



Department
of Health

Office of
Mental Health

Office of Alcoholism and
Substance Abuse Services

Linking Medicaid Members in Hospitals to Health Home Care Management Under the Affordable Care Act (ACA)

Department of Health

July 25, 2016

Today's Agenda

New York Health Home Program

- What it is
- Who is eligible
- Health Home Program Today

Affordable Care Act Provisions:

- Requirements for hospital to refer Health Home eligible patients
- Requirements for hospital to notify Health Homes when enrollees access hospital services

Panel Discussion

- What Hospitals and Health Homes are doing today to refer and notify
- Importance of linkages with PPSs
- What is on the horizon that will improve hospital/health home coordination and patient access to health home services

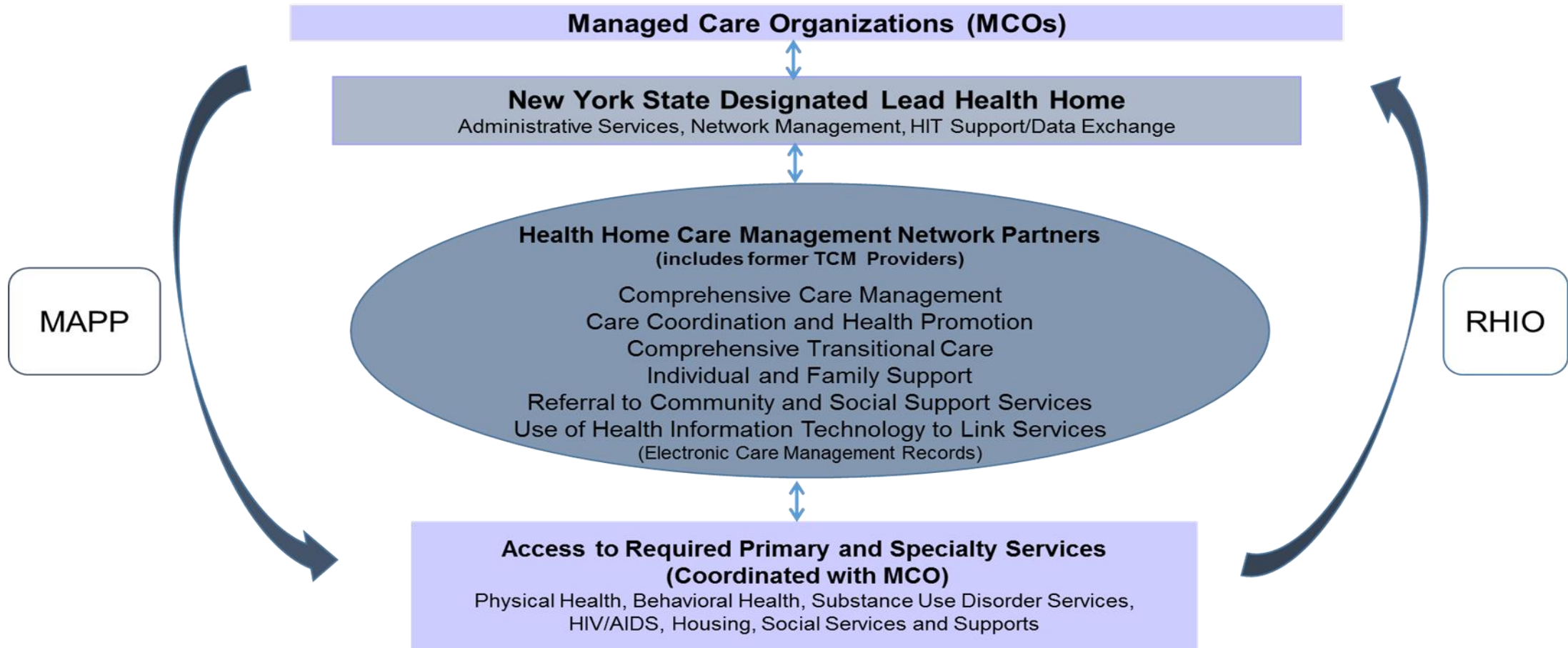


What is a Health Home?

- Health Homes are a **care management** model, authorized under the Affordable Care Act (ACA) that provide intensive care management for Medicaid members that have chronic conditions. These Medicaid members are typically “high need/ high cost” members
- Health Homes care managers, in concert with multi-disciplinary team of providers (Health Home network), and managed care plans, develop and help implement person-centered, integrated care plans (i.e., physical health, behavioral health, community and social supports)
- 32 Health Homes provide access to Health Home care management (HHs) in all 62 counties of the State
 - Beginning in December 2016 Health Homes will begin to serve children, total number of Health Homes will increase to 35
- Some Health Homes are hospitals/or tight affiliation with Hospitals – Bronx Lebanon Hospital/ Bronx Accountable Healthcare Network (Montefiore Hospital), Mary Imogene Bassett Hospital
- List of Health Homes, Regions they Serve and Contact Info:
 - http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_contacts.htm



New York State Health Home Model



MAPP: Medicaid Analytics Performance Portal: NYS System that Tracks Health Home Members



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Health Home Eligibility Criteria

Eligibility Criteria for Health Home Care Management

- Medicaid/eligible/active Medicaid
- Two or more chronic conditions* (e.g. substance use disorder, diabetes, hypertension, asthma), or
- Serious mental illness (SMI), or
- HIV/AIDS

- ✓ Many members who meet this criteria frequent hospital emergency rooms
- ✓ Roughly 1 million of New York xx million Medicaid Members are eligible for Health Homes
- ✓ ***Members enrolled in Health and Recovery Plans (HARPs) – a special needs (SNP) managed care insurance plan, meet Health Home eligibility criteria***
- ✓ Many of these members frequent your emergency departments



What is Health Home Care Management?

- **HH Care Management** should be a standard referral consideration for all individuals hospitals serve
- **Care coordination** is a vehicle for integrated care, encourages engagement, and improved health outcomes.
- HH Plans of Care are **Person-Centered** and inclusive of **behavioral and medical needs**. Health Homes are charged with providing **Comprehensive Transitional Care** which includes prompt notification of an individual's admission and/or discharge to/from an emergency room, inpatient or residential/rehabilitation setting.
- The Health Home **ensures 24 hours/seven days a week availability to a care manager** to provide information and emergency consultation services.
- The Health Home Care Manager will ensure the availability of **priority appointments** to medical and behavioral health care services within their Health Home provider network
- The Health Home Care Manager identifies available community-based resources and **actively manages appropriate referrals, access, engagement, follow-up and coordination of services**

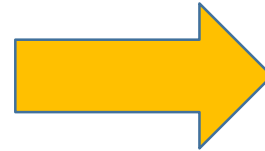


Hospital Health Home Referral Requirements included in ACA and New York's State Plan

Affordable Care Act (ACA) Provisions

“A State shall include in the State Plan amendment a requirement for hospitals that are participating providers under the State plan or a waiver of such plan to establish procedures for referring any eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.”

This language is included in New York's State Plan amendment (the document that identifies what services Medicaid will provide, the costs of which are shared with the Federal government (Centers for Medicare and Medicaid (CMS))



Hospitals are required to develop and implement policies and procedures for:

- ✓ *Referring Health Home eligible Patients, **and***
- ✓ *Notifying Health Homes when enrollees access hospital services*



Next Steps

- The Department will be following up with a letter outlining the Health Home notification and referral requirements
- Policy and Procedures to meet these requirements are due to the Department no later than **January 1, 2017**
- The DOH is very interested in learning more about current best practices, integrating PPS and HH outcome measures to decrease ED utilization



Deciding to Refer or Notify

- If an individual is already connected to a Health Home immediate notification to the Health Home of the admission is required.
- If an individual is not currently enrolled in a Health Home, then working closely with the Managed Care Organization (MCO)/Plan the member is enrolled in to determine eligibility and identify a Health Home in network is required
- If member is not enrolled in Plan, direct referral to Health Home is required (most eligible members will be enrolled in Plan)



Referrals

Step 1: Medicaid Plan enrolled or Medicaid FFS verified through EPACES- EMEDNY

Step 2: HARP RE Code = Health Home Eligibility

Step 3: In the absence of HARP RE code:

- Two or more chronic conditions (e.g., SUD, Asthma, Diabetes, Heart Disease)
- One chronic condition – HIV/AIDS
- One serious mental illness

Step 4: Provide information to the individual about the benefits of Health Home care coordination

- https://www.health.ny.gov/publications/1123/hh_brochure.pdf

Step 5: Get Consent from individual, i.e., to share information with MCO first and Health Home and care management agency if the individual has a preference or current relationship



Helping Hospitals to Meet Referral Requirements

In the Very Near Future

- Work is underway to add a Health Home specific RE code. This will allow providers that access EMedNY to verify if a member is engaged (assigned outreach enrolled) with a Health Home (will indicate Health Home assigned to and care management agency member is working with)
- This information will facilitate and expedite ability of hospital to make referrals and notifications and most importantly facilitate connective to care coordination with warm handoffs and transition planning
- The Department will provide hospitals and other providers with additional information on the completion of these changes to EMedNY and how to use the Health Home information



Health Homes and the Delivery System Reform Incentive Payment (DSRIP) Program



Health Homes Key Part of DSRIP

- Health Homes are a key tool in helping PPS meet the Statewide goal of reducing avoidable hospitalizations by 25% by 2020
- Hospital linkages to Health Homes that are part of PPS or Health Homes that serve area of PPS



DSRIP Projects Requiring Health Homes & Care Management

- Each Performing Provider System (PPS) is required to work with its area Health Home(s).
- Health Homes are a vehicle for engagement of members for PPS that selected the following projects:
 - Project 2.a.iii - Health Home At-risk Intervention Project for those with single chronic conditions who do not qualify for a Health Home
 - Project 2.b.iv - Care transitions intervention model to reduce 30-day readmissions for chronic conditions
 - ✓ Connecting members to HH/care management services on hospital discharge, whether hospitalized for a medical or a behavioral health condition.
 - These include HARP members, who by definition, are HH eligible, and can be engaged during BH admissions.
 - Project 2.d.i - Patient activation for Low- and Non-utilizers of Medicaid, and for the uninsured.



DSRIP Projects Requiring Health Homes & Care Management

- Project 2.b.ii Development of co-located, primary care services in the Emergency Department (ED) &
- Project 2.b.iii ED Care triage for at-risk populations.
 - Connecting members to HH/care management services on ED discharge, whether presenting for a medical or a behavioral health condition.
 - ✓ E.g. Maimonides PPS is embedding 6 Health Home Care Managers in network EDs to connect members to Care Management and Primary Care, with the goal to avoid the ED for problems better addressed in other settings the next time.
- Project 3.a.ii Behavioral Health community crisis stabilization services
 - Connecting members to necessary behavioral health services during times of crisis, in places other than the ED or hospital.
 - ✓ E.g., Westchester Medical Center is training police to bring people to places other than the ED, for stabilization and “cooling off.”
 - These are screening/triage centers - not where the definitive care is rendered



DSRIP Health Home Measures

Measure Name	Numerator Description	Denominator Description	Performance Goal	Achievement Value	Reporting Responsibility	Payment: DY 1 through 5
Health Home assigned/referred members in outreach or enrollment	Number of referred and assigned HH eligible members with at least one outreach or enrollment segment during the measurement year	Total number of referred and assigned HH eligible members in the Health Home Tracking System during the measurement year	NA – Pay for Reporting measure only	Reporting on this measure is required in order to earn project Quarterly Progress Report AV	NYS DOH	P4R
Health Home members who were in outreach/enrollment who were enrolled during the measurement year	Number of HH members with at least one enrollment segment in the Health Home Tracking System during the measurement year	Total number HH eligible members with at least one outreach or enrollment segment of in the Health Home Tracking System during the measurement year	NA – Pay for Reporting measure only	Reporting on this measure is required in order to earn project Quarterly Progress Report AV	NYS DOH	P4R
Health Home enrolled members with a care plan during the measurement year	Number HH with a care plan update indicated in any of the four quarters of the measurement year	Total number HH eligible members with at least one segment of enrollment in the Health Home Tracking System during the measurement year	NA – Pay for Reporting measure only	Reporting on this measure is required in order to earn project Quarterly Progress Report AV	NYS DOH	P4R

https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/2016/docs/2016-02-25_measure_specific_rpting_manual.pdf



Working Together

- Health Homes, HARP, HCBS, and Managed Care Behavioral Health Carve-in are still fairly new initiatives – important elements in Medicaid Redesign and tools that will improve health outcomes and help reach DSRIP goals
- Providers, including hospitals, Health Homes, Plans, and the State will continue to work to improve create an integrated system for our most vulnerable populations with core concepts and goals of:
 - Reduce unnecessary acute service use
 - Improve care transitions
 - Crisis Services Programs become the front door to acute care
 - Ambulatory clinic re-design
 - Implement new recovery-oriented services
 - Promote integration of behavioral and general medical health services
 - Establish cross-agency collaborations around vulnerable populations
 - Shift payment models to reward value over volume



Panel Discussion

- What are Hospitals and Health Homes doing today to refer and notify?
- How can PPSs support these linkages?
- What is on the horizon that will improve hospital/Health Home coordination and patient access to Health Home services
- How can the Department help?

