Exploring Medicaid Health Homes: New York: Transforming Care Delivery via Health Homes

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For more information or technical assistance in developing health homes, visit http://www.Medicaid.gov.

Types of Technical Assistance with Health Home Development

- One-on-one technical support to states
- Peer-learning collaboratives
- Webinars open to all states
- Online library of hands-on tools and resources

Exploring Medicaid Health Homes Webinar Series

- Provides a forum for states to share models, elements of their SPAs, and successes or challenges in their development process
- Creates a forum for CMS to engage in conversation with states considering and/or designing health home programs
- Any state considering or pursuing health homes may participate in these webinars
- Goal of disseminating existing knowledge useful to health home planning

National Landscape to Date

- 5 approved State Plan Amendments
- Small number of states in various stages of discussion with CMS
- Multiple other states exploring the opportunity

Features of the New York Health Home Model

- Focus includes both behavioral and physical health in one SPA
- Builds upon pilot project experience
- Health home consists of a network of care providers
- Extensive stakeholder process
- Phased roll-out approach

Today's Presenter

- New York
  - Greg Allen, Director, Division of Financial Planning and Policy, Office of Health Insurance Programs, New York State Department of Health
  - SPA targeting chronic medical/behavioral health population approved 2/6/12, with a 1/1/12 effective date

New York State Health Homes

Transforming Care Delivery

Governor's Vision for Medicaid Reform – Through MRT Process

- Phase I (ended February 20111) - 79 recommendations were approved by Legislature as part of the 2011-12 enacted budget.
- Three key recommendations currently being implemented:
  - ***Global Medicaid Spending Gap***
  - ***Care Management for All***
  - ***Medical Indemnity Fund***
- Phase II (ended December 2011) work groups (WG) addressed more complex issues & monitored implementation of Phase I key recommendations; each WG produced final report of recommendations.

Expansion of Care Management NYS Vision for Medicaid Reform

- **GOAL:** All members enroll in a high-quality, fully integrated care management program.
- Care management plans within five years.
  - Within three years almost the entire Medicaid population will be enrolled in some type of care management.
    - *This is a multi-year phase-in process, beginning with special populations.*
  - There is a range of care management tools
    - *Health Home is one model designed to provide comprehensive care management to specific high-need/high-cost populations.*

Examples of Care Management

- Managed Care
- Managed Long Term Care (MLTC)
- Patient Centered Medical Homes (PCMH)
- **Health Homes (HH) for complex patients**
- Expanded peer services
- Integration of substance abuse and mental health services into Behavioral Health Organizations (BHOs)
- Other innovative models of care

Draft Health Home State Plan Amendments

- NYSDOH submitted two draft SPAs to CMS on June 30, 2011.
- One SPA targeted the Managed Long Term Care population; the other targeted the chronic medical/behavioral health population.
- The focus today will be on the SPA (#11-56) targeting the chronic medical/behavioral health population
- Approved: 2/6/12 Effective date: 1/1/12
- Available on the NYSDOH Health Home Website at: http://nyhealth.gov/health_care/medicaid/program/medicaid_health_homes/index.htm

Health Homes Population in NYS

- More than five million Medicaid members in New York State.
- At least 975,000 meet the federal criteria for Health Homes.
- 278,000 are eligible during Phase 1 (20% are duals).

New Implementation Timeline for New York State Health Homes

Jan 1, 2012	Phase I (10 Counties) *Bronx, Brooklyn, Nassau, Schenectady, Clinton, Essex, Franklin, Hamilton, Warren, Washington* Existing case management (COBRA, MATS, TCMs) providers begin billing using Health Home rates
Feb 1, 2012	List assignment begins for Health Plans and FFS
Feb 15, 2012	Application deadline for Phase II Phase II (16 Counties) *Albany, Dutchess, Erie, Manhattan, Monroe, Orange, Putnam, Queens, Rensselaer, Richmond (Staten Island), Rockland, Saratoga, Suffolk, Sullivan, Ulster, Westchester*
April 1, 2012	Phase II implementation (tentatively)
April 21, 2012	Application deadline for Phase III Phase III (36 Counties) *Alleghany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Columbia, Cortland, Delaware, Fulton, Genesee, Greene, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Niagara, Ontario, Oneida, Onondaga, Orleans, Oswego, Otsego, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Wayne, Wyoming, Yates*
July 1, 2012	Phase III implementation (tentatively)

Provider Qualification Standards

- Health home providers will be required to provide the following Health Home services in accordance with federal and State requirements:
  - **Comprehensive care management**
    - *An individualized patient centered care plan based on a comprehensive health risk assessment – must meet physical, mental health, chemical dependency and social service needs.*
  - **Care coordination and health promotion**
    - *One care manager will ensure that the care plan is followed by coordinating and arranging for the provision of services, supporting adherence to treatment recommendations, and monitoring and evaluating the enrollee's needs. The Health Home provider will promote evidence based wellness and prevention by linking patient enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self-help recovery resources, and other services based on need and patient preference.*

Provider Qualification Standards

- Comprehensive transitional care
  - *Prevention of avoidable readmissions to inpatient facilities and oversight of proper and timely follow-up care.*
- Patient and family support
  - *Individualized care plan must be shared with patient enrollee and family members or other caregivers. Patient and family preferences are considered.*
- Referral to Community and Social Support Services
- Use of Health Information Technology to Link Services

What Makes a Strong NYS HH Application?

- Strong applications will include:
  - *One or more hospital systems*
  - *Connections with Mental Health/HIV/Chronic Illness/Addiction Care Management programs*
  - *Multiple ambulatory care sites with both physical, behavioral and substance abuse specialization*
  - *Community based organizations, including housing*
  - *Managed care plans*
- Applications either pass or are notified of elements missing from the proposal.
- The Department may request that multiple applicants from the same geographic area work together and submit a single proposal.

Health Homes Phase I

- Applications reviewed for:
  - *Meeting Provider Qualifications and Standards and providing adequate choice within Health Home partnerships*
  - *Care Management "Bandwidth" - ability to meet needs of all facets of complex populations (e.g., Mental Health, Housing, Substance Use Disorder, etc.)*
  - *Promoting the State vision - minimize silos and concentrate volume over a few rather than many Health Home networks/systems to assure a more limited accountability structure and more financially viable Health Homes*
  - *Creating choices, where applicable, between institutional led and community based led Health Homes*

Letters of Intent

- 165 LOIs received:
  - *Many comprehensive well planned partnerships*
  - *Some concerns about specific partnership adequacy issues*
  - *Some LOIs have more comprehensive partnerships than others*
  - *Some overlapping regions and partners*
  - *Some smaller less robust entities that would benefit from merger*
- NYSDOH worked with State Mental Health and Substance Use Disorder Agencies as well as county government partners in assessing partnership adequacy and suggesting additional partners and any beneficial mergers.

Chronic Illness Demo Patient Population

Prior Diagnostic History Patients with Risk Scores 50+ NYC Residents – Percent of Patients with Co-Occurring Condition

		CVD	AMI	Ischemic Heart disease	CHF	Hypertension	Diabetes	Asthma	COPD	Renal Disease	Sickle Cell	Alcohol/ Substance Abuse	Mental Illness	HIV/AIDS
Cerebrovascular Disease	5.0%	**100.0%**	15.0%	49.5%	36.2%	81.6%	51.7%	35.3%	24.8%	13.7%	2.9%	56.4%	62.7%	13.7%
Acute Myocardial Infarction	6.0%	12.5%	**100.0%**	80.9%	53.3%	90.1%	56.6%	40.4%	31.5%	17.4%	2.1%	55.2%	56.2%	13.5%
Ischemic Heart Disease	22.4%	11.1%	21.7%	**100.0%**	45.3%	86.9%	54.0%	42.0%	30.2%	13.2%	2.1%	53.5%	58.4%	14.0%
Congestive Heart Failure	16.2%	11.2%	19.8%	62.8%	**100.0%**	89.5%	56.9%	42.7%	34.9%	20.7%	2.7%	48.4%	48.0%	13.4%
Hypertension	50.9%	8.0%	10.6%	38.3%	28.4%	**100.0%**	46.2%	41.0%	25.4%	11.6%	1.8%	63.1%	62.9%	20.0%
Diabetes	29.0%	8.9%	11.7%	41.8%	31.7%	81.3%	**100.0%**	41.2%	23.9%	13.0%	1.4%	55.4%	62.7%	15.6%
Asthma	36.3%	4.9%	6.7%	25.9%	19.0%	57.5%	32.9%	**100.0%**	32.5%	4.3%	2.3%	72.9%	70.0%	29.6%
COPD	20.8%	6.0%	9.1%	32.5%	27.2%	62.2%	33.3%	56.7%	**100.0%**	6.0%	1.7%	74.2%	65.6%	29.9%
Renal Disease	6.3%	10.8%	16.5%	46.7%	52.8%	93.3%	59.6%	24.3%	19.8%	**100.0%**	2.2%	36.6%	37.4%	18.0%
Sickle Cell	2.9%	5.0%	4.2%	15.7%	14.9%	31.3%	14.0%	28.2%	12.3%	4.7%	**100.0%**	48.9%	50.7%	15.0%
Alcohol/ Substance Abuse	72.8%	3.9%	4.5%	16.5%	10.7%	44.1%	22.0%	36.4%	21.2%	3.2%	2.0%	**100.0%**	70.9%	33.4%
Mental Illness	66.2%	4.7%	5.1%	19.7%	11.7%	48.3%	27.4%	38.4%	20.6%	3.6%				

* High Risk of Future Inpatient Admission: Source NYU Wagner School, NYS OHIP, 2009.

Mutually Exclusive Hierarchical Selection of HH Based on Service Utilization

"Complex"

1. Serious Mental Illness Only
2. Pairs
3. Triples
4. HIV/AIDS

* Long Term Care includes: more than 120 days of consecutive LTC needs and/or enrollment in Managed Long Term Care (PACE, Partial MLTC and MAP).

NYS Health Home Populations - 2010

- **Developmental Disabilities**
  - 52,118 Recipients
  - $10,429 PMPM

- **Long Term Care**
  - 209,622 Recipients
  - $4509 PMPM

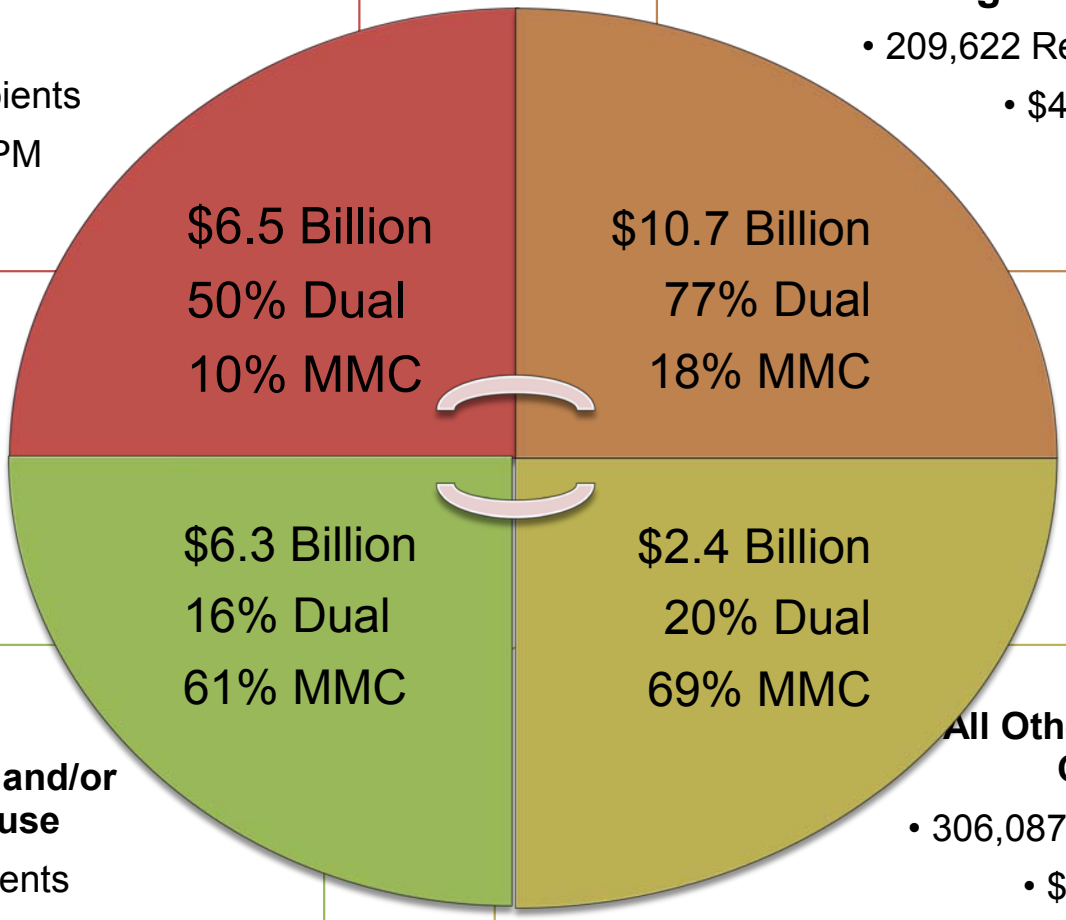
Total Complex

N=976,356

$2,338 PMPM

32% Dual

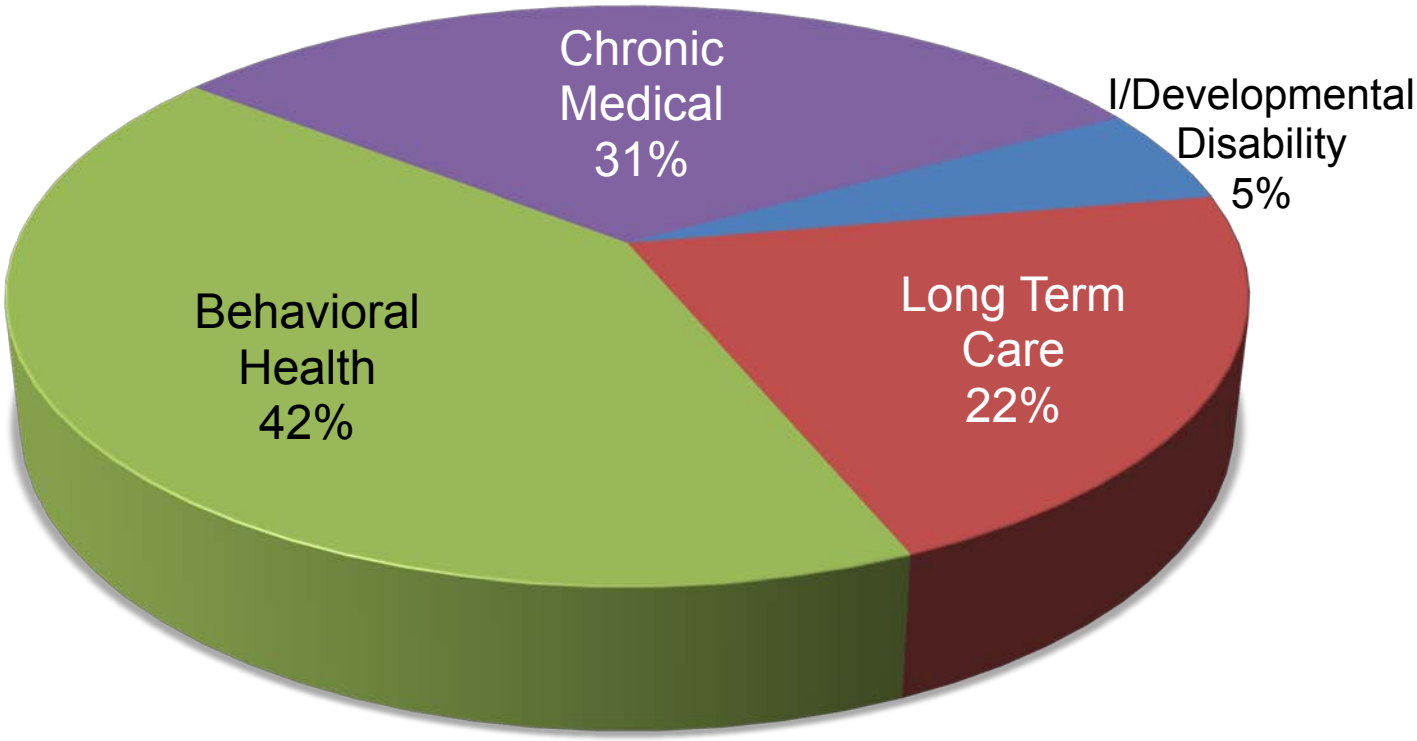
51% MMC



- **Mental Health and/or Substance Abuse**
  - 408,529 Recipients
  - $1,370 PMPM

- **All Other Chronic Conditions**
  - 306,087 Recipients
  - $698 PMPM

NYS Medicaid Members with Multiple Chronic Illnesses



CRG Grouping	Category	Developmental Disabilities	Long Term Care	Behavioral Health and/or Substance Abuse	Other Chronic	Total
Serious Mental Illness Only	Expenditures	$ 61,154,098	$ 193,305,913	$ 1,358,906,853		$ 1,613,366,865
	Member Months	20,406	58,715	1,126,636		1,205,757
	Recipients	1,740	5,328	104,366		111,434
	PMPM	$ 2,996.87	$ 3,292.27	$ 1,206.16		$ 1,338.05
	Percent Dual-Eligible (%)	21.7	68.0	20.8		23.1
	Percent MMC (%)	22.4	15.1	52.5		50.2
Chronic Condition Pairs	Expenditures	$ 5,804,521,610	$ 6,940,553,624	$ 3,605,804,276	$ 1,839,489,731	$ 18,190,369,241
	Member Months	553,939	1,667,351	2,944,128	3,083,170	8,248,588
	Recipients	46,522	147,509	256,555	271,069	721,655
	PMPM	$ 10,478.63	$ 4,162.62	$ 1,224.74	$ 596.62	$ 2,205.27
	Percent Dual-Eligible (%)	51.5	81.3	14.0	20.1	32.4
	Percent MMC (%)	9.6	18.6	65.4	71.4	54.4
Chronic Condition Triples	Expenditures	$ 564,121,257	$ 2,643,508,630	$ 644,631,036	$ 144,331,580	$ 3,996,592,502
	Member Months	42,356	520,248	310,945	138,223	1,011,772
	Recipients	3,567	45,789	26,734	12,271	88,361
	PMPM	$ 13,318.57	$ 5,081.25	$ 2,073.14	$ 1,044.19	$ 3,950.09
	Percent Dual-Eligible (%)	44.6	76.3	14.5	31.9	49.9
	Percent MMC (%)	5.1	18.2	66.9	59.1	38.2
HIV / AIDS	Expenditures	$ 37,689,875	$ 910,920,370	$ 718,818,625	$ 435,060,883	$ 2,102,489,753
	Member Months	3,420	124,340	237,256	246,382	611,398
	Recipients	289	10,996	20,874	22,747	54,906
	PMPM	$ 11,020.43	$ 7,326.04	$ 3,029.72	$ 1,765.80	$ 3,438.82
	Percent Dual-Eligible (%)	20.4	27.3	13.2	16.4	17.4
	Percent MMC (%)	12.7	11.1	29.0	42.3	30.6
Total Complex	Expenditures	$ 6,467,486,840	$ 10,688,288,537	$ 6,328,160,789	$ 2,418,882,194	$ 25,902,818,362
	Member Months	620,121	2,370,654	4,618,965	3,467,775	11,077,515
	Recipients	52,118	209,622	408,529	306,087	976,356
	PMPM	$ 10,429.39	$ 4,508.58	$ 1,370.04	$ 697.53	$ 2,338.32
	Percent Dual-Eligible (%)	49.9	77.1	15.7	20.3	32.2
	Percent MMC (%)	9.7	18.0	60.5	68.8	51.2

2010 Health Home CRG Group – MH/SA Top DXs

Diagnosis Grouping	Sum of MH/SA Spending	Sum of MH/SA Recipients	Diagnosis Grouping	Sum of MH/SA Spending	Sum of MH/SA Recipients
TOTAL	$ 7,270,312,543	411,980	Two Other Moderate Chronic Diseases	$133,721,190	16,691
Schizophrenia	$ 1,064,324,943	71,796	Moderate Chronic Substance Abuse and Other Moderate Chronic Disease	$130,702,804	10,031
Schizophrenia and Other Moderate Chronic Disease	$ 987,483,578	51,021	One Other Moderate Chronic Disease and Other Chronic Disease	$128,258,771	16,832
HIV Disease	$ 896,305,908	22,252	Bi-Polar Disorder	$104,845,381	7,233
Dementing Disease and Other Dominant Chronic Disease	$ 323,686,677	11,961	One Other Dominant Chronic Disease and One or More Moderate Chronic Disease	$97,316,553	6,436
Diabetes - Hypertension - Other Dominant Chronic Disease	$ 237,735,446	11,303	Diabetes - Advanced Coronary Artery Disease - Other Dominant Chronic Disease	$90,245,930	3,303
Diabetes and Other Dominant Chronic Disease	$ 160,873,540	7,826	Schizophrenia and Other Chronic Disease	$89,393,330	5,494
Psychiatric Disease (Except Schizophrenia) and Other Moderate Chronic Disease	$ 156,625,537	15,842	Chronic Obstructive Pulmonary Disease and Other Dominant Chronic Disease	$85,555,831	4,328
Schizophrenia and Other Dominant Chronic Disease	$ 140,336,943	5,809	Diabetes and Hypertension	$83,038,235	9,638
Diabetes and Other Moderate Chronic Disease	$ 139,516,879	11,583	Diabetes and Asthma	$79,170,754	5,484
Asthma and Other Moderate Chronic Disease	$ 138,597,650	11,757	Diabetes and Advanced Coronary Artery Disease	$57,899,075	3,577
Diabetes - 2 or More Other Dominant Chronic Diseases	$ 137,828,720	4,185	Dialysis without Diabetes	$55,750,739	904
Depressive and Other Psychoses	$ 136,096,859	13,809			

How Eligible Members are Being Identified and Assigned

- New York State Health Home Analytical Products
  - **CRG Based Attribution** – *For Cohort Selection*
  - **CRG Based Acuity** – *For Payment Tiers*
  - **Predictive Model** - Predicts future negative events (Inpatient, Nursing Home Death) using claims and encounters – *For Assignment Priority*
  - **Ambulatory Connectivity Measure** – *For Assignment Priority*
  - **Provider Loyalty Model** – Establishes Patient Connectivity to Existing Care Management, Ambulatory (including BH), ED and Inpatient – *For Matching to Appropriate HH and to Guide Outreach activity.*

HH Eligibility and Assignment Tracking

- Eligibility will initially be controlled through sharing of member tracking sheets. Key elements of the tracking sheet (outreach dates, enrollment dates) will be loaded to member eligibility files to support claims and appropriate payment edits.
- Member tracking sheets will be populated via file transfer for all Health Home candidates and participants. System changes are in progress to allow additional functions, e.g., look-up of Health Home status.

Expected "Wave One" HH Enrollment

Health Home Enrollment Phasing			Phase	Tier								Total
			Phase 1			Phase 2			Phase 3			
State Fiscal Year	State Quarter	FFY & Qrt	High Cost	Mid Cost	Low Cost	High Cost	Mid Cost	Low Cost	High Cost	Mid Cost	Low Cost	
SFY '11-'12	Qrt 1	FFY '10-'11 Qrt 3	-	-	-	-	-	-	-	-	-	-
	Qrt 2	FFY '10-'11 Qrt 4	-	-	-	-	-	-	-	-	-	-
	Qrt 3	FFY '11-'12 Qrt 1	-	-	-	-	-	-	-	-	-	-
	Qrt 4	FFY '11-'12 Qrt 2	3,715	10,661	16,401	-	-	-	-	-	-	30,778
SFY '11-'12 Total			**3,715**	**10,661**	**16,401**	**-**	**-**	**-**	**-**	**-**	**-**	**30,778**
SFY '12-'13	Qrt 1	FFY '11-'12 Qrt 3	9,289	26,652	41,003	3,663	10,510	16,168	-	-	-	107,285
	Qrt 2	FFY '11-'12 Qrt 4	-	-	-	9,157	26,274	40,421	807	2,314	3,560	82,533
	Qrt 3	FFY '12-'13 Qrt 1	5,573	15,991	24,602	-	-	-	2,016	5,785	8,901	62,869
	Qrt 4	FFY '12-'13 Qrt 2	3,715	10,661	16,401	5,494	15,764	24,253	-	-	-	76,289
SFY '12-'13 Total			**18,577**	**53,305**	**82,007**	**18,313**	**52,548**	**80,842**	**2,823**	**8,100**	**12,461**	**328,976**
SFY '13-'14	Qrt 1	FFY '12-'13 Qrt 3	1,858	5,330	8,201	3,663	10,510	16,168	1,210	3,471	5,340	55,751
	Qrt 2	FFY '12-'13 Qrt 4	-	-	-	1,831	5,255	8,084	807	2,314	3,560	21,851
	Qrt 3	FFY '13-'14 Qrt 1	1,858	5,330	8,201	-	-	-	403	1,157	1,780	18,729
	Qrt 4	FFY '13-'14 Qrt 2	1,858	5,330	8,201	1,831	5,255	8,084	-	-	-	30,559
SFY '13-'14 Total			**5,573**	**15,991**	**24,602**	**7,325**	**21,019**	**32,337**	**2,420**	**6,943**	**10,681**	**126,891**
SFY '14-'15	Qrt 1	FFY '13-'14 Qrt 3	-	-	-	1,831	5,255	8,084	403	1,157	1,780	18,511
	Qrt 2	FFY '13-'14 Qrt 4	-	-	-	-	-	-	403	1,157	1,780	3,340
	Qrt 3	FFY '14-'15 Qrt 1	-	-	-	-	-	-	-	-	-	-
	Qrt 4	FFY '14-'15 Qrt 2	-	-	-	-	-	-	-	-	-	-
SFY '14-'15 Total			**-**	**-**	**-**	**1,831**	**5,255**	**8,084**	**807**	**2,314**	**3,560**	**21,851**
Total			**27,866**	**79,957**	**123,010**	**27,470**	**78,822**	**121,263**	**6,049**	**17,356**	**26,702**	**508,496**

* Low Cost Members are not slated for Health Home enrollment under the current plan but this could change as the project progresses and as high and mid- cost members are assigned in a given region.

Health Home Tracking Sheets & List Sharing

- State has shared lists with Plans about their members who qualify for Health Home services.
- Lead Health Homes are required to submit a Data Exchange Agreement Application (DEAA) to share lists with their Health Home provider partners.
- Lead Health Homes are responsible for securing member consent at enrollment to allow full access to member data.

Monthly Tracking Sheet Elements

- Patient Demographic information
- Health Plan
- Assigned Health Home
- Health Home Direct Care Management Provider
  - ***TCM, COBRA, MATS, CIDP***
  - ***MCO, CBO***
- Enrollment/Disenrollment Status
- Various Dates
  - ***Consent***
  - ***Enrollment/disenrollment***
- Patient Profile (e.g., Risk Score, Acuity Score, Ambulatory Connectivity and Loyalty)

Health Home Assignment - Fee-For-Service

- Lists of potential members have been created (based on algorithm), with individuals scoring higher (using composite measure of risk for adverse events and lack of engagement in outpatient care) being identified for assignment first.
- Lists will be used to populate member tracking sheets, which Health Homes will access through the Health Commerce System (HCS).
- Provider led designated Health Homes have or will have access to member tracking sheets via HCS for their assigned members.

Health Home Assignment – Managed Care

- Managed Care Plans also have access to their member tracking sheets via the HCS, for individuals identified by DOH as potential Health Home candidates (based on risk and engagement, loyalty, PCP assignment).
- Managed Care Plans will evaluate potential candidates and assign them to Health Homes that best serve Medicaid member needs.

Health Home Assignment - TCM

- TCMs will identify the Health Homes that best meet their member's needs.
- DOH will make assignments to Health Homes based on these recommendations.
- Managed Care Plans and Health Homes will receive member tracking sheets that reflect these assignments and must respect them.

Assignment - New Referrals

- New referrals (via HRA, county, SPOA, care management agency, practitioners, hospital, prisons, BHO, etc) meeting Health Home criteria must be assigned to Health Homes to ensure access to care management.
- For Managed Care Members, the referring entity will contact the Plan to actuate the Health Home assignment.
- For FFS members, the referring entity will contact DOH (contact information to be provided shortly) to actuate an appropriate Health Home assignment. Process will include collaboration with OMH, AIDS Institute, and OASAS to ensure these assignments best serve the needs of their populations.

Billing and Payment - Rates

- Payment rates will be set based on region and case mix (e.g. clinical acuity).
- Eventually rates will be further adjusted by member functional status (e.g. impairment in physical and/or behavioral functioning, housing status, self management abilities, etc.).
- Plans may retain a portion of Health Home payments for administrative services and other support, as necessary.
- Except for TCM slots, outreach and engagement will pay at 80% of the rate, once the candidate is enrolled the rate will be 100%.
- Fiscal agent will notify Managed Care Plans and Provider-led Health Homes when able to electronically bill new Health Home rate codes.

Updated Rates on Website

Projected Average Health Home Payments by Base Health Status and Severity of Illness - Excludes LTC and OPWDD Populations

DRAFT FOR REVIEW AND COMMENT ONLY - (November 17, 2011)

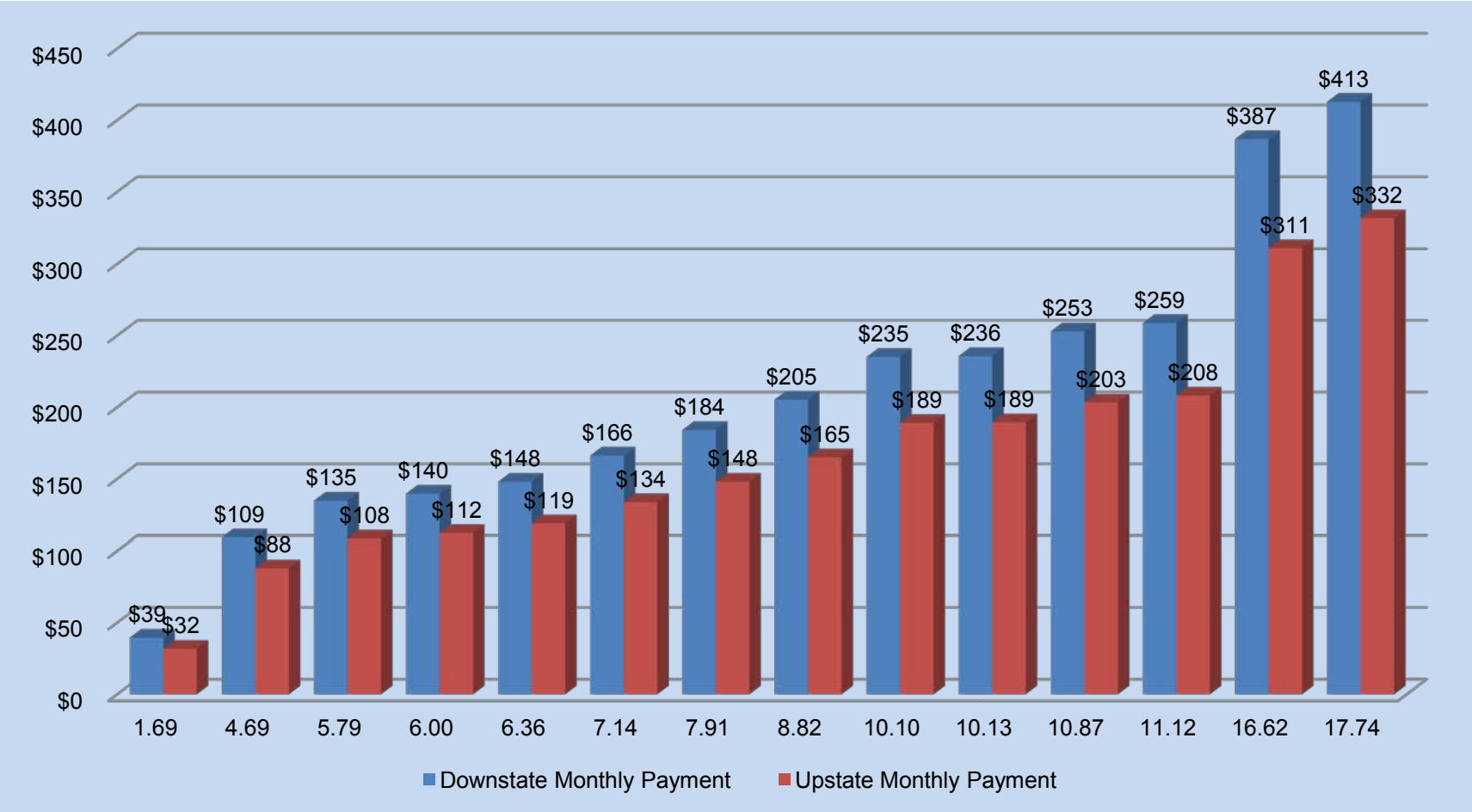
			Downstate			Upstate		
Base Health Status[1]	Severity of Illness	State-wide Average Case Manager Ratio [2]	Eligible Recip-ients[3]	Average CRG Acuity Score[4]	Average Monthly Payment[5]	Eligible Recip-ients[3]	Average CRG Acuity Score[4]	Average Monthly Payment[5]
Single SMI/SED	Low	79:1	50,346	6.3406	$148	25,182	6.3382	$119
	Mid	61:1	18,790	8.0873	$189	9,772	8.0239	$150
	High	12:1	260	16.5071	$385	60	16.6197	$312
Single SMI/SED Total		**73:1**	**69,396**	**6.8704**	**$160**	**35,014**	**6.8419**	**$128**
Pairs Chronic	Low	116:1	276,712	3.1258	$73	89,006	4.0091	$75
	Mid	76:1	103,983	6.4740	$151	36,731	7.0456	$132
	High	37:1	18,169	10.9285	$255	6,031	11.4136	$214
Pairs Chronic Total		**100:1**	**398,864**	**4.3631**	**$102**	**131,768**	**5.2032**	**$98**
Triples Chronic	Low	89:1	15,593	5.4311	$127	5,155	5.7358	$108
	Mid	62:1	21,559	7.9278	$185	7,608	8.2540	$155
	High	34:1	7,527	11.3893	$266	2,609	11.8749	$223
Triples Chronic Total		**65:1**	**44,679**	**7.6082**	**$177**	**15,372**	**8.0018**	**$150**
HIV/AIDS	Low	93:1	18,667	5.1243	$120	1,686	5.1243	$96
	Mid	51:1	19,157	9.2749	$216	2,215	9.0280	$169
	High	12:1	2,069	16.7259	$390	247	16.7148	$313
HIV/AIDS Total		**64:1**	**39,893**	**7.7507**	**$181**	**4,148**	**7.9328**	**$149**
Grand Total		**91:1**	**552,832**	**5.1654**	**$120**	**186,302**	**5.7903**	**$109**

Projected Health Home Payments

Projected Average Health Home Payments - Sample Populations

Patient #	Base Health Status	Dx Description	Severity of Illness	Acuity Score	Downstate Monthly Payment	Upstate Monthly Payment	Previous		
							Acuity Score	Downstate Monthly Payment	Upstate Monthly Payment
1	Pairs Chronic	Diabetes and Hypertension	Low	1.6947	$39	$32	0.8114	$17	$13
2	Pairs Chronic	Diabetes and Asthma	Low	4.6947	$109	$88	4.0729	$83	$67
3	Triples Chronic	Diabetes - Hypertension - Other Dominant Chronic Disease	Low	5.7894	$135	$108	5.3524	$110	$88
4	Triples Chronic	Congestive Heart Failure - Diabetes - Cerebrovascular Disease	Mid	6.0001	$140	$112	7.4909	$153	$123
5	Single SMI/SED	Conduct, Impulse Control, and Other Disruptive Behavior Disorders	Low	6.3574	$148	$119	5.6522	$116	$93
6	Pairs Chronic	Schizophrenia and Other Chronic Disease	Mid	7.1434	$166	$134	6.9474	$142	$114
7	Pairs Chronic	Asthma and Other Moderate Chronic Disease	Mid	7.1434	$166	$134	8.3686	$171	$138
8	Single SMI/SED	Schizophrenia	Mid	7.9093	$184	$148	7.9318	$163	$131
9	Pairs Chronic	Diabetes and Advanced Coronary Artery Disease	High	8.818	$205	$165	7.0289	$144	$116
10	HIV/AIDS	HIV Disease	Mid	10.0992	$235	$189	10.0992	$207	$166
11	Triples Chronic	Cystic Fibrosis	Low	10.1255	$236	$189	5.6337	$115	$93
12	Triples Chronic	Diabetes - 2 or More Other Dominant Chronic Diseases	High	10.8664	$253	$203	12.3349	$253	$203
13	Triples Chronic	Brain and Central Nervous System Malignancies	High	11.1186	$259	$208	21.1181	$433	$348
14	Triples Chronic	Non-Hodgkin's Lymphoma	High	11.1186	$259	$208	11.7499	$241	$194
15	Single SMI/SED	Schizophrenia	High	16.6197	$387	$311	16.6288	$341	$274
16	HIV/AIDS	HIV Disease	High	17.7378	$413	$332	17.7378	$363	$292

Sample Acuity Score/Payment Relationship



Billing and Payment - Claims

- Claims are submitted by, and monthly payments made to, health plans (MC) provider led Health Homes (FFS) and converting TCM programs (for both MC and FFS) through on-line electronic billing interface (eMedNY).
- Claims can only be submitted once per month and must be dated the first of the month.

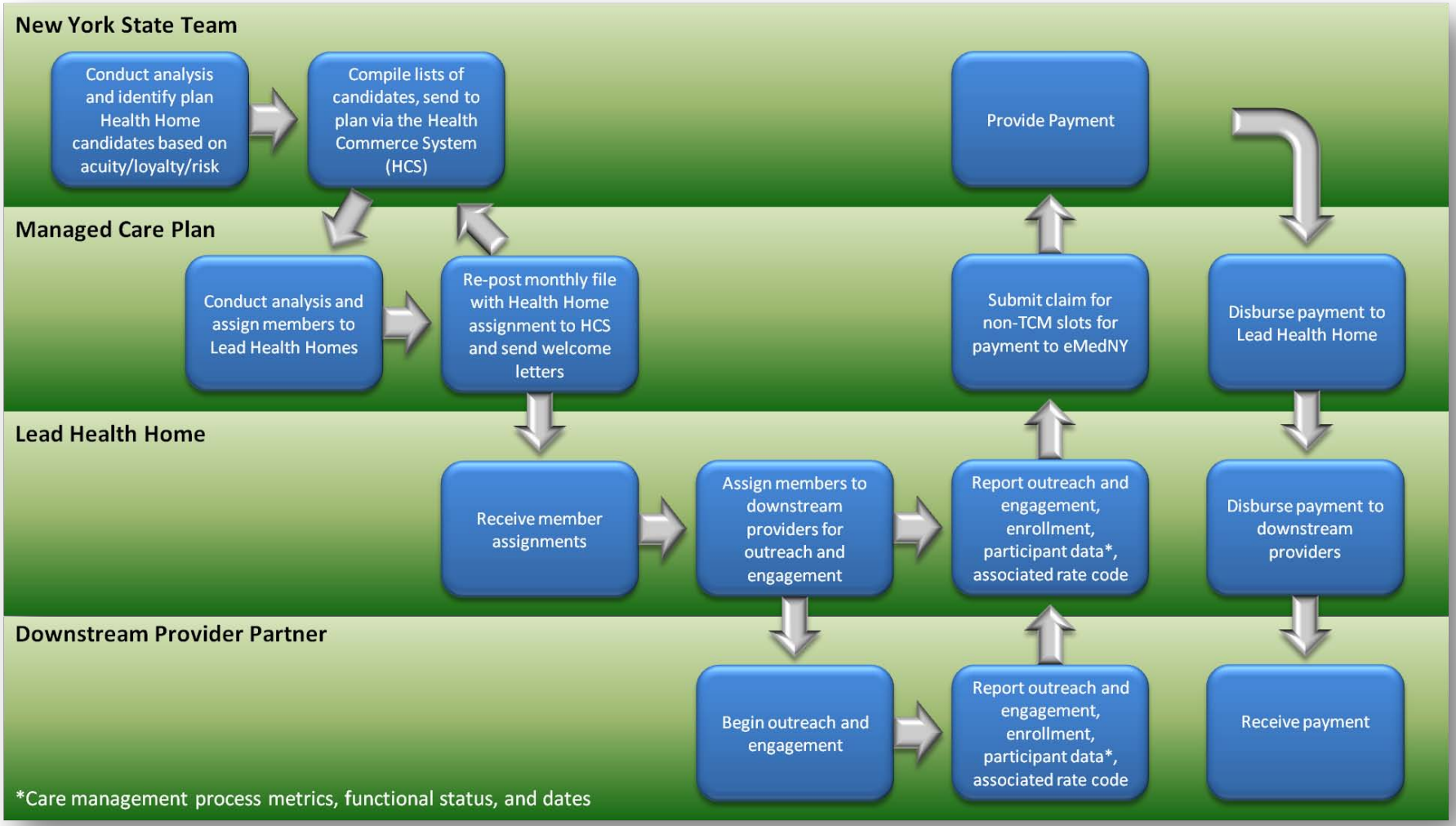
Billing and Payment - TCMs

- **TCM's have unique billing rules:**
  - *Existing case management slots, OMH-TCMs, HIV COBRA, CIDP and the MATS programs will convert to Health Home rates retroactive to January 1.*
  - *TCM's will bill at 100% of the Per Member Per Month (PMPM) for outreach and engagement and for enrollment.*
  - *TCM programs billing under their existing NPI must bill eMedNY directly for both MC and FFS participants, including their legacy TCM capacity and new Health Home capacity.*

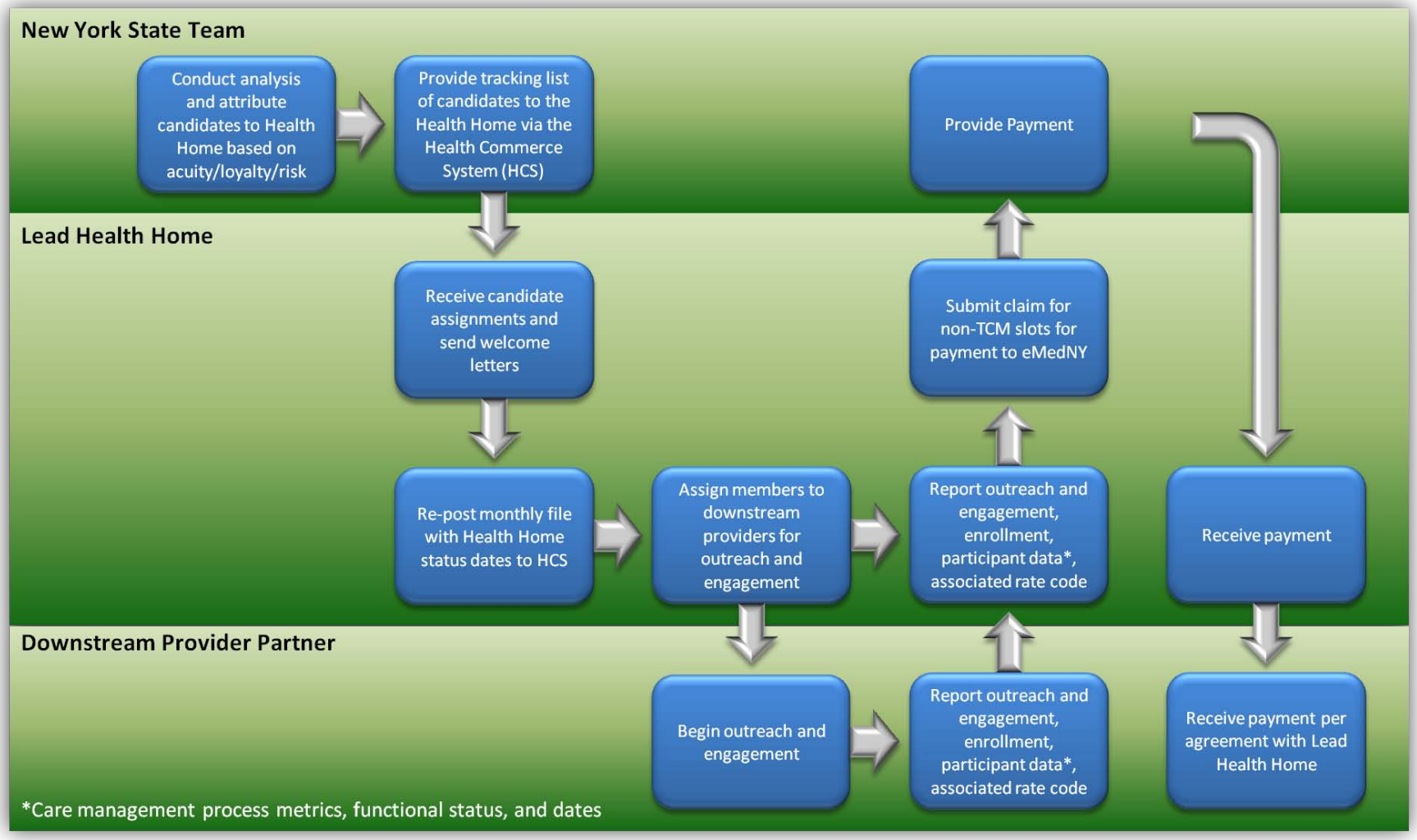
Minimum Billing Requirements

- Health Homes must provide at least one of the six core Health Home services per quarter. There will be no requirement for minimum face-to-face contacts, however, there must be active care management and evidence of activities that support billing, including:
  - *Contacts (face-to-face, mail, electronic, telephone)*
  - *Patient assessment*
  - *Development of a care management plan*
  - *Active progress towards achieving goals*

Health Home Assignments: Managed Care Workflow



Health Home Assignments: Fee-for-Service Workflow



Working with Managed Care Plans

- Managed Care Plans are working on contracts with provider led Health Homes to allow plans to assign their members into Health Homes, as appropriate.
- DOH is working with Health Homes on model clauses for contracts. See: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/tools_for_imlement.htm
- Managed Care member assignment into Phase 1 provider led Health Homes will likely commence in March 2012.

Working with Managed Care Plans

- **Provider-led Health Homes must work closely with Managed Care Plans to:**
  - *Coordinate care and services*
  - *Utilize the plan network, for in-plan benefits*
  - *Ensure prior authorization requirements are met*

Working with Managed Care Plans

- **Managed Care Plans must:**
  - *Assign members using the State algorithm and their own data (e.g., PCP assignment) to appropriate Health Homes and negotiate a viable case mix.*
  - *Reimburse Health Homes commensurate with the Health Home services being provided.*
  - *Act as State's partners in monitoring the quality of Health Homes.*
  - *Work with Health Homes that are not achieving quality goals and/or meeting the member's needs, to help them improve.*

Functional Assessment

- State is evaluating a functional self-assessment tool based on the FACIT-GP to evaluate each Health Home participant on a range of measures. Please see http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/forms/
- Validated tool administered face-to-face upon enrollment, annually thereafter and at discharge; results reported to the State
- Results of assessments used to adjust initial rates, which were based on calculated acuity and risk scores.

Additional Info

Visit the Health Home Website at:

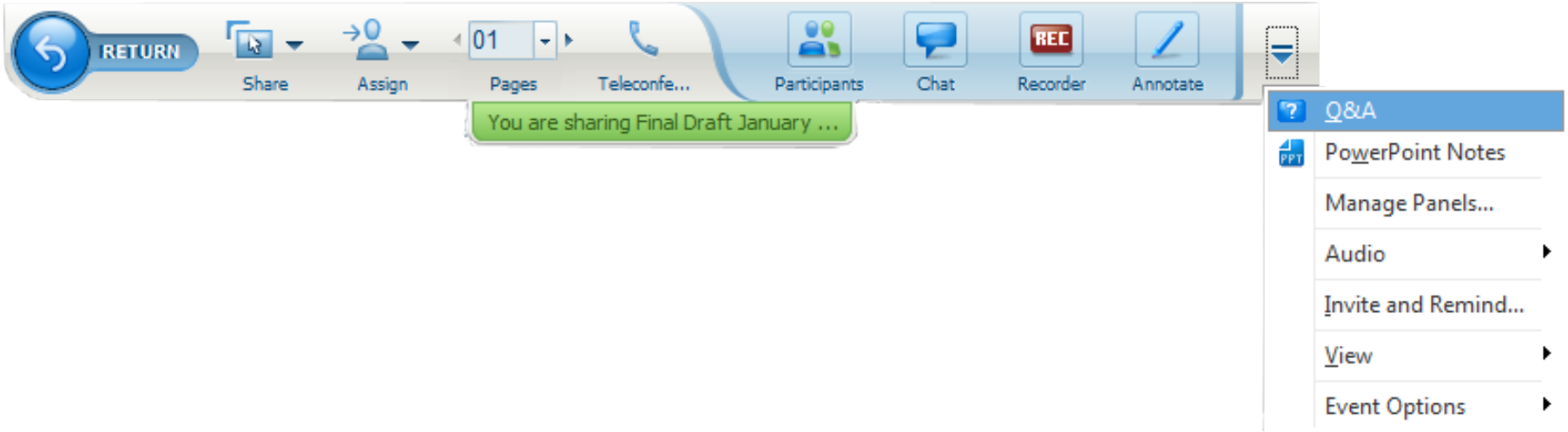
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes

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

Send an e-mail to the Health Homes Bureau Mail at: hh2011@health.state.ny.us

Questions?

To submit a question please click the question mark icon located in the toolbar at the top of your screen.

Your questions will be viewable only to CHCS staff and the panelists.

Answers to questions that cannot be addressed due to time constraints will be posted online after the webinar.