MEDICAID INSTITUTE
AT UNITED HOSPITAL FUND

Implementing Medicaid Health Homes in New York: Early Experience

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Established in 2005, the Medicaid Institute at United Hospital Fund provides information and analysis explaining the Medicaid program of New York State. The Medicaid Institute also develops and tests innovative ideas for improving Medicaid's program administration and service delivery. While contributing to the national discussion, the Medicaid Institute aims primarily to help New York's legislators, policymakers, health care providers, researchers, and other stakeholders make informed decisions to redesign, restructure, and rebuild the program.

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Implementing Medicaid Health Homes in New York: Early Experience

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UNITED HOSPITAL FUND

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Introduction

In New York, where the most complex and costly Medicaid beneficiaries drive the majority of program spending—and there is recognition that service delivery for these beneficiaries has not been adequately coordinated—the State has made the establishment of care management structures and the achievement of better service integration top priorities. "Health homes," designed to reduce costs and improve health outcomes, are being embraced as one of the main vehicles for achieving these goals under New York's ongoing Medicaid reforms.

Health homes were authorized by the federal Patient Protection and Affordable Care Act (ACA) of 2010 as a care management and coordination vehicle for Medicaid enrollees with chronic conditions, including serious mental illness, substance use disorders, asthma, diabetes, and heart disease. (For a brief discussion of the health home model's evolution, see Appendix A.) The ACA gave states the option of making care coordination by health homes a Medicaid-covered service with a federal medical assistance percentage (FMAP) of 90 percent for the first two years after the effective date of a state plan amendment.[1] Six health home services are eligible for federal reimbursement:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care;
- Patient and family support;
- Referral to community and social support services; and
- Use of health information technology to link services.[2]

While the ACA defines health homes as care coordination vehicles, there is no standard definition of care coordination or care management, terms often used interchangeably. But the common thread among care coordination programs is the goal of facilitating access to appropriate care and containing costs. The health home model addresses the fragmented and disjointed nature of care for complex patients and, most significantly, defines that care broadly, addressing needs outside of as well as within the health care system. Currently, for the highest-cost Medicaid patients, no single entity is responsible for connecting and integrating physical health care, behavioral health care, and social supports and services. The result is either poor quality care or no care until a moment of crisis.

Eight states, including New York, have already received approval for their Medicaid state plan amendments for health homes from the Centers for Medicare & Medicaid Services (CMS); 18

[1] ACA § 2307

[2] ACA § 2307

other states and the District of Columbia have shown interest in developing health homes.[3] How states structure health homes to pursue the common goal of care coordination varies considerably. Some states' health home initiatives serve narrowly defined cohorts, use existing care coordination entities, and tightly define roles and credentials for health home team members, but New York has taken a notably broad and open approach instead. (For details on Medicaid health home initiatives in three other states—Rhode Island, Missouri, and Oregon—see Appendix B.)

New York's Approach to Health Homes

New York's embrace of the ACA health home option is central to the State's goal of reshaping its health care delivery system. The health home initiative challenges the system to do things differently by promoting patient-centered models of service delivery, more formalized relationships among providers, new payment arrangements, and a commitment to quality measurement. The following section summarizes key elements of the State's vision by examining the beneficiaries to be enrolled, describing the organizational structure of health homes, and outlining the ways they are expected to operate.

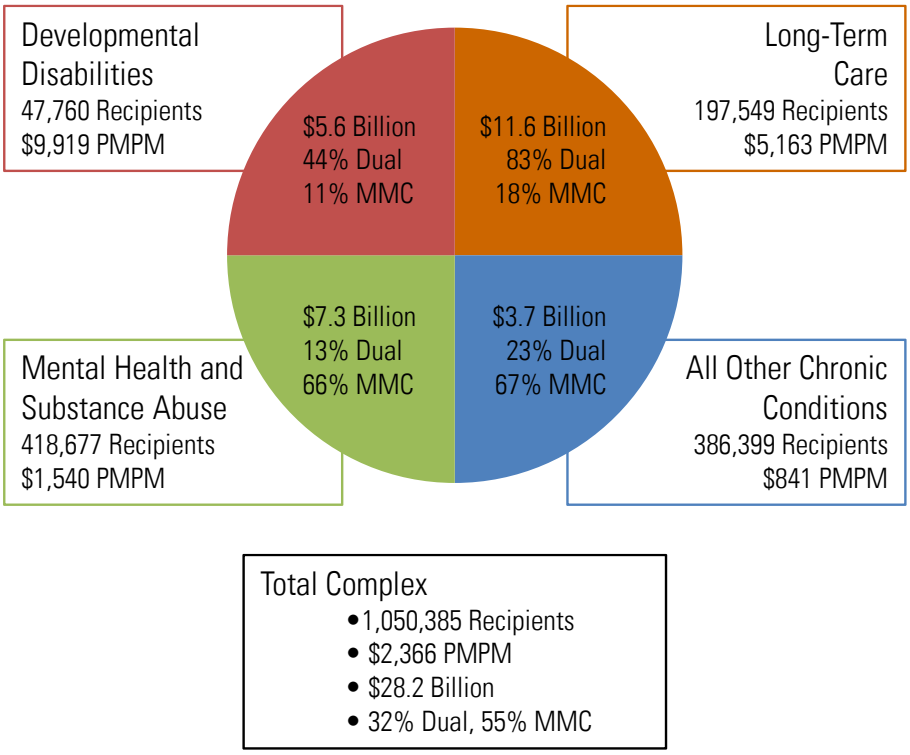
The New York State Department of Health (DOH) initially identified about 1 million high-cost, high-need enrollees as meeting state and federal health home eligibility standards. These enrollees fall into four mutually exclusive cohorts: individuals with developmental disabilities, long-term care recipients, individuals with behavioral health conditions, and other individuals with multiple chronic conditions.[4] Individuals are determined to be eligible for health homes based on a clinical risk group attribution model that places beneficiaries into one of the four defined cohorts. The State has identified these individuals based on claims and encounter data and, using risk scores, categorized beneficiaries as high-need, medium-need, or low-need.

The health home rollout is staged to occur in three distinct waves. The first, currently underway, targets those with behavioral health conditions and multiple chronic conditions; the second and third waves will target long-term care recipients and beneficiaries with developmental disabilities, respectively (see Figure 1).

[3] U.S. Department of Health and Human Services. December 11, 2012. What's New in Multiple Chronic Conditions? A 2012 Update [Office of the Assistant Secretary for Health webinar].

[4] New York State Department of Health. 2012. Preliminary New York State Health Home Rollout Plan. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/2012-01-24_preliminary_hh_rollout_plan.pdf

Figure 1.
Medicaid Health Home Cohorts



Source: New York State Department of Health. Note: The term "duals" refers to beneficiaries who are dually enrolled in Medicaid and Medicare.

The first health home wave draws from about 805,000 Medicaid beneficiaries with behavioral health conditions, multiple chronic conditions, or both, accounting for the majority of the 1 million total individuals eligible for health homes. The first wave is occurring in three phases, based on geography. Phase I of the health home initiative, for which New York submitted and received approval from CMS effective January 1, 2012, includes ten counties: Bronx and Kings (Brooklyn) in New York City, plus Clinton, Essex, Franklin, Hamilton, Nassau, Schenectady, Warren, and Washington. The State received approval of its Phase II[5] and Phase III[6] health home state plan amendments in December 2012.

Health home provider requirements are so comprehensive[7] that it would be difficult for any single entity to meet them. By design, this feature promotes partnerships across the health

[5] Phase II counties are Dutchess, Erie, Monroe, New York (Manhattan), Orange, Putnam, Queens, Richmond (Staten Island), Rockland, Suffolk, Sullivan, Ulster, and Westchester.

[6] Phase III counties are Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Columbia, Cortland, Delaware, Fulton, Genesee, Greene, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Niagara, Ontario, Oneida, Onondaga, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Wayne, Wyoming, and Yates.

[7] New York State Health Home State Plan Amendment for Individuals with Chronic Behavioral and Medical Health Conditions- SPA # 11-56. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/chronic_conditons_spa_11-56_phase.pdf

care system and beyond. It sends the message that many distinct providers are needed to achieve care coordination and to integrate service delivery. New York's state plan amendment, or SPA, describes the health home provider as the central point for directing patient-centered care though the six aforementioned health home coordination services.

As described in the SPA, the health home model is expected to lower rates of emergency department use, reduce hospital admissions and re-admissions, reduce reliance on long-term care facilities, and improve the experience of care and health outcomes for the individual beneficiary. These stated goals will eventually be the basis for health home evaluation and a corresponding set of outcome measures. Initially, however, the State will collect process metrics, primarily to assess the level of care coordination delivered and record the specific management services provided.[8] Health homes are expected to report those process metrics using a modified version of the Case Management Annual Reporting Tool (CMART), which is currently used by Medicaid managed care plans to report to the State on case management.[9] DOH has indicated that a finalized CMART platform for health homes will be implemented shortly.[10]

Organizational Structure

New York's stated goal for health homes is to create a vehicle to coordinate delivery of all services, encompassing the full spectrum of a Medicaid beneficiary's health and social service needs. To accomplish this goal, DOH designed health homes to include a broad array of providers. Each health home is thus actually a network of providers, known as network partners. For each eligible beneficiary, one of these providers is designated as the downstream care management partner, or care manager, which is expected to act as the leader of a multidisciplinary team of providers and "assure that the enrollee receives needed medical, behavioral, and social services in accordance with a single plan of care."[11]

Within each health home is a lead health home agency, responsible for maintaining information systems and beneficiary data, securing health home payment, and assuring quality. While only one organization may be designated as lead agency, that organization may be made up of multiple providers under one joint governance structure.

[8] New York State Department of Health. April 2012. Introducing Health Homes: Improving Care for Medicaid Recipients with Chronic Conditions. *New York State Medicaid Update* 28(4). http://www.health.ny.gov/health_care/medicaid/program/update/2012/april12muspec.pdf

[9] New York State Department of Health (NYSDOH). June 2012. Health Home Implementation Update [webinar]. Albany: NYSDOH. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/2012-06_hh_webinar_and_town_hall_mtgs.ppt

[10] New York State Department of Health. November 2012. Health Home Implementation Update [webinar]. Albany: NYSDOH. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/2012-11-19_hh_implement_webinar_8.ppt

[11] New York State Health Home State Plan Amendment for Individuals with Chronic Behavioral and Medical Health Conditions- SPA # 11-56. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/chronic_conditons_spa_11-56_phase.pdf

Phase I Lead Agencies by County

- **Bronx:** Montefiore Medical Center (establishing the Bronx Accountable Health Network with partners), New York City Health and Hospitals Corporation (HHC), Visiting Nurse Service of New York Home Care, and Bronx–Lebanon Hospital Center in partnership with Coordinated Behavioral Care/FEGS Health and Human Services System
- **Brooklyn:** Maimonides Medical Center, HHC, Community Health Care Network, and Institute for Community Living
- **Nassau:** North Shore-LIJ Health System and FEGS Health and Human Services System
- **Schenectady:** Visiting Nurse Service of Schenectady County
- **Clinton, Essex, Franklin, Hamilton, Warren, and Washington counties:** Adirondack Health Institute and Glens Falls Hospital

Managed care organizations (MCOs) play differing roles in the health home initiative. At a minimum, MCOs contract with health homes to provide health home services to their eligible members. All health homes are required to have administrative service agreements with MCOs, but the State is not requiring that all health homes contract with all MCOs. Some plans are providing administrative support, including data management, to their contracted health homes. Because it wanted to focus on the role of providers in health homes, the State indicated that it would only ask MCOs to apply to be health homes in areas of the state in which no provider-led health home could provide those services. Thus far, provider-led capacity has been identified for all three phases of the first wave of health home implementation.

Identification and Enrollment of Newly Eligible Beneficiaries

For the first health home wave, the State plans to enroll about 224,000 of the 805,000 potentially eligible individuals with behavioral health issues or two or more chronic medical conditions.[12] That subset has been identified by a predictive risk model as having a high risk of an adverse event—an inpatient hospital stay, nursing home stay, or death—in the coming year, and little to no connectivity to ambulatory services. Based on recent concern about low volume from the lead health homes and downstream partners, the State is working to expand the assignment volume above the 224,000 level. Categories of chronic medical conditions triggering eligibility include cardiovascular disease, HIV/AIDS, metabolic disease, and respiratory disease.[13] Phase I of the first wave includes about 84,000 beneficiaries targeted for enrollment, representing those with the highest need. Health homes are not mandatory; beneficiaries can choose to opt out of the program at any time.

[12] New York State Department of Health. 2012. Preliminary New York State Health Home Rollout Plan. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/2012-01-24_preliminary_hh_rollout_plan.pdf

[13] New York State Health Home State Plan Amendment for Individuals with Chronic Behavioral and Medical Health Conditions- SPA # 11-56. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/chronic_conditons_spa_11-56_phase.pdf

As an alternative to the state-generated rosters, the State recently laid out guidance on how individuals can be referred to health homes from the community. Referrals can be made by health home providers themselves, as well as by managed care plans, hospitals, inpatient psychiatric centers, and the criminal justice system. The referring entity must make a presumptive assessment of an individual's health home eligibility before referring him or her to a health home or managed care plan for a more comprehensive assessment and, potentially, enrollment.[14]

For eligible beneficiaries in fee-for-service (FFS) Medicaid, the State is using a loyalty analysis to ensure that beneficiaries will be assigned to health homes that include the providers from whom they primarily receive care, with the lead agency then making the assignment to the care manager. For those without a usual source of care, assignments will be based on geography. For those in Medicaid managed care, enrollees' current plans are responsible for assigning eligible beneficiaries to health homes, based on plans' own information about enrollee service use and on information provided by the State. Again, the designated health home's lead agency will then assign a downstream care management partner for each beneficiary.

Each beneficiary assigned to a health home will receive an enrollment letter. For those in FFS Medicaid, the health home is responsible for sending an enrollment letter; for Medicaid managed care enrollees, the plan is responsible. Once a beneficiary is assigned to a health home, the health home may begin a process of outreach and engagement. If the beneficiary is engaged and begins receiving billable health home services, he or she is considered to be in active care management.

The flow of all enrollment and billing will be controlled through a secure portal known as the Health Home Member Tracking System. This system provides a mechanism to support the claims path, which maps how payment flows, as well as a means to track member assignments to health homes. Ultimately, health homes will track the following data for each assigned beneficiary: demographic information, health plan name (if applicable), assigned health home (lead agency), care manager (downstream care management partner), enrollment/disenrollment status, and patient profile (which includes a predictive risk score, an acuity score, frequency of ambulatory care, and information on the individual's last five outpatient Medicaid claims).

Pivotal to the success of care coordination is the sharing of personal health information. Beneficiaries must sign patient consent forms authorizing their assigned health homes to access that information and share it among their different providers. Initially, the State

[14] New York State Department of Health. November 2012. *New York State Medicaid Update* 28(12). Albany: NYSDOH. http://www.health.ny.gov/health_care/medicaid/program/update/2012/nov12sped.pdf

required health homes to obtain signed consent forms prior to providing services, but to ease the burden on providers and to give beneficiaries time to understand the program, the State is now allowing health homes to provide services before they have obtained signed consent. While there is currently no time limit on health homes' ability to bill for services without a signed consent form in hand, the State has affirmed that achieving patient consent remains the ultimate goal, as well as a prerequisite for realizing the full potential of health homes.

Payment Rates and Billing

The State's projected average per member per month (PMPM) payment rates for health homes are $175 for upstate counties and $209 for downstate (see Figure 2). New York has taken a refined approach to payment by adjusting rates to reflect enrollees' conditions. The State uses clinical risk groups to determine patient-specific acuity, with adjustments for HIV status, mental health or substance abuse issues, and severity of illness. Average rates for high-acuity members with multiple chronic conditions and serious mental illness are as high as $593; average rates for lower-acuity members with multiple chronic conditions are as low as $68. In the future, with additional data collection, the State hopes to be able to adjust rates for functional status, including factors such as homelessness, as well. On October 1, 2012, the State transitioned from paying a single rate to each health home based on the average acuity of its enrollees to paying enrollee-specific rates based on each individual's acuity; the rate is now automatically calculated for each member and health home by the claims payment system.

The member tracking data described above play a key role in documenting the claims path. Because MCOs serve a pass-through function for health home payments, health homes will bill their associated MCOs for the delivery of health home services. Payments to MCOs for health home services are separate from those for premiums; they consist of a monthly care management fee, under a new and distinct rate code for health home services. For FFS beneficiaries, health homes bill the State directly using the new health home rate code. Under State guidance, no more than 6 percent of the payment may be retained by the MCO and lead agency for administrative costs; at least 94 percent flows downstream to care managers. That portion may be shared between the health home and MCO if applicable, with MCOs retaining no more than 3 percent of the total care management fee.

During the period of initial outreach and engagement of new enrollees, which may last up to three months, health homes will be paid 80 percent of the active care management per-member-per-month rate. A health home may not bill the State for enrollees who remain unengaged by the end of that period for another three-month period; at that point, another three months of billing for outreach and engagement may resume. Once a beneficiary is engaged, the health home can bill the full active PMPM in that month and any subsequent month, as long as it provides at least one core service each month to that individual.

Figure 2.

Projected Average Health Home Payments by Base Health Status and Severity of Illness (Excludes Recipients of LTC and Office for People with Developmental Disabilities Services) Effective October 1, 2012

			Downstate			Upstate		
Base Health Status	**SMI**	**Severity of Illness**	**Eligible Recipients**	**Average Acuity Score**	**Average Monthly Payment**	**Eligible Recipients**	**Average Acuity Score**	**Average Monthly Payment**
Single SMI/SED	**Yes**	Low	15,989	6.6993	$155.89	7,231	6.6775	$124.93
		Mid	7,261	9.3623	$217.86	3,621	9.0329	$169.00
		High	292	22.1821	$516.18	68	21.9944	$411.52
Single SMI/SED Total			**23,542**	**7.7127**	**$179.48**	**10,920**	**7.5539**	**$141.33**
Pairs Chronic	**No**	Low	39,736	3.0966	$72.06	13,270	3.6602	$68.48
		Mid	20,983	7.2789	$169.38	7,804	7.6747	$143.59
		High	9,140	13.8438	$322.14	3,045	13.9366	$260.75
	Yes	Low	12,231	10.6780	$248.48	5,244	10.5974	$198.28
		Mid	14,357	15.8052	$367.79	6,771	15.4097	$288.32
		High	2,881	25.4821	$592.97	1,276	24.2513	$453.74
Pairs Chronic Total			**99,328**	**8.3888**	**$195.21**	**37,410**	**9.1355**	**$170.92**
Triples Chronic	**No**	Low	2,562	4.9587	$115.39	963	5.3808	$100.67
		Mid	7,762	7.8965	$183.75	3,053	8.2988	$155.27
		High	6,148	13.7811	$320.69	2,057	14.3990	$269.40
	Yes	Low	2,519	12.5158	$291.24	747	12.4206	$232.39
		Mid	4,266	17.4123	$405.18	1,649	17.4152	$325.84
		High	1,306	25.2165	$586.79	530	25.0789	$469.23
Triples Chronic Total			**24,563**	**12.1102**	**$281.80**	**8,999**	**12.3819**	**$231.66**
HIV/AIDS	**No**	Low	5,997	5.4996	$127.97	752	5.4517	$102.00
		Mid	5,160	10.5293	$245.02	815	9.5101	$177.93
		High	1,424	18.9814	$441.70	160	17.6933	$331.04
	Yes	Low	192	5.5550	$129.26	36	5.5029	$102.96
		Mid	3,713	10.4834	$243.95	450	9.6692	$180.91
		High	507	20.1222	$468.24	65	19.3610	$362.24
HIV/AIDS Total			**16,993**	**9.6825**	**$225.31**	**2,278**	**8.9943**	**$168.28**
Grand Total			**164,426**	**8.9816**	**$209.00**	**59,607**	**9.3305**	**$174.57**

Source: New York State Department of Health
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/2010_10_12_hh_biweekly_webinar_6_final.ppt

Note: "SMI" = serious mental illness; "SED" = serious emotional disturbance; "Pairs Chronic" refers to individuals with two chronic conditions, defined for the purposes of health home eligibility to include behavioral health conditions that are not a serious mental illness or serious emotional disturbance; "Triples Chronic" refers to individuals with three or more chronic conditions.

Legacy Programs

About 35,000 of New York's Medicaid beneficiaries already receive case management through the Targeted Case Management program, the Managed Addiction Treatment Services program, the Comprehensive Medicaid Case Management Program, and the Chronic Illness Demonstration Project. For these beneficiaries, providers will be given the opportunity to convert to health homes.[15] Two years into health home implementation, all of these existing case management programs will be fully converted to the health home model or risk being phased out.[16]

Office of Mental Health Targeted Case Management Program

About 150 provider organizations participate in the New York State Office of Mental Health's Targeted Case Management, or TCM, program.[17] These providers offer varying levels of case management and coordination of community resources for adults with severe mental illness and children and youth with severe emotional disorders.[18]

TCM providers converting to health home status will undergo a different transition process from other health home providers. For a two-year transition period, TCMs will be paid, for beneficiaries in a limited number of "legacy" slots, at special rates calculated to preserve their total revenue from federal fiscal year 2011.[19] They will also be able to enroll additional beneficiaries at standard health home rates. Converting TCMs will directly bill eMedNY, New York's electronic Medicaid claims processing system, for the health home services they provide to both categories of beneficiaries. The State has indicated that TCM rates and billing processes will be aligned with those of non-TCM providers in the third year of implementation.

Once they begin billing for health home services, converting TCMs will no longer be subject to Office of Mental Health TCM regulations. However, TCMs must maintain their contracts with local governmental units responsible for mental health, which have historically overseen

[15] New York State Department of Health. September 9, 2011. Draft Medicaid Health Homes for Individuals with Chronic Conditions Year One Targeted Case Management Conversion Logic. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/targ_case_mgmt/2011-09-09_year_one_tcm_conversion_logic.htm; New York State Department of Health. August 31, 2012. Questions and Answers. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/questions_and_answers.htm#targ_case_mgmt

[16] New York State Department of Health. August 31, 2012. Questions and Answers. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/questions_and_answers.htm#targ_case_mgmt

[17] New York State Office of Mental Health. August 26, 2011. TCM Programs—Location with Program Capacity. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/targ_case_mgmt/docs/2011-08-11_omh_tcm_location_with_program_capacity.xls

[18] New York State Office of Mental Health. [no date] Program Definitions. http://bi.omh.ny.gov/bridges/definitions

[19] New York State Office of Mental Health. February 2012. Transition from Targeted Case Management (TCM) to Health Home Care Management and Non-Medicaid Funded Care Management (CM). Albany: New York State Office of Mental Health. http://www.omh.ny.gov/omhweb/adults/health_homes/content/tcm_to_hh_cm.pdf

access to TCMs via a Single Point of Access intake system for individuals with serious mental illness.[20] In the current first phase of health home implementation, DOH has assigned enrollees to the contracted health homes recommended by converting TCMs as those that would best serve their members. For Phases II and III of implementation, DOH anticipates that converting TCMs will make health home assignments directly, through their lead health home.[21]

Managed Addiction Treatment Services Program

The Managed Addiction Treatment Services program, MATS, is a care coordination and case management program operated by New York's Office of Alcoholism and Substance Abuse Services (OASAS) for high-cost, high-need individuals with substance use disorders. It is not currently funded by Medicaid.[22] New York City has three providers offering MATS services, and Dutchess, Erie, Orange, Suffolk, and Westchester counties each have one.[23] The guidance offered to MATS providers by OASAS has been largely identical to that provided to TCMs by the Office of Mental Health. Former MATS slots will be reimbursed at a PMPM rate targeted to keep total reimbursement constant during the first two years of implementation. Those slots must continue to be used for persons with significant substance use disorders. Local governmental unit processes to refer high-cost, high-need individuals may remain in place. Additional individuals may be enrolled; their care will be reimbursed at the standard health home services rate. For up to two years, converting MATS providers will bill eMedNY directly for all health home services.

Comprehensive Medicaid Case Management Program

Providers in the Comprehensive Medicaid Case Management Program—generally referred to as COBRA Case Management but also known as the HIV/AIDS Targeted Case Management Program—offer family-centered intensive case management services to HIV-infected persons and their families. The program serves a largely minority population; enrollees include persons with mental illness, active substance users, and those at advanced stages of illness. There are 46 COBRA providers statewide, 34 of them located in New York City.[24] Guidance on

[20] New York State Office of Mental Health. February 2012. Transition from Targeted Case Management (TCM) to Health Home Care Management and Non-Medicaid Funded Care Management (CM). Albany: New York State Office of Mental Health. http://www.omh.ny.gov/omhweb/adults/health_homes/content/tcm_to_hh_cm.pdf

[21] New York State Department of Health. June 2012. Health Home Implementation Update [webinar]. Albany: NYSDOH. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/2012-06_hh_webinar_and_town_hall_mtgs.ppt

[22] New York State Office of Alcoholism and Substance Abuse Services. [no date] Services and Medicaid in the OASAS Treatment System [presentation]. www.health.ny.gov/health_care/medicaid/redesign/docs/bhg_oasas_treatment_system.ppt

[23] New York State Department of Health. August 11, 2011. MATS Providers 2011. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/2011_mats_providers.htm

[24] New York State Department of Health. July 2012. Community Support Services. http://www.health.ny.gov/diseases/aids/about/comm_support_services.htm

transitioning to health homes has, to date, been similar to that given to TCM providers. For COBRA providers, reimbursement changes will require a transition from unit-based billing to PMPM rates.[25]

Chronic Illness Demonstration Project

Under the Chronic Illness Demonstration Project, CIDP, New York State awarded funds in 2009 to six providers across the state to improve coordination of care for individuals at high risk of medical, substance abuse, or psychiatric hospitalizations. Participating providers received a monthly care coordination fee to assess and coordinate patient care, improve self-management and caregiver/family involvement, and develop a network of providers to facilitate access to needed medical and social services.[26] CIDP contracts ended on March 29, 2012. Going forward, CIDP providers will bill eMedNY directly, using a unique rate code, for members becoming health home enrollees, much as in the other converting case management programs; unlike those programs, they will begin receiving standard health home rates after one year, not two. For new health home enrollees who were not previously enrolled in a CIDP, billing will be through health home lead agencies or managed care organizations, using the same process as health home providers that are not converting case management programs.[27]

Challenges to Implementation

The State's health home initiative reflects the ambition of its efforts to reform New York's health care delivery system. The difficulties it faces are consistent with the scale of the changes it seeks to achieve. Although the State has set an aggressive timeline for its initiative, implementation of Phase I, approved in February 2012, has been slower than anticipated. That is due, at least in part, to a broad range of challenges, including the differing states of readiness among health homes at the outset of the initiative. These challenges fall in six key areas: becoming operational, enrolling eligible beneficiaries, determining payment rates, building relationships and defining roles, developing health information exchange, and measuring quality.

[25] New York State Department of Health. September 9, 2011. Draft Medicaid Health Homes for Individuals with Chronic Conditions Year One Targeted Case Management Conversion Logic. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/targ_case_mgmt/2011-09-09_year_one_tcm_conversion_logic.htm

[26] Bachrach D. May 27, 2008. Reforming Medicaid in New York State: Targeting Care to High-Need Patients [webinar]. http://www.chcs.org/usr_doc/DBachrach.pdf

[27] New York State Department of Health. April 2012. Introducing Health Homes: Improving Care for Medicaid Recipients with Chronic Conditions. *New York State Medicaid Update* 28(4). http://www.health.ny.gov/health_care/medicaid/program/update/2012/april12muspec.pdf

Becoming Operational

Health homes are newly created entities. Many see themselves as small businesses, and have experienced the start-up challenges common to them, including establishing governance, selecting financial models, and building infrastructure. Health home networks start out as groups of unaffiliated providers that must come together around a new structure and—for some players—a new mission. Before they can begin to deliver services, therefore, health homes have had to spend considerable time and resources developing functional structures among their diverse community of partners, with the outcome of those investments uncertain.

Many downstream care management partners face resource constraints. Providing health home services requires additional administrative work, related to locating and enrolling beneficiaries, tracking and managing their care, and then documenting their activities for lead agencies, plans, and the State. For example, conforming to differing specifications for member tracking data among lead agencies, plans, and the State is a time-consuming process. In recognition of these challenges, some lead agencies have sought to create standardized care management tools to make these tasks more efficient and less costly. Health home leads have chosen different paths to pursuing efficiencies through standardization. Some are requiring certain shared policies and procedures up front, while others are trying not to micromanage their network partners by dictating protocols and overseeing care plans.

In the early stages of health home implementation, New York has generally given priority to flexibility over standardization. DOH has laid out a broad model of care without imposing standards in some key areas. For example, it has not created any new credentialing processes to expand the workforce to meet the needs of health homes. In fact, the health home model includes no standards on training and credentials. Some direct care providers are retraining their existing staff to work with high-need patients and potentially larger caseloads under the health home model. Others have hired new staff, creating specific positions to fit the model. Some providers, however, have to wait for the new health home revenue to start flowing before they can hire new staff, leaving them with a workforce stretched thin.

The State is allowing this kind of flexibility in order to test different working arrangements. This means that, for now, each health home is a uniquely functioning entity. New entities need time to develop protocols and hire and train new staff. Predictably, where the state built on the existing infrastructure of converting case management programs, service delivery has been quicker to start and smoother. Even these existing entities, however, have had to grapple with how to retrain staff to provide services and manage care in new ways.

Enrolling Eligible Beneficiaries

Finding and enrolling eligible beneficiaries have been among the biggest challenges to initial implementation. Specific issues include delays in the enrollment of MCO beneficiaries because of the time-consuming contracting process between health homes and the MCOs, and the quality of the information provided on the initial rosters of health home beneficiaries, particularly for those in fee-for-service Medicaid.

The 84,000 individuals targeted for Phase I implementation represent those beneficiaries whose high risk scores and low levels of connectivity to ambulatory care made them a priority for assignment. Essentially, this approach means that the State is starting with the highest-need beneficiaries—those who also are among the most difficult to reach and to manage.

The initial roll-out began with 41,000 beneficiaries. Rosters containing the names of roughly 35,000 Medicaid managed care (MMC) beneficiaries—about 85 percent of the initial cohort—were sent to plans for health home assignment. For the remaining 6,000 FFS beneficiaries, the State made direct assignments to health homes and passed along enrollees' contact information to the relevant lead agencies. (Enrollees in converting case management programs are not included in these counts.)

For the majority of the initial cohort enrolled in MMC, assignment to a health home was delayed by contracting issues. Prior to contracting, the State released key provisions to be included in agreements between MCOs and health homes. When negotiations began, however, parties sought significant modifications to those provisions; to speed the process, DOH created a standard contract that parties could use without DOH approval. Even with this option, however, the fee arrangements specifying how much of the State's payment to MMC plans is directed to their health homes must still be reviewed and approved by DOH. Allocation of administrative payments between plans and health homes has been a particular point of contention. Because each plan must contract with all the health homes to which it will assign its members, the contract approval process has consumed significant time and administrative resources.

As of January 2013, about 17,000 individuals are receiving health home services or are in the outreach and engagement phase, including about 13,000 in converting case management programs. While health home rosters for individuals in Medicaid managed care may draw on the relatively current, high-quality information available to MCOs, early experience has shown that issues with the reliability of the State-generated rosters have been a major obstacle to engaging eligible fee-for-service beneficiaries. Contact information, which can be difficult to obtain and which changes frequently for many eligible beneficiaries, has often been incomplete or out of date. Some health homes have reported that rosters contained names of

deceased individuals and hospice patients who are in end-of-life care. Other rosters did not accurately indicate which beneficiaries remained in FFS or were no longer exempt or excluded from MMC and had enrolled in a plan. The State recently released a new set of rosters of an additional 62,000 individuals, three-quarters of whom are in MMC. The rosters now use a more automated system that includes several cross checks against more recent eligibility and plan enrollment information, to reduce the kinds of errors found on earlier rosters.

While the new rosters may mitigate previous issues, finding individuals from the initial rosters has been a real challenge and a source of frustration for providers. Some health homes have had more success using their own information and provider networks to track down eligible individuals. Others are waiting to receive additional names from the State. The State has worked to provide more recent claims data to facilitate outreach, and, as discussed above, has also begun to encourage community referrals as another pathway to enrollment. The policy decision to allow health homes to make and receive referrals from the community has benefited providers, who have been able to significantly increase their enrollment by building on already-established relationships with some of their patients.

Once an individual is located, the next step is engagement. The period of time between finding the patient and getting buy-in and consent is a challenging one for health homes. In order to give the care manager time to build rapport and gain the individual's trust, the health home can begin billing without a signed consent form, as long as it provides at least one of the core health home coordination services. Notably, some providers have expressed concern over how to deliver these services without full access to the individual's health information and the ability to share it across providers. Therefore, despite State-provided flexibility, gaining patient consent is critical for health homes.

Determining Payment Rates

In the early days of implementation, payment rates have been in flux, which has affected the ability of some health homes to design their financial models. As previously mentioned, health home payment rates are tied to CRG acuity, with higher patient acuity driving higher PMPM payments. Initial health home rates were released in early 2012, but after hearing concerns about payment adequacy DOH decided to incorporate more information into its calculations. These data include the risk of negative events, based on DOH's predictive model of hospitalizations, nursing home admissions, and death. In late September, DOH announced rate adjustments resulting in a statewide average increase of 38 percent. For example, rate increases for beneficiaries with both mental health conditions and multiple chronic conditions exceeded 90 percent, reflecting the complex interaction between patients' physical and behavioral health needs.

Since October 2012, a health home provider's payments have been determined by a given patient's acuity. Due to information system limitations that DOH has since addressed, payments under the previous methodology were based on the average acuity of all patients served by that health home—except in the case of converting case management programs, whose payments reflected the average acuity of patients across all providers within a program. For health home providers, many of whom are operating on tight budgets, it is difficult to make planning decisions based on uncertain or changing information on payment rates. Allocating payments between plans, lead health home agencies, and downstream direct care managers poses an additional administrative burden.

Building External Relationships and Defining Roles

Structural relationships among all the entities involved in a beneficiary's care are starting to take shape, with very promising and productive partnerships emerging in some health homes. Within that context, there are still very complex interrelationships among health homes, MCOs, a broad range of providers, and the patient.

Managed Care Organizations

Since most health home beneficiaries in the initial rollout are enrolled in managed care plans, the relationship between health homes and MCOs is an important one. Because MCOs have their own form of care coordination, clear lines must be drawn in order to prevent the duplication of services. Some plans see an opportunity to shift certain care coordination functions to health homes, while others will continue their own activities but coordinate them with health homes.

Health homes will also have to interface with providers who are not part of their health home networks. Exactly how this will work is an open question. One concern is that these non-network providers may feel they have no incentive to work with health home care managers. Some health homes believe that once providers understand how a care manager can help their patient, they will work together cooperatively—this means, however, that it will be up to both the care manager and the patient to make a case for the utility of the health home. Without a direct financial incentive for outside providers to communicate with health homes, and with competing demands for their time, making this case could be challenging. Despite this real challenge, the comprehensive networks that health homes have developed are designed to reduce the amount of out-of-network communication and to improve connectivity between formerly disconnected providers. While some of this benefit is emerging, it will take time to mature.

Behavioral Health Organizations

Another set of relationships applies for beneficiaries with behavioral health conditions. For some of these enrollees, health homes will need to work with a behavioral health organization (BHO), a newly created regional entity that plays a role in managing care for beneficiaries in FFS Medicaid with serious mental illness or substance use disorders. Currently, in the initial phase of BHO implementation, the primary function of the BHO is to monitor inpatient care and length of stay through concurrent review. Through BHOs, the State is seeking to identify service gaps and unmet needs that contribute to hospital readmissions and unnecessary emergency department visits.

Given the makeup of this first wave of enrollees, some beneficiaries will have both a health home and a BHO. At this point, however, there seems to be minimal coordination, both at the policy level and on the ground, between these two kinds of entities. The State Department of Health has said it will compile lists of health home enrollees to share with BHOs, so BHOs can inform health homes if their enrollees are admitted to the hospital. Although DOH requires hospitals to inform BHOs when a beneficiary is admitted, there is currently no requirement for either hospitals or BHOs to inform health homes.

DOH has described the BHO's role relative to the health home as one of "additional notification and information-gathering."[28] The State has begun encouraging all health homes to enter into confidentiality agreements with their regional BHOs, to allow for alerts to be generated when health home enrollees enter the hospital. Some health homes have already coordinated with their region's BHO, and vice versa. At least one Phase I health home has a formal data-sharing arrangement with the BHO operating in its region. In one Phase II county, the BHO has signed a data-sharing agreement with health homes in its region so that they can access information from the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES), a report-based system available to Office of Mental Health providers to track administrative data and quality indicators for individuals with mental illness. This kind of coordination could go a long way toward helping health homes perform their responsibilities effectively.

As behavioral health reform moves into its next phase starting in 2013, the role of health homes will become even more significant. In New York City, the State plans to prioritize full-benefit integrated special needs plans as a single entity to manage and pay for those behavioral health services now provided under fee-for-service for higher-need members. In other regions, where capacity for such plans may be limited, and for individuals not enrolled

[28] New York State Department of Health. August 29, 2012. Health Home Implementation Update [webinar]. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/2012-08-29_health_homes_implementation_updates_session_4.wmv

in special needs plans in New York City, the State will look to mainstream Medicaid managed care plans that provide physical health services to either provide managed behavioral health services as well or to contract with a State-certified BHO. These are the same managed care plans now contracting with health homes for care coordination services. As the State moves forward with behavioral health reform and continues to mandate health homes as a plan benefit, how best to optimize the relationships among health homes, managed care plans, and BHOs remains an open question.

Local Government Units

Health homes will also need to coordinate with their local government units. These LGUs—which include the commissioners, directors, and staff of each of the 57 county mental hygiene agencies and the Bureau of Mental Health Services in the New York City Department of Health and Mental Hygiene—play a role in managing their respective county systems of behavioral health care for all patients, not just those enrolled in Medicaid.[29] LGUs receive State funding for an array of services in the public mental health system. As local boots on the ground, they are important potential partners for any organization charged with managing Medicaid beneficiaries with behavioral health conditions.

One example of both the importance and complexity of the health home relationship with LGUs is court-ordered Assisted Outpatient Treatment, which monitors individuals who are likely to have difficulty with mandatory participation in treatment. The local mental health system is charged with ensuring that these people have priority access to case management and other services necessary to ensure their safety and their success living in the community. Undoubtedly, though, there will be overlap between participation in this program and enrollment in health homes, highlighting the need for the LGU and the care manager to work in a coordinated fashion to avoid duplication of services. Recently, the State has recommended that each health home pursue a Data Exchange Application and Agreement with its respective LGU and its local department of social services to facilitate proper coordination between these entities.

Patients

Finally, health homes mean changes for patients. The health home model revolves around the concept of "patient-centered" care—defined broadly as making the patient a central and active player in the development and execution of a care plan. That often requires major behavioral and cultural change by plans and providers, as well as patients. Many individuals, particularly those with significant behavioral health conditions, have no meaningful connection to their care providers and tend to bounce from provider to provider, turning to hospital emergency

[29] The core function of the LGUs, vested in Article 41 of the State's Mental Hygiene Law, is to develop plans to meet the needs of those diagnosed with mental illness and substance use disorders.

departments and relying on resulting inpatient admissions in moments of crisis. For many, going to the emergency room is a coping mechanism. For the health home model to work, many patients will need help to reorient themselves to new patterns, making their care managers regular points of contact. In turn, care managers must adapt to being accessible to their patients at all times, and serving as system navigators. These major shifts in attitudes and behavior will take time.

Developing Health Information Exchange

Using health information technology (HIT) to link services is both a core health home responsibility and a major challenge for health home providers. Many network partners have little, if any, experience with HIT or health information exchange (HIE). Others have significant experience, in part due to support from the State and the federal government. While the State has made expanded use of HIT and HIE a priority in health home implementation, its vision of health homes as a unifying platform for data sharing presents both opportunities and hurdles.

The State's emphasis on flexibility over standardization in health home implementation extends to how beneficiaries' health information is exchanged, but HIT requirements and deadlines still present substantial challenges. The State's Health Care Efficiency and Affordability Law (HEAL) Capital Grant Program has provided support for HIT development to hospitals, medical practices, and, to a lesser degree, some behavioral health providers. Significant up-front costs and technical limitations associated with implementing HIT and HIE are particularly large obstacles for many community-based service providers. These providers' participation is central to the health home initiative, but they have received little financial or technical support for HIT development in the past.[30] A recent State HEAL grant has provided for technical—though not financial—support for behavioral health providers to develop HIE capability, in recognition of remaining gaps.

Beyond immediate implementation hurdles, even HIT-enabled health home providers face difficulties in exchanging information with other providers and managed care entities involved in the care of their patients. Specifically, health homes must implement a common care plan management platform that can accommodate differing protocols, information workflows, and data contribution methods among various providers.[31] The State envisions these platforms as important vehicles for data sharing for many network providers. The health home consent form allows lead agencies to access patient data from Regional Health

[30] New York State Department of Health. August 2012. New York State Medicaid Redesign Team (MRT) Waiver Amendment: Achieving the Triple Aim. Albany: NYSDOH. http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08-06_waiver_amendment_request.pdf

[31] New York eHealth Collaborative. March 15, 2012. Health Homes: HIT Needs Assessment Meeting.

Information Organizations (RHIOs) and to share that data among network partners. Network partners must obtain consent separately to access data from the RHIOs directly.

Connectivity to both health plan and State data is also an emerging HIT need for providers, who require such data to better understand and meet the needs of their patients.[32] For example, the State has not yet finalized a way to link all health homes to PSYCKES,[33] but when these data become available they will be an important source of information on individuals with mental illness.

Providers understand that a dynamic HIT capacity is vital to the success of health homes, and many have pursued this goal vigorously. Several health homes, recognizing the HIT limitations of the smaller organizations in their networks, have developed separate applications that are available to their network partners through the internet. Such Web-based systems allow even smaller partners to access actionable data on their patients, with some lead health homes sharing their electronic medical record systems with downstream network partners. This has allowed many smaller organizations to receive information in real time, including notifications of hospital admissions.

The State has identified many HIT challenges in its application to CMS for a waiver to continue implementing comprehensive Medicaid reform based on the recommendations of New York's Medicaid Redesign Team. This application requested health home implementation funds, including one-time gap funding for HIT implementation. Targets for investment would include the development of common care management platforms and a common provider portal for data sharing.[34] With a major federal funding request outstanding and health homes a year into implementation, HIT remains one of the most complex issues in the successful implementation of health homes.

Measuring Quality

A robust quality measurement system is crucial to assessing health homes' performance in improving the management of care for their enrollees. Much of the State's proposed framework—and its specific outcome measures—were outlined in its approved SPA for Phase I health homes. Continued implementation of that framework will allow the State to evaluate health homes' impact on the management of care for their high-need, high-cost enrollees.

[32] New York eHealth Collaborative. April 2012. Health Information Exchange and Interoperability. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/2012-04-25_nyec_presentation.pdf

[33] New York State Department of Health. August 29, 2012. Health Home Implementation Update [webinar]. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/2012-08-29_health_homes_implementation_updates_session_4.wmv

[34] New York State Department of Health. August 2012. New York State Medicaid Redesign Team (MRT) Waiver Amendment: Achieving the Triple Aim. Albany: NYSDOH. http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08-06_waiver_amendment_request.pdf

Quality measurement for complex populations has received significant attention recently. The Medicaid Institute at United Hospital Fund released a report in December 2011 identifying existing structural, process, and outcome measures, as well as gaps in measures, for complex and high-cost beneficiaries—including individuals with behavioral health conditions and those with multiple chronic conditions.[35] In 2012, the National Quality Forum both released a broad quality measurement framework for individuals with multiple chronic conditions[36] and endorsed 12 measures to assess care coordination.[37] With its health home initiative, New York has an opportunity to leverage existing work on quality measurement to evaluate the impact of its new approach to care management, thereby making a significant contribution to the knowledge base on quality improvement for complex and high-cost Medicaid beneficiaries.

The State is implementing an outcome-based quality measurement system directed toward a number of goals, including reduced utilization associated with avoidable or preventable inpatient stays and emergency department visits, improved outcomes for beneficiaries with behavioral health issues, improved care for specific chronic conditions, and improved preventive care.[38] Its outcome measures include NCQA-approved Healthcare Effectiveness Data and Information Set (HEDIS) measures and New York State-specific measures, which will be employed in a longitudinal study evaluating care management, engagement in "guideline-concordant care," and cost of utilization.[39] The State is awaiting CMS guidance on the agency's core quality measure set for health homes, which has yet to be finalized, and plans to incorporate it as well.

In addition, DOH has released draft process metrics for health homes, including counts of interactions between patient and care manager (in person, by mail, and by phone), descriptions of completed interventions, and outcomes of care management, including whether management goals were met.[40] As discussed earlier, the modified Case Management Annual Reporting Tool (CMART) for those metrics will be finalized in the near future. The

[35] Lind A. December 2011. Measuring Quality for Complex Medicaid Beneficiaries in New York. New York: Medicaid Institute at United Hospital Fund. http://www.uhfnyc.org/assets/962

[36] National Quality Forum. May 2012. Multiple Chronic Conditions Measurement Framework. Washington, DC: National Quality Forum. http://www.qualityforum.org/Projects/Multiple_Chronic_Conditions_Measurement_Framework.aspx

[37] National Quality Forum. August 2012. NQF Endorses Care Coordination Measures. Washington, DC: National Quality Forum. http://www.qualityforum.org/News_And_Resources/Press_Releases/2012/NQF_Endorses_Care_Coordination_Measures.aspx

[38] New York State Health Home State Plan Amendment for Individuals with Chronic Behavioral and Medical Health Conditions- SPA # 11-56. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/chronic_conditons_spa_11-56_phase.pdf

[39] New York State Health Home State Plan Amendment for Individuals with Chronic Behavioral and Medical Health Conditions- SPA # 11-56. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/chronic_conditons_spa_11-56_phase.pdf

[40] New York State Department of Health. February 2012. DRAFT Proposed Health Home Case Management Metrics. Albany: NYSDOH. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/proposed_case_mgmt_metrics.doc

State has already begun to examine rates of engagement of enrollees assigned to health homes via rosters, as an early indicator of health home performance.[41]

The State will also draw on enrollment data, claims and encounter data, and pharmacy records to evaluate the health home initiative's impact on hospital admission rates, chronic disease management, coordination of care, and Medicaid spending. Beneficiaries enrolled in health homes will be compared with matched groups of comparable beneficiaries not in health homes. Finally, the State is using an ongoing learning collaborative made up of early adopter health home providers to assess health home implementation. It also plans to convene a Health Home Advisory Group, consisting of state officials, providers, community advocates, and members of academic institutions.[42]

This is an ambitious and multifaceted plan for the quality measurement and performance evaluation of health homes, and significant work lies ahead for the State. Some providers have expressed concern that making a fair assessment of their performance will be difficult with low enrollment and at an early stage of implementation. Others have objected to the use of the modified CMART to report process metrics. Due to gaps in their experience and infrastructure related to quality measurement and reporting, some providers face a steep learning curve. Variation in providers' approaches to health home implementation also poses a challenge to building a standardized evaluation process. The State has made a significant investment in the health home model; it requires and is pursuing a comprehensive and operational system of quality measurement to evaluate the return on that investment.

Health Homes in the Context of Medicaid Reform in New York

Delivering two years of health home services to all 224,000 first-wave individuals could cost about $1.2 billion, with about $1.1 billion paid by the federal government.[43] Recognizing the time-limited nature of the enhanced federal contribution, New York has taken steps to maintain health home sustainability. Its recent waiver application to CMS proposes to "invest $525 million over the next five years to fully deploy health homes across the state and ensure that they thrive long after waiver funds have been expended."[44]

[41] New York State Department of Health. November 19, 2012. Health Home Implementation Update [webinar]. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/2012-11-19_hh_implementation_update_8.wmv

[42] New York State Health Home State Plan Amendment for Individuals with Chronic Behavioral and Medical Health Conditions- SPA # 11-56. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/chronic_conditons_spa_11-56_phase.pdf

[43] Data provided by the New York State Department of Health.

[44] New York State Department of Health. August 2012. New York State Medicaid Redesign Team (MRT) Waiver Amendment: Achieving the Triple Aim. p. 30. Albany: NYSDOH. http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08-06_waiver_amendment_request.pdf

Health homes are central to the State's Medicaid reform vision for complex and high-cost beneficiaries as it seeks to change how care is delivered at both the patient and provider levels; how the diverse players in the delivery system interact; how money flows through the system; and, finally, how the system establishes accountability. The early implementation challenges encountered by health homes reflect the broader challenges related to fundamentally changing a complex and wide-ranging health care system.

In addition to the culture shift that must take place for patients, providers will need to change both their thinking and practice patterns, as they are now charged with looking at the whole patient and all of that person's needs. Operationally, this means moving toward team-based care that can bring together the diverse health care practitioners and social service providers serving individual patients.

Ultimately, these changes in care delivery require providers to build new relationships. Those who have never worked together must now do so. For the first wave of health home enrollees, the fragmentation that exists between physical and behavioral health care providers requires attention. The State is counting on care coordination to connect these two sets of providers, and the locus of this coordination is the health home. The challenge of building new relationships for health homes has only begun; it will continue to play out throughout the implementation process.

New payment arrangements, particularly those between Medicaid managed care plans and health homes, will raise additional challenges. Health homes are responsible for coordinating care for a managed care organization's patients, but the MCO retains authority over service utilization for those patients. Ultimately, health homes are charged with coordinating services for which they do not have direct financial responsibility. This raises concerns for some health home providers, who are unsure how to manage care without some control over utilization. Thus, early in the implementation process, with no single entity controlling all the levers of change, there are real questions about how the key pieces of the puzzle will come together—and how, exactly, this will affect the initiative's success.

Finally, the planned movement toward rigorous quality measurement and evaluation—and, within that framework, from process to outcome measures—is a significant step in transforming New York's approach to establishing accountability. It also opens a new pathway to more rigorous and consistent measurement of the State's success in achieving value for its Medicaid dollars.

Overall, New York has adopted an ambitious strategy for payment and delivery system reform, and health homes are a central component of this landmark effort. Health homes have the

potential to transform service delivery by better linking clinical services to care management and essential supports—an approach that could fundamentally change care for the most complex patients. Achieving this kind of systemic change is not an easy task, but it is a vital one. For a select group of health home providers—some of whom years ago began the hard work of coming together within their communities to tackle the challenges of caring for high-cost patients—this approach is yielding concrete operational progress. These experiences will serve as early models for how health homes can work effectively. Going forward, the State's overarching challenge is to help move providers toward full implementation and a meaningful evaluation of their performance.

Appendix A: Evolution of the Health Home Model

The concept of the health home is rooted in the medical home model, which was envisioned, originally, by the American Academy of Physicians in 1967, as a way to centralize recordkeeping in order to improve coordination of care. Since then, through the contributions of medical associations, government entities, and other health care organizations, the medical home has evolved and matured as a model of care. Many states have developed medical home models, and several federal initiatives have supported medical home implementation.[45] In addition, the National Committee for Quality Assurance has developed a set of standards and a recognition process for three levels of patient-centered medical homes.[46]

Definitions of the medical home vary in their specifics, but the model generally promotes a whole-person orientation, enhanced access to primary care, team-based care coordinated across services, and use of health information technology.[47] Although the health home is an outgrowth of this medical home model, its definition, too, has evolved over time.

The term "health home" first emerged in federal legislation in the proposed Healthy Americans Act of 2008. Under that legislation a health home would be "a health care provider, such as a primary care physician, nurse practitioner, or other qualified health provider" that would "monitor the health and health care" of an individual. Plans would designate health homes for individuals covered by private insurance; Medicare beneficiaries would designate their own health homes, which would receive a management fee if so designated.[48] Senator Ron Wyden (D-OR), a sponsor of the bill, stated at hearings in 2008 that while the health home was rooted in the concept of the medical home, the newer term was intended to promote a less physician-centric approach to care coordination, involving practitioners including nurses and physician assistants.[49] Previously, joint principles released by the American Academy of Family Physicians, American Academy of Pediatrics, American

[45] Centers for Medicare & Medicaid Services. November 16, 2010. State Medicaid Director Letter re: Health Homes for Enrollees with Chronic Conditions. SMDL #10-024, ACA #12. https://www.cms.gov/smdl/downloads/SMD10024.pdf

[46] National Committee for Quality Assurance. 2011. Patient-Centered Medical Home. http://www.ncqa.org/tabid/631/default.aspx

[47] National Committee for Quality Assurance. January 31, 2011. NCQA's Patient-Centered Medical Home (PCMH) 2011. http://www.ncqa.org/LinkClick.aspx?fileticket=ag3nmlPXs5s%3d&tabid=631&mid=2435&forcedownload=true; American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association. February 2007. Joint Principles of the Patient-Centered Medical Home. http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.tmp/022107medicalhome.pdf; United States Agency for Healthcare Quality and Research. Patient-Centered Medical Home Research Center: Defining the PCMH. http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/pcmh_defining_the_pcmh_v2

[48] 110th Congress, 1st Session, S. 334. Healthy Americans Act. http://www.gpo.gov/fdsys/pkg/BILLS-110s334is/pdf/BILLS-110s334is.pdf

[49] Senate Hearing 110-808. July 28, 2008. Person-Centered Care: Reforming Services and Bringing Older Citizens Back to the Heart of Society. Hearing before the Special Committee on Aging; Senate Hearing 110-821. July 31, 2008. Aging in Rural America: Preserving Seniors' Access to Healthcare. Hearing before the Special Committee on Aging.

College of Physicians, and American Osteopathic Association had explicitly identified the physician as the lead actor in primary care delivery and care coordination.[50]

A paper commissioned for the Institute of Medicine's Summit on Integrative Medicine and the Health of the Public in February 2009 echoed Senator Wyden's vision, but with an added emphasis on complementary and alternative medicine. The paper distinguished the health home from the medical home in much the same way that Senator Wyden did, but further suggesting that complementary and alternative medicine providers—including chiropractors, naturopathic physicians, and health coaches—could act as points of entry to the primary care system.[51] In testimony before the Senate Committee on Health, Education, Labor, and Pensions, one of the paper's authors linked Minnesota's 2008 legislation establishing "health care homes" (rather than "medical homes") to the state's recognition of nurse practitioners, pharmacists, and physician assistants as primary care providers.[52]

Showing the fluidity of the term "health home," Health and Human Services Secretary Kathleen Sebelius later took a yet more expansive view. At a confirmation hearing and in further testimony at a House Ways and Means Committee hearing on health care reform, she defined a health home as a regular source of primary care and tied it broadly to prevention and wellness, rather than embracing a particular model or provider type.[53]

The current vision of health homes as providing care coordination for individuals with multiple chronic conditions emerged in the America's Healthy Future Act, a health reform law proposed by Senator Max Baucus (D-MT) in 2009.[54] This bill contained an option for states to cover health home services through Medicaid—in language nearly identical to the Affordable Care Act's provision—but health homes were not enacted into federal law until passage of the ACA in 2010.

[50] American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association. February 2007. Joint Principles of the Patient-Centered Medical Home. http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.tmp/022107medicalhome.pdf

[51] Kreitzer MJ, B Kligler, and WC Meeker. February 2009. Health Professions Education and Integrative Health Care. Commissioned for the IOM Summit on Integrative Medicine and the Health of the Public. http://www.iom.edu/~/media/Files/Activity%20Files/Quality/IntegrativeMed/Health%20Professions%20Education%20and%20Integrative%20HealthCare.pdf

[52] Senate Hearing 111-387. February 23, 2009. Examining Principles of Integrative Health, Focusing on a Path to Healthcare Reform. Hearing of the Committee on Health, Education, Labor, and Pensions.

[53] Senate Hearing 111-804. March 31, 2009. Nomination of Governor Kathleen Sebelius. Hearing of the Committee on Health, Education, Labor, and Pensions; Serial No. 111-18. May 6, 2009. Health Care Reform in the 21st Century: a Conversation with Health and Human Services Secretary Kathleen Sebelius. Hearing before the U.S. House of Representatives Committee on Ways and Means.

[54] 111th Congress, 1st Session, S. 1796. America's Healthy Future Act of 2009. http://www.gpo.gov/fdsys/pkg/BILLS-111s1796pcs/pdf/BILLS-111s1796pcs.pdf

Appendix B: Health Homes in Other States

Rhode Island[55]

Rhode Island's approach to health homes, unlike New York's, builds exclusively on existing care management structures for tightly defined beneficiary cohorts. Of Rhode Island's two approved health home state plan amendments (SPAs), the first targets about 12,000 children and youth with special health care needs. For these beneficiaries, coordination services are provided by a state network of Comprehensive Evaluation, Diagnosis, Assessment, Referral, and Reevaluation, or CEDARR, family centers. The CEDARR centers already provide the majority of health home services to children and youth with special health care needs in Rhode Island. Unlike in New York, only minor modifications to existing service delivery arrangements were necessary to make the transition to health homes. CEDARR centers receive a combination of fee-for-service payments and hourly rates for health home services rendered.

Rhode Island's second SPA targets 7,000 adults with serious and persistent mental illness. As with health homes for children and youth with special health care needs, the health homes for these adults are built upon existing programs—nine community mental health organizations—that require few changes in existing service delivery arrangements to qualify as health homes. Unlike the CEDARR centers, community mental health organizations receive per-member-per-month (PMPM) rates for delivering health home services.

Missouri[56,57]

Missouri also has two approved SPAs. The first targets individuals with $10,000 in costs for the previous year and with either serious and persistent mental illness or a behavioral health condition and another chronic condition. The second is for individuals with at least two chronic physical health conditions, or one and the risk of developing another, and at least $2,600 in health care costs in the previous year. Services for the former cohort are provided through community mental health centers certified by the Missouri Department of Mental Health. Services for the latter are provided through federally qualified health centers, public hospital clinics, and a rural health clinic. Under both SPAs, Missouri's health homes receive PMPM rates to provide services.

[55] Integrated Care Resource Center. February 2012. Exploring Medicaid Health Homes: Building on Existing Infrastructure. Slides available at http://www.chcs.org/usr_doc/ICRC_HH_Slides_Feb_2012_FINAL2.pdf.

[56] Integrated Care Resource Center. November 2011. Initial Models for Health Home Program Development. Slides available at http://www.chcs.org/usr_doc/ICRC_HH_SlidesFull2.pdf.

[57] Kaiser Commission on Medicaid and the Uninsured. August 2012. Medicaid Health Homes for Beneficiaries with Chronic Conditions. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. http://www.kff.org/medicaid/upload/8340.pdf.

One notable difference from New York's approach to the health home model is that Missouri's SPAs delineate specific roles for health home team members and specify their required credentials. Another difference is that Missouri's health homes not only have access to but are also required to use CyberAccess, Missouri's online electronic record, in order to collect patient demographics and to track prescriptions, utilization, place of service, and diagnoses.

Oregon[58,59]

Oregon's health home initiative is built on its existing initiative to develop Patient-Centered Primary Care Homes (PCPCHs). While health homes in New York are newly created entities exclusively for Medicaid beneficiaries, Oregon's PCPCH initiative targets enhanced primary care for all Oregonians statewide, including all covered lives for which the State is the payer—state employees as well as Medicaid beneficiaries. Oregon has developed its own standards and attributes for recognizing three tiers of PCPCHs, which are largely identical for individuals eligible under Oregon's SPA—about 118,000 persons with multiple chronic conditions, one chronic condition and the risk of developing another, or serious mental illness—and those who are not. PCPCHs receive per-member-per-month payments, which are larger for health home enrollees ($10-$24) than for other Medicaid beneficiaries ($2-$6). As in New York, PCPCHs receive payments directly for fee-for-service beneficiaries and as a pass-through from managed care organizations for individuals in managed care.

[58] Integrated Care Resource Center. November 2011. Initial Models for Health Home Program Development. Slides available at http://www.chcs.org/usr_doc/ICRC_HH_SlidesFull2.pdf

[59] Kaiser Commission on Medicaid and the Uninsured. August 2012. Medicaid Health Homes for Beneficiaries with Chronic Conditions. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. http://www.kff.org/medicaid/upload/8340.pdf

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