U.S. Department of Health and Human Services
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Office of Disability, Aging and Long-Term Care Policy

MEDICAID HEALTH HOMES IN NEW YORK:

REVIEW OF PRE-EXISTING INITIATIVES AND STATE PLAN AMENDMENT(S) FOR THE STATE'S FIRST HEALTH HOMES UNDER SECTION 2703 OF THE AFFORDABLE CARE ACT

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New York's Health Home Program at a Glance	
Health Home Eligibility Criteria	2 chronic conditions, HIV/AIDS, or a serious mental illness
Qualifying Conditions	• Substance use disorder • Respiratory disease • Cardiovascular disease • Metabolic disease • Body mass index over 25 • HIV/AIDS • Other chronic conditions
Enrollment*	158,460
Designated Providers	Any Medicaid-enrolled provider that meets health home standards
Administrative/ Service Framework	The initiative was rolled out in 3 geographically-based phases and ultimately covered Medicaid enrollees with chronic physical or behavioral conditions statewide. Health home providers include hospital networks with affiliated physical health, behavioral health, and community support providers, existing condition-specific Targeted Case Management programs, and community-based organizations.
Required Care Team Members	Multidisciplinary team led by a dedicated case manager
Payment System	Per member per month care management fee
Payment Level	Paid at 2 levels depending on enrollee status, and adjusted for case-mix and geography
Health Information Technology (HIT) Requirements	HIT standards are phased-in over time; providers must meet the initial standards on becoming a health home and the final, more comprehensive standards must be met within 18 months. The state has provided funding and learning opportunities to support health home providers in HIT development.
* January 2014 data provided to the Centers for Medicare and Medicaid Services' Health Home Information Resource Center.	

Introduction

New York's Medicaid Health Home State Plan Amendment (SPA) was approved by the Centers for Medicare and Medicaid Services (CMS) on February 2, 2012, with a retroactive effective date of January 1, 2012.[1] The state envisioned this program as the first step in a health home initiative that was rolled out in three geographically-based phases and ultimately covered Medicaid enrollees with chronic physical or behavioral conditions statewide. The first approved SPA represents Phase I and covers ten counties. Separate SPAs have been submitted and approved for Phase II, which covers an additional 12 counties, and Phase III, which expands health homes to the remaining 39 counties. The retroactive effective dates for the latter phases are April 1, 2012, and July 1, 2012, respectively.

The three-phase initiative cover enrollees in two groups: those who have a serious mental illness (SMI), who have HIV/AIDS and are at risk of developing another chronic condition, or those with two or more chronic conditions (including substance abuse). The state also plans to extend statewide coverage two additional population groups in later SPAs: enrollees with developmental disabilities and enrollees in need of long-term care services. The state organized Medicaid enrollees who qualify for health homes into these four groups (Chronic Condition, Intellectual Developmental Disabilities, Long-Term Care, and Behavioral Health) hierarchically so that they are mutually exclusive, and estimates that about 975,000 of its approximately five million Medicaid members fall into one of the four population groups. The population with chronic physical or behavioral conditions covered by Phases I, II, and III represents by far the largest share, with the combined eligible population estimated at 700,000.

The state identifies health home providers through an application process in which a health home lead organization demonstrates how it will meet the health home requirements through its partners and affiliated providers. Health home lead organizations have already been designated for all three Phases. Approved health home providers include hospital networks with affiliated physical health, behavioral health, and community support providers, existing condition-specific Targeted Case Management (TCM) programs, and community-based organizations.

The second health home wave will expand coverage to the long-term care population. The design of this wave is currently under discussion, but it is expected that the program will be based on the existing managed long-term care program and a network of nursing home and noninstitutional providers. The third wave will target enrollees with developmental disabilities. Care for this population is currently managed by a TCM program, which is expected to convert to a health home in conjunction with implementation of the state's Section 1115 Medicaid Waiver program, People First, currently under development.

Implementation Context

In January 2011, Governor Andrew Cuomo convened a Medicaid Redesign Team (MRT) to assess the Medicaid program overall and develop recommendations for reform, with a focus on quality of care and cost containment and a vision of care management for all. The state's Medicaid program currently has both fee-for-service (FFS) and managed care components. About 70% of all beneficiaries are currently enrolled in managed care, although the share in managed care varies across different eligibility groups. The state has asserted that care for most enrollees is being managed well within a primary care setting but that population groups with increasingly costly and complex medical, behavioral, and long-term health care needs could benefit from additional care management. One of the MRT's 78 approved recommendations was to initiate a statewide health home program. A second key recommendation was to extend managed care to all program enrollees.

A wide range of programs similar to health homes has informed the development and implementation of the state's initiative. Some are geographically-based initiatives; others are statewide and target enrollees with specific conditions. Many programs are limited to Medicaid enrollees, but a substantial number include other payers as well.

The TCM programs have given the state a decade of experience in comprehensive case management and community support services for particular populations. Three existing case management initiatives will eventually be incorporated into health homes. The Office of Mental Health (OMH) has a TCM program that supports people with behavioral or mental health issues. The AIDS/COBRA program provides case management for people who are HIV-positive, and an Office of Alcoholism and Substance Abuse Services (OASAS), Managed Addiction Treatment Services (MATS) program serves enrollees with substance abuse problems.

Some programs, such as the New York Care Coordination Program (NYCCP) and the Chronic Illness Demonstration Projects (CIDPs), are particularly relevant for health home implementation, as they both focus on care coordination for patients with mental/behavioral health conditions. The NYCCP is a regional consortium of mental health providers and state and county governments, which over the past decade has developed and implemented a program aimed at coordinating physical and behavioral health care for Medicaid patients.[2] The CIDP initiative began in 2009, when the state-funded six provider groups to provide FFS comprehensive care management for enrollees with both physical and mental health conditions, as well as to address their social service needs. The state has identified the CIDPs as a direct precursor to the health home initiative.[3] One significant lesson from CIDP was that outreach and enrollment costs were much higher than expected. The state found that the complexity and severity of enrollee's needs often made it difficult to interest this population in joining a CIDP when they were struggling with other life issues.[4] This experience led to enhanced consideration and provisions for community outreach in the development of health homes, as well as for strong community supports, especially those related to housing and services following hospital discharge. The state's demonstrations and past

initiatives have also highlighted the importance of the existing health information technology (HIT) infrastructure and the changes necessary to implement and support health home activities.

The state also is engaged in two patient-centered medical home (PCMH) initiatives authorized in the state's 2009 legislative session. The Adirondack Medical Home Demonstration is a five-year regional multi-payer initiative to improve care, expand access, and contain costs in the rural upstate region.[5] Participating payers include Medicare, Medicaid, and the state's civil service system along with several private payers.[6] The pilot was initiated in 2010 and focuses on preventive care and coordination of care for people with chronic conditions. Reimbursement includes a FFS component, a care coordination fee, and performance-based payment for improved patient outcomes. Providers must achieve National Committee for Quality Assurance (NCQA) Physician Practice Connections-Patient-Centered Medical Home (PPC-PCMH) Level 2 or Level 3 status within one year of the beginning of the pilot, and they must report on quality improvements for access of care, coordination and disease management, and hospitalization rates/readmission rates.[7]

The second PCMH initiative, also begun in 2010, is a statewide program for individuals enrolled in Medicaid, Family Health Plus (the state's public health insurance program for adults), or Child Health Plus (the state's Children's Health Insurance Program [CHIP]).[8] Eligible providers include office-based practices, federally qualified health centers (FQHCs), and mental health diagnostic and treatment centers, and may serve both FFS and managed care beneficiaries. As in the Adirondack pilot program, the state adopted NCQA standards for practice certification. The MRT recommended that the PCMH program be expanded to new payers and a broader patient population. The 2011 legislative session authorized the Department of Health (DOH) to establish additional multi-payer medical home initiatives throughout the state. In response, Medicaid submitted a SPA to CMS in June 2011 to test new payment models for qualifying medical home practices, including risk-adjusted global payments and pay-for-performance (P4P).[8]

In August 2011, DOH announced a three-year initiative to improve the quality and coordination of primary care services provided to Medicaid patients by teaching hospitals under a grant from CMS.[9] This initiative has two components: (1) the Hospital-Medical Home project, which provides financial incentives for the transformation of hospital teaching programs; and (2) the Potentially Preventable Readmissions (PPR) project, which provides competitive grants to hospitals to develop strategies to reduce the rate of preventable medical or behavioral health-based readmissions.[9] The agreement includes increased financial support for mental health clinics through grants to diagnostic and treatment centers for services provided to uninsured individuals throughout the state. These programs are authorized to operate through December 31, 2014, and are supported under a Section 1115 waiver called the Partnership Plan.[9]

The Capital District Physicians' Health Plan (CDPHP) Enhanced Primary Care Program pilot is a medical home initiative in the Albany region that is considered a "virtual all-payer" system. It began in 2008 and now encompasses 24 practices, 50,000 members, and nearly 160 network physicians.[10] The CDPHP uses a capitation payment model with a bonus incentive based on quality and efficiency.[10] Participating practices receive payments under a risk-adjusted capitation model based on expected levels of care utilization and costs associated with a patient's individual risk profile.[11] The plan keeps "shadow" FFS billing in place. Further, it promised to help doctors if their costs were higher than predicted by the model and to give them the difference if the practice billed less than the model predicted.[11] Data on clinical quality (based on 18 Healthcare Effectiveness Data and Information Set [HEDIS] measures), cost and efficiency (utilization-based hospital and emergency department rates, population-based metrics, and episode-based medical costs), and patient/provider experience (from surveys) are collected for evaluation.[10]

The Hudson Valley P4P Medical Home Initiative was created under a 2008 grant from DOH to Taconic Health Information Network and Community. It targets adults with chronic conditions in the Mid-Hudson Valley region. The five-year initiative brings IBM, a dominant employer in the region, together with six commercial health plans, who are underwriting the pilot with DOH. This project bases quality and care coordination benchmarks and incentives on the NCQA Level 2 PPC-PCMH standards. The program also seeks to facilitate adoption and use of electronic health records (EHRs) in office practices in the Hudson Valley.[12]

In addition to these state-level initiatives, New York is involved in several CMS projects. It is one of eight states selected to participate in the Medicare Advanced Primary Care Practice demonstration program, and it is also participating in the CMS duals demonstration program.[7] In addition, the Capitol District-Hudson Valley Region of New York has been selected to participate in the CMS's Comprehensive Primary Care Initiative, a multi-payer initiative promoting collaboration between public and private health care payers to strengthen primary care. Medicare will work with these payers and offer bonus payments to primary care doctors who better coordinate care for their Medicare patients.[7]

DOH staff has developed a comprehensive Medicaid reform action plan based on the work of the MRT.[13] In particular, the action plan recommends the development of a comprehensive Section 1115 Medicaid waiver to ensure that the state has flexibility to enact all of the reforms proposed by the MRT. This new waiver is designed to allow the state to reinvest in its health care infrastructure in preparation for national health care reform and to work to contain the overall health care cost growth rate.[13] The state expects to use the Section 1115 savings to assist health homes in attaining long-term sustainability, including help with costs, HIT investment, and recruitment and training of care managers.[14]

The state has also undertaken a numbered series of state-funded initiatives under the Health Care Efficiency and Affordability Law for New Yorkers, known as HEAL NY,

to improve its information technology capacity, several of which are relevant for health homes. In particular, HEAL 10 provides financial support to PCMH projects throughout New York to help providers improve care coordination and enhance the continuum of care through HIT linked through the Statewide Health Information Network for New York (SHIN-NY).[15] HEAL 17 builds on this funding for PCMH projects, and HEAL 22 authorizes state funding to support EHR implementation specifically for behavioral health providers.[16,17]

Implications for the New York Section 2703 Medicaid Health Homes Evaluation

These various initiatives have several key implications for both the implementation and evaluation of the health homes program. The state has worked with a range of providers over many years to improve care coordination and disease management services to Medicaid enrollees with chronic conditions and SMI, targeted variously to particular conditions, specific geographic areas, and particular providers. Thus, both providers and state officials have a substantial base of experience in organizing and providing health home-type services. It will be critical to establish how the enhanced federal match will be used by the state and to what extent the health home initiatives represent a new kind of service rather than an expansion of an existing initiative. The variety of models that are being developed means that the evaluation will need to pay close attention to changes in structure and process across the individual health homes and any differences in outcomes.

Given that some providers have offered services that are similar to health home services for a number of years while other providers will be relatively new to the program, it will be necessary to clearly identify and describe the structures and processes that are in place at baseline, and to characterize the changes that providers make to these structures and processes as a consequence of becoming health homes. The state and the participating health homes will likely make adjustments to the program based on feedback from providers and periodic internal review, so it will also be necessary to conduct regular follow-ups with key stakeholders over the course of the evaluation.

Population Criteria and Provider Infrastructure[18]

New York's health home program both builds on existing provider relationships and encourages development of new provider partnerships. Eligible health home providers include any type of provider that is enrolled in the Medicaid program and meets the state's designated health home requirements. Health homes are empowered to determine the most appropriate composition of the health home team for the members it will serve, the state only requires that the team be "multidisciplinary" and led by a dedicated care manager. Health homes can use teams consisting of medical, mental health and substance abuse treatment providers, social workers, nurses, and

other care providers. All members of the team are responsible for reporting to the care manager and for ensuring that care is patient-centered, culturally competent, and linguistically appropriate. Table 1 summarizes the population criteria, the designated providers, and the health home team composition requirements.

Enrollee Identification and Assignment[19]

The identification of eligible health home enrollees is based on a set of algorithms and is the same for FFS and managed care enrollees, although the process for assigning eligible enrollees to specific health homes differs. DOH identifies the enrollees eligible for health home services using a proprietary clinical risk group (CRG) software and an "intelligent" assignment algorithm that predicts for negative events using claims and encounters. The state uses an Ambulatory Connectivity Measure to help determine enrollees' health home assignment priority, with priority given to assigning enrollees with high costs and low ambulatory care connections. The state is also exploring ways to include information on housing and other social services needs and use. Assignment to a particular health home is made using a "loyalty" algorithm to match beneficiaries with providers based on their existing relationships with providers. Managed care plans (MCPs) may use the same assignment algorithm to assign their members to an appropriate health home if they so choose, but may also use additional information.

Health home beneficiaries are categorized into mutually exclusive CRGs using claims data and, when available, additional data. These CRGs can be used to predict the amount and type of health care services that individuals should have used in the past and can be expected to use in the future. CRG-based attribution modeling is being used for group selection, and CRG-based acuity modeling is being used to establish different health home payment tiers. The state then assigns enrollees to a specific health home-based on their level of clinical risk and their current level of connectivity to an outpatient provider. Eligible beneficiaries with a higher level of clinical risk and a lower level of connectivity have higher assignment priority. Health homes may also accept members that are referred to them from providers or other sources such as local health districts; these are known as community referrals.

Table 2 shows how each of the State Health Home Analytical Products is used in enrollee identification and assignment.

For FFS enrollees, the state provides candidate "tracking lists" to health homes electronically via the Health Commerce System (HCS). Lead health homes send out welcome letters to these candidates and assign them to individual providers for outreach and engagement, with participant data to be reported to the lead health home. For managed care enrollees, the state provides candidate "tracking lists" to the MCPs for their members via the HCS, based on the same intelligent assignment algorithm, loyalty model, and risk scores as used for FFS members. MCPs are responsible for assigning candidates to the lead health home that can best serve their needs. The lead health homes receive these member assignments and again assign candidates to individual providers for outreach and engagement. Established case management

providers (OMH TCM, MATS, HIV COBRA TCM, and CIDPs) that choose to convert to health homes will determine the most appropriate assignment for each of their members. DOH is designing portals to allow real-time access to beneficiary-level data.

Service Definitions and Provider Standards

There are six core health home services (identified in Table 3) that must be provided by designated health home providers. Health homes must provide at least one of the first five core services (use of HIT is excluded for first 18 months as a billable service) per month to receive payment. Service "touches" include face-to-face meetings, mailings, telephone calls, consultation meeting with family, and referrals. Providers must provide written documentation that clearly demonstrates how the core service requirements are being met for each patient.

Health home provider qualification standards were developed to ensure that health homes adhere to the federal health home model and state Medicaid standards. Representatives from the DOH Offices of Health Insurance Programs, Office of Health Information Technology Transformation (OHITT), the AIDS Institute, OASAS, and OMH participated in the development of these standards. Designated health homes must be enrolled (or be eligible to be enrolled) in the Medicaid program and they must agree to comply with all of the health home requirements. Providers can either directly provide or subcontract for health home services but remain responsible for all the health home program requirements.

Health homes are required to have dedicated care managers to lead care management and coordination, and the care managers must be involved in all aspects of transitional care management. The health home provider standards do not require that any other roles be specifically assigned to particular care team members.

As described in the SPA, health home providers must meet six general qualifications:

1. They must be enrolled (or be eligible for enrollment) in the state Medicaid program and agree to comply with all Medicaid program requirements.

2. They can either provide services directly, or subcontract for their provision, but they remain responsible for all health home program requirements, including services performed by the subcontractor.

3. Care coordination and integration of heath care services will be provided by an inter-disciplinary team of providers, under the direction of a care manager who is accountable for ensuring access to services and community supports as defined in the enrollee care plan.

4. Hospitals that are part of the health home network must have procedures in place for referring eligible individuals who seeks treatment in a hospital emergency department to a designated health home provider.

5. They must demonstrate their ability to perform the eleven core functions as defined in the CMS State Medicaid Director's Letter of November 2010.

6. They must meet standards for delivery of six core health home services (see Table 3), and they must provide written documentation that clearly demonstrates how the requirements are being met.

In order to guide health home providers as they implement the new program, DOH has held a series of teleconferences and webinars; several health homes were also awarded a contract from the Department of Labor and DOH to provide workforce retraining for current TCM providers as they transition into their new roles as health home providers.[20] This training will include both web-based and face-to-face training and will be based on curriculum developed by the NYCCP. DOH will also convene a Learning Collaborative for health home providers, which will allow providers to share best practices around health home design and implementation.

Use of Health Information Technology

DOH developed standards for HIT use by health homes that will be phased-in over time. Providers must meet the initial standards on becoming a health home; final, more comprehensive standards must be met within 18 months. Under the initial standards, qualified health homes must have a systematic process to follow referrals and services provided, and must have a health record system to ensure that protected health information and an individual's plan of care is accessible to the health home team. Final standards require that health homes have interoperable HIT systems and policies that allow for the development and maintenance of the care plan, that they use a certified EHR that complies with the official Statewide Policy Guidance on HIT, that they participate in the RHIOs for the purposes of sharing data, and that they employ clinical decision-making tools where feasible. (See Table 4 for a full list of the initial and final requirements.)

Health home providers will be encouraged to use wireless technology as available to improve coordination and management of care and patient adherence to provider recommendations. In order to support providers in their efforts to meet final HIT requirements, New York has made additional funding and learning opportunities available to them through the HEAL program and upcoming Learning Collaborative. OHITT is also working to identify additional opportunities for health homes to enhance their HIT capacity.[1]

Payment Structure

Payment is made on a per member per month (PMPM) basis at two levels: Outreach and Engagement, and Active Care Management. Members in the outreach and engagement group are those who have been assigned to the provider but have not yet engaged in active care management. The active care management group consists of actual health home participants.

Health homes are reimbursed directly by the state for FFS members and through the MCPs for managed care members. MCPs may keep up to 3% of payments for administrative services. TCMs, MATs, and CIDPs bill the state directly for a limited period of time. All monthly payments will be made through eMedNY (the New York State Medicaid program claims processing system).

Health home providers' payment rates vary based on region and case-mix. Rates are calculated and paid at a member-specific level directly by eMedNY. The state intends to adjust the rates by member functional status once such data is available. Outreach and engagement for Medicaid FFS and managed care members will be paid at 80% of the active care management rate. Once a patient is fully engaged in the program and receiving active care management services, the provider receives full active care management group PMPM rate.

Rate Information and Determination

The health home care management rates were calculated based on caseload variation, case management cost, and patient-specific acuity. Caseload variation data was developed based on experience in the TCM programs, CIDPs, and other states' demonstrations related to chronic illness management. Case management cost analysis is based on financial data reported to DOH from existing programs. Patient-specific risk factors were developed using CRG software. DOH is currently developing an additional adjustment for functional status.

Converting TCMs and CIDPs will bill eMedNY directly for their existing caseload at their historical rates. These rates will be phased out over two years for TCMs and over one year for CIDPs, at which time only health homes and MCPs will be reimbursed through eMedNY for health home services.

Quality Improvement Goals and Measures

The state has identified five quality improvement goals:

- Reducing utilization associated with avoidable inpatient stays;
- Reducing utilization associated with avoidable emergency department visits;
- Improving outcomes for persons with mental illness and/or substance use disorders;

- Improving disease-related care for chronic conditions; and
- Improving preventative care.

Table 5 lists each goal with its corresponding measures. Most of the measures are based on HEDIS specifications; two are measures proposed in the Affordable Care Act,[21] and two are specific to New York. Data for these measures are to be drawn entirely from administrative and pharmacy claims.

Evaluation Measures and Methods

Care management metrics are divided into process metrics and outcome (quality) metrics. The state's goal was to have a uniform platform and a standard set of process metrics in place by fall 2012. Outcome metrics are taken from Medicaid records--enrollment, claims, encounter, and pharmacy data--as well as other state databases that record provisions of substance abuse treatment services. The selected outcome metrics are described in full in Table 6.

The state will work with CMS to develop a patient experience survey that draws from both the Consumer Assessment of Healthcare Providers and Systems survey, and behavioral health-specific items from the Mental Health Statistics Improvement Program. New York will work with academic partners to supplement these databases with additional data.

The state proposes a variety of approaches to measuring the impact of health homes on selected quality and cost outcomes (hospital admission rates, chronic disease management, assessment of quality improvements and clinical outcomes, and estimates of cost savings). It will analyze historical utilization and cost data, employ statistical matching, and explore the possibility of using propensity score methods by region to identify comparison groups of people with similar demographic, geographic, and medical characteristics as health home enrollees. It expects that the phased nature of enrollment will allow identification of variations in outcome measures between enrollees and the eligible but not yet enrolled beneficiaries. Finally, it may look at the differences in outcomes across the designated health homes, adjusting for differences in client characteristics. The state will be working with local academic partners in completing these analyses.

TABLE 1. Target Population and Designated Providers--New York	
SPA Approval (Effective Date)	February 3, 2012 (January 1, 2012)
Designated Provider(s)	Any Medicaid-enrolled provider that meets health home standards; includes MCPs, primary care providers (PCPs), home health agencies, and substance abuse treatment facilities
Health Home Team Composition	Required: Multidisciplinary team; led by a dedicated case manager Optional: Nutritionist/dietician, pharmacist, outreach workers (peer specialist, housing representatives, etc.)
Target Population	Beneficiaries must have: • 2 chronic conditions • HIV/AIDS • A serious mental condition
Qualifying Chronic Conditions	Mental health condition: • Bipolar disorder • Conduct, impulse control, and other disruptive behavior disorders • Dementing disease • Depressive and other psychoses • Eating disorder • Major personality disorders • Psychiatric disease (except schizophrenia) • Schizophrenia Substance use disorder: • Alcohol liver disease • Chronic alcohol abuse • Cocaine abuse • Drug abuse--cannabis/NOS/NEC • Substance abuse • Opioid abuse • Other significant drug abuse Respiratory disease: • Asthma • Chronic obstructive pulmonary disease Cardiovascular disease: • Advanced coronary artery disease • Cerebrovascular disease • Congestive heart failure • Hypertension • Peripheral vascular disease Metabolic disease: • Chronic renal failure • Diabetes BMI over 25 HIV/AIDS Other chronic conditions diagnosed in the population

TABLE 2. New York's Health Home Analytical Products	
Methodology	**Purpose**
CRG-Based Attributions	For cohort selection
CRG-Based Acuity	For payment tiers
"Intelligent" Assignment Algorithm	For assignment priority
Ambulatory Connectivity Measure	For assignment priority
Provider Loyalty Model (connectivity to existing providers)	For matching to appropriate health home and to guide outreach activity

TABLE 3. Health Home Service Definitions--New York	
Care Coordination	The care manager ensures the coordination of services, adherence to treatment recommendations, and generally oversees the needs of the health home member. The health home provider will promote prevention and wellness by providing resources for prevention and any other services members need.
Comprehensive Care Management	An individualized patient-centered care plan based on a comprehensive health risk assessment. Care management must be comprehensive, meeting physical health, mental health, chemical dependency, and social service needs.
Comprehensive Transitional Care	Health home providers must emphasize the prevention of avoidable readmissions and must ensure proper and timely transitions from 1 setting to another and follow-up care post-discharge.
Individual and Family Support Services	Individualized care plans must be shared and clear for the patient, family members, or other caregivers to understand. Patient and family preferences must be given appropriate consideration.
Referral to Community and Social Supports	Health home providers are responsible for identifying and actively managing appropriate referrals, and coordinating with other community and social supports.
Use of HIT to Link Services, as Feasible and Appropriate	Health homes are encouraged to use regional health information organizations (RHIOs) to access patient data and to maximize the use of HIT in the services they provide and in care coordination. Health home provider applicants have 18 months from program implementation to submit a plan for achieving compliance with the final health home HIT requirements.

TABLE 4. Health Information Technology (HIT) Standards--New York	
Initial Standards	• Health home provider has structured information systems, policies, procedures and practices to create, document, execute, and update a plan of care for every patient. • Health home provider has a systematic process to follow-up on tests, treatments, services, and referrals which is incorporated into the patient's plan of care. • Health home provider has a health record system which allows the patient's health information and plan of care to be accessible to the inter-disciplinary team of providers and which allows for population management and identification of gaps in care including preventive services. • Health home provider makes use of available HIT and accesses data through the RHIO/qualified entity to conduct these processes, as feasible.
Final Standards	• Health home provider has structured interoperable HIT systems, policies, procedures and practices to support the creation, documentation, execution, and ongoing management of a plan of care for every patient. • Health home provider uses an EHR 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 inter-disciplinary 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. • Health home provider will be required to comply with the current and future version of the Statewide Policy Guidance which includes common information policies, standards and technical approaches governing health information exchange (HIE). • Health home provider commits to joining regional health information networks or qualified HIT entities for data exchange and includes a commitment to share information with all providers participating in a care plan. RHIOs/qualified entities provides policy and technical services required for HIE through SHIN-NY.

TABLE 5. Health Home Goals and Quality Measures--New York	
Reduce Utilization Associated with Avoidable (preventable) Inpatient Stays	Clinical outcome measures: • *Inpatient utilization*--The rate of utilization of acute inpatient care per 1,000 member months. Data will be reported by age for categories: Medicine, Surgery, Maternity and Total Inpatient.
Reduce Utilization Associated with Avoidable (preventable) Emergency Room Visits	Clinical outcome measures: • *Ambulatory care (emergency department visits)*--The rate of emergency department visits per 1,000 member months. Data will reported by age categories.
Improve Outcomes for Persons with mental Illness and/or Substance Use Disorders	Clinical outcome measures: • *Mental health utilization*--The number and percentage of members receiving the following mental health services during the measurement year for: (1) any service; (2) inpatient; (3) intensive outpatient or partial hospitalization; and (4) outpatient or emergency department. • *Follow-up after hospitalization for mental illness*--Percentage of discharges for treatment of selected mental illness disorders who had an outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health provider within 7 days and within 30 days of discharge. In addition, "retention" in services, defined as at least 5 qualifying visits with mental health providers within 90 days of discharge. • *Follow-up after hospitalization for alcohol and chemical dependency detoxification*--The percentage of discharges for specified alcohol and chemical dependency conditions that are followed up with visits with chemical treatment and other qualified providers within 7 days and within 30 days and who have ongoing visits within 90 days of the discharges. Quality of care measures: • *Antidepressant medication management*--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. • *Follow-up care for children prescribed ADHD medication*--Percentage of children newly prescribed ADHD medication that had appropriate follow-up in the initial 30 days and in the continuation and maintenance phase. • *Adherence to antipsychotics for individuals with schizophrenia*--Percentage of patients with a schizophrenia diagnosis who received an antipsychotic medication that had a proportion of days covered (PDC) for antipsychotic medication $\geq$0.8 during the measurement period. • *Adherence to mood stabilizers for individuals with bipolar I disorder*--Percentage of patients with bipolar I disorder who received a mood stabilizer medication that had a PDC for mood stabilizer medication $\geq$0.8 during the measurement period.

TABLE 5 (*continued*)	
Improve Disease-Related Care for Chronic Conditions	Quality of care measures: • *Use of appropriate medications for people with asthma*--Percentage of members who are identified with persistent asthma and who were appropriately prescribed preferred asthma medication. • *Medication management for people with asthma*--The percentage of members who were identified as having persistent asthma and were dispensed appropriate medications in amounts to cover: (1) at least 50% of their treatment period; and (2) at least 75% of their treatment period. • *Comprehensive diabetes care (HbA1c test and LDL-C test)*--Percentage of members with diabetes who had at least 1 HbA1c test and at least 1 LDL-C test. • *Persistence of beta-blocker treatment after heart attack*--Percentage of members who were hospitalized and discharged alive with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for 6 months after discharge. • *Cholesterol testing for patients with cardiovascular conditions*--Percentage of members who were discharged alive for AMI, coronary artery bypass graft or percutaneous coronary intervention or who have a diagnosis of ischemic vascular disease and who had a least one LDL-C screening. • *Comprehensive care for people living with HIV/AIDS*--Percentage of members living with HIV/AIDS who received: (a) 2 outpatient visits with primary care with 1 visit in the first 6 months and 1 visit in the second 6 months; (b) viral load monitoring; and (c) syphilis screening for all who 18 and older.
Improve Preventive Care	Quality of care measures: • *Chlamydia screening in women*--Percentage of women who were identified as sexually active and who had at least 1 test for Chlamydia. • *Colorectal cancer screening*--Percentage of members 50+ who had appropriate screening for colorectal cancer.

TABLE 6. Evaluation Methodology--New York	
Hospital Admission Rates	New York has been monitoring avoidable hospital readmissions (PPRs) for Medicaid populations since 2009 using 3M software. This software has an algorithm for determining whether a readmission is plausibly connected to an initial admission. New York will calculate PPRs within 30 days of an initial inpatient discharge; calculating the rate across all conditions and also within condition (i.e., mental health condition, substance use disorder, asthma, diabetes, heart disease, HIV/AIDS, and hypertension). As indicated, historical avoidable readmission rates for statistically matched comparison group will be calculated. The state will also compare avoidable readmission rates across health home providers.
Chronic Disease Management	Data on chronic disease management will be collected in 2 ways. First, New York will examine how the health homes implement disease management across key chronic illness management functional components of state health home qualification criteria. With the aid of state and academic partners, New York will work with stakeholders to assess the key functional components to include: (1) inclusion of preventive and health promotion services; (2) coordination of care between primary care, specialty providers and community supports; (3) emphasis on collaborative patient decision-making and teaching of disease self-management; (4) structuring of care to ensure ongoing monitoring and follow-up care; (5) facilitation of evidence-based practice; and (6) use of clinical information systems to facilitate tracking of care as well as integration between providers. The state will modify standardized assessment tools as well as use qualitative interviews with health home administrative staff and providers to determine the implementation of these functional components. Additionally, the patient Experience of Care measure will provide information on self-management support from the health home. Second, New York will conduct cohort analyses as part of the evaluation focusing on groups at-risk to incur high costs.
Coordination of Care for Individuals with Chronic Conditions	New York will use claims, encounter, and pharmacy data to collect information on coordination of care. As indicated in the quality measures section of this SPA, the state will use claims, encounter, and pharmacy data to collect information on post-inpatient discharge continuation of care (e.g., persistent beta-blocker treatment after hospitalization for AMI) or transition to another level of care (e.g., outpatient care following hospitalization for a behavioral health condition). This coordination of care measures will be compared to historical controls, to statistically matched comparison groups, and across health home providers. In addition, New York State is considering the feasibility of more closely examining provider behavior through medical chart reviews, case record audits, team composition analysis, and key informant interviews. As part of this process, the state will carefully monitor the use of HIT as a primary modality to support coordination of care.
Assessment of Program Implementation	As indicated above, Learning Collaboratives will be constituted with a group of providers of health homes to identify implementation challenges as well as potential solutions. Other data related to implementation including responses to the health home experiences of care survey and, if feasible, provider audits and surveys, and stakeholder interviews will be collected. All implementation data will be shared with the Health Home Advisory Group (comprised of state, provider, community, and academic members) and a compilation of lessons learned.
Processes and Lessons Learned	Learning Collaboratives will be constituted with a group of early adopter providers of health homes to identify implementation challenges as well as potential solutions. New York will use the Health Home Advisory Group to monitor, comment, and make recommendations on implementation strategies that are working as well as those that are not. The group will use the health home functional components as well as the provider qualification criteria as guides in assessing program processes and outcome success. The Advisory Group will use information gathered through assessments of program implementation as well as from ongoing quality monitoring using administrative data to review program successes and failures.

TABLE 6 (*continued*)	
Assessment of Quality Improvements and Clinical Outcomes	New York has identified an extensive list of quality and outcome measures that will be derived from administrative claims and encounter data. The quality measures are indicators of chronic illness management while the clinical outcome measures are indicators of poor disease management leading to high-cost treatment episodes. Ongoing assessments of these quality measures will be conducted at the levels of health home providers, region, and statewide. The endpoint evaluation will be designed as a quasi-experimental longitudinal study where endpoint outcomes will be patient-level indicators of poorly managed care of chronic conditions; indicators of stable engagement in guideline concordant care; and high-cost utilization of services. There are a number of clear indicators of poorly managed care across disorders: emergency department visits, hospital readmissions, poor transition from inpatient to outpatient care, etc. In addition, the state will attempt to define, where possible, more refined measures that are disease-specific (e.g., repeated detox in substance abuse.
Estimates of Cost Savings	New York will work with state and academic partners to devise a sophisticated econometric analysis of the overall health home initiative as well as of each vendor. First, the state will monitor costs savings through by tracking high-cost forms of utilization (e.g., preventable hospitalizations, emergency department use, and detoxification). Utilization of high-cost events will be compared with historical rates as well as with statistically matched comparison groups as indicated above. Additionally, New York will compare total costs of care for health home enrollees--including all services costs, health home costs and managed capitation--to statistically matched comparisons. The econometric analyses will begin with descriptive statistics and increase in complexity to the minimal level necessary to address the question of cost savings. Analyses will focus on PMPM expenditures of enrollees compared to controls as described in this section's preamble. For regression analyses that examine changes in cost relative to controls, New York employs longitudinal nested designs that account for serial correlation within person and within provider and region. Regression analyses will account for prior year costs by type of utilization (e.g., emergency department, inpatient, mental health), clinical complexity (e.g., PPR risk score), regional utilization characteristics, and demographic factors. Parameter estimates for health home participants will indicate differences in PMPM relative to controls while controlling for historical utilization patterns, regional practice variation, and individual demographic characteristics.

APPENDIX: Pre-Existing Initiatives in New York				
	NYCCP	**CIDP[22,23]**	**Adirondack Medical Home Demonstration[24,25]**	**Statewide PCMH Program[7,26]**
Timeline	• Founded by 6 counties in West and Central New York in 2000 • Formed partnership with Beacon Health Strategies (MCO) in 2009 • Awarded contract as Behavioral Health Organization for Western Region in 2011	• Program authorized in 2007 legislation • Demonstration project began January 2009 • Contract ended March 29, 2012, and program participants were converted into health home members	• New York legislature authorized the Adirondack Medical Home Demonstration in 2009 • Demonstration began January 2010 • Participating practices applied for NCQA certification in February 2011 • Began participating in the Advanced Primary Care Practice demonstration in 2011 • Demonstration will end in 2015	• New York legislature established a statewide PCMH program for Medicaid, CHIP, and Family Health Plus enrollees in 2009 • Program was expanded to include other payers in 2011 • State submitted a SPA to CMS to test new payment models for medical home practices in 2011
Geographic Area	7 state counties concentrated in west and central New York	5 state counties and 4 boroughs of New York City	5-county region in Northeast New York	Statewide
Sponsors	State OMH, county government	New York DOH, Center for Health Care Strategies (CHCS), New York Health Foundation	DOH and 7 private payers	DOH
Scope	Targeted at all levels of the mental health system	6 provider organizations covering the areas listed above	Nearly all PCPs in the region; 5 hospitals, 123 physicians in group and solo practice	Eligible providers include PCPs, nurse practitioners, FQHCs, diagnostic and treatment centers

APPENDIX (*continued*)				
	NYCCP	**CIDP**[22,23]	**Adirondack Medical Home Demonstration**[24,25]	**Statewide PCMH Program**[7,26]
Goals	• Build culture of person-centered care and individual empowerment • Coordination of services delivered by multiple providers • A rehabilitation and recovery model of services • Implementation of evidence-based best practices, with outcome-based performance measurement • Improved information systems	• Establish inter-disciplinary models of care designed to improve health care quality • Ensure appropriate use of services • Improve clinical outcomes • Reduce the cost of care for Medicaid beneficiaries with medically complex conditions	• Strengthen regional ability to attract and retain PCPs • Improve quality, access, and outcomes • Contain costs • Create a new clinically integrated model that can be replicated in other parts of the state	• Incent the development of PCMHs through enhanced payment to providers who obtain NCQA recognition • Improve health outcomes through better coordination and integration of patient care
Payment Approach	1 initiative involved P4P in 2 counties; providers rewarded for achieving undefined performance targets	PMPM care management fee, with a risk corridor and shared savings available in second and third year to entities that met performance targets	FFS, plus a $7 PMPM care management fee	Enhanced payment for certain evaluation, management, and preventive services, plus a PMPM incentive payment from MCPs for participating enrollees. Rates for both enhanced FFS and the PMPM are tiered by NCQA recognition. Fees range from $5.50-$21.25, and PMPM rates range from $2-$6. Enhanced payment for Level 1 certification will end in December 2012
Technical Assistance (TA)	Beacon has provided technical assistance to providers on care management, and various pilot projects have involved training for providers on care integration and person-centered care	Participating providers took part in learning collaboratives led by DOH and CHCS	Technical assistance was provided to participating providers in implementing HIT, practice transformation, as well as in establishing the cost basis and rates to be paid to participating practices	A quality improvement contractor is providing some support to practices in meeting NCQA requirements

APPENDIX (*continued*)				
	NYCCP	**CIDP**[22,23]	**Adirondack Medical Home Demonstration**[24,25]	**Statewide PCMH Program**[7,26]
HIT Use	No information found	Contractors were expected to use or develop HIT capacity to support care management functions	Practices had to adopt electronic medical records and information exchange capacity, including connection to the RHIO, specialists and hospitals, and 2 data warehouses. 2 grants supported this; 1 from HEAL 10 and 1 from the state medical society	No information found
Evaluation Methods	Many of the projects have been formally evaluated, with the results published on the program website: http://www.carecoordination.or/results.shtm	The program is being evaluated by MDRC, and final reports are expected in 2013[27]	Evaluation will be conducted by the demonstration's governance council	The state health commissioner is required to report on the program's impact on quality, cost, and other outcomes by December 2012

Endnotes

1. Unless otherwise noted, information contained in the first two pages of this memorandum are drawn from one of two sources: (1) New York State Medicaid Update. "Introducing Health Homes: Improving Care for Medicaid Recipients with Chronic Conditions." Volume 28, Number 4, April 2012. Available from: http://www.health.ny.gov/health_care/medicaid/program/update/2012/2012-04_pharmsped_edition.htm. (2) National Academy for State Health Policy webinar. "Implementing Section 2703 Health Homes: Lessons from Leading States." June 2012. Available from: http://www.nashp.org/webinar/implementing-section-2703-health-homes-lessons-leading-states.

2. New York Care Coordination Program website. Available from: http://www.carecoordination.org/about_the_wnyccp.shtm.

3. National Academy for State Health Policy webinar. "Implementing Section 2703 Health Homes: Lessons from Leading States." June 2012. Available from: http://www.nashp.org/webinar/implementing-section-2703-health-homes-lessons-leading-states.

4. New York Department of Health website. "Medicaid Health Home Question and Answer." Available from: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/questions_and_answers.htm#cidp.

5. Adirondack Region Medical Home Pilot website. Available from: http://www.adkmedicalhome.org/.

6. Private insurers include BlueShield of Northeastern New York, Capital District Physicians' Health Plan, Empire BlueCross, Excellus, Fidelis Care, MVP Healthcare, and United Healthcare.

7. National Academy for State Health Policy website. Available from: http://www.nashp.org/med-home-states/new-york.

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15. New York Department of Health website. "Improving Care Coordination and Management through a Patient Centered Medical Home Model Supported by an Interoperable Health Information Infrastructure." Available from: http://www.health.ny.gov/technology/efficiency_and_affordability_law/phase_10.htm.

16. New York Department of Health. "Expanding Care Coordination Through the Use of Interoperable Health Information Technology- HEAL NY Phase 17." Press release. Available from: http://www.health.ny.gov/technology/efficiency_and_affordability_law/heal_ny_17.htm.

17. New York eHealth Collaborative website. Available from: http://nyehealth.org/heal22/.

18. Unless otherwise noted, information provided on the design of the Health Home program is drawn from the text of the New York Health Home SPA. Available from: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/chronic_conditons_spa_11-56_phase.pdf.

19. This section draws from a state-sponsored webinar conducted on June 6, 2012. PowerPoint slides. Available from: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/meetings_webinars.htm.

20. New York State Care Management Training Initiative website. Available from: http://healthhometraining.com/.

21. Section 2701 outlines quality directives for Medicaid.

22. New York Department of Health. "Health Department Launches New Projects to Improve the Care of Chronically Ill Medicaid Patients." Press release, 2009. Available from: http://www.health.ny.gov/press/releases/2009/2009-01-05_medicaid.htm.

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25. Adirondack Region Medical Home Pilot website. Available from: http://www.adkmedicalhome.org/home/.

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This paper is an attachment to the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation (ASPE) report "***Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Annual Report - Year Two***". The full report is available at: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.cfm.

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EVALUATION OF THE MEDICAID HEALTH HOME OPTION FOR BENEFICIARIES WITH CHRONIC CONDITIONS: Annual Report - Year Two

Files Available for This Report

Full Report (including state appendices)
- Executive Summary: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2es.cfm
- HTML: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.cfm
- PDF: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.pdf

Alabama appendix only
- HTML: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.cfm#AL
- PDF: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2-AL.pdf

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