



Overview of New York's Health Home Model

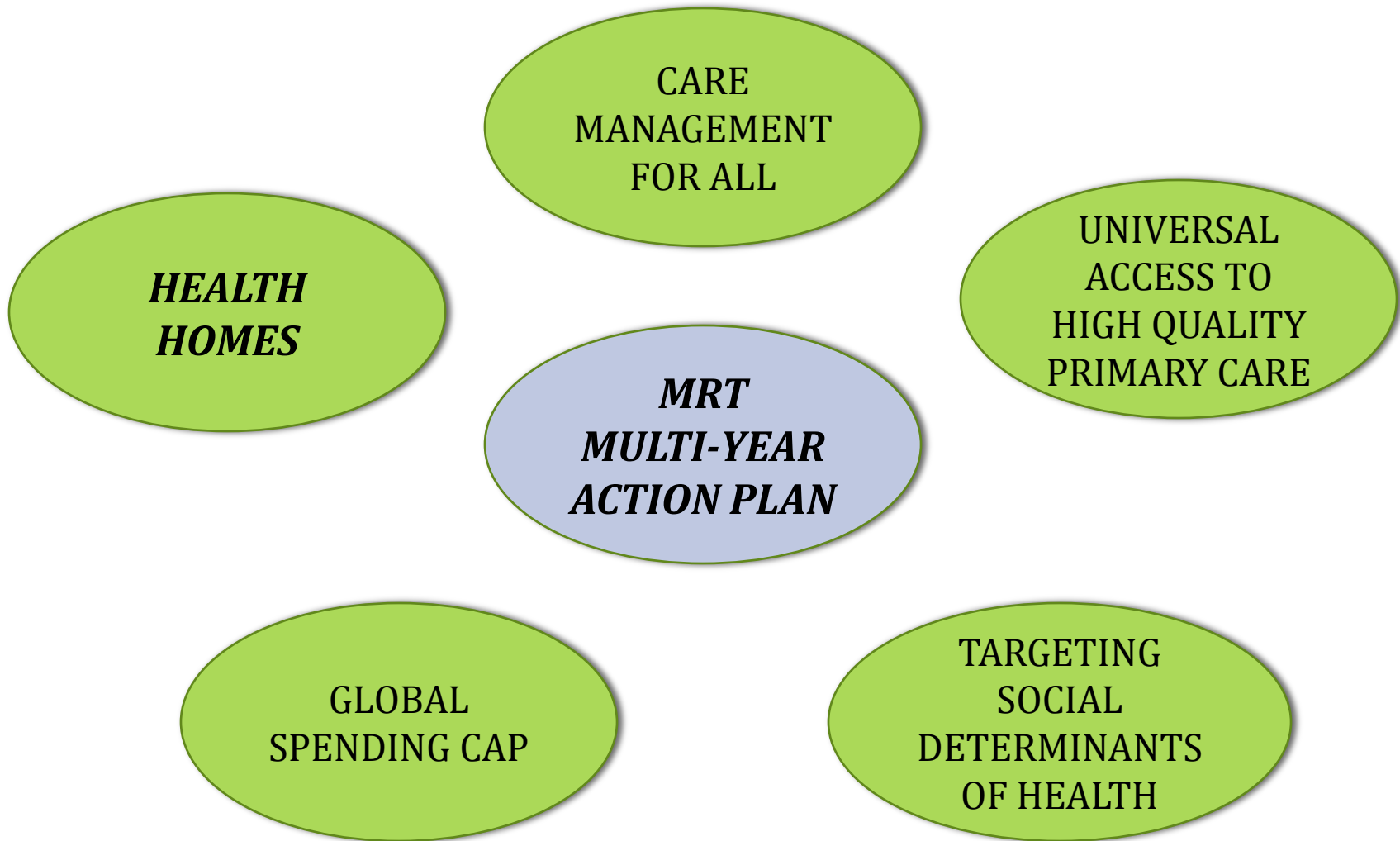
Tailoring New York's Health Home Model for Children

New York State Department of Health
January 27, 2014

Overview of Discussion

- Health Homes Critical Part of Medicaid Redesign
- Recap of Principles for Serving Children in Health Home and Health Home Model for Children
- NYS Health Home Model – Comprehensive Network of Providers
 - ✓ Tailoring Network Requirements for Children
- Health Home Core Care Management Requirements
 - ✓ Ability to tailor the delivery of core requirements to meet the needs of children and family
- Health Home Eligibility Criteria
 - ✓ Considerations and options for modifying criteria for children
- Health Home Payments – Transitional Payment Provisions
- Health Home and Managed Care Plans
- Consent
- Monitoring Quality Outcomes
- Next Steps

Health Homes are a Critical Part of MRT Action Plan to Fundamentally Reform the Medicaid Program



New York State Health Home Model

Managed Care Organizations (MCOs)

New York State Designated Lead Health Homes

Administrative Services, Network Management, HIT Support/Data Exchange

Health Home Care Management Network Partners

(includes former TCM Providers)

Comprehensive Care Management
Care Coordination and Health Promotion
Comprehensive Transitional Care
Individual and Family Support
Referral to Community and Social Support Services
Use of Health Information Technology to Link Services
(Electronic Care Management Records)

Access to Required Primary and Specialty Services (Coordinated with MCO)

Physical Health, Behavioral Health, Substance Use Disorder Services, HIV/AIDS,
Housing, Social Services and Supports

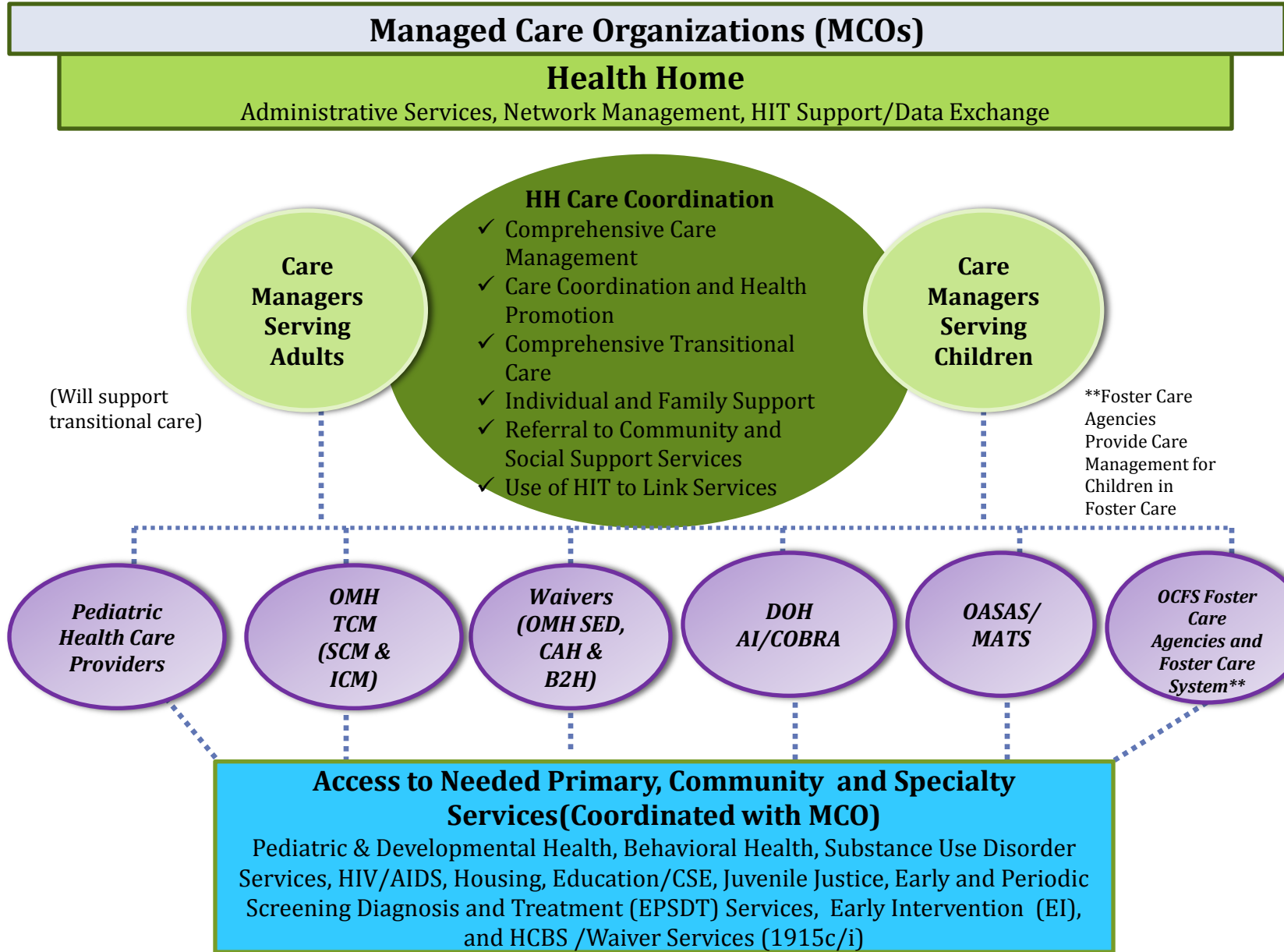
Health
Home
Portal

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Principles for Serving Children in Health Homes and Managed Care

- Ensure managed care and care coordination networks provide comprehensive, integrated physical and behavioral health care that recognizes the unique needs of children and their families
- Provide care coordination and planning that is family-and-youth driven, supports a system of care that builds upon the strengths of the child and family
- Ensure managed care staff and systems care coordinators are trained in working with families and children with unique, complex health needs
- Ensure continuity of care and comprehensive transitional care from service to service (education, foster care, juvenile justice, child to adult)
- Incorporate a child/family specific assent/consent process that recognizes the legal right of a child to seek specific care without parental/guardian consent
- Track clinical and functional outcomes using standardized pediatric tools that are validated for the screening and assessing of children
- Adopt child-specific and nationally recognized measures to monitor quality and outcomes
- Ensure smooth transition from current care management models to Health Home, including transition plan for care management payments

New York State Health Home Model for Children



Note: While leveraging existing Health Homes to serve children is the preferred option, the State may consider authorizing Health Home Models that exclusively serve children.

Tailoring New York's Health Home Model for Children

Children's Health Home Work Group

- Children's Health Home Work Group
 - ✓ Work Group will develop recommendations (e.g., network requirements, eligibility, transitional payment and policy provisions, consent) to present to Health Home/Managed Care Work Group
 - Members of MRT Children's Behavioral Health Work Group
 - Members of Medically Fragile Children Work Group
 - Managed Care Plans

Health Homes

Authorization and Purpose

- Health Homes are an optional State Plan benefit authorized under Section 2703 of the Affordable Care Act (ACA) to coordinate care for people with Medicaid who have chronic conditions
- Health Home is a Care Management model that provides:
 - ✓ Enhanced care coordination and integration of primary, acute, behavioral health (mental health and substance abuse) services, and
 - ✓ Linkages to community services and supports, housing, social services, and family services for persons with chronic conditions

How Members are Currently Enrolled in Health Homes

- **DOH Assignments**

- ✓ DOH identifies and assigns members to Health Homes using analytical tools:
 - Clinical Risk Group (CRG) Based Attribution: for cohort selection
 - CRG Based Acuity: to establish payments
 - Predictive Model: predicts future negative events (inpatient or nursing home admission, death) using claims and encounters to identify assignment priority
 - Provider Loyalty: existing patterns of service utilization (care management, ambulatory physical and behavioral health, ED and inpatient) are analyzed to match member to appropriate Health Home
- ✓ Can be Modified for Children - CRGs, predictive risk etc. may not be appropriate

- **Community Referrals**

- ✓ New referrals (e.g., via HRA, LDSS, LGU and SPOA, care management agency, practitioners, hospital, prisons, BHO):
 - For Managed Care Members, the referring entity will contact the Plan to initiate the Health Home assignment
 - For FFS members, the referring entity will have to make an appropriate Health Home assignment. Referrals can be made directly to care management programs, which will make the Health Home assignment
 - Health Homes and Plans are required to make an assignment that is in the best interests of the patients and to confirm referral meets Health Home eligibility criteria

New York State Health Home Model

Comprehensive Network of Providers

- In New York State, Health Homes are led by one provider (single point of accountability) which is required to create a comprehensive network to help members connect with:
 - ✓ One or more hospital systems;
 - ✓ Multiple ambulatory care sites (physical and behavioral health);
 - ✓ Existing care management and converting targeted case management (TCM) programs;
 - ✓ Community and social supports, e.g., housing and vocational services; and
 - ✓ Managed care plans
- Medicaid enrolled providers that meet Health Home provider qualifications and are approved by the State team are eligible to be Health Homes (e.g., Hospitals; medical, behavioral health and chemical dependency treatment providers, primary care practitioner practices, patient centered medical homes, Case Management Providers, Certified Home Health Care Agencies)
- There are currently 48 designated Health Homes (32 unique entities) serving 58 counties in the State (DOH is working with provider to establish HH in Schoharie, Delaware, Otsego and Chenango)

Examples of NYS Designated Health Home (Lead and Network of Providers)

FEGS Health & Human Services System (Long Island)	Spectrum (HH Partners of Western NY)
Network of Providers	Network of Providers
363 Providers, including:	131 Providers, including:
Options for Community Living (HIV/AIDS)	Evergreen Health Services (HIV/AIDS)
Conifer Park (SUD)	Allegany Rehabilitation Associates (SUD)
Eastern Long Island Hosp Psych Center (BH)	Niagara County Dept of Mental Health (BH)
Family Residences & Essential Enterprises INC (Housing)	Community Missions of Niagara Frontier (Housing)
LI Jewish Medical Center (PH)	Catholic Health Systems (PH)

Designated Health Homes in New York State

Region	Implemented in 3 Phases Effective January, April and July 2012
Central	Catholic Charities, Central New York HH Network, Greater Rochester HH Network, Huther Doyle Memorial Institute, Onondaga Case Management, St. Joseph's Care Coordination Network, United Health Services Hospital
Hudson Valley	Hudson River Health Care, Hudson Valley Care Coalition, Institute for Family Health,
Long Island	Hudson River Health Care, FEGS Health & Human Services System, North Shore LIJ HH
New York City	Bronx Lebanon Hospital Ctr, Bronx Accountable Healthcare Network, Community Care Management Partners, Community Health Care Network, Continuum Health Home Network (St. Luke's), Coordinated Behavioral Care, Heritage Health, NYC Health and Hospitals Corporation, The New York and Presbyterian Hospital, North Shore LIJ, Southwest Brooklyn Health Home (Maimonides)
Northern	Adirondack Health Institute, Capital Region Health Connections (Samaritan), Visiting Nurse Service of Schenectady and Saratoga, Glens Falls Hospital, Hudson River Health Care, St. Mary's Healthcare
Western	Chautauqua County Department of Mental Hygiene, Greater Buffalo United Accountable Health Care Network, Spectrum (HH Partners of Western NY), Niagara Falls Memorial Medical Center

Tailoring Health Home Network for Children

- In order to take advantage of the considerable infrastructure that has already been developed for adults, existing Health Homes will be given an opportunity to apply *with an expanded network* to serve children.
- Conversations between children's providers and existing health homes are strongly encouraged now.
- It is expected that children's health homes would be regional (eg. Western, LI, Bronx/Upper Manhattan) instead of county based like the existing health homes.
- If needed in a given region, additional applications from new lead entities/HHs with expertise in serving children would be considered based on capacity or need for access to specialty services.
- Applications will be reviewed by a broad state/local team: DOH (including OHIP, AIDS Institute, Public Health and OHITT), OCFS, OMH, OASAS and NYC DOHMH

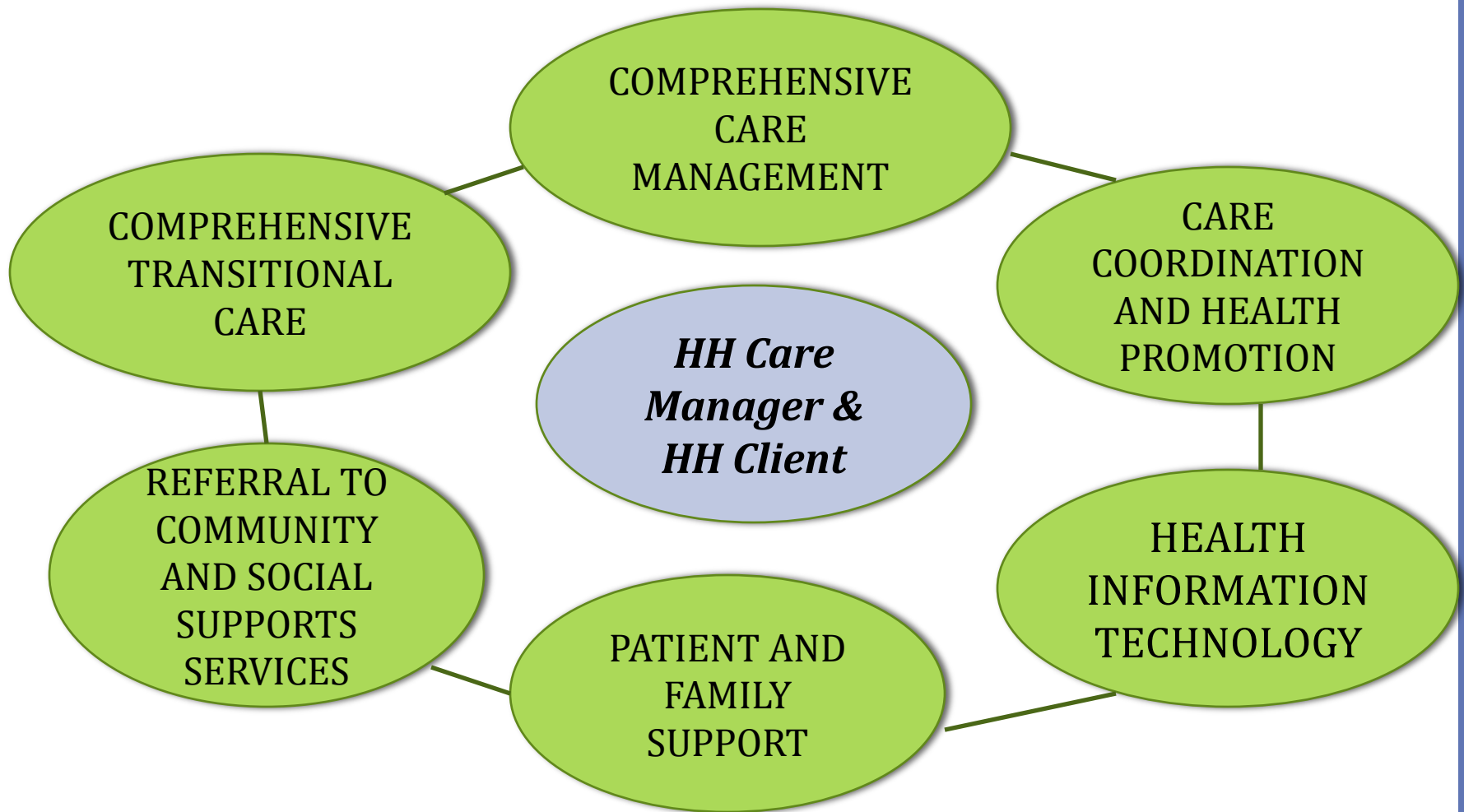
Tailoring Health Home Network for Children

- HH Applicant must Demonstrate Capacity and Ability of Network to:
 - ✓ Meet child specific Health Home qualifications and standards (developed by state team with input from Children's Health Home Work Group and Health Home Managed Care Work Group) and to abide by the principles for serving children and families
 - ✓ Meet the needs of complex populations (e.g., children with chronic conditions, those with SED/SUD, children in the Foster Care and Juvenile Justice systems)
 - ✓ Partner with school districts and the education system
 - ✓ Requirement to partner with and use Foster Care agencies for care management when a child enters Foster Care

Tailoring Health Home Network for Children

- Expand Network Requirements to Include:
 - ✓ Persons and entities that have experience in providing care management for children (i.e., Foster Care agencies, B2H, TCM for Children, HCBS)
 - ✓ Pediatric Health Care Providers and Specialty Providers– Primary Care, Developmental Health, Behavioral Health, Substance Use Disorder Services, HIV/AIDS, Dentists
 - ✓ Volunteer Foster Care Agencies and Foster Care System
 - *Foster Care Agencies provide care management for children in Foster Care*
 - ✓ Youth and Family Peer Supports
 - ✓ Early Intervention (EI)
 - ✓ Education – Preschool Special Education and Committee on Special Education
 - ✓ Juvenile Justice
 - ✓ Waiver Services [1915(c)]
 - ✓ Other ??

Six Core Functions of NYS Health Home Model



Health Home care management is “whole-person” and “person-centered” and integrates a care philosophy that includes both physical/behavioral care and family and social supports – includes the foundation for and elements of Wraparound Models

Six Core Requirements of Health Homes – *Draft for Discussion*

1) **Comprehensive Care Management** -Examples of Services and Activities

- Complete a comprehensive health assessment, inclusive of medical, behavioral, rehabilitative and long term care and social service needs
- Complete and revise, as needed, an individualized patient centered plan of care with the patient to identify patient's needs and goals, and include family members and other social supports as appropriate
- Consult with multidisciplinary team, primary care physician, specialists on client's care plan needs goals
- Consult with primary care physician and/or specialists involved in the treatment plan
- Conduct clinic outreach and engagement activities to assess on-going and emerging needs and to promote continuity of care and improved health outcomes
- Prepare client crisis intervention plan

Applicants Demonstrate Ability to Tailor the Delivery of Core Requirement to Children's Needs

- Transition to Standardized Assessment tool for Children (e.g. CANS)?
- Patient centered plan is family driven and youth-guided
- Involvement and role of parent/guardian/family in development of care plan
- Interaction between care manager and systems – Education, Juvenile Justice and Foster Care (Requirement to use Foster care agencies as downstream care manager when a child enters foster care)

Six Core Requirements of Health Homes – *Draft for Discussion*

2) Care Coordination and Health Promotion - Examples of Services and Activities

- Coordinate with service providers and health plans to secure necessary care, share crisis intervention and emergency information
- Coordinate with treating clinicians to assure that services are provided and to assure changes in treatment or medical conditions are addressed
- Conduct case reviews with interdisciplinary team to monitor/evaluate client status/service needs
- Crisis intervention – revise care plan/goals as required
- Advocate for services and assist with scheduling of services
- Monitor, support, accompany the client to scheduled medical appointments
- Provide conflict free case management

Applicants Demonstrate Ability to Tailor the Delivery of Core Requirement to Children’s Needs

- Transition to High Fidelity Wraparound model of care coordination and planning for children
- Ensure care givers are trained to work with children and families
- Crises intervention/de-escalation for children/family/guardian

Six Core Requirements of Health Homes – *Draft for Discussion*

3) Comprehensive Transitional Care - Examples of Services and Activities

- Follow up with hospitals/ER upon notification of client's admission and/or discharge to/from an ER, hospital/residential/rehabilitative setting
- Facilitate discharge planning and follow up with hospitals/ER upon notification of a client's admission and/or discharge to/from ER, hospital, residential and rehabilitative setting
- Link client with community supports to ensure that needed services are provided
- Follow up post discharge with client and family to ensure needed services are provided
- Notify consult with treating clinicians, schedule follow up appointments, as assist with medication reconciliation

Applicants Demonstrate Ability to Tailor the Delivery of Core Requirement to Children's Needs

- Existing HHs that are tailored to enroll children have built-in ability to facilitate transition of child to adult care
- Shift in and out of Foster Care
- Shift in and out of Juvenile Justice
- Shift in and out of special education
- Shift in and out of school districts
- Shift from out of home placement to family/home

Six Core Requirements of Health Homes – *Draft for Discussion*

4) Individual and Family Support - Examples of Services and Activities

- Develop, review, revise individual's plan of care with client and family to ensure plan reflects individuals preferences, education, and support for self management
- Consult with client/family/caretaker on advanced directives and educate on client rights and health care issues as needed
- Meet with client and family, inviting any other providers to facilitate needed interpretation services
- Refer client and family to peer supports, support groups, social services, entitlement programs as needed

Applicants Demonstrate Ability to Tailor the Delivery of Core Requirement to Children's Needs

- Build plan of care around strengths of youth and family
- Role of and focus on parents/family/ legal guardians in plan of care and consent
- Include peer and family supports in care plan
- Skill building for family/parents/legal guardian

Six Core Requirements of Health Homes – *Draft for Discussion*

5) Referral to Community and Social Support Services - Examples of Services and Activities

- Identify resources and link client to community supports as needed
- Collaborate and coordinate with community based providers to support effective utilization of services based on client/family need

Applicants Demonstrate Ability to Tailor the Delivery of Core Requirement to Children's Needs

- Family and youth focused organizations
- Experienced youth and family peer supports
- Linkages to social support in home, community and school (after school programs, sports, youth groups)
- Skill Building Services for children's needs (completing homework, socializing, skills to transition from child to adult)

Six Core Requirements of Health Homes – Draft for Discussion

6) Health Information Technology	Applicants Demonstrate Ability to Tailor the Delivery of Core Requirement to Children's Needs
<ul style="list-style-type: none">• Demonstrate capacity to use HIT to link services facilitate communication among the network and individual and family caregivers• Use HIT to create, document, execute and update a plan of care for every patient that is accessible to the network providers	<ul style="list-style-type: none">• Use HIT to facilitate connectivity to systems (educational and juvenile systems)

- **Resources to Assist Children's Providers and Health Homes with HIT and Connectivity**

- ✓ **2014-15 Executive Budget Initiatives**

- Provides funds to voluntary foster care agencies to collect encounter data to analyze utilization of services, and develop infrastructure required to electronically share health information (\$5 million 2014-15 and \$15 million 2015-16)
 - Provide funds to voluntary providers of behavioral health services to children and adults to develop infrastructure required to electronically share health information (\$20 million in 2014-15)

- ✓ **Health Home Development SPA (part of MRT Waiver) - \$525 million over five years to be allocated under application process**

- Member Engagement and Health Promotion
 - Workforce Training and Retraining
 - Clinical Connectivity and Health Information Technology Implementation
 - Joint Governance Technical Assistance and Implementation Funds

Existing Eligibility Criteria for Health Homes

Will be Modified for Children

- Person Must be **enrolled in Medicaid** and have:
 - ✓ **Two chronic conditions** or
 - ✓ **One single qualifying condition of**
 - **HIV/AIDS** or
 - **Serious Mental Illness (SMI)**
- **Chronic Conditions** include (but are not limited to)
 - ✓ Alcohol and Substance Abuse
 - ✓ Mental Health Condition
 - ✓ Cardiovascular Disease (e.g., Hypertension)
 - ✓ Metabolic Disease (e.g., Diabetes)
 - ✓ Respiratory Disease (e.g., Asthma)
 - ✓ Obesity BMI >25

- Persons meeting criteria **must be appropriate** for HH Care Management
 - ✓ At risk for adverse event, e.g., death, disability, inpatient or nursing home admission
 - ✓ Inadequate social/family/housing support
 - ✓ Inadequate connectivity with healthcare system
 - ✓ Non-adherence to treatments or difficulty managing medications
 - ✓ Recent release from incarceration or psychiatric hospitalization
 - ✓ Deficits in activities of daily living
 - ✓ Learning or cognition issues

Considerations for Modifying Eligibility Criteria to Better Serve Children

- Requires State Plan Amendment/CMS Approval
 - ✓ Criteria for defining current HH eligible population has been chronic condition based
 - Cannot target by age (child or adult)
 - Cannot target by type of group (e.g., children enrolled in Foster care, children in juvenile justice)
 - CAN target by Chronic Condition or Geography
 - ✓ Federal Match will likely be 50/50 (not 90/10)
- Serious Emotional Disturbance (SED) would likely be added as single HH qualifying condition (comparable to SMI in current criteria)
- Other single qualifying chronic conditions for children?
- CMS would likely require modifications to HH qualifying conditions to be universally applied (i.e., also apply to adults)- important when thinking through “at risk of” conditions.

Options for Modifying Eligibility to Tailor Health Homes to Children

- Current Health Home eligibility requirements continue to apply to children (2 chronic conditions, SMI, HIV)
- All children with Serious Emotional Disorder (SED) (as opposed to Serious Mental Illness)

SED (Federal Waiver Definition): means a child or adolescent has a designated mental illness diagnosis according to the most current DSM of Mental Disorders AND has experienced functional limitations due to emotional disturbance over the past 12 months on a continuous or intermittent basis. The functional limitations must be moderate in at least 2 of the following areas or severe in at least one of the following areas:

- ✓ (i) ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
- ✓ (ii) family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
- ✓ (iii) social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
- ✓ (iv) self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
- ✓ (v) ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

Options for Modifying Eligibility to Tailor Health Homes to Children

- All Children in Foster Care (have to think through how to target)

- Medically Fragile Children

Medically Fragile Children (Definition from February 2013 MFC Report):

An individual who is under 21 years of age and has a chronic debilitating condition or conditions*, who may or may not be hospitalized or institutionalized, and is:

- technologically-dependent for life or health-sustaining functions, and/or
- requires a complex medication regimen or medical interventions to maintain or to improve their health status, and/or
- in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk.

*Chronic debilitating medical conditions include, but are not limited to, bronchopulmonary dysplasia, cerebral palsy, congenital heart disease, microcephaly, and muscular dystrophy.

- Other Criteria (single conditions), Juvenile Justice or Criminal Justice Systems
- Modifications to Appropriateness Criteria for HH Enrollment

Challenge: how do we develop a federally approvable condition based criteria that covers Foster Care Children (trauma?), Medically Fragile Children and OMH and B2H Waiver Children

Existing and Modified Eligibility Options Target Conditions (2011 Medicaid Data)

Number of
Children

Children that Meet Existing HH Eligibility Criteria

Foster Care (With SMI*, HIV or 2 or more Chronic Conditions)	6,152
Medically Fragile Children (With SMI*, HIV or 2 or more Chronic Conditions)	3,558
Foster Care and Medically Fragile Children (With SMI*, HIV or 2 or more Chronic Conditions)	64
All Other Children (With SMI*, HIV or 2 or more Chronic Conditions)	80,112
Total	89,886

Potential Eligibility Modifications

Foster Care not Eligible under Existing Criteria	27,070
Medically Fragile Children not Eligible under Existing Criteria	8,393
Expanded MH Definition SED-Like	63,344
Foster Care and Medically Fragile Children not Eligible under Existing Criteria	131
Foster Care and SED –Like not Eligible under Existing Criteria	3,459
SED Like and Medically Fragile Children not Eligible under Existing Criteria	173
Foster Care, SED and Medically Fragile Children not Eligible under Existing Criteria	4
ADHD	42,243
Total	144,817
Total Children that Meet Current and Potential Eligibility Modifications	234,703

*SMI: Schizophrenia, Bi-Polar Disorder, Depressive Psychosis

** Expanded MH Definition – Single condition of eating disorder; conduct, impulse control, other disruptive behaviors, major personality disorders, chronic mental health diagnoses, depression, chronic stress and anxiety, post traumatic stress disorder)

Total Foster Care Children: 36,830

Total Medically Fragile Children: 12, 868

Health Home Payment Arrangements

- Current Payment Arrangements
 - ✓ For Fee-for-Service Members HH bills the State the PMPM fee directly
 - ✓ For Managed Care Members the Plan bills the State the PMPM fee and passes care management fee to HH
 - ✓ Under transition provisions, Legacy (e.g., TCM) providers bill the State the PMPM fee directly
 - ✓ The HH and the Plan retain an administrative fee (typically 3% each)
- When transition to managed care is fully implemented, the Plans will pay HHs directly (fees included in capitated payment) and rates will be negotiated
 - ✓ During transition period mandated government rates would be in effect for a period of time (2 years)
- Health Homes can directly provide care management services or they can contract with care management entities

Health Home PMPM Care Management Payments

- The Health Home PMPM is calculated on a member specific basis (member specific acuity score multiplied by applicable regional rate)
- Legacy providers bill their average pre-Health Home rate until the transition to Managed Care begins (January 2015)
- PMPM fees for enrolled members currently range \$215 for new (non-Legacy) HH members and \$570 for Legacy slots
 - ✓ Does not include outreach payments which are 80% of enrollment PMPM
- State is working with HH MCO Workgroup to revise rate structure to three tier structure of High, Medium, Low for HARP and Non-HARP population – method considers case load size
- It is anticipated those revised rates would be the mandated government rates during the first two years of the transition to Managed Care
- Transitional Legacy provision would be developed for existing care management programs for children (need to think through waiver transition rules)
 - ✓ Similar High Medium Low structure for children would likely be developed – case load size needs to be discussed

Roles of Health Home and Plans

Collaborative Relationship

- Plans enter into contracts with Health Homes to provide HH care management services
 - ✓ Plans are not currently required to contract with every Health Home. If children's health homes are regional plans would likely be required to contract with the health home in any region they serve.
- Health Homes required to use plan services to meet Health Home objectives and work with the Plan, as needed, to expand the plan network or authorize out of network care to meet member needs.
- Plans manage all in-Plan services and work closely with Health Homes to meet Health Home objectives. The Plan must work with Health Homes to expand the plan network, as needed, to meet member needs.
- Health Homes and Plans submit member tracking information to DOH – Funds have been approved to develop Health Home Portal for tracking, care management software, EHR, RHIO connectivity– work is underway

Consent and Monitoring Quality Outcomes

- **Consent**

- ✓ Enrollment in Health Home is voluntary
 - HH Consent forms and procedures are in place
 - Member signs consent form at enrollment to allow PHI to be shared with network providers
- ✓ Incorporation of procedures for assent and consent for children in the Health Home model – role of parent/guardian needs to be discussed/considered

- **Monitoring Quality Outcomes**

- ✓ State must meet CMS approved quality measures. These will have to be tailored for children.
- ✓ State is building a robust provider/plan portal to manage quality.

Anticipated Schedule for Enrolling Children in Health Homes

Review Health Home Children's Model with Stakeholders - MRT Children's Work Group, HH-MCO Work Group	October 2013
Collaborate with Stakeholders to Refine Health Home Model and Develop Health Home Application for Children	November 2103 - March 2014
Applications for Health Homes Serving Children Made Available	April 2014 May 2014
Due Date for Submission of Applications for Health Homes Serving Children	August 2014
Health Home State Agency Team Review and Approval of Applications	October 2014
Develop and Distribute Health Home Assignment /Eligibility Lists for Children	November - December 2014
Begin Enrolling Children in Health Homes	January 2015
Behavioral Health Services for Children in Managed Care	January 2016

Next Steps / Feedback and Comments

- Receive feedback / comments on:
 - ✓ Eligibility
 - ✓ Network Requirements
- Next Steps
 - ✓ Do additional data analysis on modified eligibility requirements
 - ✓ Discuss Transition Rules (policy and payment) for TCM and Waivers (OMH and B2H)
 - ✓ Draft Health Home Application for Children
 - ✓ Develop Consent Forms for Children
 - ✓ Statewide Webinar for Stakeholders on Draft Design
 - ✓ Develop/Submit State Plan Amendment