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New York's Health Home Project Criminal Justice Pilot Program

Overview

As a result of Governor Andrew Cuomo's 2011 Medicaid Redesign Team recommendations, the New York State Department of Health (DOH) established a Health Homes program. Six of the state's 37 health homes were selected to participate in a criminal justice pilot program, aimed at enrolling criminal-justice involved individuals with one or more of the following characteristics:

- Has a serious mental illness
- Has two or more chronic conditions (including a substance use disorder)
- Has HIV/AIDS and is at risk of developing another chronic condition

These pilot health homes are responsible for developing or leveraging existing linkages with the criminal justice system to identify possibly eligible individuals, deploy case managers to make eligibility determinations and create care transition and discharge plans for the potential enrollee, and provide comprehensive, coordinated care that meets DOH Health Home criteria.

Medicaid's Role

DOH was the lead agency for developing state-specific Health Home criteria under the broad framework provided by the federal Centers for Medicare and Medicaid Services.[1] Additionally, DOH partnered with numerous other New York state agencies, including the Office of Health Insurance Programs, the Office of Health Information Technology Transformation, the Office of Mental Health, the Office of Substance Abuse Services, and the New York state AIDS Institute to develop the Health Homes initiative.

DOH also convened numerous workgroups which incorporated providers, managed care organizations, and other stakeholders. These workgroups informed and assisted in planning the Health Homes initiative, including development of the risk-adjusted per member per month payment methodology and development of acuity scores to identify and categorize enrollees.

[1] NYS Health Home Provider Standards for Chronic Medical and Behavioral Health Patient Populations, http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/provider_qualification_standards.htm

Planning Challenges and Considerations

Health IT System Interoperability

New York's Health Homes encompass a variety of providers and settings. Facilitating the electronic exchange of patient data across these varied settings in some cases required a substantial resource investment by the Health Home, which in turn required the creation of funding opportunities by DOH. One Health Home invested over $1 million in order to stand up its health IT system across the 25 providers and agencies within its purview.

DOH received $15 million in federal grants and made funding available for these and other Health Home start-up costs via a formula which scored Health Homes based on lack of access to other funding sources, level of health IT connectivity, geographic and demographic factors, and the prevalence of qualifying conditions.

Building Relationships between Health Homes and the Criminal Justice Community

Health Home pilot site staff consistently identified building working relationships with local law enforcement, corrections department, and other relevant institutions as a key factor in ensuring the overall success of the initiative. They indicated that educating providers, prospective enrollees, and criminal justice partners about the program's existence, purpose, and potential benefits was also a useful step to promote successful engagement.

DOH developed and disseminated a variety of education materials tailored to specific stakeholders in the overall Health Home initiative and holds regular webinars on specific topics. Providers, managed care organizations, and other stakeholders were also included in DOH's collaborative planning process that produced the Health Homes initiative.

Ensuring Effective Health Home "In-Reach" Activities

A key aspect of ensuring the success of the criminal justice Health Home pilot is facilitating effective identification of, and engagement with, potential enrollees prior to their discharge from criminal justice settings. These activities are referred to as "in-reach" activities, and they are typically undertaken by Health Home case managers who travel directly to potential enrollees to make an eligibility determination and initiate post-discharge planning to ensure a smooth transition to Health Home services.

Currently DOH does not reimburse Health Homes for in-reach activities due to the federal Medicaid inmate exclusion, which prohibits Medicaid payment for services to inmates other than an inpatient hospital or nursing facility stay lasting longer than 24 hours. DOH plans to explore funding for these activities from other state sources in future budget cycles.