New York Health Homes Q-and-A

What is a Health Home?

A Health Home is a care management service model in which all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner. This is done primarily through a dedicated "care manager" who oversees and provides access to all of the services an individual needs to assure that s/he receives everything necessary to stay healthy, out of the emergency room and out of the hospital. Health records are shared (either electronically or on paper) among providers so that services are not duplicated or neglected. The Health Home services are provided through a network of organizations — providers, health plans and community-based organizations. When all the services are considered collectively, they become a virtual Health Home.

New York State initiated a Health Home program for Medicaid members with chronic medical and behavioral conditions effective in January 2012, with the CMS approval. Health Home eligibility criteria require members to have one of the following:

- Two or more chronic conditions (e.g., mental health condition, substance use disorder, asthma, diabetes, heart disease, BMI over 25 or other chronic conditions)
- One qualifying chronic condition (HIV/AIDS) and the risk of developing another
- One serious mental illness

What is the difference between Medical Homes and Health Homes?

The Patient Centered Medical Home (PCMH) is a model for care provided by physician-led practices that seeks to strengthen the physician-patient relationship by replacing episodic care based on illnesses and individual's complaints with coordinated care for all life stages — acute, chronic, preventive and end of life — and a long-term therapeutic relationship. The physician-led care team is responsible for coordinating all of the individual's health care needs and arranges for appropriate care with other qualified physicians and support services. The Health Home model of service delivery expands on the traditional medical home model to build linkages to other community and social supports and to enhance coordination of medical and behavioral health care *with the main focus on the needs of persons with multiple chronic illnesses.*

The Health Home model includes providers that are closest to meeting the member's most urgent needs to play the care manager's role. This means that Health Homes can be care management agencies, housing providers and other types of community-based service providers in addition to the physician and/or hospital-led care management teams.

Does the Health Home program include long-term care?

Yes, on a short-term basis. Health Homes are responsible for assuring that their members receive all necessary services, including long-term care. However, members needing substantial long-term care services, i.e., greater than 120 days, will need to be transitioned into other long-term care management programs. The process for conducting this transition is under discussion by State staff. Members in need of long-term care services greater than 120 days are excluded from being enrolled into Health Homes under this State Plan Amendment (SPA).

Is a special Health Home consent form needed?

The state of New York is developing a patient consent form for use by the Health Homes, which will allow for patient information to be shared between the Health Home partners, including RHIOs, and address HIV/AIDS, mental health and substance abuse information.

Who is responsible for obtaining consent – lead Health Home applicant or Health Home provider?
The care manager from a Health Home is responsible for securing the consent from Medicaid members.

Will the Health Home be responsible for coordinating all transportation needs?
Yes, but actual costs of transportation will be covered by HealthPlus Amerigroup as a member's covered benefit. LogistiCare will continue to manage transportation for Health Home on behalf of HealthPlus Amerigroup.

What is the relationship between Health Homes, Managed Care Organizations (MCOs) and Behavioral Health Organizations (BHOs)?
The BHO monitors Fee-For-Service (FFS) Medicaid admissions for inpatient psychiatric care and detox and reviews discharge planning. Health Homes may want to work with their legal counsel to execute a confidentiality agreement with their regional BHO that would allow the Health Home to receive alerts if one of their members was admitted for these services. DOH would then request a copy of such agreement be sent to the DEAA office, enabling the BHO to review the discharge plan with the Health Home. The role of the MCOs regarding these services has not changed. If the services are covered by the capitated rate, they will continue to be paid by the MCO; if they are carved out and paid as FFS, they will continue to be paid subject to any applicable limits.

Can multiple health care practitioners get together to establish a Health Home?
Yes. However, the Health Home needs to be certified as a designated entity by the state.

Can a Health Home have more than one managed care organization in its network?
Yes.

Who can be the Health Home lead applicant?
Any enrolled Medicaid provider can be the lead applicant.

How will the State make Health Home services available to the homeless Medicaid population?
The State will assign a Health Home to homeless Medicaid enrollees that meet Health Home eligibility requirements using provider loyalty information, available information regarding their homeless status and the enrollee's last known address.

Can a Health Home member also be in a Managed Long-Term Care plan?
Managed Long-Term Care plans are for individuals needing more than 120 days of long-term care services. If a Health Home member requires more than 120 days of these services, they would have the option to enroll in a Managed Long-Term Care plan if available or receive services from a fee-for-service long-term care provider. The member would no longer be eligible to be enrolled in a Health Home.

What will be the reimbursement for Health Home services?
Health Homes are reimbursed for two types of care coordination services — outreach and enrollment. Health Home payments are based on each member's risk score (i.e., acuity score) multiplied by PMPM for each type of service provided for each month. Health Homes are allowed to bill for outreach services up to three months. The managed care plans will be responsible for billing to and receiving payments from the state. MCOs will pass through 97 percent of the Health Home payments and retain 3 percent for administrative fees.

Information regarding Health Home reimbursement can be found at
http://health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_information.htm.

How will health plans pay for conducting Health Home care management services?

For non-TCM managed care enrollees, the health plan will reimburse 97 percent of the PMPM proportionate to the care management effort of Health Homes.

How do providers follow up on payments if they are a Health Home?

For non-TCM providers, Health Homes will bill through HealthPlus Amerigroup on a monthly basis and receive payments from HealthPlus Amerigroup once the state sends the reimbursements for the billed amounts.

For TCM providers, they will directly bill the state for managed care members through 2013. MCOs will need to work with TCM Health Homes to recoup 3 percent.

Who should providers contact to request authorization for Health Home members?

Providers should continue to follow processes and guidelines of HealthPlus Amerigroup.

Who should providers contact for assistance with care and/or service issues for members with complex conditions?

The provider can contact the member's Health Home Case Manager. The Health Home Case Managers will work with the HealthPlus Amerigroup Health Home liaison to facilitate care coordination of services available in and out of the network.

Source: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/questions_and_answers.htm