NEW YORK STATE DEPARTMENT OF HEALTH
AIDS Institute
HIV/AIDS • STD • VIRAL HEPATITIS • LGBT HEALTH • DRUG USER HEALTH

Medicaid Health Homes & HIV Care Overview

November 2014

ENDING the EPIDEMIC

HEALTH HOMES

- Care management for high need/high risk individuals with multiple chronic and complex conditions to
  - Improve health and quality of care
  - Reduce costs
    - Prevent avoidable inpatient admissions and emergency room visits
    - Reduce the need for long term care
- Enhanced coordination/integration of medical and behavioral health
- Linkage to community and social supports

HEALTH HOME STRUCTURE

- Led by a single provider (hospital, FQHC, CBO, or other eligible entity)
- Lead Health Home creates a multi-disciplinary network to help members connect with all of the following:
  - Managed Care plans
  - One or more hospital systems
  - Multiple ambulatory care sites (physical and behavioral health)
  - Existing care management and converting targeted case management (TCM) programs
  - Social supports, including housing and vocational services

NYS HEALTH HOME MEMBER ELIGIBILITY

- ✓ One serious and persistent mental health condition;
- ✓ HIV/AIDS;
- ✓ Mental Health condition;

  or

- ✓ At least two chronic conditions including:
  - Substance Abuse disorder
  - Asthma
  - Diabetes
  - Heart Disease
  - Hypertension
  - BMI>25
  - Other chronic illness

HIV+ TARGET FOR HEALTH HOMES

- Highest risk HIV+ Medicaid recipients with co-occurring conditions
  - 72% Substance Use
  - 50% Severe Mental Illness
  - 48% Mental Illness
  - 42% Asthma
  - 31% Heart Disease
  - 25% Hypertension
  - 20% Hyperlipidemia
  - 18% Diabetes

Health Home eligible adults 21+ years. Diagnosis history period of July 1, 2010 – June 30, 2011

HEALTH HOME REFERRALS

STATE

- Prior Medicaid claims data is used by NYS DOH to generate lists of eligible Health Home candidates
- Lists sent to recipients' Managed Care Organization or directly to a Health Home (fee-for-service)
- MCO assigns recipient to a Health Home based on prior services (loyalty analysis)
- Health Home assigns to a care management provider or provides outreach and/or care management itself

COMMUNITY

- New referrals meeting Health Home eligibility criteria are identified by medical, social service, criminal justice, county, etc., agencies
- Community referrals can be made to a care management provider, Lead Health Home, or Managed Care Organization. "Bottom up referral"

MEMBER QUALIFICATION FOR HEALTH HOME ENROLLMENT

- Both community and state referrals must meet chronic illness criteria and have current need for care management to qualify for enrollment

- Need criteria:
  - No primary care practitioner
  - No specialty doctor
  - Poor appointment or medication compliance
  - Inappropriate emergency department use
  - Repeated recent hospitalization for preventable physical or psychiatric conditions
  - Recent release from incarceration
  - Cannot be effectively treated in Patient Centered Medical Home (PCMH)
  - Homelessness

HEALTH HOME ACTIVITIES

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

TRANSITION OF HIV TARGETED CASE MANAGEMENT (TCM) PROGRAMS: COBRA

- Continue to monitor retention and access to medical and supportive services, adherence and viral load suppression.
- 46 diverse providers serving nearly 12,000 HIV+ clients transitioned to the Health Home model
- Converted HIV TCMs are subcontractors to Health Home Leads for outreach and care management
- Most have expanded their mission to serve HIV negative Medicaid recipients with broad array of complex conditions

CONTRIBUTIONS OF HIV COBRA TARGETED CASE MANAGEMENT TO NYS HEALTH HOMES

- Skilled in community outreach to find those lost or never in care
- Harm reduction approach to engagement
- Cultural competency
- History of working with stigmatized and marginalized populations
- Extensive work with peers
- Expertise at community-based services: home visits, patient escort, advocacy, etc.
- Many years experience in case management. Care management enhances case management model with better connections to external medical care

EMERGING HEALTH HOME INITIATIVES

- **Additional populations:** behavioral health, children, long term care, developmentally disabled (DD), adult home residents

- **Shared Savings State Plan Amendment (SPA**): DOH has begun initial discussions with CMS for future implementation.

- **HH and Criminal Justice demonstrations:** Provide pre-release and post-release assistance to ensure mental health, substance use and other health issues are addressed to prevent recidivism and inappropriate use of emergency rooms.

- **Health Home and Housing**: Grants for supportive housing providers are underway to house and serve unstably housed high cost Medicaid recipients enrolled in Health Homes.

TRANSITION CHALLENGES HIV TCMS

- Identity
  - Change in mission and autonomy
- Financial
  - Funding for capital costs, especially HIT
  - Monthly administrative rates to Leads/MCOs
  - Low Health Home payment rates necessitated high caseloads in order to achieve financial stability
    - State currently adjusting rate structure
- Administration and Program
  - Complex tracking and reporting
  - Multiple electronic platforms
  - Training in multiple disease areas
  - No State infrastructure for HIV negative persons with chronic illnesses

WHAT'S WORKED SO FAR?

- Partnership with key government and community players
- State committed to transitioning and expanding existing capacity, including HIV services
- Transition period for converting providers with maintained rates and direct Medicaid billing
- Frequent direct communication between AIDS Institute and converting HIV providers
- Advocacy and policy input by HIV provider community
- Innovative new provider entities to meet new challenges (iHealth)
- Evolving Health Home model

HEALTH HOMES AND ETE GOALS

- Care coordination and referrals to social supports based on retention and viral load needs.
- Dedicated care manager works with clinical team to coordinate supports for achieving clinical goals related to retention and VLS.
- Provides link to Medicaid supportive housing
- Requires more frequent contact with client in the community.
- Experienced care management agencies have expanded high risk populations that can include HIV testing as part of Patient Centered Service Plan.
- Health promotion support can include messages on limiting HIV transmission and protecting HIV- partners.

HEALTH HOMES AND DSRIP

- How can Health Home services support Performing Provider Systems (PPS) HIV related engagement and retention efforts?
- What will HH partnerships with PPSs look like?
- Who are the non- identified HIV patients?
- Who are the high need HIV patients? What are the challenges to getting and keeping them in care?
- Who are the newly diagnosed, not yet in care?
- How can peers assist with DSRIP efforts?

Contact

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DOH Link to Medicaid Redesign :
www.health.ny.gov

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