Id: NEW YORK
State: New York
Health Home Services

Effective Date-
July 1, 2012

SPA includes both
Categorically Needy and
Medically Needy
Beneficiaries- check box

3.1 - A: Categorically Needy View

Attachment 3.1-H
Page
Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Health Home Services

How are Health Home Services Provided to the Medically Needy?

New York's Medicaid program serves over 5 million enrollees with a broad array of health care needs and challenges. While many Medicaid enrollees are relatively healthy and access practitioners to obtain episodic and preventive health care, the Medicaid program also has several population groups who have complex medical, behavioral, and long term care needs that drive a high volume of high cost services including inpatient and long term institutional care.

Of the 5.4M Medicaid enrollees who access services on a fee for service or managed care basis, 975,000 (including dual eligibles) have been identified as high cost/high need enrollees with two or more chronic conditions and/or a Serious Persistent Mental Illness. These high cost/high need enrollees are categorized into four groups representing enrollees with intellectual disabilities, enrollees in need of long term care services, enrollees with behavioral health issues, and enrollees with two or more chronic medical conditions. One of NY's first health home initiatives will focus on enrollees with behavioral health and/or chronic medical conditions.

The NYS Medicaid program plans to certify health homes that build on current provider partnerships. Applicant health home providers will be required to meet State defined health home requirements that assure access to primary, specialty and behavioral health care that support the integration and coordination of all care. Recently passed New York State Law provides the Commissioners of Health, Mental Health, Alcoholism and Substance Abuse Services, and People with Developmental Disabilities the authority to integrate care delivery by synching health care, substance abuse services, and mental health certification requirements for health homes. Approved health homes will directly provide, or contract for, health home services to the identified eligible beneficiaries. To meet this goal, it is expected that health home providers will develop health home networks with primary, medical, specialty and mental health providers, substance abuse service providers, community based organizations, managed care plans and others to provide enrollees access to needed services.

Individuals eligible for health home services will be identified by the State. Individuals will be assigned to a health home provider based on existing relationships with health care providers or health care delivery system relationships, geography, and/or qualifying condition. Individuals will be enrolled into an appropriate health home and be given the option to choose another health home when available, or opt out of enrollment in a health home. Individuals

will be notified by U.S. mail of their health home enrollment. The notification letter will identify the assigned health home, describe the individual's option to select another health home or opt-out from receiving health home services with in a designated time period, and briefly describe health home services. The State will provide health home providers a roster of assigned enrollees and current demographic information to facilitate outreach and engagement.

To facilitate the use of health information technology by health homes to improve service delivery and coordination across the care continuum, NY has developed initial and final HIT standards for health homes that are consistent with NYS' Operational Plan for Health Information Technology and Exchange approved by CMS. Providers must meet initial HIT standards to implement a health home. Furthermore, applicants must provide a plan to achieve the final standards within eighteen months of program initiation in order to be approved as a health home provider.

To the extent possible health home providers will be encouraged to utilize regional health information organizations or qualified entities to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMs). Health home providers will be encouraged to utilize HIT as feasible to create, document, execute and update a plan of care that is accessible to the interdisciplinary team of providers for every patient. Health home providers will also be encouraged to utilize HIT as feasible to process and follow up on patient testing, treatments, community based services and provider referrals.

i. Geographic Limitations

If Targeted Geographic Basis:

New York Health Homes have been implemented under the approved SPA 11-56, with the effective date of 1/1/12 in the following counties:

Bronx, Brooklyn, Nassau, Warren, Washington, Essex, Hamilton, Clinton, Franklin and Schenectady

New York's Health Homes in Phase II will be implemented in the following counties with the approval of this SPA (12-10), with an effective date of 4/1/12.

Dutchess, Erie, Manhattan, Monroe, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, Westchester

New York's Health Homes will be implemented in Phase III in the following counties, with the approval of this SPA (12-11) with an effective date of July 1, 2012.

Albany, Alleghany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenago, Columbia, Cortland, Delaware, Fulton, Genesee, Greene, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Niagara, Ontario, Oneida, Onondaga, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Wayne, Wyoming, Yates

ii. Population Criteria

The State elects to offer Health Home Services to individuals with:

☑ Two chronic conditions

☑ One chronic condition (HIV/AIDS) - and the risk of developing another

☑ One serious mental illness

From the list of conditions below:

☑ Mental Health Condition

☑ Substance Use Disorder

☑ Asthma

☑ Diabetes

☑ Heart Disease

☑ BMI over 25

☑ Other Chronic Conditions

NY will target populations for health homes services in the major categories and the associated 3M™ Clinical Risk Group categories of chronic behavioral and medical conditions listed below.

Major Category: Alcohol and Substance Abuse

3M™ Clinical Risk Group (3M CRGs) Category

1. Alcohol Liver Disease
2. Chronic Alcohol Abuse
3. Cocaine Abuse
4. Drug Abuse – Cannabis/NOS/NEC
5. Substance Abuse
6. Opioid Abuse
7. Other Significant Drug Abuse

Major Category: Mental Health

3M™ Clinical Risk Group (3M CRGs) Category

1. Bi-Polar Disorder
2. Conduct, Impulse Control, and Other Disruptive Behavior Disorders
3. Dementing Disease
4. Depressive and Other Psychoses
5. Eating Disorder
6. Major Personality Disorders
7. Psychiatric Disease (Except Schizophrenia)
8. Schizophrenia

Major Category: Cardiovascular Disease

3M™ Clinical Risk Group (3M CRGs) Category

1. Advanced Coronary Artery Disease
2. Cerebrovascular Disease
3. Congestive Heart Failure
4. Hypertension
5. Peripheral Vascular Disease

Major Category: HIV/AIDS

3M™ Clinical Risk Group (3M CRGs) Category

1. HIV Disease

Major Category: Metabolic Disease
3M™ Clinical Risk Group (3M CRGs) Category
1. Chronic Renal Failure
2. Diabetes

Major Category: Respiratory Disease
3M™ Clinical Risk Group (3M CRGs) Category
1. Asthma
2. Chronic Obstructive Pulmonary Disease

Major Category: Other
3M™ Clinical Risk Group (3M CRGs) Category
1. Other Chronic Disease- conditions listed above as well as other specific diagnoses of the population.

Health Home services in New York will be available to all categorically eligible Medicaid recipients, including children, dual eligibles, and waiver participants.

Health Home services in New York are currently available and will continue to be available to all categorically eligible Medicaid recipients, including children, dual eligibles, and waiver participants. New York State is prioritizing list assignment for recipients who meet Health Home criteria and do not currently have access to equivalent care management services and those who are part of a care management program which is converting to a Health Home services. Eligible members who are not list assigned may still access Health Home services. Health Homes are designated by New York State to serve populations based on a review of their qualifications, experience and an evaluation of their provider networks.

New York's Health Home priority list assignment and start date for Health Home services is as follows:

1. Mental Health/Substance Abuse and Other Chronic Medical Conditions Population
   - Adults (including Duals) January 2012 for Phase I
   - Adults July 2012 for Phase II
   - Adults July 2012 for Phase III
   - Duals January 2013 for Phases II and III.
   - Children Spring 2013.

2. Long Term Care and Developmental Disabilities Population
   - Fall 2013.

Description of population selection criteria

The target population to receive health home services under this amendment includes categorically needy and medically needy beneficiaries served by Medicaid managed care or fee for service and Medicare/Medicaid dual eligible beneficiaries who meet health home selection criteria. NY will offer Health Home Services to individuals with two or more chronic conditions, individuals with HIV/AIDS who are at risk for developing another chronic condition and to those individuals with one serious mental illness.

Enrollees in the behavioral health category have been identified through claims and encounter data analysis as having received mental health or substance abuse services and/or having select mental health diagnoses. These enrollees often have co-morbid chronic, medical conditions. In addition, based on experience in working with this population, many of these enrollees have social issues, such as lack of permanent housing, that take priority to these individuals over their health care conditions. Enrollees in the chronic medical condition

category have been identified through claims and encounter data analysis as having two or three chronic medical conditions.

iii. Provider Infrastructure

☑ Designated Providers as described in §Section 1945(h)(5)

New York's health home provider infrastructure will include designated providers working with multidisciplinary teams as described below. NYS Medicaid providers eligible to become health homes include managed care plans; hospitals; medical, mental and chemical dependency treatment clinics; primary care practitioner practices; PCMHs; FQHCs; Targeted Case Management (TCM) providers; certified home health care agencies and any other Medicaid enrolled provider that meet health home provider standards. To assure that NY health homes meet the proposed federal health home model of service delivery and NYS standards, health home provider qualification standards were developed. The standards were developed with input from a variety of stakeholders including hospitals, clinics, physicians, mental health experts, chemical dependency treatment experts and housing providers. Representatives from the Department of Health's Offices of Health Systems Management, Health IT Transformation, and the AIDS Institute and the NYS Offices of Mental Health and Alcoholism and Substance Abuse Services also participated in the development of these standards. The standards set the ground work for assuring that health home enrollees will receive appropriate, and timely access to medical, behavioral, and social services in a coordinated and integrated manner.

NY health homes will use multidisciplinary teams of medical, mental health, chemical dependency treatment providers, social workers, nurses and other care providers led by a dedicated care manager who will assure that enrollees receive needed medical, behavioral, and social services in accordance with a single plan of care. Optional team members may include nutritionists/dieticians, pharmacists, outreach workers including peer specialists and other representatives as appropriate to meet the enrollee needs (housing representatives, entitlement, employment). All members of the team will be responsible for reporting back to the care manager on patient status, treatment options, actions taken and outcomes as a result of those interventions. All members of the team will also be responsible for ensuring that care is person-centered, culturally competent and linguistically capable.

A single care management record will be agreed to and shared by all team professionals and case reviews will be conducted on a regular basis. The care manager will be responsible for overall management and coordination of the enrollee's care plan which will include both medical/behavioral health and social service needs and goals.

In order to ensure the delivery of quality health home services, the State will provide educational opportunities for health home providers, such as webinars, regional meetings and/ or learning collaboratives to foster shared learning, information sharing and problem solving. Educational opportunities will be provided to support the provision of timely, comprehensive, high-quality health homes services that are whole person focused and that integrate medical, behavioral health and other needed supports and social services. The State will maintain a highly collaborative and coordinated working relationship with individual health home providers through frequent communication and feedback. Learning activities and technical assistance will also support providers of health home services to address the following health home functional components:

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
4. Coordinate and provide access to mental health and substance abuse services;

5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
8. Coordinate and provide access to long-term care supports and services;
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

The Department of Health in partnership with the Office of Mental Health and the Office of Alcoholism and Substance Abuse Services will closely monitor health home providers to ensure that health home services are being provided that meet the NYS health home provider standards and CMS' health home core functional requirements. Oversight activities will include, but not be limited to: medical chart and care management record review, site audits, team composition analysis, and review of types and number of contacts, etc.

☐ Team of Health Care Professionals as described in §section 1945(h)(6)

☐ Health Team as described in §section 1945(h)(7), via reference to §section 3502

iv. Service Definitions

Comprehensive Care Management
Service Definition

A comprehensive individualized patient centered care plan will be required for all health home enrollees. The care plan will be developed based on the information obtained from a comprehensive health risk assessment used to identify the enrollee's physical, mental health, chemical dependency and social service needs. The individualized care plan will be required to include and integrate the individual's medical and behavioral health services, rehabilitative, long term care, social service needs, as applicable. The care plan will be required to clearly identify the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager and other providers directly involved in the individual's care. The individual's plan of care must also identify community networks and supports that will be utilized to address their needs. Goals and timeframes for improving the patient's health, their overall health care status and the interventions that will produce this effect must also be included in the plan of care.

The care manager will be required to make sure that the individual (or their guardian) plays a central and active part in the development and execution of their plan of care, and that they are in agreement with the goals, interventions and time frames contained in the plan. Family members and other supports involved in the patient's care should be identified and included in the plan and execution of care as requested by the individual.

The care plan must also include outreach and engagement activities which will support engaging the patient in their own care and promote continuity of care. In addition, the plan of care will include periodic reassessment of the individual's needs and goals and clearly identify

the patient's progress in meeting goals. Changes in the plan of care will be made based on changes in patient need.

Ways Health IT Will Link

To facilitate the use of health information technology by health homes to improve service delivery and coordination across the care continuum, NY has developed initial and final HIT standards. Providers must meet the initial HIT standard to implement a health home, as feasible. NY anticipates that a portion of health home providers may not utilize HIT in their current programs. These providers will be encouraged to utilize regional health information organizations (RHIOs) or a qualified entity to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMs). Applicants must provide a plan in order to achieve the final HIT standards within eighteen months of program initiation in order to be approved as a health home provider. Health home providers will be encouraged to utilize HIT as feasible to create, document and execute and update a plan of care for every patient that is accessible to the interdisciplinary team of providers. Health home providers will also be encouraged to utilize HIT as feasible to process and follow up on patient testing, treatments, services and referrals.

Care Coordination
Service Definition

The health home provider will be accountable for engaging and retaining health home enrollees in care, as well as coordinating and arranging for the provision of services, supporting adherence to treatment recommendations, and monitoring and evaluating the enrollee's needs. The individualized plan of care will identify all the services necessary to meet goals needed for care management of the enrollee such as prevention, wellness, medical treatment by specialists and behavioral health providers, transition of care from provider to provider, and social and community services where appropriate.

In order to fulfill the care coordination requirements, the health home provider will assign each individual enrollee one dedicated care manager who is responsible for overall management of the enrollee's plan of care. The enrollee's health home care manager will be clearly identified in the patient record and will have overall responsibility and accountability for coordinating all aspects of the individual's care. The health home provider will be responsible to assure that communication will be fostered between the dedicated care manager and treating clinicians to discuss as needed enrollee's care needs, conflicting treatments, change in condition, etc. which may necessitate treatment change (i.e., written orders and/or prescriptions).

The health home provider will be required to develop and have policies, procedures and accountabilities (contractual agreements) in place, to support and define the roles and responsibilities for effective collaboration between primary care, specialist, behavioral health providers and community-based organizations. The health home providers policies and procedures will direct and incorporate successful collaboration through use of evidence-based referrals, follow-up consultations, and regular, scheduled case review meetings with all members of the interdisciplinary team. The health home provider will have the option of utilizing technology conferencing tools including audio, video and /or web deployed solutions when security protocols and precautions are in place to protect PHI to support care management/coordination activities.

The health home provider will be required to develop and utilize a system to track and share patient information and care needs across providers, monitor patient outcomes, and initiate changes in care as necessary to address patient need.

Ways Health IT Will Link

Health home providers will be encouraged to utilize RHIOs or a qualified entity to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMs). Health home providers will utilize HIT as feasible to create, document and execute and update a plan of care for every patient that is accessible to the interdisciplinary team of providers. Health home providers will also be encouraged to utilize HIT as feasible to monitor patient outcomes, initiate changes in care and follow up on patient testing, treatments, services and referrals.

Health Promotion
Service Definition

Health promotion begins for eligible health home enrollees with the commencement of outreach and engagement activities. NYS' health home plan for outreach and engagement will require a health home provider to actively seek to engage patients in care by phone, letter, HIT and community "in reach" and outreach. Each of these outreach and engagement functions will all include aspects of comprehensive care management, care coordination, and referral to community and social support services. All of the activities are built around the notion of linkages to care that address all of the clinical and non-clinical care needs of an individual and health promotion. The health home provider will support continuity of care and health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers. The health home provider will promote evidence based wellness and prevention by linking health home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self- help recovery resources, and other services based on individual needs and preferences. Health promotion activities will be utilized to promote patient education and self management of their chronic condition.

Ways Health IT Will Link

Health home providers will be encouraged to utilize RHIOs or a qualified entity to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMs). The health home providers will utilize HIT as feasible to promote, link, manage and follow up on enrollee health promotion activities.

Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)
Service Definition

Comprehensive transitional care will be provided to prevent enrollee avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing or treatment facility) and to ensure proper and timely follow up care. To accomplish this, the health home provider will be required to develop and have a system in place with hospitals and residential/rehabilitation facilities in their network to provide the health home care manager prompt notification of an enrollee's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.

The health home provider will also have policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings, providers and community-based services to ensure coordinated, and safe transition in care for its patients who require transfer to/from sites of care.

The health home provider will be required to develop and have a systematic follow-up protocol in place to assure timely access to follow-up care post discharge that includes at a minimum receipt of a summary care record from the discharging entity, medication reconciliation, and a plan for timely scheduled appointments at recommended outpatient providers.

The health home care manager will be an active participant in all phases of care transition: including: discharge planning and follow-up to assure that enrollees received follow up care and services and re-engagement of patients who have become lost to care.

Ways Health IT Will Link

Health home providers will be encouraged to utilize RHIOs or a qualified entity to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMs). The health home provider will utilize HIT as feasible to communicate with health facilities and to facilitate interdisciplinary collaboration among all providers, the patient, family, care givers and local supports.

Individual and Family Support Services (including authorized representatives)
Service Definition

The patient's individualized plan of care will reflect and incorporate the patient and family or caregiver preferences, education and support for self-management; self help recovery, and other resources as appropriate. The provider will share and make assessable to the enrollee, their families or other caregivers (based on the individual's preferences), the individualized plan of care by presenting options for accessing the enrollee's clinical information.

Peer supports, support groups, and self-care programs will be utilized by the health home provider to increase patients' and caregivers knowledge about the individual's disease(s), promote the enrollee's engagement and self management capabilities, and help the enrollee improve adherence to their prescribed treatment. The provider will discuss and provide the enrollee, the enrollee's family and care givers, information on advance directives in order to allow them to make informed end-of-life decisions ahead of time.

The health home provider will ensure that all communication and information shared with the enrollee, the enrollee's family and caregivers is language, literacy and culturally appropriate so it can be understood.

Ways Health IT Will Link

Health home providers will be encouraged to utilize RHIOs or a qualified entity to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMs). The health home provider will utilize HIT as feasible to provide the patient access to care plans and options for accessing clinical information.

Referral to Community and Social Support Services
Service Definition

The health home provider will identify available community-based resources and actively manage appropriate referrals, access to care, engagement with other community and social supports, coordinate services and follow-up post engagement with services. To accomplish this, the health home provider will develop policies, procedures and accountabilities (through contractual agreements) to support effective collaboration with community-based resources, that clearly define the roles and responsibilities of the participants.

The plan of care will include community-based and other social support services, appropriate and ancillary healthcare services that address and respond to the patient's needs and preferences, and contribute to achieving the patient's goals.

Ways Health IT Will Link

Health home providers will be encouraged to utilize RHIOs or a qualified entity to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e.

hospitals, TCMs). The health home providers will utilize HIT as feasible to initiate, manage and follow up on community-based and other social service referrals.

v. Provider Standards

Under New York State's approach to health home implementation, a health home provider is the central point for directing patient-centered care and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual arrangements with appropriate service providers, of comprehensive, integrated services.

General Qualifications

1. Health home providers/plans must be enrolled (or be eligible for enrollment) in the NYS Medicaid program and agree to comply with all Medicaid program requirements.

2. Health home providers can either directly provide, or subcontract for the provision of, health home services. The health home provider remains responsible for all health home program requirements, including services performed by the subcontractor.

3. Care coordination and integration of health care services will be provided to all health home enrollees by an interdisciplinary team of providers, where each individual's care is under the direction of a dedicated care manager who is accountable for assuring access to medical and behavioral health care services and community social supports as defined in the enrollee care plan.

4. Hospitals that are part of a health home network must have procedures in place for referring any eligible individual with chronic conditions who seek or need treatment in a hospital emergency department to a DOH designated health home provider.

5. Health home providers must demonstrate their ability to perform each of the eleven CMS health home core functional components. (Refer to section iii. Provider Infrastructure) Including:
    i. processes used to perform these functions;
    ii. processes and timeframes used to assure service delivery takes place in the described manner; and
    iii. description of multifaceted health home service interventions that will be provided to promote patient engagement, participation in their plan of care and that ensures patients appropriate access to the continuum of physical and behavioral health care and social services.

6. Health home providers must meet the following core health home requirements in the manner described below. Health home providers must provide written documentation that clearly demonstrates how the requirements are being met.

* Please note whenever the individual/ patient /enrollee is stated when applicable, the term is interchangeable with guardian.

I. Comprehensive Care Management

Policies and procedures are in place to create, document, execute and update an individualized, patient centered plan of care for each individual.
1a. A comprehensive health assessment that identifies medical, mental health, chemical dependency and social service needs is developed.
1b. The individual's plan of care integrates the continuum of medical, behavioral health services, rehabilitative, long term care and social service needs and clearly

identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager and other providers directly involved in the individual's care.
1c.The individual (or their guardian) play a central and active role in the development and execution of their plan of care and should agree with the goals, interventions and time frames contained in the plan.
1d. The individual's plan of care clearly identifies primary, specialty, behavioral health and community networks and supports that address their needs.
1e. The individual's plan of care clearly identifies family members and other supports involved in the patient's care. Family and other supports are included in the plan and execution of care as requested by the individual.
1f. The individual's plan of care clearly identifies goals and timeframes for improving the patient's health and health care status and the interventions that will produce this effect.
1g. The individual's plan of care must included outreach and engagement activities that will support engaging patients in care and promoting continuity of care.
1h. The individual's plan of care includes periodic reassessment of the individual needs and clearly identifies the patient's progress in meeting goals and changes in the plan of care based on changes in patient's need.

II. Care Coordination and Health Promotion

2a. The health home provider is accountable for engaging and retaining health home enrollees in care; coordinating and arranging for the provision of services; supporting adherence to treatment recommendations; and monitoring and evaluating a patient's needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services where appropriate through the creation of an individual plan of care.
2b. The health home provider will assign each individual a dedicated care manager who is responsible for overall management of the patient's care plan. The health home care manager is clearly identified in the patient record. Each individual enrolled with a health home will have one dedicated care manager who has overall responsibility and accountability for coordinating all aspects of the individual's care. The individual cannot be enrolled in more than one care management program funded by the Medicaid program.
2c. The health home provider must describe the relationship and communication between the dedicated care manager and the treating clinicians that assure that the care manager can discuss with clinicians on an as needed basis, changes in patient condition that may necessitate treatment change (i.e., written orders and/or prescriptions).
2d. The health home provider must define how patient care will be directed when conflicting treatment is being provided.
2e. The health home provider has policies, procedures and accountabilities (contractual agreements) to support effective collaborations between primary care, specialist and behavioral health providers, evidence-based referrals and follow-up and consultations that clearly define roles and responsibilities.
2f. The health home provider supports continuity of care and health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers.
2g. The health home provider supports care coordination and facilitates collaboration through the establishment of regular case review meetings, including all members of the interdisciplinary team on a schedule determined by the health home provider. The health home provider has the option of utilizing technology conferencing tools including audio, video and /or web deployed solutions when security protocols and precautions are in place to protect PHI.
2h. The health home provider ensures 24 hours/seven days a week availability to a care manager to provide information and emergency consultation services.

2i. The health home provider will ensure the availability of priority appointments for health home enrollees to medical and behavioral health care services within their health home provider network to avoid unnecessary, inappropriate utilization of emergency room and inpatient hospital services.
2j. The health home provider promotes evidence based wellness and prevention by linking health home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self help recovery resources, and other services based on individual needs and preferences.
2k. The health home provider has a system to track and share patient information and care needs across providers and to monitor patient outcomes and initiate changes in care, as necessary, to address patient need.

III. Comprehensive Transitional Care

3a. The health home provider has a system in place with hospitals and residential/rehabilitation facilities in their network to provide the health home prompt notification of an individual's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.
3b. The health home provider has policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings, providers and community-based services to help ensure coordinated, safe transitions in care for its patients who require transfers in the site of care.
3c. The health home provider utilizes HIT as feasible to facilitate interdisciplinary collaboration among all providers, the patient, family, care givers, and local supports.
3d. The health home provider has a systematic follow-up protocol in place to assure timely access to follow-up care post discharge that includes at a minimum receipt of a summary care record from the discharging entity, medication reconciliation, timely scheduled appointments at recommended outpatient providers, care manager verification with outpatient provider that the patient attended the appointment, and a plan to outreach and re-engage the patient in care if the appointment was missed.

IV. Patient and Family Support

4a. Patient's individualized plan of care reflects patient and family or caregiver preferences, education and support for self-management; self help recovery, and other resources as appropriate.
4b. Patient's individualized plan of care is accessible to the individual and their families or other caregivers based on the individual's preference.
4c. The health home provider utilizes peer supports, support groups and self-care programs to increase patients' knowledge about their disease, engagement and self management capabilities, and to improve adherence to prescribed treatment.
4d. The health home provider discusses advance directives with enrollees and their families or caregivers.
4e. The health home provider communicates and shares information with individuals and their families and other caregivers with appropriate consideration for language, literacy and cultural preferences.
4f. The health home provider gives the patient access to care plans and options for accessing clinical information.

V. Referral to Community and Social Support Services

5a. The health home provider identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.
5b. The health home provider has policies, procedures and accountabilities (contractual agreements) to support effective collaborations with community-based resources, which clearly define roles and responsibilities.

5c. The plan of care should include community-based and other social support services as well as healthcare services that respond to the patient's needs and preferences and contribute to achieving the patient's goals.

VI. Use of Health Information Technology to Link Services

Health home providers will make use of available HIT and accesses data through the regional health information organization (RHIOs)/Qualified Entities (QE) to conduct these processes as feasible, to comply with the initial standards cited in items 6a.-6d for implementation of health homes. In order to be approved as health home provider, applicants must provide a plan to achieve the final standards cited in items 6e.-6i. within eighteen (18) months of program initiation.

Initial Standards

6a. Health home provider has structured information systems, policies, procedures and practices to create, document, execute, and update a plan of care for every patient.

6b. Health home provider has a systematic process to follow-up on tests, treatments, services and, and referrals which is incorporated into the patient's plan of care.

6c. Health home provider has a health record system which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers and which allows for population management and identification of gaps in care including preventive services.

6d. Health home provider makes use of available HIT and accesses data through the RHIO/QE to conduct these processes, as feasible.

Final Standards

6e. Health home provider has structured interoperable health information technology systems, policies, procedures and practices to support the creation, documentation, execution, and ongoing management of a plan of care for every patient.

6f. Health home provider uses an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers. If the provider does not currently have such a system, they will provide a plan for when and how they will implement it.

6g. Health home provider will be required to comply with the current and future version of the Statewide Policy Guidance (http://health.ny.gov/technology/statewide_policy_guidance.htm) which includes common information policies, standards and technical approaches governing health information exchange.

6h. Health home provider commits to joining regional health information networks or qualified health IT entities for data exchange and includes a commitment to share information with all providers participating in a care plan. RHIOs/QE provides policy and technical services required for health information exchange through the Statewide Health Information Network of New York (SHIN-NY).

6i. Health home provider supports the use of evidence based clinical decision making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance. One example of such a tool is PSYCKES.

VII. Quality Measures Reporting to State

7a. The health home provider has the capability of sharing information with other providers and collecting and reporting specific quality measures as required by NYS and CMS.

7b. The health home provider is accountable for reducing avoidable health care costs specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes as measured by NYS and CMS required quality measures.

vi. Assurances

☐ ☑ A. The State assures that hospitals participating under the State plan or a waiver of such plan will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

☐ ☑B. The State has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

☐ ☑C. The State will report to CMS information submitted by health home providers to inform the evaluation and Reports to Congress as described in section 2703(b) of the Affordable Care Act, and as described by CMS.

vii. Monitoring

A. Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications.

NYS has been monitoring avoidable hospital readmissions since 2009, using 3M software called Potentially Preventable Readmissions (PPRs). This software incorporates clinical judgment to determine if the original admission and subsequent readmissions are clinically related. NYS calculates PPRs for all of Medicaid including fee for service and managed care. Using health home rosters, rates of PPRs can be calculated for health home participants as well as comparison groups.

B. Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications.

NYS will monitor cost savings from health homes through measures of preventable events, including PPRs, potentially preventable hospital admissions and potentially avoidable ER visits. These metrics are the same metrics for evaluation in section IX. Measures of preventable hospitalizations and avoidable ER will be calculated for the entire Medicaid program. Similar to Section VII, A, NYS will use health home rosters to calculate potential cost savings for enrollees in health homes.

NYS will also compare total costs of care for enrollees in health homes, including all services costs, health home costs and managed care capitation to similar cohorts that are not receiving health home services.

C. Describe the State's proposal for using health information technology in providing health home services under this program and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

To facilitate the use of health information technology by health homes to improve service delivery and coordination across the care continuum, NY has developed initial and final HIT standards. Providers must meet the initial HIT standard to implement a health home. In addition, provider applicant must provide a plan in to achieve the final standards within eighteen months of program initiation in order to be approved as a health home provider.

The initial standards require health home providers to make use of available HIT for the following processes, as feasible:

1. Have a structured information systems, policies, procedures and practices to create, document, execute, and update a plan of care for every patient;

2. Have a systematic process to follow-up on tests, treatments, services and, and referrals which is incorporated into the patient's plan of care;
3. Have a health record system which allows the patient health information and plan of care to be accessible to the interdisciplinary team of providers and allow for population management and identification of gaps in care including preventive services; and
4. Is required to make use of available HIT and access members' data through the RHIO or QE to conduct all processes, as feasible.

The final standards require health home provider to use HIT for the following:

1. Have structured interoperable health information technology systems, policies, procedures and practices to support the creation, documentation, execution, and ongoing management of a plan of care for every patient;
2. Utilize an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act that allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers. If the provider does not currently have such a system, they will have to provide a plan for when and how they will implement it. Health home providers will comply with all current and future versions of the Statewide Policy Guidance (http://health.ny.gov/technology/statewide_policy_guidance.htm) which includes common information policies, standards and technical approaches governing health information exchange;
3. Join regional health information networks or qualified health IT entities for data exchange and make a commitment to share information with all providers participating in a care plan. Regional Health Information Organization /Qualified Entities will be provided policy and technical services required for health information exchange through the Statewide Health Information Network of New York (SHIN-NY); and
4. Support the use of evidence based clinical decision making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance. For example, in New York the Office of Mental Health has a web and evidence based practices system, known as Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES), which utilizes informatics to improve the quality of care, accountability, and cost-effectiveness of mental health prescribing practices in psychiatric centers.

   NY health home providers will be encouraged to use wireless technology as available to improve coordination and management of care and patient adherence to recommendations made by their provider. This may include the use of cell phones, peripheral monitoring devices, and access patient care management records, as feasible.

   To facilitate state reporting requirements to CMS, NY is working toward the development of a single portal to be used by health homes for submission of functional assessment and quality measure reporting to the State. Consideration is being given to also include a care management record, also accessed via the portal as an option for health home providers who currently do not have an electronic care management record system.

   Significant investment has been made in New York's Health Information Infrastructure to ensure that medical information is in the hands of clinicians and New Yorkers to guide medical decisions and supports the delivery of coordinated, preventive, patient-centered and high quality care. Ongoing statewide evaluation designed to evaluate the impact of HIT on quality and outcomes of care is underway by the Office of Health Information Technology and Transformation.

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

viii. Quality Measures: Goal based Quality Measures

A. Goal 1: Reduce utilization associated with avoidable (preventable) inpatient stays

1. Clinical Outcomes-

Measures	Data Source	Specifications	HIT Utilization
Inpatient Utilization – General hospital/Acute Care	Claims	(HEDIS 2012 – Use of Services) The rate of utilization of acute inpatient care per 1,000 member months. Data is reported by age for categories: Medicine, Surgery, Maternity and Total Inpatient.	Inpatient stays will be identified from administrative claims. Results of aggregated rates will be shared with health homes including their results and benchmarking to the overall peer results.

2. Experience of Care

Measures	Data Source	Specifications	HIT Utilization
NA	NA	NA	NA

3. Quality of Care-

Measures	Data Source	Specifications	HIT Utilization
NA	NA	NA	NA

B. Goal 2: Reduce utilization associated with avoidable (preventable) emergency room visits

1. Clinical Outcomes

Measures	Data Source	Specifications	HIT Utilization
Ambulatory Care (ED Visits)	Claims	(HEDIS 2012 – Use of Services) The rate of ED visits per 1,000 member months. Data is reported by age categories.	Emergency Department visits will be identified from administrative claims. Results of aggregated rates will be shared with health homes including their results and benchmarking to the overall peer results.

2. **Experience of Care**

Measures	Data Source	Specifications	HIT Utilization
NA	NA	NA	NA

3. Quality of Care

Measures	Data Source	Specifications	HIT Utilization
NA	NA	NA	NA

C. Goal 3: Improve Outcomes for persons with Mental Illness and/or Substance Use Disorders

1. Clinical Outcomes

Measures	Data Source	Specifications	HIT Utilization
Mental Health Utilization	Claims	(HEDIS 2012 – Use of Services) The number and percentage of members receiving the following mental health services during the measurement year. • Any service • Inpatient • Intensive outpatient or partial hospitalization • Outpatient or ED	Mental health services will be identified by data analysis of administrative claims. Results of aggregated rates will be shared with health homes including their results and benchmarking to the overall peer results.
Follow Up After Hospitalization for Mental Illness	Claims	(HEDIS 2012 - Effectiveness of Care) Percentage of discharges for treatment of selected mental illness disorders who had an outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health provider within 7 days and within 30 days of discharge. In addition, 'retention' in services, defined as at least five qualifying visits (see above) with mental health providers within 90 days of discharge.	The transition of care HEDIS indicator is developed from treatment guidelines. The State's Office of Mental Health added quantification standards for retention to capture quality of ongoing care for a persistently severe mentally ill population targeted by NYS SPA for Health Home. The follow up visits will be identified from vendor data and claims. We will use data analytics to aggregate results by health home and compare to peers.
Follow up After Hospitalization for Alcohol and Chemical Dependency Detoxification	Claims	(New York State Specific) The percentage of discharges for specified alcohol and chemical dependency conditions that are followed up with visits with chemical treatment and other qualified providers within 7 days and within 30 days and who have ongoing visits within 90 days of the discharges.	The transition of care is patterned after the HEDIS indicator for mental health. The State's Office of Alcohol and Substance Abuse Services added quantification standards for retention to capture quality of ongoing care for a chemically dependent population targeted By NYS SPA for Health Home. The follow up visits will be identified from vendor data and claims. We will use data analytics to aggregate results by health home and compare to peers.

2. Experience of Care

Measures	Data Source	Specifications	HIT Utilization
NA	NA	NA	NA

3. Quality of Care

Measures	Data Source	Specifications	HIT Utilization
Antidepressant	Claims and	(HEDIS 2012 - Effectiveness of	The medication adherence HEDIS

Medication Management	Pharmacy	Care) Percentage of members who had a new diagnosis of depression and treated with an antidepressant medication who remained on the antidepressant for acute phase and recovery phase of treatment.	indicators are developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Follow Up Care for Children Prescribed ADHD Medication	Claims and Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of children newly prescribed ADHD medication who had appropriate follow up in the initial 30 days and in the continuation and maintenance phase.	The medication adherence HEDIS indicators are developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Adherence to Antipsychotics for Individuals with Schizophrenia	Claims and Pharmacy	(RAND section 2701 ACA proposed measure) Percentage of patients with a schizophrenia diagnosis who received an antipsychotic medication that had a proportion of days covered (PDC) for antipsychotic medication ≥0.8 during the measurement period.	This medication adherence indicator is based on the RAND measure and includes advice from the State's mental health agency to better reflect the standards of quality of care for a persistently severe mentally ill population targeted for Health Home. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	Claims and Pharmacy	(RAND section 2701 ACA proposed measure) Percentage of patients with bipolar I disorder who received a mood stabilizer medication that had a proportion of days covered (PDC) for mood stabilizer medication ≥0.8 during the measurement period.	This medication adherence indicator is based on the RAND measure and includes advice from the State's mental health agency to better reflect the standards of quality of care for a persistently severe mentally ill population targeted for Health Home. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.

D. Goal 4: Improve Disease-Related Care for Chronic Conditions

1. Clinical Outcomes

Measures	Data Source	Specifications	HIT Utilization
NA	NA	NA	NA

2. Experience of Care

Measures	Data Source	Specifications	HIT Utilization
NA	NA	NA	NA

3. Quality of Care

Measures	Data Source	Specifications	HIT Utilization
Use of Appropriate	Claims and Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of members	The medication adherence HEDIS indicator is developed from

Medications for People with Asthma		who are identified with persistent asthma and who were appropriately prescribed preferred asthma medication.	treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Medication Management for People With Asthma	Claims and Pharmacy	(HEDIS 2012 – Effectiveness of Care) The percentage of members who were identified as having persistent asthma and were dispensed appropriate medications in amounts to cover: 1) at least 50% of their treatment period and 2) at least 75% of their treatment period.	The medication adherence HEDIS indicator is developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Comprehensive Diabetes Care (HbA1c test and LDL-c test)	Claims, Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of members with diabetes who had at least one HbA1c test and at least one LDL-C test.	The service-related HEDIS indicators are developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Persistence of Beta-Blocker Treatment after Heart Attack	Claims and Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of members who were hospitalized and discharged alive with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.	The medication adherence HEDIS indicators are developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Cholesterol Testing for Patients with Cardiovascular Conditions	Claims, Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of members who were discharged alive for AMI, CABG or PCI or who have a diagnosis of IVD and who had at least one LDL-C screening.	The service-related HEDIS indicators were developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Comprehensive Care for People Living with HIV/AIDS	Claims and Pharmacy	(NYS Specific QARR 2010) Percentage of members living with HIV/AIDS who received the following services: (A) two outpatient visits with primary care with one visit in the first six months and one visit in the second six months, (B) viral load monitoring, and (C) Syphilis screening for all who 18 and older.	The service-related HEDIS indicators were developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.

E. Goal 5: Improve Preventive Care

1. Clinical Outcomes

Measures	Data Source	Specifications	HIT Utilization
NA	NA	NA	NA

2. Experience of Care

Measures	Data Source	Specifications	HIT Utilization
NA	NA	NA	NA

3. Quality of Care

Measures	Data Source	Specifications	HIT Utilization
Chlamydia Screening in Women	Claims and Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of women who were identified as sexually active and who had at least one test for Chlamydia.	The preventive care HEDIS indicator was developed from preventive care guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Colorectal Cancer Screening	Claims (administrative method only)	(HEDIS 2012 - Effectiveness of Care) Percentage of member 50 and older who had appropriate screening for colorectal cancer.	The preventive care HEDIS indicator was developed from preventive care guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.

viii. Quality Measures: Service Based Quality Measures- N/A

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

ix. Evaluations

A. Describe how the State will collect information from health home providers for purposes of determining the effect of this program on reducing the following (include the data source and frequency of data collection):

NYS plans on calculating all of these measures using existing resources, and sharing the results with each Health Home provider. Measures will be calculated minimally annually and possibly quarterly to monitor the effectiveness of each Health Home.				
Evaluation				
Hospital Inpatient	Hospital Admissions	Claims and Encounters	Hospital Utilization and cost per member per month	Claims and Encounters
Emergency Room Visits	ER Visits	Claims and Encounters	ER Utilization and cost per member per month	Claims and Encounters
Skilled NH Admissions	NH Admissions	Claims and Encounters	Nursing Home Utilization and cost per member per month	Claims and Encounters

B. Describe how the State will collect information for purposes of informing the evaluations, which will ultimately determine the nature, extent and use of this program, as it pertains to the following:

New York will use a number of methods for collecting information for purposes of informing the evaluations. For evaluation data, NY will draw upon Medicaid records—enrollment, claims, encounter, pharmacy—as well as other state databases that record use of substance use disorder treatment (which include demographic and clinical characteristics as well as treatment utilization). Additionally, NY will work with CMS to develop a patient experience of care survey that draws from survey items included in CAHPS (Consumer Assessment of Healthcare Programs and Systems) and, potentially, behavioral health specific items from MHSIP (Mental Health Statistics Improvement Program). New York State has extensive experience adapting CAHPS to survey managed Medicaid and other populations. NY will also work with academic partners to supplement these databases with data collection that informs program implementation.

New York will use quasi-experimental approaches to create comparison groups for the empirical items derived from administrative databases that are noted below (items i, ii, vi, & vii). We note that the analytical strategy will begin with descriptive examination of the Health Home population and the characteristics of individuals enrolled. The analysis will then increase in complexity to the level necessary to address questions of implementation effectiveness and impact on utilization and costs. Comparison groups will be devised using examination of historical utilization and costs of the eligible population and by statistical matching, which will use population databases to identify patients with similar demographic, geographic, and clinical characteristics as Health Home enrollees. For historical comparisons, NY will look at utilization patterns of the population of individuals who met the Health Home criteria prior to program implementation as well as utilization of Health Home clients in the year prior to enrollment. For purposes of creating statistically matched comparisons, NY will examine the feasibility of using propensity score methods by region from individuals meeting eligibility criteria but who were not recruited into the health homes due to staggered enrollment or variations in Health Home penetration within the eligible population. NY will also be able to compare across Health Home providers while adjusting for client characteristics. The statistical matching will be based on demographic characteristics, clinical complexity, and historical utilization patterns. The feasibility of other analytical strategies, such as instrumental variable, will be considered to adjust for bias associated with self-selection. NY will partner with state and academic researchers who have expertise in applying these health services research methods.

i. Hospital admission rates

NYS has been monitoring avoidable hospital readmissions for Medicaid populations since 2009 using 3M software called Potentially Preventable Readmissions (PPRs). This software has an algorithm for determining whether a readmission is plausibly connected to an initial admission. NY will calculate PPRs within 30 days of an initial inpatient discharge. For the avoidable readmission rate, we will calculate an overall rate with total counts of acute hospitalizations for the eligible chronic conditions in the denominator and a numerator with counts of PPRs. NY will calculate the rate across all conditions and also within condition (i.e., mental health condition, substance use disorder, asthma, diabetes, heart disease, HIV/AIDS, and hypertension).

As indicated above, NY will calculate historical avoidable readmission rates for comparison as well as compute rates for a statistically matched comparison group. We will also compare avoidable readmission rates across Health Home providers.

ii. Chronic disease management

Data on chronic disease management will be collected in two ways. First, we will examine how the Health Homes implement disease management across key chronic illness management

functional components of our state Health Home qualification criteria. With the aid of state and academic partners, NY will work with stakeholders to assess the key functional components to include: 1) inclusion of preventive and health promotion services, 2) coordination of care between primary care, specialty providers and community supports, 3) emphasis on collaborative patient decision making and teaching of disease self-management, 4) structuring of care to ensure ongoing monitoring and follow-up care, 5) facilitation of evidence based practice, and 6) use of clinical information systems to facilitate tracking of care as well as integration between providers. NY will modify standardized assessment tools as well as use qualitative interviews with HH administrative staff and providers to determine the implementation of these functional components. Additionally, the patient Experience of Care measure will provide information on self-management support from the health home.

Second, NY will conduct cohort analyses as part of the evaluation focusing on groups at-risk to incur high costs.

iii. Coordination of care for individuals with chronic conditions

NYS will use claims, encounter, and pharmacy data to collect information on coordination of care. As indicated in the quality measures section of this SPA, NYS will use claims, encounter, and pharmacy data to collect information on post-inpatient discharge continuation of care (e.g., persistent beta-blocker treatment after hospitalization for AMI) or transition to another level of care (e.g., outpatient care following hospitalization for a behavioral health condition). This coordination of care measures will be compared to historical controls, to statistically matched comparison groups, and across Health Home providers.

In addition NY is considering the feasibility of more closely examining provider behavior through medical chart reviews, case record audits, team composition analysis, and key informant interviews. As part of this process we will carefully monitor the use of HIT as a primary modality to support coordination of care.

iv. Assessment of program implementation

Learning Collaboratives will be constituted with a group of early adopter providers of Health Homes to identify implementation challenges as well as potential solutions. Other data related to implementation including responses to the Health Home experiences of care survey and, if feasible, provider audits and surveys, and stakeholder interviews will be collected. All implementation data will be shared with the Health Home Advisory Group (comprised of state, provider, community, and academic members) and a compilation of lessons learned.

v. Processes and lessons learned

Learning Collaboratives will be constituted with a group of early adopter providers of Health Homes to identify implementation challenges as well as potential solutions. NYS will use the Health Home Advisory Group to monitor, comment, and make recommendations on implementation strategies that are working as well as those that are not. The group will use the Health Home functional components (see section iii. Provider Infrastructure) as well as the provider qualification criteria (see section v. Provider Standards) as guides in assessing program processes and outcome success. The Advisory Group will use information gathered through assessments of program implementation as well as from ongoing quality monitoring using administrative data to review program successes and failures.

vi. Assessment of quality improvements and clinical outcomes

As detailed in the quality measures section, NYS has identified an extensive list of quality and outcome measures that will be derived from administrative claims and encounter data. The quality measures are indicators of chronic illness management while the clinical outcome measures are indicators of poor disease management leading to high-cost treatment episodes.

Ongoing assessments of these quality measures will be conducted at the levels of Health Home providers, region, and state-wide.

The endpoint evaluation will be designed as a quasi-experimental longitudinal study where endpoint outcomes will be patient-level indicators of poorly managed care of chronic conditions; indicators of stable engagement in guideline concordant care; and high-cost utilization of services. There are a number of clear indicators of poorly managed care across disorders: emergency department (ED) visits, hospital re-admissions, poor transition from inpatient to outpatient care, etc. In addition, we will attempt to define, where possible, more refined measures that are disease specific (e.g., repeated detox in substance abuse).

vii. Estimates of cost savings

NYS will work with state and academic partners to devise a sophisticated econometric analysis of the overall Health Home initiative as well as of each vendor. First, NYS will monitor costs savings through by tracking high-cost forms of utilization (e.g., preventable hospitalizations, ED use, detoxification). Utilization of high cost events will be compared with historical rates as well as with statistically matched comparison groups as indicated above. Additionally, NYS will compare total costs of care for Health Home enrollees—including all services costs, health home costs and managed capitation—to statistically matched comparisons.

The econometric analyses will begin with descriptive statistics and increase in complexity to the minimal level necessary to address the question of cost savings. Analyses will focus on per member per month (PMPM) expenditures of enrollees compared to controls as described in this section's preamble. For regression analyses that examine changes in cost relative to controls, we employ longitudinal nested designs that account for serial correlation within person and within provider and region. Regression analyses will account for prior year costs by type of utilization (e.g., ED, inpatient, mental health), clinical complexity (e.g., PPR risk score), regional utilization characteristics, and demographic factors. Parameter estimates for Health Home participants will indicate differences in PMPM relative to controls while controlling for historical utilization patterns, regional practice variation, and individual demographic characteristics.

4.19 – B: Payment Methodology View
Attachment 4.19-B

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Payment Methodology

Payment Type: Per Member Per Month
Provider Type
Description

Tiered? N/A

Provider Type

NYS Medicaid providers eligible to become health homes include managed care plans; hospitals; medical, mental and chemical dependency treatment clinics; primary care practitioner practices; PCMHs; FQHCs; Targeted Case Management (TCM) providers; certified home health care agencies and any other Medicaid enrolled provider that meet health home provider standards.

Description

Care Management Fee:

Health Homes meeting State and federal standards will be paid a per member per month care management fee that is adjusted based on region and case mix (from 3M™ Clinical Risk Groups (CRG) method) and this fee will eventually be adjusted by (after the data is available) patient functional status. This risk-adjusted payment will allow providers to receive a diverse population of patients and assign patients to various levels of care management intensity without having to meet preset standards for contact counts. Providers will be able to respond to and adjust the intensity and frequency of intervention based on patient's current condition and needs (from tracking to high touch). All rates will be published on the DOH website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.
The fee schedule maybe found at:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_information.htm

This care management fee will be paid in two increments based on whether a patient is in 1) the case finding group or 2) the active care management group. The case finding group will receive a PMPM that is a reduced percentage (80 %) of the active care management PMPM. The case finding PMPM will be available for the three months after a patient has been assigned to a health home. Then, nothing can be billed for that patient for the next three months. Following this interval, case finding can be billed for another three months while outreach and engagement is attempted once again. This PMPM is intended to cover the cost of outreach and engagement.

A unit of service will be defined as a billable unit per service quarter that will be distributed monthly. In order to be reimbursed for a billable unit of service per quarter health home providers must at a minimum, provide one of the core health home services. The monthly distribution will be paid via the case finding and active care management PMPM. Once a patient has been assigned a care manager and is enrolled in the health home program the active care management PMPM may be billed.

Managed Care Considerations:

Similar to the NY patient centered Medical Home program, it is the intention of the State to coordinate and pay for health home services through health plans but at State set rates for the service. The State will address any existing care management resources in the current plan premium for health home enrollees under CMS guidelines (bring this resource out of the capitation and create federal matching for those resources under the health home payment). Plans will pay health home providers State set rates when providers are contracted to provide all health home services. In the case where the plan does a portion of the health home service (e.g., telephonic post discharge tracking) and downstream providers do a separate portion (e.g. face to face care management) the plan will then split the State generated PMPM proportional to the contracted effort.

The Medicaid/FHP Model Contract will be modified at the next scheduled amendment to include language similar to that outlined below which will address any duplication of payment between the MCO capitation payments and health home payments. The delivery design and payment methodology will not result in any duplication of payment between Health Homes and managed care.

- The managed care plan is not required to provide services that would duplicate the CMS reimbursed Health Home services for members participating in the State's Health Home program.
- The managed care organization will be informed of members assigned to a Health Home or will assign its members to a Health Home for health home services. Plans may need to expand their networks to include additional State designated health home providers to ensure appropriate access.

- Plans will need to have signed contracts including clearly established responsibilities with the provider based health homes.
- The managed care plan will be required to inform either the individual's Health Home or the State of any inpatient admission or discharge of a Health Home member that the plan learns of through its inpatient admission initial authorization and concurrent review processes as soon as possible to promote appropriate follow-up and coordination of services.
- Plans will assist State designated Health Home providers in their network with coordinating access to data, as needed.
- Plans will, as appropriate, assist with the collection of required care management and patient experience of care data from State designated Health Home providers in it's network.

The State has a health home advisory committee of providers and managed care plans through which any issues with payment would be raised and addressed. Directions have been given to health plans to match health home payment to providers based on relative health home care management effort. Further information on specific construction on health home rates includes specific administration compensation to guide rate differential construct.

Targeted Case Management (TCM) and Chronic Illness Demonstration Projects (CIDPs) Conversion Considerations:

The State envisions that eventually all targeted case management programs operating in New York will convert to or become part of health homes. However, given that some of these providers will require time to meet State and Federal health home standards this conversion will take place over the next two years. The State will allow TCM providers that can meet health home standards to convert to health homes or join with larger health homes. TCM providers that convert to health homes will be governed under NYS Health Home Provider Qualification Standards, not TCM standards. The State will allow TCM providers that can meet health home standards to convert to health homes or join with larger health homes. The payment method will be designed to transition all existing TCM capacity from the current rates to the new Health Home payment structure. TCM programs will be paid their existing TCM rates for a period of one (1) year from the effective date of the SPA if they convert to or become part of a health home. This existing TCM rate will be paid for both case finding and active care management. The case finding PMPM will be available for the three months after a patient has been assigned to a health home. Then, nothing can be billed for that patient for the next three months. Following this interval, case finding can be billed for another three months while outreach and engagement is attempted once again. Beginning with second year after the effective date of the SPA, these converted TCM programs or health homes affiliated with TCM programs will be paid for all patients under a blended methodology that will include a component of the TCM payment and the component of the new Health Home payment. This rate would be paid for both case finding and active care management. Case finding rules would apply as describe previously in this section. In the third year all payments will be made under the health home payment detailed above in the care management fee section.

The State anticipates that most of the six CIDPs will convert to health homes. The CIDP providers are well positioned to become health homes and meet State and Federal health home standards. The CIDPs that convert to health homes will be paid at their existing CIDP rate for a period of one (1) year from the effective date of the SPA if they convert to health home for their existing patients. For new patients that may be assigned to a CIDP program that has converted to health home the State will pay the State set health home PMPM. At the beginning of the second year after the effective date of the SPA these converted programs will be paid for all patients under the State set health home PMPM. CIDPs that do not convert to health homes, if any, will end operations as CIDPs on March 29, 2012 when the contract with the State terminates.

New York States' health home services are set as of January 1, 2012 and are effective for services on or after that date. All rates will be published on the DOH website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. All of the above payment policies have been developed to assure that there is no duplication of payment for health homes services.