INTRODUCTION

The NewYork-Presbyterian Hospital Health Home has developed these policies and procedures with consideration for the continued development of Health Home requirements from the State of New York Department of Health ("NYSDOH"). This document generally provides expectations for care management services and as further standards are being developed and guidance is provided from NYSDOH. These policies and procedures also reflect feedback we receive from our Care Management Agencies. Services provided to Health Home enrollees must be in compliance with NYSDOH Regulations and Federal and State Laws including compliance with New York State's Plan Amendment and Medicaid regulations. All care management services that are billed to the Health Home for the purposes of Medicaid billing must meet Medicaid billing standards. Federal Law and State Regulations require providers to retain financial and health records necessary to fully disclose the extent of services, care and supplies provided to Medicaid clients.

Care Management Agencies are required to timely comply with all guidance issued by NYSDOH and The NewYork-Presbyterian Hospital Health Home regarding policies and procedures and other changes in the rules governing Medicaid Health Homes. This manual will be available on The NewYork-Presbyterian Hospital Health Home website https://www.nyp.org/pps/health-home and updated as necessary and at a minimum biannually.

HEALTH HOMES OVERVIEW

What is a Health Home?

A Health Home is an intensive care management service program for Medicaid patients with complex and high-cost medical conditions to address their medical, behavioral and social needs in a comprehensive manner. Each patient is assigned a care manager who oversees and facilitates access to appropriate services, including community-based resources. The care manager, patient, and professionals involved in the patient's care work closely together to develop a patient-centered care plan that empowers the patient to be an active participant in his/her health care.

What are the goals of Health Homes?

- Improve patient's overall wellbeing and ensure patient stays healthy
- Reduce unnecessary emergency department visits, inpatient stays, and use of long-term care services through care coordination
- Facilitate exchange of patient health information among providers to minimize duplication or neglect of services
- Ensure patients have access to the resources and tools, including social service programs, needed to become and remain healthy

What are the patient eligibility criteria for Health Homes?

The New York State Department of Health defines two main criteria for patients to be eligible for a Health Home:

- Patient must be actively enrolled in Medicaid; and
- Patient must have a single qualifying condition (HIV/AIDS or a Mental Health Diagnosis), or two or more chronic conditions as defined by the 3M Clinical Risk Groups (CRGs) (e.g., asthma, diabetes, heart disease, hypertension, obesity, Chronic Alcohol Abuse and Dependency)

Patients must also demonstrate an unmet social need, which can include:

- Probable risk for adverse events (e.g., death, disability, inpatient or nursing home admission);
- Lack of or inadequate social/family/housing support;
- Lack of or inadequate connectivity with healthcare system;
- Non-adherence to treatments or medication(s) or difficulty managing medications;
- Recent release from incarceration or psychiatric hospitalization;
- Daily living activities limitations (e.g., dressing or eating); and
- Learning or cognition issues

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