Medicaid Health Homes & HIV Care Overview

November 2014
HEALTH HOMES

- Care management for high need/high risk individuals with multiple chronic and complex conditions to
  - Improve health and quality of care
  - Reduce costs
    - Prevent avoidable inpatient admissions and emergency room visits
    - Reduce the need for long term care
- Enhanced coordination/integration of medical and behavioral health
- Linkage to community and social supports
HEALTH HOME STRUCTURE

- Led by a single provider (hospital, FQHC, CBO, or other eligible entity)

- Lead Health Home creates a multi-disciplinary network to help members connect with all of the following:
  - Managed Care plans
  - One or more hospital systems
  - Multiple ambulatory care sites (physical and behavioral health)
  - Existing care management and converting targeted case management (TCM) programs
  - Social supports, including housing and vocational services
NYS HEALTH HOME MEMBER ELIGIBILITY

✓ One serious and persistent mental health condition;
✓ HIV/AIDS;
✓ Mental Health condition;
   or
✓ At least two chronic conditions including:
   ▶ Substance Abuse disorder
   ▶ Asthma
   ▶ Diabetes
   ▶ Heart Disease
   ▶ Hypertension
   ▶ BMI > 25
   ▶ Other chronic illness
HIV+ TARGET FOR HEALTH HOMES

- Highest risk HIV+ Medicaid recipients with co-occurring conditions
  - 72% Substance Use
  - 50% Severe Mental Illness
  - 48% Mental Illness
  - 42% Asthma
  - 31% Heart Disease
  - 25% Hypertension
  - 20% Hyperlipidemia
  - 18% Diabetes

Health Home eligible adults 21+ years. Diagnosis history period of July 1, 2010 – June 30, 2011
## HEALTH HOME REFERRALS

### STATE
- Prior Medicaid claims data is used by NYS DOH to generate lists of eligible Health Home candidates.
- Lists sent to recipients’ Managed Care Organization or directly to a Health Home (fee-for-service).
- MCO assigns recipient to a Health Home based on prior services (loyalty analysis).
- Health Home assigns to a care management provider or provides outreach and/or care management itself.

### COMMUNITY
- New referrals meeting Health Home eligibility criteria are identified by medical, social service, criminal justice, county, etc., agencies.
- Community referrals can be made to a care management provider, Lead Health Home, or Managed Care Organization. “Bottom up referral”
MEMBER QUALIFICATION FOR
HEALTH HOME ENROLLMENT

Both community and state referrals must meet chronic illness criteria and have current need for care management to qualify for enrollment.

Need criteria:
- No primary care practitioner
- No specialty doctor
- Poor appointment or medication compliance
- Inappropriate emergency department use
- Repeated recent hospitalization for preventable physical or psychiatric conditions
- Recent release from incarceration
- Cannot be effectively treated in Patient Centered Medical Home (PCMH)
- Homelessness
HEALTH HOME ACTIVITIES

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care
  - inpatient discharge, jail to community, etc.
- Patient and family support
- Referral to community and social support services
  - housing, legal, food, etc.
- Use of Health Information Technology (HIT) to link services
TRANSITION OF HIV TARGETED CASE MANAGEMENT (TCM) PROGRAMS: COBRA

- Continue to monitor retention and access to medical and supportive services, adherence and viral load suppression.

- 46 diverse providers serving nearly 12,000 HIV+ clients transitioned to the Health Home model

- Converted HIV TCMs are subcontractors to Health Home Leads for outreach and care management

- Most have expanded their mission to serve HIV negative Medicaid recipients with broad array of complex conditions
CONTRIBUTIONS OF HIV COBRA TARGETED CASE MANAGEMENT TO NYS HEALTH HOMES

- Skilled in community outreach to find those lost or never in care
- Harm reduction approach to engagement
- Cultural competency
- History of working with stigmatized and marginalized populations
- Extensive work with peers
- Expertise at community-based services: home visits, patient escort, advocacy, etc.
- Many years experience in case management. Care management enhances case management model with better connections to external medical care
EMERGING HEALTH HOME INITIATIVES

- **Additional populations**: behavioral health, children, long term care, developmentally disabled (DD), adult home residents

- **Shared Savings State Plan Amendment (SPA)**: DOH has begun initial discussions with CMS for future implementation.

- **HH and Criminal Justice demonstrations**: Provide pre-release and post-release assistance to ensure mental health, substance use and other health issues are addressed to prevent recidivism and inappropriate use of emergency rooms.

- **Health Home and Housing**: Grants for supportive housing providers are underway to house and serve unstably housed high cost Medicaid recipients enrolled in Health Homes.
TRANSITION CHALLENGES HIV TCMS

- Identity
  - Change in mission and autonomy

- Financial
  - Funding for capital costs, especially HIT
  - Monthly administrative rates to Leads/MCOs
  - Low Health Home payment rates necessitated high caseloads in order to achieve financial stability
    - State currently adjusting rate structure

- Administration and Program
  - Complex tracking and reporting
  - Multiple electronic platforms
  - Training in multiple disease areas
  - No State infrastructure for HIV negative persons with chronic illnesses
WHAT’S WORKED SO FAR?

• Partnership with key government and community players

• State committed to transitioning and expanding existing capacity, including HIV services

• Transition period for converting providers with maintained rates and direct Medicaid billing

• Frequent direct communication between AIDS Institute and converting HIV providers

• Advocacy and policy input by HIV provider community

• Innovative new provider entities to meet new challenges (iHealth)

• Evolving Health Home model
HEALTH HOMES AND ETE GOALS

- Care coordination and referrals to social supports based on retention and viral load needs.
- Dedicated care manager works with clinical team to coordinate supports for achieving clinical goals related to retention and VLS.
- Provides link to Medicaid supportive housing
- Requires more frequent contact with client in the community.
- Experienced care management agencies have expanded high risk populations that can include HIV testing as part of Patient Centered Service Plan.
- Health promotion support can include messages on limiting HIV transmission and protecting HIV- partners.
HEALTH HOMES AND DSRIP

- How can Health Home services support Performing Provider Systems (PPS) HIV related engagement and retention efforts?
- What will HH partnerships with PPSs look like?
- Who are the non-identified HIV patients?
- Who are the high need HIV patients? What are the challenges to getting and keeping them in care?
- Who are the newly diagnosed, not yet in care?
- How can peers assist with DSRIP efforts?
Contact

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