



**Department
of Health**

Medicaid
Redesign Team

Tailoring Health Homes to Serve Children

Commissioner's Advisory Panel

February 27, 2015

Overview of Today's Discussion

- Health Homes provide opportunity to improve health of children with chronic conditions and complex needs
- Overview of Health Home Care Management Model
- Tailoring New York's Health Home Model to Better Serve Children
- Schedule for Enrolling Children in Health Homes
- Collaboration and Discussion

Health Homes Provide an Important Opportunity to Improve Health and Outcomes for Children with Chronic Conditions

- Health Homes provide *person-centered comprehensive care management to individuals* with chronic conditions
- Health Homes will expand the availability of care management from the limited population of children served by “waivers” (e.g., Bridges to Health) and targeted case management programs (~12,000 children) to potentially 150,000-200,000 children across the Medicaid population that have unique needs and may qualify and be appropriate for Health Home
- Health Homes provide an opportunity to establish critical linkages and help break down silos of care of by linking systems and programs (education, child welfare, Early Intervention) to comprehensive care planning



Health Homes Authorization and Purpose

- Health Home is an *optional* State Plan benefit authorized under Section 2703 of the Affordable Care Act (ACA) to coordinate care for people with Medicaid who have *chronic conditions*

- Health Home is a Care Management model that provides:
 - Enhanced care coordination and integration of primary, acute, behavioral health (mental health and substance abuse) services, and
 - Linkages to community services and supports, housing, social services, and family services for persons with chronic conditions

New York's Health Home Model

- In New York State, Health Homes are led by one provider (single point of accountability) which is required to create a comprehensive network of providers to help members connect with:
 - One or more hospital systems;
 - Multiple ambulatory care sites (physical and behavioral health);
 - Existing care management and targeted case management (TCM) programs that now operate under the Health Home program;
 - Community and social supports, e.g., housing and vocational services; and
 - Managed care plans.
- Health Homes were implemented across the State beginning January 1, 2012
 - There are 33 Health Homes now serving every county of the State (http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_contacts.htm)



New York's Health Home Model

- Current Eligibility Criteria is condition-based (per ACA):
 - At least 2 chronic conditions* (e.g., substance abuse disorder, diabetes, asthma, heart disease, over weight (BMI> 25), hypertension), or
 - Serious Mental Illness, or
 - HIV/AIDS
 - Must be “appropriate” for Health Homes (i.e., need intensive care management and coordination)

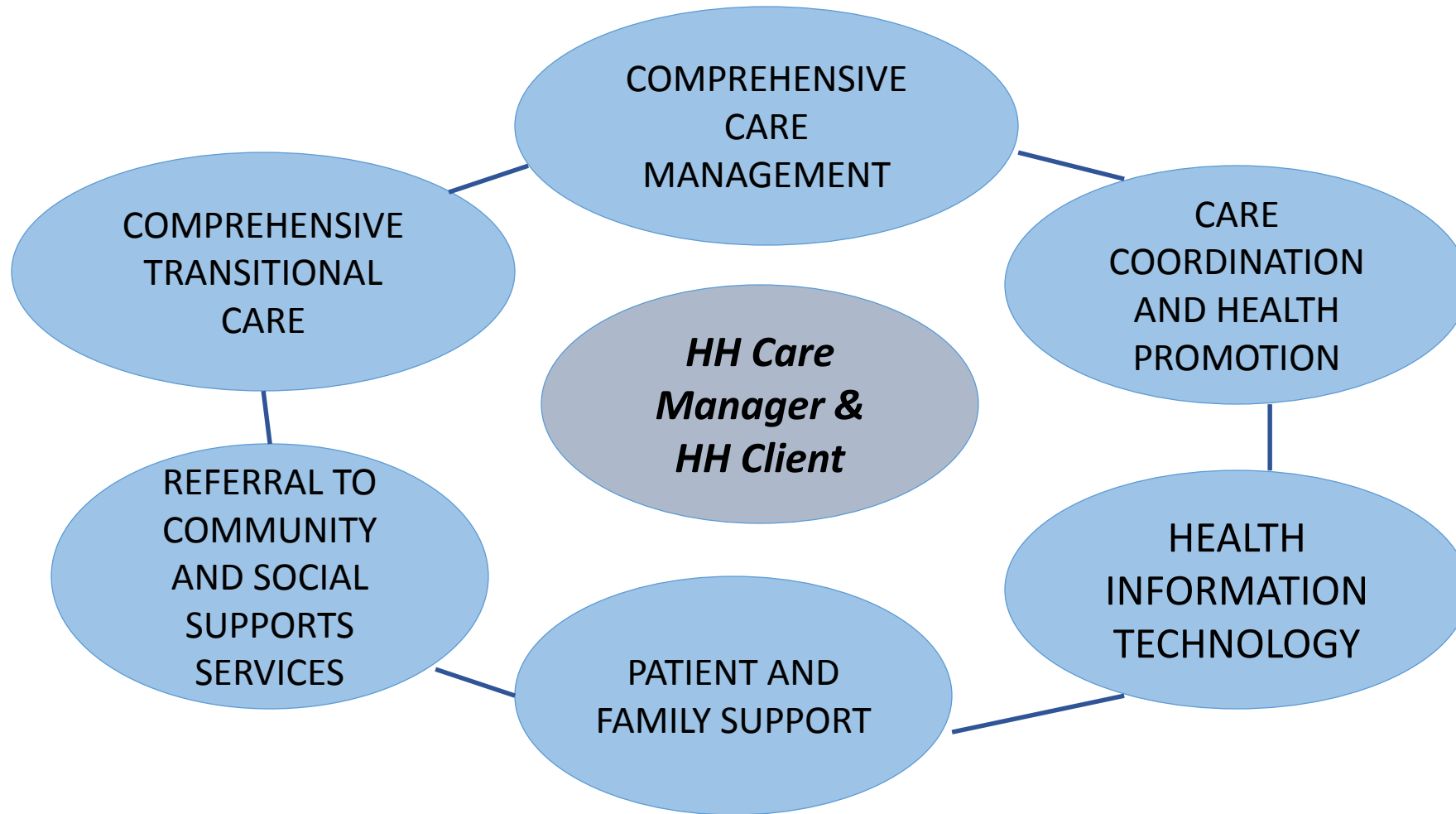
* For detailed list of chronic conditions please see:

(http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/09-23-2014_eligibility_criteria_hh_services.pdf)



Health Homes Provide Six Core Care Management Functions

7



Health Home care management is “whole-person” and “person-centered” and integrates a care philosophy that includes both physical/behavioral care and family and social supports



Tailoring New York's Health Home Model to Better Serve Children

- As planned, New York State initially implemented the Health Home Program by prioritizing the enrollment of adults
- This approach allowed the State to establish the Health Home infrastructure and subsequently tailor that infrastructure to recognize the differences between children and adults by:
 - Tailoring the eligibility criteria for Health Homes
 - Expanding the networks of existing Health Homes and potentially new Health Homes serving children to ensure Health Homes and their provider networks accommodate the special needs of children including:
 - Care managers with expertise in serving children
 - Networks of providers that meet special needs of children with chronic and complex conditions (pediatricians, children's specialty providers)
 - Linkages to systems and programs that care for an interface with children (education, child welfare, juvenile justice)
- Tailoring the delivery of the six core Health Home services to the needs of children and their families



Tailoring Health Homes to Serve Children ~ Collaborative Effort of State Agency Partners and Stakeholders

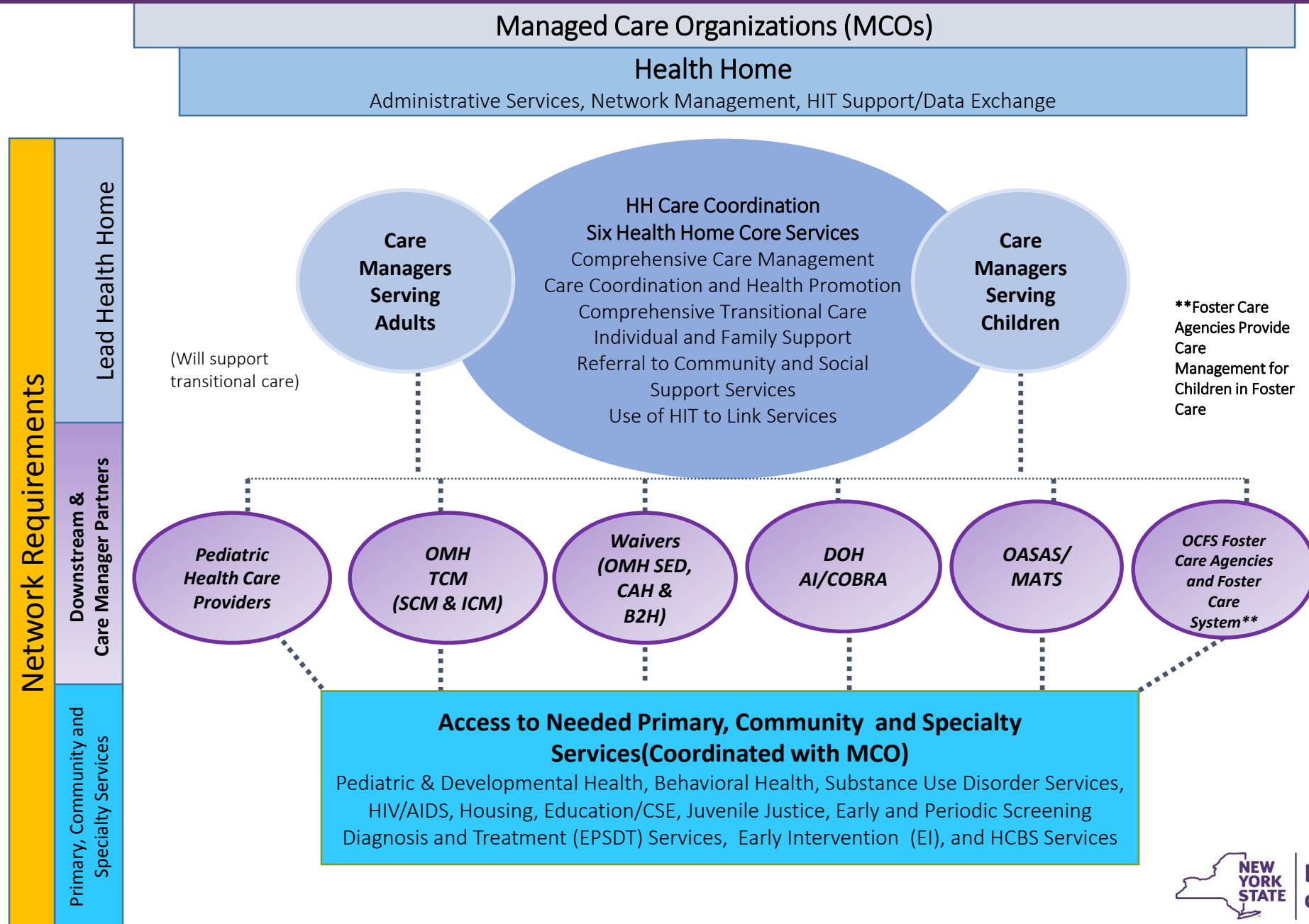
- State Agency Partners
 - Office of Mental Health (OMH)
 - Office of Alcoholism and Substance Abuse Services (OASAS)
 - Office of Children and Family Services (OCFS)
 - Department of Health (DOH) (including Office of Health Insurance Programs, Center for Health-Division of Family Health, AIDS Institute)
 - New York State Education Department
- Stakeholders
 - Health Homes, Managed Care Plans and Care Managers
 - Associations
 - Advocates
 - Local Government Partners (LDSS, LGU, SPOA, NYCDOHMH)

Principles for Serving Children in Health Homes and Managed Care

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

New York State Health Home Model for Children

11



Tailoring Health Homes to Better Serve Children

- Health Home eligibility criteria must be condition based (i.e., not population based)
- To achieve the goal of ensuring eligibility condition-based criteria captures high needs children's populations, including Medically Fragile Children with complex health issues, children in foster care, children with Serious Emotional Disturbance (children complement to adult SMI), children enrolled in "Waiver" programs and other case management programs the **State is proposing to Centers for Medicare and Medicaid Services (CMS)** to modify Health Home eligibility criteria to include trauma
 - Definition of Trauma: Exposure to a single severely distressing event, or multiple or chronic or prolonged traumatic events as a child or adolescent, which is often invasive and interpersonal in nature. Trauma includes complex trauma exposure which involves the simultaneous or sequential occurrence of child maltreatment, including psychological maltreatment, neglect, exposure to violence and physical and sexual abuse.
 - A child or adolescent who has experienced trauma would be defined **to be at risk for another chronic condition** if they have one or more functional limitations that interferes with their ability to function in family, school, or community activities, or they have been placed outside the home.
 - ✓ Functional limitations are defined as difficulties that substantially interfere with or limit the child in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills, or for a child who experienced trauma due to child maltreatment, a functional limitation is defined as a serious disruption in family relationships necessary for normal childhood growth and development

Health Home Eligibility Criteria – Current and Proposed

Current Health Home Eligibility Criteria and Proposal to Modify Health Home Eligibility Criteria (Modifications in Bold)

Person must be enrolled in Medicaid and have:

- Two or more chronic conditions or
- One single qualifying condition of
 - ✓ HIV/AIDS or
 - ✓ Serious Mental Illness (SMI) / *Serious Emotional Disturbance (SED)*
- **Trauma at risk for another condition (Requires Centers for Medicare and Medicaid Services (CMS) Approval)**

Chronic Conditions Include:

- ✓ Alcohol and Substance Abuse
- ✓ Mental Health Condition
- ✓ Cardiovascular Disease (e.g., Hypertension)
- ✓ Metabolic Disease (e.g., Diabetes)
- ✓ Respiratory Disease (e.g., Asthma)
- ✓ Obesity BMI >25 (**BMI at or above 25 for adults or at or above the 8th percentile for children of the same age and sex**)
- ✓ Other (http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/09-23-2014_eligibility_criteria_hh_services.pdf)

Persons meeting criteria must be appropriate for Health Homes Care Management:

- ✓ At risk for adverse event, e.g., death, disability, inpatient or nursing home admission, **mandated preventive services or out of home placement**
- ✓ Inadequate social/family/housing support; **or serious disruptions in family relationships**
- ✓ Inadequate connectivity with healthcare system
- ✓ Non-adherence to treatments or difficulty managing medications
- ✓ Recent release from incarceration, **placement, detention** or psychiatric hospitalization
- ✓ Deficits in activities of daily living
- ✓ Learning or cognition issues
- ✓ **Concurrent eligibility or enrollment of a child and the family/caregiver in Health Home**



Draft Application Health Home Application to Serve Children, Comments and Letters of Interest

- On June 30, 2014 the State released Draft Application to existing Health Homes, other providers interested in serving children in Health Homes and stakeholders for review and comment
- Comments and Letters of Interest due July 30, 2014
- 34 Letters of Interests Submitted
 - 21 Currently Designated Health Home (some of which indicated the potential formation of partnerships among Designated Health Homes)
 - 13 New Organizations
 - Proposed coverage areas span every county of the State
 - Letters of Interest have been posted to DOH Health Home Website
- Final Application released on November 3, 2014
- ***Applications due March 2, 2015***



Anticipated Schedule of Activities for Expanding Health Homes to Better Serve Children	Due Date
<i>Draft Health Home Application to Serve Children Release</i>	<i>June 30, 2014 -Completed</i>
<i>Due Date to Submit Comments on Draft Health Home Application to Serve Children</i>	<i>July 30, 2014 -Completed</i>
<i>Due Date to Submit Letter of Interest</i>	<i>July 30, 2014 -Completed</i>
<i>Final Health Home Application to Serve Children Released</i>	<i>November 3, 2014 -Completed</i>
Due Date to Submit Health Home Application to Serve Children	March 2, 2015
Review and Approval of Health Home Applications to Serve Children by the State	March 2, 2015 to June 15, 2015
HH and Network Partner Readiness Activities	June 15, 2015 to September 30,2015
State Webinars, Training and Other Readiness Activities	Through September 30, 2015
Begin Phasing in the Enrollment of Children in Health Homes	October 2015
Children's Behavioral Health Services and other Children's Populations Transition to Managed Care http://www.health.ny.gov/health_care/medicaid/redesign/care_management_for_all.htm	January 2016



Phasing-in the Enrollment of Children into Health Homes

- Executive Budget includes Global Cap resources for the enrollment of children into Health Homes
 - ✓ \$45 million in 2015-16
 - ✓ \$90 million in 2016-17
- State Anticipates it will begin to phase-in the enrollment of children in Health Homes October 1, 2015
- Phase-in approach under development and preliminarily includes:
 - OMH Targeted Case Management Program will be transitioned to Health Home October 1, 2015
 - Pilot (October 2015-June 2016) for High Fidelity Wraparound (HFW) Model in Health Homes under development and anticipated to be conducted under a Substance Abuse and Mental Health Services Administration (SAMHSA) grant to the New York State Success Initiative
 - Waiver Programs (Bridges to Health, OMH Serious Emotional Disturbance, Care At Home I,II: January 2016)
 - Early Intervention (Likely in 2016 - Requires separate CMS State Plan Amendment (SPA) approvals under EI State Plan – likely will follow the adoption of the Health Home Children’s SPA)



Phasing-in the Enrollment of Children into Health Homes

- Other factors that could impact approach to phase-in process:
 - ✓ Timing of Health Home Designations
 - ✓ “Readiness” of Health Homes designated to serve children
 - ✓ Approach to the development of Assignment Lists
 - Progress has been made towards finalizing Serious Emotional Disturbance definition (children complement to adult Serious Mental Illness) and projected estimates of number of children potentially eligible for Health Homes
 - ✓ Approach to referrals

School/Health Home Collaboration

- The State is continuing to work with its State Agency partners and stakeholders to work with children's systems of care to obtain guidance and feedback about best practices and approaches for providing linkages and connectivity to Health Homes
- The Department of Health and the State Agency Partners would like to similarly continue to collaboratively work with the State Education Department and the Commissioner's Advisory Panel to:
 - ✓ Educate and train:
 - Health Homes and care managers on the role and responsibilities of Committee on Special Education (CSE)/Committee on Preschool Special Education (CPSE)
 - CSE/CPSE on Health Home Care Management Model and role of care manager
 - Other? educators about Health Home and its eligibility criteria (who? And method for training and disseminating information?)
 - ❑ What is the best venue, method or approach for conducting these types of educational and training forums?



School/Health Home Collaboration (Continued)

- ✓ Develop and encourage pathways for Health Homes and CSE/CPSE to collaborate and share information to ensure development of comprehensive care plan that reflects IEP and other needs

By definition, Health Home eligible children will have comprehensive needs, of which the IEP would be important element to be considered. Health Home children may also be eligible for expanded State Plan services and Home and Community Based Services (HCBS) now underdevelopment

- State has been working with State Education Department program and legal staff to develop draft Health Home consent forms that authorize a parent/guardian to share educational records such as Individualized Education Programs (IEPs), Special Education Evaluation Reports(e.g. social history, psychological, classroom observation, other assessments that describe the physical, mental, behavioral and emotional factors that contribute to the disability)

- Are there other “process” factors to consider regarding the method for sharing such information?

School/Health Home Collaboration (Continued)

- ✓ Identify natural points in education where children can be identified and referred to Health Home
 - CSE/CPSE, others in education system (the “who”)
 - Medicaid Analytics Performance Portal (MAPP): Health Home Tracking and Performance Portal – Under Development
 - Later this summer MAPP Internet Health Home Referral Portal will be developed (including protocols and information for making referrals)

- ❑ Considerations for developing referral portal (inputs), authorization and access to portal (the “who”)

- ❑ Other topics for discussion? Questions ?

Resources and Updates

- Please send any questions, comments or feedback on Health Homes Serving Children to: hhsc@health.ny.gov
- Stay current by visiting our website:
http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm

