MEDICAID HEALTH HOME PROVIDER APPLICATION INSTRUCTIONS

The New York State Department of Health invites interested organizations meeting eligibility and practice requirements to apply to participate in the Health Home Program.

PROGRAM DESCRIPTION

The Health Home Program will provide reimbursement for care management to approved health home providers for the following health home services provided to enrollees with behavioral health and/or chronic medical conditions:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support, which includes authorized representatives;
- Referral to community and social support services, if relevant; and
- The use of health information technology to link services, as feasible and appropriate.

NY health homes will be required to use multidisciplinary teams comprised of medical, mental health, and chemical dependency treatment providers, social workers, nurses and other care providers. The team will be led by a dedicated care manager who will assure that enrollees receive all needed medical, behavioral, and social services in accordance with a single care management plan. The health home provider will be accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions, skilled nursing facility admissions and emergency room visits and meeting quality measures.

The NYS Medicaid program is seeking applicants whose model of service delivery is an integrated health care system and community provider network that ensures coordinated care across the continuum of medical, mental health, rehabilitative care, substance abuse and social services required by patients with complex needs. Health home applicants that demonstrate strong linkages with medical, behavioral, and social service providers will be given priority in the application review process. Applicants must attest that contractual arrangements exist for all health home network providers that define the terms of participation, minimum time frames for access to services, provision of crisis intervention and responsibilities of each provider.

Health home providers will be approved for an initial period of three years. Approved providers must agree to report outcome and performance metrics as required by CMS and NYS. Continuing Health Home designation is contingent upon satisfactory performance of activities, demonstrated by meeting the quality and functional measures, and that cost effective methods for better utilization of health care resources have been put into practice.

NYS Health Home Program information may be accessed at:
http://www.health.state.ny.us/health_care/medicaid/program/medicaid_health_homes/index.htm

ELIGIBILITY AND GENERAL QUALIFICATIONS
NYS providers eligible to become health homes include managed care plans; hospitals; medical, mental health and chemical dependency treatment providers and/or clinics; primary care practitioner practices; patient centered medical homes (PCMH); federally qualified health centers (FQHCs); Targeted Case Management (TCM) providers; and certified home health care agencies that meet health home provider standards. Preferred health home applications will include an integrated health care and community provider network that includes 1) managed care plans; 2) hospitals; 3) community based organizations, targeted case management providers; 4) mental health and substance abuse services providers.

1. Health home providers/plans must be enrolled (or be eligible for enrollment) in the NYS Medicaid program and agree to comply with all Medicaid program requirements.

2. Health home providers can either directly provide, or subcontract for the provision of, health home services. The health home provider remains responsible for all health home program requirements, including services performed by the subcontractor.

3. Care coordination and integration of health care services will be provided to all health home enrollees by an interdisciplinary team of providers, where each individual’s care is under the direction of a dedicated care manager who is accountable for facilitating access to medical and behavioral health care services and community social supports as defined in the enrollee’s care plan.

4. Hospitals that are part of a health home network must have procedures in place for referring any eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to a DOH designated health home provider.

REIMBURSEMENT

Health homes that meet state and federal standards will be paid a per member per month (PMPM) care management fee that is adjusted based on 1) region, 2) enrollment volume, 3) case mix (based on 3M Clinical Risk Groups™ [CRG]) , *4) patient functional status. The care management fee will be paid in two increments: case finding and active care management. The case finding PMPM is 80% of the active care management PMPM and is only available for the first three months after a patient is assigned to a given health home. Health home care management fee rate ranges will be available on the Health Home website before the application period for phase 1 closes on September 1, 2011.

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

*(Note: Criteria 4, patient functional status will be incorporated into calculating the PMPM when data becomes available.)

APPLICATION

Statewide implementation of the Health Home program is scheduled for October 1, 2011. Interested organizations may apply to participate in the Health Home Program by completing the Medicaid Health Home Provider application from the Health Home website: http://nyhealth.gov/health_care/medicaid/program/medicaid_health_homes/index.htm
Submission of the completed online application must also include sending an email using the link provided within the online application form. Once the email link is clicked, a blank email form will open which contains an assigned subject including a unique identifier. The assigned subject must be included on the email in order to join the applicant's attachments to their application.

The email must include the following two (2) attachments:
1) a spreadsheet containing Table 1.1 Health Home Network Provider/Organization Information (in Section B.2.b.) Table 2.1 Proposed Health Home Program Enrollee Capacity Slots: At Initiation (in Section B.3) and Table 2.2 Proposed Health Home Program Enrollee Capacity/Slots: At Maturity (in Section B.3).
2) a PDF of the signed Health Home Provider Attestation Form found on the last page of the application. The Attestation Form must be signed by an official of the applicant organization who is authorized to attest to the accuracy of the information contained in the Health Home application.

The application will not be considered complete until a hardcopy of the Health Home Provider Attestation Form with an original signature is received by the DOH. Please send the form to:

Health Home Management Unit
Division of Financial Planning and Policy
NYS Department of Health
Office of Health Insurance Programs
Medicaid Policy & Care Delivery Group, OCP-716
Empire State Plaza
Corning Tower
Albany, New York 12237

Applications for phase 1 will be accepted continuously from August 1, 2011- September 1, 2011. Successful applicants under this phase will be assigned beneficiaries and be eligible to bill for health home services starting October 1, 2011. Additional application opportunities will be available at a date to be determined based on geographic need.

NOTIFICATION

A letter of decision regarding the application will be sent by this Department to the applicant’s address as listed on the application.

INSTRUCTIONS TO THE APPLICANT

This is an application for designation as a New York State Medicaid Health Home Provider. Responses to this application will be used to assess your organization’s ability to meet the NYS Health Home Provider Qualification Standards for Chronic Medical and Behavioral Health Patient Populations. Supplementary information may be requested from your organization to comply with any additional program rules and regulations promulgated by the Centers for Medicare & Medicaid Services (CMS) or by the State.

The NYS Medicaid Health Home Provider Qualification Standards may be accessed at: http://www.health.state.ny.us/health_care/medicaid/program/medicaid_health_homes/docs/inter_health_home.pdf
APPLICANT INFORMATION

Organization Name: ____________________________________________    NPI#_________________
Correspondence Address__________________________________________________________
City________________________State__________________Zip Code______________________
Telephone Number________________________County________________________

Type of Organization/Provider Applicant: (Please check applicable box)

☐ Managed Care Plan          ☐ Targeted Case Management Provider
☐ Hospital                  ☐ Certified Home Health Care Agency
☐ Primary Care Practitioner  ☐ Federally Qualified Health Center
☐ Patient Centered Medical Home ☐ Substance Abuse Services Provider
☐ Mental Health Providers
☐ Ambulatory Providers/ Clinics (please specify)
   ☐ Article 16
   ☐ Article 28
   ☐ Article 31
   ☐ Article 32

☐ Other _______________________

Licensure/ Certification number ______________________________________________________
Pay-To- Address____________________________________________________________________
City________________________________State______________Zip Code____________________
Organization Contact Person: ______________________________________________________
Title____________________Telephone Number________________________
Fax Number ______________E-mail____________________________________________________
Proposed Health Home program start date ________________________
( October 1, 2011)

SECTION A. HEALTH HOME PROVIDER SPECIFIC INFORMATION

Please respond to the following questions in a brief, concise manner.

1. Provide a general description of your organization and experience in providing integrated care services. Limit 500 characters

2. Identify the proposed health care professionals and other members of the interdisciplinary provider team that will provide care management and coordination of integrated services. Limit 500 characters

3. Provide the description of the proposed care manager position, including professional discipline (if applicable), and relevant education, training and experience. Limit 500 characters each
   a. Describe level and intensity of care management that will be provided to the following populations:
      i. Low need- stable in ambulatory care with episodic crisis or inpatient need
      ii. Intermediate need- not as connected to ambulatory care, more frequent emergency room and inpatient use
iii. High need- very unstable such as those serviced by OMH and HIV/AIDS COBRA TCMs and the MATS program.

4. Describe the process and time frames for providing crisis intervention for both medical and behavioral health events. Limit 500 characters

5. Describe the specific process that will be used to assure the Health Home prompt notification of emergency room and inpatient facility admissions/discharges. Limit 500 characters

6. A. Describe your organization’s current health information technology (HIT) capability to meet the initial HIT standards as referenced in NYS Health Home Provider Qualification Standards items 6a.-6d. Limit 500 characters for each.

   6a. Health home provider has structured information systems, policies, procedures and practices to create, document, execute, and update a plan of care for every patient.

   6b. Health home provider has a systematic process to follow-up on tests, treatments, services and referrals which is incorporated into the patient’s plan of care

   6c. Health home provider has a health record system which allows the patient’s health information and plan of care to be accessible to the interdisciplinary team of providers and which allows for population management and identification of gaps in care including preventive services.

   6d. Health home provider makes use of available HIT and accesses data through the regional health information organization/qualified entity to conduct these processes, as feasible

B. In order to be approved as a health home provider, the application must provide your organization’s plan for achieving final HIT standards within eighteen (18) months of program initiation as referenced in NYS Health Home Provider Qualification Standards items 6e.-6i.

Instructions: For each of the standards listed below, if capabilities exist today, please acknowledge with a ‘Yes’. For the standards you are not able to comply with at the time of application, please document plans for attaining the standards in the 18 month time-frame. Limit 500 characters for each:

   6e: Health home provider has structured interoperable health information technology systems, policies, procedures and practices to support the creation, documentation, execution, and ongoing management of a plan of care for every patient.

   6f: Health home provider uses an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the patient’s health information and plan of care to be accessible to the interdisciplinary team of providers. If the provider does not currently have such a system, they will provide a plan for when and how they will implement it.

   6g: Health home provider will be required to comply with the current and future version of the Statewide Policy Guidance
which includes common information policies, standards and technical approaches governing health information exchange.

6h: Health home provider commits to joining regional health information networks or qualified health IT entities for data exchange and includes a commitment to share information with all providers participating in a care plan. RHIOs/QE (Qualified Entities) provides policy and technical services required for health information exchange through the Statewide Health Information Network of New York (SHIN-NY).

6i: Health home provider supports the use of evidence based clinical decision making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance. One example of such a tool is PSYCKES.

SECTION B. HEALTH HOME PROVIDER NETWORK & PROGRAM CAPACITY

In order to provide comprehensive and timely high quality services, health home providers are expected to develop health home networks to provide enrollees access to needed services. Health home networks should include medical care providers (e.g. primary care, ambulatory care, preventive and wellness care, FQHCs, clinics, specialists including HIV/AIDS providers, hospitals, rehabilitation/skilled nursing facilities, pharmacies/medication management services, home health services, chronic disease self-management and patient education services, etc.); behavioral health care providers (e.g. acute and outpatient mental health, substance abuse services and rehabilitation providers, etc.); and community based organizations and social services providers (e.g. TCMs, public assistance support services, housing services, etc.).

1. Check the appropriate provider types included in your network. Inclusion of TCM programs (including OMH and HIV/AIDS COBRA TCMs, and Managed Addiction Treatment Services Providers (MATS)), housing and other community based organizations is strongly encouraged. Beneficiary assignment to health homes will partially be based on an organization’s network capacity.

Types of Providers: (Please check applicable box)

- [ ] Managed Care Plan
- [ ] Hospital
- [ ] Primary Care Practitioner
- [ ] Patient Centered Medical Home
- [ ] OMH
- [ ] HIV/AIDS COBRA
- [ ] Substance Abuse Services Provider
- [ ] MATS Provider
- [ ] Federally Qualified Health Center
- [ ] Ambulatory Providers/Clinic (Please specify)
  - [ ] Article 16
  - [ ] Article 28
  - [ ] Article 31
  - [ ] Article 32
- [ ] Certified Home Health Care Agency
- [ ] Community Base Organizations ________________
- [ ] Other _________________________
2. a. Provide a complete description and organizational structure of the applicants Health Home Model, including how the applicant will accomplish providing the required services, provider linkages and care coordination necessary. Limit 5000 characters

b. Create and attach a spread sheet to identify each Health Home network provider organization, as well as associated individual practitioners for each of the locations using the column headings in Table 1.1.

**Health Home Network Provider/ Organization Information**

**Name of Applicant**

<table>
<thead>
<tr>
<th>Entity or Provider (First Name)</th>
<th>Entity or Provider (Last Name)</th>
<th>Street Address</th>
<th>Additional Address Information</th>
<th>City</th>
<th>State</th>
<th>Zip code</th>
<th>National Provider Identification number (NPI required)</th>
<th>Licensure Type</th>
<th>Certification Type</th>
</tr>
</thead>
</table>

Table 1.1

3. Create and attach a spread sheet to identify the proposed Health Home Program enrollee capacity at program initiation and at full program maturity using the column headings in Tables 2.1 and 2.2.

Program capacityslots should be stratified into the following three levels based on definition as provided in Section A #3.

Also include the number of care management slots for proposed health home enrollees who are currently enrolled in an OMH or HIV/AIDS COBRA TCM, MATS program, Chronic Illness Demonstration Project (CIDP) or managed care plan operated by your organization.

**Proposed Health Home Program Enrollee Capacity/Slots: At Initiation**

**Name of Applicant**

<table>
<thead>
<tr>
<th>Populations</th>
<th>Number of Slots</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not currently in Care Management</td>
<td>Managed Care Plan</td>
</tr>
<tr>
<td>High need</td>
<td></td>
</tr>
<tr>
<td>Intermediate need</td>
<td></td>
</tr>
<tr>
<td>Low need</td>
<td></td>
</tr>
</tbody>
</table>

Table 2.1
Proposed Health Home Program Enrollee Capacity/Slots: At Maturity

Name of Applicant

<table>
<thead>
<tr>
<th>Number of Slots</th>
<th>Managed Care Plan</th>
<th>OMH TCM</th>
<th>COBRA TCM</th>
<th>CIDP</th>
<th>MATS</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not currently in Care Management</td>
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<td>Populations</td>
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<td>Low need</td>
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Table 2.2

SECTION C: ATTESTATION

I. Health Home Program Requirements

1. Health Home applicant will be required to attest that their services will include the following:

   a. Coordination of care and services post critical events, such as emergency department use, hospital inpatient admission and discharge;
   b. Language access/translation capability;
   c. 24 hour 7 days a week telephone access to a care manager;
   d. Crisis intervention;
   e. Links to acute and outpatient medical, mental health and substance abuse services;
   f. Links to community based social support services—including housing;
   g. Beneficiary consent for program enrollment and for sharing of patient information and treatment.

2. The health home applicant must attest that contractual agreements are in place with all organizations included in the provider network.

3. The health home applicant must attest that payment to an OMH or HIV/AIDS COBRA TCM operating in a health home’s provider network will be at the State set, mandated TCM rate for current and new TCM assignees for the first year.

4. The health home applicant must attest that payment to a CIDP will be made at the State set, mandated rate for current CIDP enrollees for the first year.

II. NYS Medicaid Health Home Provider Qualification Standards

Health Home Provider applicants must submit a written attestation that the core health home requirements specified below will be provided in totality and in accordance with the NYS Health Home Provider Qualification Standards for Chronic Medical and Behavioral Health Patient Populations located at

http://nyhealth.gov/health_care/medicaid/program/medicaid_health_homes/docs/inter_health_home.pdf
A. Core Health Home Requirements

Describe for each of the following how the health home will meet each core requirement included in the NYS Health Home Provider Qualification Standards.
Limit 500 characters each

1. Comprehensive Care Management
2. Care Coordination and Health Promotion
3. Comprehensive Transitional Care
4. Patient and Family Support
5. Referral to Community and Social Support Services
6. Use of Health Information Technology (HIT) to Link Services
7. Quality Measure Reporting to NYS

B. CMS Health Home Provider Functional Requirements

Health Home Provider applicants must submit a written attestation that the services specified below will be provided in accordance with the following health home functional components referenced in the CMS State Medicaid Director’s Letter, 10-024 (https://www.cms.gov/smdl/downloads/SMD10024.pdf):

Describe for each of the following how the health home will meet each functional component as required by CMS.
Limit 500 character each

1. How will the health home provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services?
2. How will the health home coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines?
3. How will the health home coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders?
4. How will the health home coordinate and provide access to mental health and substance abuse services?
5. How will the health home coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings? Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care.
6. How will the health home coordinate and provide access to chronic disease management, including self-management support to individuals and their families?
7. How will the health home coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services?
8. How will the health home coordinate and provide access to long-term care supports and services?
9. How will the health home develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;
10. How will the health home use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate?
11. How will the health home establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

III. Rights of the State

1. The State reserves the right to assign beneficiaries to a specific health home.

2. The State reserves the right to cancel a Health Home provider’s approved status based upon failure of the provider to provide health home services in accordance with the NYS Health Home Provider Qualification Standards, provide quality health home services to its clients, or upon other significant findings determined by the State.

3. The State reserves the right to cancel the program at any time for lack of funding, and/or if, after evaluation of the program, desired results in quality, efficiency and decreased costs are not shown, or any other reason determined by the State.

Attestation Instructions: The Health Home Provider Attestation Form, below must be signed by an official of the applicant organization who is authorized to attest to the accuracy of the information contained in the Health Home application and must be submitted electronically as a PDF to hh2011@health.state.ny.us.

Health Home Provider Attestation Form

The undersigned certifies that the information submitted in this Health Home Provider Application and any attached pages are true, accurate and complete. The Health Home applicant agrees to comply with all current and future Health Home Program rules, payment and operational policy, regulations and directives of the NYS Department of Health and CMS. The Health Home applicant also agrees to immediately notify the NYS Department of Health of any changes that may occur either as a Health Home Provider or with any changes of providers/subcontractors within the Health Home network.

Organization: ____________________________________________________________

Authorized
Original
Signature: ______________________________________________________________

Print Name: ______________________________________________________________

Title: ___________________________________________________________________

Date: ___________________________________________________________________