

Id: NEW YORK
State: New York
Health Home Services

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

There are no geographic limitations.

If Targeted Geographic Basis, n/a

ii. Population Criteria

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

- Two chronic conditions
- One chronic condition 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 Covered?

Description of Other Chronic Conditions Covered.

- HIV/AIDS
- Hypertension

Description of population selection criteria

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 including HIV/AIDS.

The target population to receive health home services under this amendment includes categorically needy beneficiaries served by Medicaid managed care or fee for service and Medicare/Medicaid dual eligible beneficiaries who meet health home selection criteria and are not in need of long term care and do not have intellectual disabilities.

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; and certified home health care agencies 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 State 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 and behavioral health providers. 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

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:
 - o processes used to perform these functions;
 - o processes and timeframes used to assure service delivery takes place in the described manner; and
 - o 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 include 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.

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:

- Have a structured information systems, policies, procedures and practices to create, document, execute, and update a plan of care for every patient;
- Have a systematic process to follow-up on tests, treatments, services and, and referrals which is incorporated into the patient’s plan of care;
- 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
- 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:

- 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;
- 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;

- 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
- 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

vii. Quality Measures

The proposed quality measures fall into three categories: measures currently collected by managed care plans; measures per NQF and/or are meaningful use measures; and new measures to satisfy the SPA requirements. NYS has been moving toward enrolling all Medicaid recipients in NYS into managed care, even some traditionally vulnerable populations, which would include the populations targeted for Health Home. The list of measures is comprehensive, and NYS and its health home partners will need time to develop systems to collect and report this information. In addition, NYS will develop the infrastructure to calculate a subset of these measures across all health homes, for comparability and to reduce reporting burden.

There is a requirement to report on Experience of Care measures for each of the six areas. We look forward to working with CMS on development of an Experience of Care Survey. The patient perspective is essential for understanding the effectiveness of the health home model. The survey will also help measure services that are least likely to be found currently on administrative data systems, including individual and family support, and referral to community support services. NYS will rely on survey data initially to understand how successful these linkages are. We also will work with CMS on the depth and breadth of the proposed Health Home Experience of Care Survey. The proposed measure set includes

experience of care measures from CAHPS® which has been the survey instrument used for Medicaid for the past ten years.

The measures for health home will be phased in over a three year period as follows:

Year 1 (calendar year 2012) – 50% of proposed measures reported

Year 2 (calendar year 2013) – 75% of proposed measures reported

Year 3 (calendar year 2014) – 100% of proposed measures reported

Populations: BH/SA = Behavioral Health/Substance Abuse CC = Chronic Conditions

| Domains | Measures | Data Source | Specifications | Populations | HIT Utilization |
|--------------------------------------|---|----------------------|---|-------------|---|
| Comprehensive Case Management | | | | | |
| Clinical Outcomes | Inpatient Utilization - General Hospital/Acute Care | Claims | (HEDIS 2012 - Use of Services) Utilization of acute inpatient care and services for: total, medicine, surgery and maternity | BH/SA, CC | Claims Data |
| Experience of Care | CAHPS for Medical Home or Health Plan | Survey Vendor | (CAHPS 4.0H) Selected Questions with added NYS questions for case management | BH/SA, CC | |
| Quality of Care | Case Management Structure and Process Measures | NYS DOH CM Data File | (NYS DOH Case Management Data File Specifications) Percent of members participating in CM, mean count of interventions, mean length of time in CM, percent of members meeting goals | BH/SA, CC | Member Level File Required |
| Care Coordination | | | | | |
| Clinical Outcomes | Use of Appropriate Medications for People with Asthma | Claims and Pharmacy | (HEDIS 2012 - Effectiveness of Care) Percentage of members who are identified with persistent asthma and who were appropriately prescribed preferred asthma medication | BH/SA, CC | Meaningful Use Clinical Quality Measure for HH with EHR |
| | Cholesterol Testing for Patients with Cardiovascular Conditions | Claims, Pharmacy | (HEDIS 2012 - Effectiveness of Care) Percentage of members who were discharged alive for AMI, | BH/SA, CC | Meaningful Use Clinical Quality Measure for HH with EHR |

| | | | | | |
|--|--|---------------------|---|-----------|---|
| | | | CABG or PCI or who have a diagnosis of IVD and who had at least one LDL-C screening | | |
| | 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 | BH/SA, CC | Meaningful Use Clinical Quality Measure for HH with EHR |
| | Annual Monitoring for Patients on Persistent Medications (ACE/ARB and Diuretics) | Claims and Pharmacy | (HEDIS 2012 - Effectiveness of Care) Percentage of members who had 180 days of treatment with ambulatory medication therapy for ACE/ARB or Diuretics and who had the appropriate therapeutic monitoring | BH/SA, CC | Meaningful Use Clinical Quality Measure for HH with EHR |
| | Antidepressant Medication Management | Claims and Pharmacy | (HEDIS 2012 - Effectiveness of 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 | BH/SA, CC | Meaningful Use Clinical Quality Measure for HH with EHR |
| | 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 | BH/SA, CC | |

| | | | | | |
|--|--|---------------------|--|-----------|-------------|
| | 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 | BH/SA, CC | Claims Data |
| | Proportion of Schizophrenia Patients With Long-Term Utilization of Antipsychotic Medications | Claims and Pharmacy | (RAND section 2701 ACA proposed measure) Percentage of patients with a schizophrenia diagnosis who received an antipsychotic medication for the following periods of time: (A) Patients with at least 50% days supply of an antipsychotic medication during the measurement year, (B) Patients with at least 80% days supply of an antipsychotic medication during the measurement year, (C) Patients with no filled prescription for an antipsychotic during the measurement year *The State's mental health agency advised the quantification standards to better reflect quality of care for a persistently | BH/SA | |

| | | | | | |
|--------------------|---|---------------------|---|-------|-------------|
| | | | severe mentally ill population targeted for Health Home. | | |
| | Proportion of Patients with Bipolar I Disorder Treated With Mood Stabilizer Medications During the Course of Bipolar I Disorder Treatment | Claims and Pharmacy | (RAND section 2701 ACA proposed measure) Percentage of patients with bipolar I disorder who had evidence of (A) Patients with at least 50% days supply of a mood stabilizing medication during the measurement year, (B) Patients with at least 80% days supply of a mood stabilizing medication during the measurement year, (C) Patients with no filled prescription for a mood stabilizing medication during the measurement year *The State's mental health agency advised the quantification standards to better reflect quality of care for a persistently severe mentally ill population targeted for Health Home. | BH/SA | |
| Experience of Care | CAHPS for Medical Home or Health Plan | Survey Vendor | (CAHPS 4.0H) Selected Care Coordination Questions | | |
| Quality of Care | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | Claims | (HEDIS 2012 - Access/Availability of Care) Percentage of members with a new episode of alcohol or other drug dependence who initiated treatment within 14 days of the diagnosis and | BH/SA | Claims Data |

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|--|---|-------------------------------------|---|--|--|
| | | | who continued treatment for the 30 days following the initial visit | | |
| Health Promotion | | | | | |
| Experience of Care | CAHPS for Medical Home or Health Plan | Survey vendor | (CAHPS 4.0H) Selected Health Promotion Questions | BH/SA, CC | |
| Quality of Care | 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 | BH/SA, CC | |
| | 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 | BH/SA, CC | Meaningful Use Clinical Quality Measure for HH with EHR |
| | Medical Assistance with Smoking and Tobacco Use Cessation | Survey Vendor | (CAHPS 4.0H) Selected Questions | BH/SA, CC | Meaningful Use Core Clinical Quality Measure for HH with EHR |
| Comprehensive Transitional Care | | | | | |
| Clinical Outcomes | 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 | CC (BH/SA if diagnosis prevalence is sufficient) | Meaningful Use Clinical Quality Measure for HH with EHR |
| Experience of Care | CAHPS for Medical Home or Health Plan | Survey Vendor | (CAHPS 4.0H) Selected Care Coordination Questions | BH/SA, CC | |
| Quality of Care | Follow Up After Hospitalization for Mental Illness | Claims | (HEDIS 2012 - Effectiveness of Care) Percentage of discharges for treatment of selected mental illness disorders | BH/SA | Claims Data |

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|--|---|--------|--|-----------|-------------|
| | | | <p>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.</p> <p>In addition, 'retention' in services, defined as at least five qualifying visits (see above) with mental health providers within 90 days of discharge.</p> | | |
| | Follow Up After Hospitalization for Substance Use | Claims | <p>(NYS Specific Measure) Percentage of discharges for treatment of selected substance use disorders who had an outpatient visit, intensive outpatient encounter or partial hospitalization with a substance use treatment provider within 7 days and within 30 days of discharge.</p> <p>In addition, 'retention' in services, defined as at least five qualifying visits (see above) with substance use treatment providers within 90 days of discharge.</p> | BH/SA | |
| | Follow Up After Hospitalization for Medical Illness | Claims | <p>(NYS Specific Measure) Percentage of discharges from</p> | BH/SA, CC | Claims Data |

| | | | | | |
|---|--|---|---|-----------|----------------------------|
| | | | acute inpatient care (excluding mental health and substance use admissions) to a non-acute setting who had an outpatient or non-acute setting visit with a primary care provider within 7 days and within 30 days of discharge | | |
| Individual and Family Support Services | | | | | |
| Clinical Outcomes | Stable or Improved Functional Status | Sample using functional assessment tool or survey | TBD - Member level data with results of functional assessments collected at designated intervals will be submitted annually | BH/SA, CC | |
| Experience of Care | CAHPS for Medical Home or Health Plan | Survey Vendor | (CAHPS 4.0H) Selected Questions | BH/SA, CC | |
| Quality of Care | Case Management Structure and Process Measures | NYS DOH CM Data File | (NYS DOH Case Management Data File Specifications) Percent of members participating in CM, mean count of interventions, mean length of time in CM, percentage meeting goals. In addition, assessment of housing status will be collected in case management data for annual reporting. | BH/SA, CC | Member Level File Required |
| Referral to Community Support Services | | | | | |
| Clinical Outcomes | Follow Up After Referral | Survey Tool | Potential survey questions to be developed. | BH/SA, CC | |
| Experience of Care | | | | | |
| Quality of Care | Case Management Structure and | NYS DOH CM Data File | (NYS DOH Case Management Data File | BH/SA, CC | Member Level File Required |

| | | | | | |
|--|------------------|--|---|--|--|
| | Process Measures | | Specifications) Percent of members participating in CM, mean count of interventions, mean length of time in CM, percentage meeting goals. In addition, assessment of housing status will be collected in case management data for annual reporting. | | |
|--|------------------|--|---|--|--|

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 | BH/SA, CC | Claims and Encounters |
| Hospital Inpatient | Preventable Hospitalizations | Claims and Encounters | Hospital Utilization and cost per member per month | BH/SA, CC | Claims and Encounters |
| Hospital Inpatient | Potentially Preventable Readmissions | Claims and Encounters | PPR Utilization and costs | BH/SA, CC | Claims and Encounters |
| Hospital ER | Potentially Avoidable ER Visits | Claims and Encounters | Potentially Avoidable ER visits and costs per member per month | BH/SA, CC | Claims and Encounters |
| Skilled NH Admissions | NH Admissions | Claims and Encounters | Nursing Home Utilization and cost per member per month | BH/SA, CC | 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’s response to this section is still under development.

- i. Hospital admission rates**
- ii. Chronic disease management**
- iii. Coordination of care for individuals with chronic conditions**
- iv. Assessment of program implementation**
- v. Processes and lessons learned**
- vi. Assessment of quality improvements and clinical outcomes**
- vii. Estimates of cost savings**

**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

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 1) region, 2) enrollment volume, 3) case mix (from Clinical Risk Group (CRG) method) and this fee will eventually be adjusted by (after the data is available) 4) 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).

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 (perhaps 80 percent) of the active care management PMPM. The case finding PMPM is only available for the first few months (e.g.3-6) after a patient has been assigned to a given health home and this PMPM is intended to cover the cost of outreach and engagement. 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.

The active care management PMPM will be paid in two installments. The first installment maybe billed up front and the second installment will automatically be paid once the health home provider meets certain pre-set state quality metrics. In the first year, some percentage

(perhaps 90 percent) of the PMPM will be paid up front and the remaining percentage (perhaps 10%) will be reserved against meeting the quality benchmarks.

Shared Savings:

If the State achieves overall savings from the implementation of this program, Health home providers will be eligible to participate in a shared savings pool. The pool will be developed at the end of the first year of health home operation and will consist of a percentage (perhaps 15 percent) of the documented State share savings derived from health home operation. The State will use a method to adjust savings for regression to the mean before setting up the pool. If the federal portion of savings becomes eligible for shared savings with providers then a portion of those savings will be included in the pool based on any federal conditions that may be applied to such savings. Under Federal rules, some shared savings incentive payments cannot exceed 105% of the aggregate payment for Medicaid services received.

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. Plans may also participate in shared savings but shall do so proportional to the PMPM distribution.

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. 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 date they convert to or become part of a health home. After one year of operation, 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. In the third year we expect all payments will be made under the health home payment detailed above in the care management fee section.

Identical to fee for service, Health Plans will be required to pay TCM programs operating as health homes or health homes affiliated with TCM programs the State set TCM rate for current and new TCM assignees up to the TCM's historical capacity.

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 date that 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. After one year 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.