



# HEALTH HOME UPDATE: MCO AND HEALTH HOME WORKGROUP

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Deirdre Astin, Program Manager  
New York State Health Home Program

# Status of Health Home Implementation

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<b>Statewide Health Home Statistics</b>	
Total Number of Health Homes	50
Total Health Home Eligible Individuals (MHSA and Others)	805,000
# of higher risk members <sup>1</sup>	224,000
% of higher risk members	28.0%
% of higher risk members enrolled	13.9%
<b>Health Home Implementation Status</b>	
# of Health Homes Recipients in Outreach (Converting)	549
# of Health Homes Recipients in Outreach (New)	8,461
# of Health Homes Recipients in Active Care Management (Converting)	21,094
# of Health Homes Recipients in Active Care Management (New)	5,796
# of Total Unique Recipients	31,158
<sup>1</sup> Based on Predictive Risk model and Ambulatory Connectivity measure – Higher risk means Individuals with lower ambulatory connectivity and those more likely to die or have an inpatient or nursing home admission.	

# Designated Health Homes: Phase 1

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- **Bronx:** BAHN, HHC, VNS of NY Home Care, Bronx Lebanon Hospital Center
- **Brooklyn:** Maimonides, Community Health Care Network, ICL, HHC
- **Nassau:** NS-LIJ, FEGS
- **Schenectady :** VNS of Schenectady and Saratoga
- **Northern Region:** Adirondack Health Institute, Inc., Glens Falls Hospital

# Designated Health Homes: Phase 2

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- **Monroe** : Anthony L. Jordan , Huther Doyle
- **Erie** : Alcohol & Drug Dependency Services, Inc., Mental Health Services Erie County -SE Corp V, Urban Family Practice,
- **Hudson Valley** : Hudson River HealthCare, Inc., Open Door Family Medical Ctr. Institute for Family Health
- **Suffolk**: FEGS,, Inc, NS-LIJ, Hudson River HealthCare
- **Staten Island** : Jewish Board of Family & Children's Services
- **Queens** : Community Healthcare Network, HHC, NS-LIJ with PSCH, JBFCS
- **Manhattan**: Heritage Health & Housing Inc., Presbyterian, HHC, St. Luke's-Roosevelt, VNS of NY, and JBFCS

# Designated Health Homes: Status of Phases 1 and 2

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- Network partners and MCOs continue to develop operational policies and procedures.
- Governance models continue to evolve.
- Subcontracts and agreements continue to be formalized with network partners.
- Active billing for Health Home services.

# Designated Health Homes: Phase 3

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- **Northern Region** : Hudson River HealthCare, Inc., St. Mary's Healthcare, Samaritan Hospital, **Adirondack Health Institute\***, Glens Falls Hospital, Visiting Nurse Service of Schenectady & Saratoga Counties.
- **Central Region: Thomas R. Mitchell\***, Onondaga Care Management ,Upstate Cerebral Palsy, Huther Doyle, St. Joseph's Hospital Health Center, Catholic Charities of Broome County, United Health Services Hospitals.
- **Western Region:** Mental Health Services Erie County-Southeast Corp V, Niagara Falls Memorial Medical Center, Chautauqua County Dept. of Mental Hygiene. \* **Changes pending**

# Designated Health Homes: Phase 3 Status

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- Adirondack Health Institute stepping down as lead for Saratoga County, Thomas R. Mitchell stepping down and entering into a partnership for Chemung County.
- Designations still pending for Otsego, Schoharie, Delaware and Chenango counties.
- Contingencies have been satisfied and DEAA's have been approved for all Phase 3 Health Homes.
- Subcontracts and agreements being formalized with network partnerships and Managed Care Plans

# Health Homes: Current Activities

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- DOH collecting process data for Health Home C-MART. Submission for first quarter of 2013 due May 13<sup>th</sup>.
- Health Home Provider Manual under review, publication targeted for May 2013.
- Refining Member Tracking System, working with internal resources to build additional capabilities into the system.
- Beginning to develop new Health Home models and populations (Children, LTC, OPWDD, Adult Home residents, Health Home Plus)



# Health Homes: Current Activities

- Special projects: Health Homes and Supported Housing, Criminal Justice and Health Home Pilots.
- Health Home and MCO Contracts are being executed on an ongoing basis. There are 99 approved contracts between Health Homes & MCOs.
- Over 80 responses were received to a survey sent out to Health Homes and converting case management agencies to determine how they are sharing payments for Health Home services. Data will be tabulated and analyzed to assess the extent to which payment arrangements are being resolved.

# Health Homes: Current Activities

- A State Plan Amendment has been submitted to CMS to implement shared savings and discussions with have been initiated.
- Biweekly webinars, CMART Technical Support, and biweekly tracking system calls will continue through 2013.
- A streamlined version of the Health Home tracking system was released on March 18.

# Member Assignment and Rates

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- New lists sent to Phase 1 and Phase 2 Health Homes and Managed Care Plans in January 2013: Approximately 30,000 members assigned (included dual eligibles).
- Health Homes are asking for more volume-looking at ways to accelerate assignment by Managed Care Plans, facilitate contracting, and re-examine acuity thresholds.
- Equitable sharing of administrative costs continues to be a challenge.
- Health Homes are concerned that payments do not accurately reflect acuity; looking at CRG formula to see if other conditions can be factored in.

# Member Acuity

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- CRGs are created through an algorithm using data from claims submitted to the Department.
- CRGs can only consume data from claims, some discontinuities in severity appear to be related to other factors.
- Where homelessness and non-compliance data is coded in claims, there is improvement in the data.
- Certain V codes are available for lack of housing, employment and food as well as non-compliance.
  - V15.81 (non-compliance)
  - V 60.0 Lack of housing
- There is interest in working with this committee to determine how to collect this data efficiently to improve acuity scoring.

# TCM Transition to Health Home

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The TCM and MATS transition poses unique challenges:

- Negotiating contracts with leads.
- Payment models, projecting cash flow.
- For OMH, new models of working with LGUs/SPOAs and integrating special programs e.g., AOT and ACT).
- Adapting legacy policies and procedures to Health Home requirements and standards.
- Integrating care.

# Health Home Referrals

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- MCO/HH Clinical Workgroup helped to develop the referral guidance published in the November 2012 Health Homes Edition of the Medicaid Update (Thank you!)
- Health Home providers still seeking guidance and clarification; need to develop ways to assess acuity.
- Need to develop process for referrals that will ensure rapid access to care management

# Health Home Readiness Reviews

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DOH is conducting site visits to assess readiness in key areas:

- Compliance with data security outlined in the Data Exchange Agreement Application (DEAA) with DOH
- Progress addressing any contingencies
- Confidentiality
- Composition of provider teams
- Outreach and engagement strategies
- Assessment and care plan development
- Information sharing
- Scope of services

# Health Home Readiness Reviews

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- Readiness site visits have been completed for 12 of the 13 designated Phase 1 Health Homes and 13 of the 17 designated Phase 2 Health Homes.
- Visits have been scheduled for the remainder of Phase 1 and Phase 2 Health Homes.
- Site visits for Phase 3 Health Homes are anticipated to begin in September 2013.



# Health Home Readiness Reviews

Findings that support readiness criteria:

- Administrative requirements met, including DEAAAs and MCO contracts in place, contingencies met and HCS accounts established.
- Health Homes are using a combination of systems to ensure network security, e.g., password protections, firewalls and web filtering.
- HIPAA policies and procedures are in place. Staff training on security awareness and breach notification procedures has been conducted.

# Health Home Readiness Reviews

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Findings that support readiness criteria:

- Consent forms are maintained in secured file cabinets and/or electronically.
- Most Health Homes are using or are in the process of selecting a structured information system to share and update care plans.
- Members of the provider network are communicating to develop uniform policies and procedures and create cohesive Health Home partnerships.
- Health Homes are developing referral processes.

# Health Home Readiness Reviews

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Areas that need to be addressed:

- The ability for care managers to respond to prompt notification of emergency and inpatient facility admissions/discharge.
- A process and time frame for providing crisis intervention for both medical and behavioral health events.
- Further integration of behavioral health and physical health through interdisciplinary teams.

# Health Home Readiness Reviews

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Areas that need to be addressed:

- Linkage of the EHR for communication among interdisciplinary care team members.
- Connectivity to the local RHIO to satisfy Health Home HIT standards.
- Uniform use and identification of the official Health Home name in all Health Home documents (i.e. consent forms, promotional information, care plans, etc.).

**Questions?**