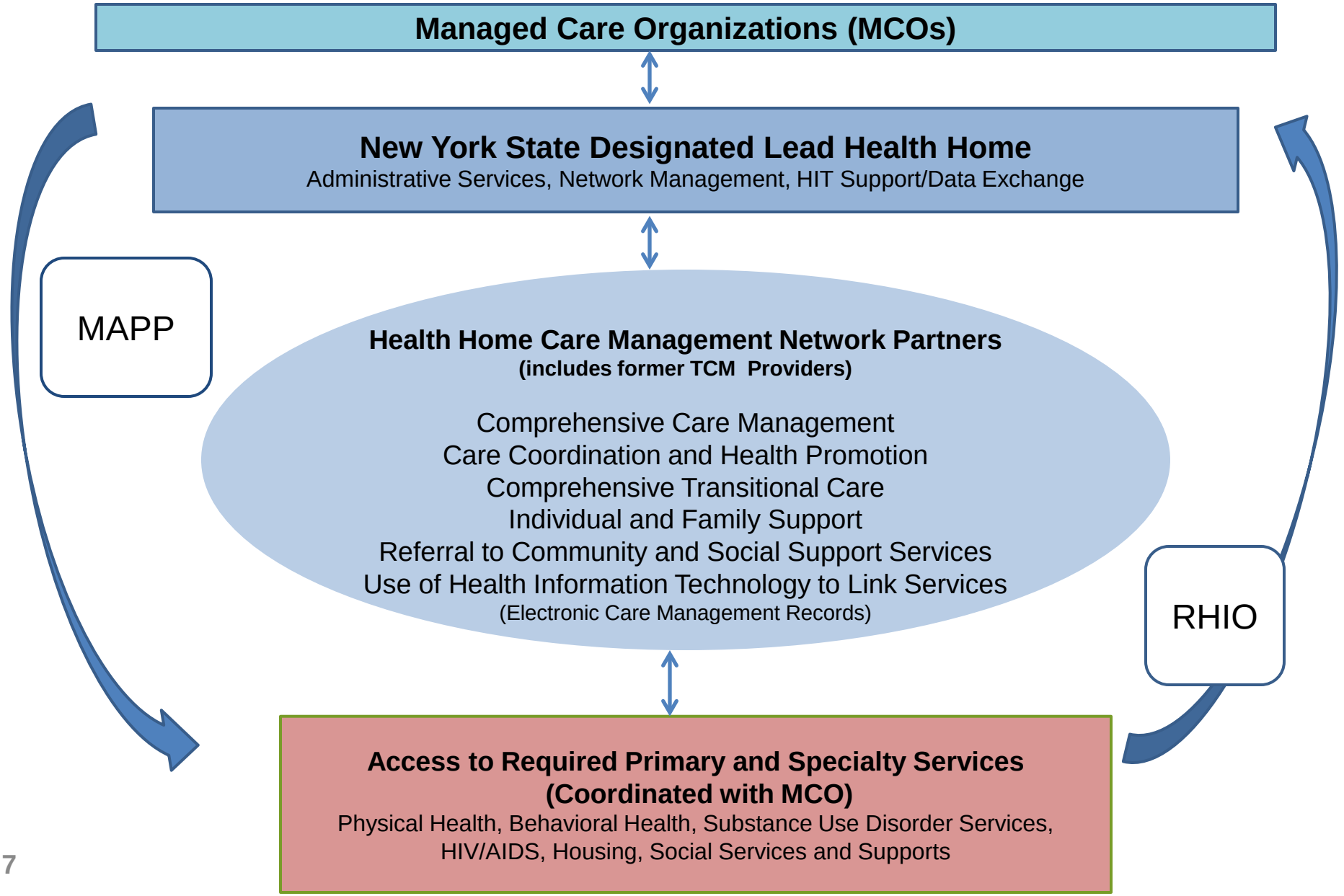
New York's Health Home Population

- More than five million Medicaid members in New York State.
- Almost a million individuals meet the Federal criteria for Health Homes.
- Target enrollment for NYS is about 500,000 (prioritizing for highest risk).
- Nearly 140,000 individuals are currently enrolled.
- Health Home services are available Statewide-there are 33 designated Health Homes.

New York State Health Home Model

- Health Homes must have connected under a single point of accountability all of the following:
  - One or more hospital systems
  - Multiple ambulatory care sites (physical and behavioral health)
  - Community based organizations, including existing care management and housing providers
- Health Homes are critical to the DSRIP initiative as they are providing care management services to the population of Medicaid members who are driving more than 50% of the avoidable costs.

New York State Health Home Model



Processes for Identifying, Enrolling and Referring Members to Health Homes

DOH Assignment Lists: DOH uses Medicaid claims data to identify eligible members (relies upon Clinical Risk Groups to identify cohort, CRG acuity to establish behavioral condition, predictive model to assess risk of negative events, and provider loyalty (existing patterns of service utilization)

- Fee-for-Service Members are assigned to Health Home for enrollment.
- Managed Care Members are assigned to Managed Care Organization for Assignment to Health Home.
- Care management programs ("legacy" providers, including TCM, AIDS COBRA TCM, and the Managed Addiction Treatment (MATS) programs in existence prior to Health Homes converted to the Health Program (i.e., as downstream care managers that contract with Health Homes or as Health Homes themselves).
- Converting members were enrolled in Health Homes by legacy providers.

Processes for Identifying, Enrolling and Referring Members to Health Homes

Community Referrals: New referrals (via HRA, county, SPOA, care management agency, practitioners, hospital, prisons, BHO, etc) meeting Health Home criteria can be referred to Health Homes

- For Managed Care Members, the referring entity may contact the Plan, or may contact the Health Home directly, which is expected to work with member's Plan to confer on assignment
- For FFS members, the referring entity can contact the Health Home directly, Health Home should explore loyalty and make appropriate assignment.
- Referrals can also be made directly to or by care management programs, which will make the Health Home assignment and the Health Home will work with Plan.

Health Homes and PROS Programs

- Health Homes provide care management through a network of behavioral health, physical health and community support service providers.

- The Health Home provider standards include the requirement that care planning be person-centered and recovery oriented

  Health Home Provider Standard 2J:

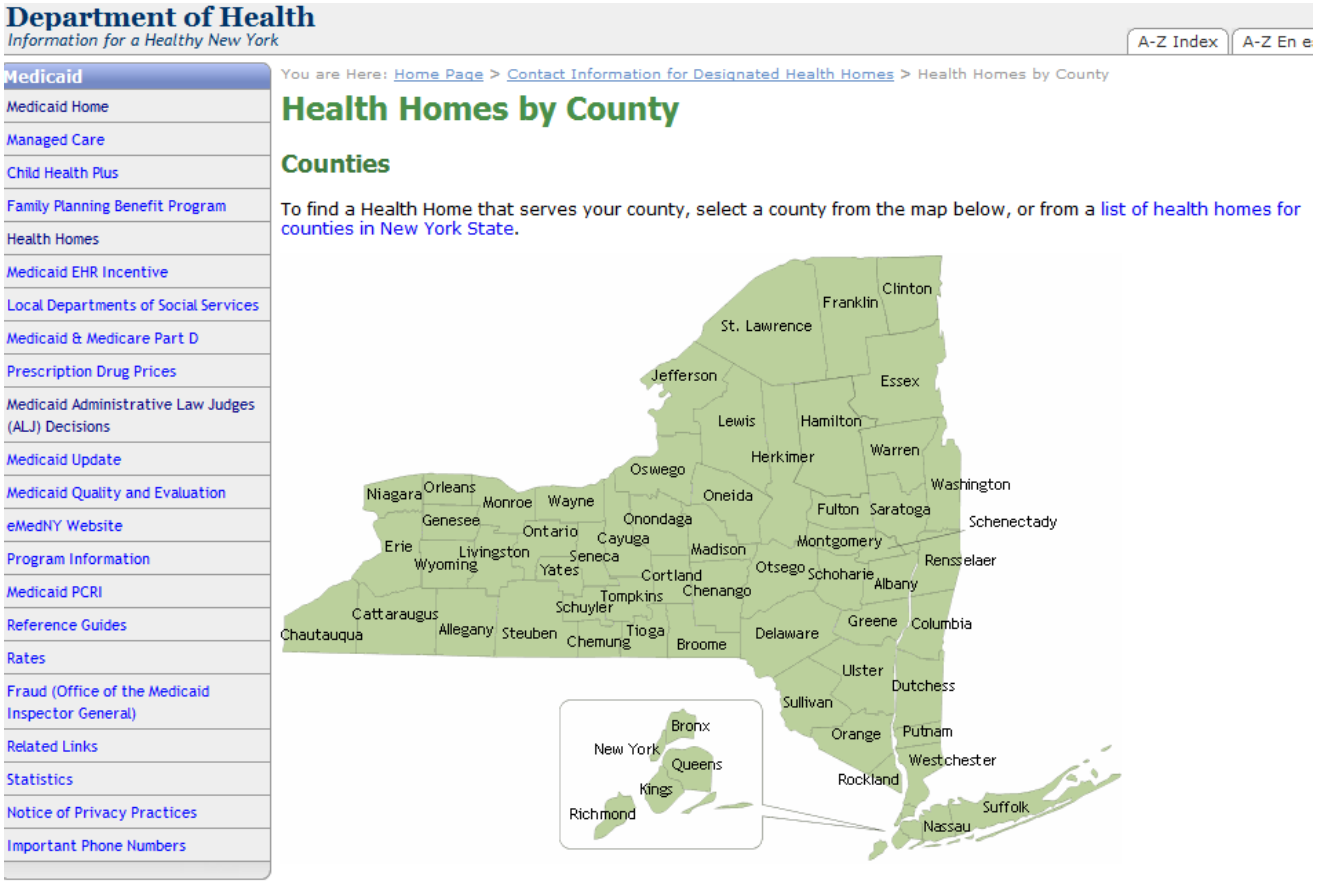
  "The health home provider promotes evidence based wellness and prevention by linking health home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self help and ***recovery resources,*** *and other services* ***based on individual needs and preferences".***

Health Homes and PROS Programs

Health Homes are encouraged to use PROS to assist individuals with severe and persistent mental illness achieve their goals for recovery and integration into the community.

- Health Home care management agencies (including former OMH TCM programs) can refer clients to PROS programs, and PROS programs can refer clients to Health Homes;
- The client's PROS goals and recovery plan should be reflected in the person-centered plan of care developed and maintained by the Health Home care manager;
- The Health Home care manager can complement the PROS program by identifying additional services that may assist the client in meeting their goals, or to identify barriers to recovery and work with the client to resolve them. PROS bills for services independently of the Health Home.

Use the Health Home locater map to find a Health Home serving your county



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

Coming Soon-the Medicaid Analytic Performance Portal (MAPP)

- Web based portal that will allow Health Homes, MCOs and care management agencies to communicate and share Health Home member tracking and billing information (early 2015);
- Later phases of development will include a referral portal that will allow community based providers the option to make referrals for Health Home services;
- A care management record is being developed.

If You Need More Information

- The Health Home program is described in detail in Special Editions to the *Medicaid Update* released in April 2012 and November 2012.
- A Health Home Provider Manual is available on the eMEDNY website; a link is also provided on the Health Home website:

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

- Questions about the Health Home program? Send an email (use the email form on the Health Home website) or call the Health Home Provider Line at (518) 473-5569