Purpose

The Health Home monitoring review process has been designed to review the performance of each Health Home in its progress towards meeting the stated triple aim of the ACA: to improve the health of Medicaid members, to improve the delivery of health care service to Medicaid members, lower Medicaid costs, reduce preventable hospitalizations and emergency room visits and avoid unnecessary care. The Health Home Monitoring process will ensure all Health Homes across the State are in compliance with Health Home standards.

Statutory and Regulatory Authority

The authority to implement Health Homes is included in Section 1945 of the Social Security Act. The 2011 New York State (NYS) Executive budget provided for the establishment of a model for person-centered integrated care coordination and care management services called Health Homes. Authorization for the establishment of Health Homes was included in the Affordable Care Act (P.L. 111-148 & P.L.111-152), Section 2703 (SSA 1945b) and the NYS Social Services Law Section 365-l entitled "State option to provide Health Homes for members with chronic conditions under the Medicaid State Plan." On February 3, 2012 the US Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) approved New York State's first State Plan Amendment (SPA) #11-56, Health Home SPA for Individuals with Chronic Conditions, Phase 1 of the Health Home Program with an effective date of January 1, 2012. On December 4, 2012 CMS approved two additional Health Home SPAs for Phase 2 (SPA #12-10) and Phase 3 (SPA #12-11) with effective dates of April 1, 2012 and July 1, 2012 respectively. The combined approval of these three SPAs allows for statewide implementation of the Health Home Program.

Section 1: Monitoring Surveys

Scope of Surveys

The Department of Health, Division of Program Development and Management (DPDM) along with its State Implementation Partners (AIDS Institute, Division of Health Plan Contracting and Oversight, OMH, OASAS, and DHITT) are responsible for overseeing the Health Home Program and collaboratively reviewing each Health Home's performance. The Department, with assistance from the State Implementation Partners and input from stakeholders and provider associations, will develop policies and procedures for the performance of surveys to evaluate Health Homes in the following areas:

- Outcomes and Quality
- Delivery of Health Home Services
- Governance and Operational Integrity

Surveys will generally be performed as an on-site visit; however, desk reviews of process and quality measures against program benchmarks will be used to monitor

Health Homes and identify opportunities for improvement, as well as determine the scope of the comprehensive survey. The method of monitoring may vary over time and will be determined by the joint, on-going efforts of the Department and its State Implementation Partners.

Section 1A: Comprehensive Survey

A comprehensive survey is a full review of Health Home operations. Representatives from each of the State Implementation Partners will be given the option to participate in the survey. The survey checklist will include the following domains:

- Review of Health Home Policies, Procedures and Compliance
- Provider Qualifications, Network and Program Capacity
- Health Information Technology (HIT) Standards
- Confidentiality, Data Access and Security
- Qualifications of Staff and Training
- Assignment and Member Tracking
- Success of the Delivery of Six Health Home Core Services
- Outreach Policies and Practices
- Informed Consent, Enrollment and Disenrollment Process and numbers of individuals passing through each stage of the process
- Quality of Care (including, but not limited to, individual record review)
- Member Referral Process and Outcomes
- Enrollee Eligibility Status
- Medicaid Provider Enrollment
- Billing, Claims and Encounter Data
- Management of Member Complaints and Incidents
- Quality Improvement

A comprehensive survey is performed in the following circumstances:

a) Initial Readiness
During specific designated application periods, and as directed by the Department, organizations may apply to participate in the Health Home Program. Application periods for additional Health Homes will be determined by the State as needed. Newly designated Health Homes will have an initial Readiness review. Health Homes passing that initial readiness review typically will be granted a three-year period prior to the first re-designation review. However, based on the findings of the Initial Readiness review, the Department or its State Implementation Partners may opt to have the Department grant a period of less than three years prior to a re-designation review. Within one year of designation, Health Homes will have a comprehensive survey to determine initial readiness.

b) Significant Change in Operations and/or Governance
A significant change in operations or governance is defined as a change in ownership, executive control, or composition of the governing body, or the addition

or withdrawal of a significant partner such that the original structure of the Health Home organization, is considered by the Department or one of its State Implementation Partners to be materially changed as presented in the original application reviewed and approved by the Department. A Health Home **must** submit a Health Home Notification of Change form to the Department to report **any** changes in operations and/or governance. If the change is determined to be significant, a comprehensive survey will be performed within three months of the notification of the event (Note: a change that is not determined to be significant may, at the option of DOH or one of its State Implementation Partners, be evaluated through the performance of a focused survey- see Section 1B)

c) Re-designation

After the initial three year period of designation and prior to the renewal of a Health Homes' designation, the Department along with its State Implementation partners will collaboratively review each Health Home's performance to determine if the program's designation status will continue. State re-designation of Health Homes will be determined based on the needs of the State and compliance with Federal and State program requirements. Performance on program benchmarks and quality metrics will be reviewed and considered when determining whether a Health Home should be re-designated.

Health Homes that have met or exceeded process and quality benchmarks and have demonstrated a successful self-evaluation/monitoring program, which includes effective internal policies and processes to identify and address non-compliance and subsequent corrective actions, may be deemed by the Department, with the agreement of its State Implementation Partners, to have met re-designation criteria and the requirement for a comprehensive re-designation survey may be waived once.

If the Department with the agreement of its State Implementation Partners determines that a Health Home does not meet performance standards, including but not limited to compliance with State and Federal program requirement, program benchmarks and quality metrics, the Health Home's request for re-designation may be declined. In instances where Health Home performance does not prevent re-designation but does require corrective action, progressive sanctions may be placed on the Health Home by the Department until compliance can be demonstrated by the Health Home (e.g., limitations may be placed on future enrollments until appropriate corrective action is taken).

Section 1B: Focused Survey

A focused survey is an in-depth review which focuses on one or more specific areas of Health Home operations. Focused surveys are an essential tool to be used for verifying objective evidence and reviewing objective data to determine the ability of the Health Home to meet established benchmarks, to assess how successfully the program has been implemented, and to investigate complaints and incidents. Information gleaned from a focused survey may also be used to identify best practices, allowing other programs to amend their working practices and, contributing to continual improvement of Case Management/Coordination overall.

The team for the focused survey will be selected based on the issues that are identified. The focused survey checklist will include one or more previously listed domains in **Section 1A** and can be customized as needed to address the areas of concern at State discretion.

A focused survey may be authorized by the Department of Health, Health Home Program Manager in the following circumstances:

a) Evaluation of Process and Quality Metrics
Health Home performance will be monitored regularly through a variety of quality and process metrics. Benchmarks and thresholds will be established for key indicators; failure to meet established benchmarks and thresholds may result in a recommendation for a focused survey. To date, process and quality metrics include:

- **CMART Data,** including but not limited to outreach and engagement rates, Health Home service delivery
- **Salient Data** including but not limited to metrics identified in the continuous program monitoring and trigger event domains; and
- **Annual Health Home Quality Metrics**

b) Trigger Events
Trigger events are episodes or events that are determined to be serious enough to warrant an on-site investigation.

- **Complaints**
  - Complaints about Care Managers, Care Management Services, or other services identified in the member's plan of care
  - Complaints about breach of privacy issues

- **Incidents**
  - Allegations of abuse or mistreatment committed by staff to a member or between members, a suicide attempt; or an unexpected death of an individual
  - Reports of theft, fraud, or other crimes that have been reported to the police
  - Significant injuries resulting in inpatient hospitalization

Note: Refer to Section 2 – Monitoring the Reporting of Complaints and Incidents

- **Threats to Program Integrity**
  Program integrity creates an environment that supports better health outcomes within a context that avoids over- or underutilization of services. It also requires effective program management and ongoing program and

fiscal monitoring.

- **Member Tracking System/Billing Data**
  - Duplicate Billing
  - Mismatch between members billed for and members in the Health Home Member Tracking system

- **Contract Partner Network Issues**
  - Network adequacy: after a partner of one of the core services leaves Health Home Network. Note: this may or may not be a trigger event depending on the scope of the services provided and the role of the provider (e.g., if a partner with a governance role leaves the network) this may trigger a comprehensive survey].

c) Other Issues
  - Follow up on Issues Discovered During Comprehensive Site Visit
  - Issues Identified by Other State Agencies
  - Evaluate the ability of Health Home to identify and successfully deliver the Six Core Services