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**APRIL IS NATIONAL MINORITY HEALTH MONTH**



The death rate for Blacks/African Americans is generally higher than whites for heart diseases, stroke, cancer, asthma, influenza and pneumonia, diabetes, HIV/AIDS, and homicide.

American Indians/Alaska Natives also have a high prevalence and risk factors for mental health and suicide, unintentional injuries, obesity, substance use, sudden infant death syndrome (SIDS), teenage pregnancy, diabetes, liver disease, and hepatitis.

Puerto Ricans have a low-birth-weight rate that is almost twice that of non-Hispanic whites. Also, Puerto Ricans suffer disproportionately from asthma, HIV/AIDS and infant mortality. Mexican Americans suffer disproportionately from diabetes.

Ensure your practice engages in cultural competency training on an annual basis.  
Cultural literacy leads to better engagement and connection to care providers.

**For free training that includes CEU's, please visit**  
<https://monroeplan.com/provider-news-events/>


**COMPLEX PATIENTS? HELP IS HERE!**

*Dealing with complex patients is difficult and can cause staff burnout. Monroe Plan can help your team!*


It's easy...simply make a referral to Monroe Plan for Medical Care's Health Home Care Management Agency by contacting [triage@monroeplan.com](mailto:triage@monroeplan.com) or calling 1.866.255.7969. The data proves that Health Home Care Management Services can make a real difference in improving practice performance and patient health!

**HEALTH HOME IMPROVED MEMBER QUALITY AND SERVICES**

- Expanded more intensive care management for highest risk populations.
- Improved quality outcomes despite medical complexity of patients.
- Exceeded statewide results on 20 of 24 key performance measures.
- Exceeded statewide performance for all 6 behavioral health hospital follow-up measures including: alcohol/drug dependence treatment; medication management, HIV; monitoring, and screening for sexually transmitted disease.




**NY Health Home Coalition**



*The Key to Integrated Care*  
**NEW YORK STATE CARE MANAGEMENT COALITION**


**HEALTH HOMES ACHIEVE SAVINGS AND IMPROVE QUALITY**

180,000 high-risk, high-need adults and children are enrolled in Health Homes, being served by 4,000 care managers through care management agencies in their local communities. As a result:



- **27% reduction** in inpatient PMPM costs for Health Home members post enrollment compared to the same period prior to enrolling in Health Home (most recent data 2016-17) resulting in \$275m savings for inpatient costs
- **11.1% reduction** in All-Cause Readmissions (a measure of readmission following acute inpatient stays)

After enrollment, individuals saw an **Increase** in:



- Visits to primary care
- Medication compliance

According to NYS DOH, primary care costs **increased 23%**, and Rx Cost **increased 12%**, both of which indicate that individuals are going to their PCP and taking their medications - major goals of the program.

**WHAT IS A HEALTH HOME?**

A network of community-based Care Management Agencies that work to engage individuals with serious and complex physical health, mental health and substance use disorders in their local community to achieve better health outcomes, member satisfaction and overall cost reduction.

**HEALTH HOME FAST FACTS**

Over the last 5-6 years individuals enrolled in a Health Home saw an:

- ✓ 11.4% improvement in follow-up after hospitalization for mental illness within 30 days statewide for health home enrollees
- ✓ 8.4% increase in adherence to antipsychotics for individuals with schizophrenia enrolled in HH (State established measure)
- ✓ 86% of Health Homes improved comprehensive diabetes care rates with a corresponding statewide 4.5% improvement rate during that time period
- ✓ 27% improvement in follow-up after hospitalizations with mental illness within 30 days
- ✓ 29% reduction in homelessness and a 37.5% reduction in incarceration from 2018 to 2019 for the same cohort of individuals, based on a representative sample.

**To learn more about our Health Home Care Management Services, visit [www.monroeplan.com/health-homes/](http://www.monroeplan.com/health-homes/).**

**Monroe Plan for Medical Care IPA**  
**April 2022 Newsletter**

**LET’S FIGHT HUNGER TOGETHER**



Rising inflation is leaving households poorer, with a significant impact on low-income households and the patients we serve. Poor diets are known to lead to higher rates of obesity, diabetes, heart disease, cancer, and poor developmental and cognitive outcomes resulting in \$50 BILLION a year spent in avoidable healthcare costs.

**Did you know?**

- \*44% of Supplemental Assistance Nutrition Program (SNAP) participants are *under the age of 18*
- \*14% of SNAP participants are *60 years of age or older*
- \*10% of SNAP participants are *disabled adults*

**What can I do?**

Share the Double Up Food Bucks on your social media, print them for your office staff and place in your waiting areas.

[Double Up Food Bucks NYS – Farm fresh healthy food for every budget!](https://doubleupnys.com)  
 [\(doubleupnys.com\)](https://doubleupnys.com)

**SELECT HCBS SERVICES TRANSITIONING TO CORE**



Transitioning select behavioral health Home and Community-Based Services (HCBS) to Community Oriented Recovery and Empowerment Services (CORE) will help make accessing services easier for Health and Recovery Plan (HARP) members. On February 1, 2022, HARP enrolled members who meet eligibility requirements can access CORE services with a referral based on a Licensed Practitioner of the Healing Arts (LPHA) recommendation, for more information click [HERE](#).

**The services that will be transitioning include:**

- Psychosocial Rehabilitation (PSR)
- Community Psychiatric Support and Treatment (CPST)
- Empowerment Services- Peer Supports
- Family Support and Training (FST)

**For more information on CORE, visit [Community Oriented Recovery and Empowerment \(CORE\) Overview \(ny.gov\)](https://ny.gov). For billing and benefit guidance, access [CORE Benefit and Billing Guidance October 2021 \(ny.gov\)](https://ny.gov).**

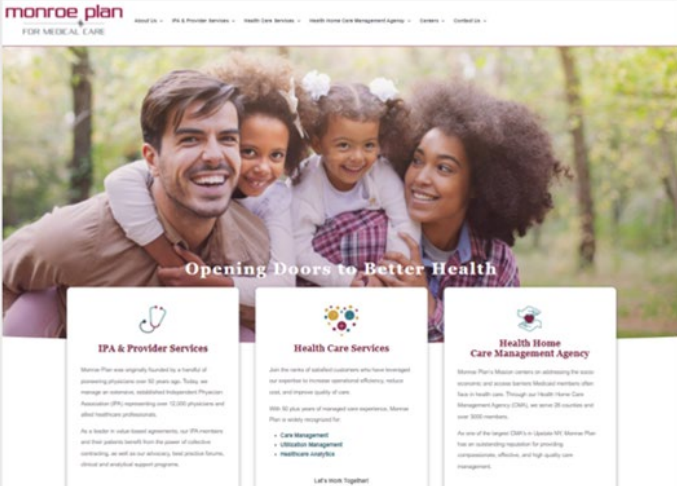
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<b>PROVIDER DATA MANAGEMENT - Keeping Your Records Straight</b>	
<b>ITEM</b>	<b>WHAT YOU NEED TO KNOW</b>
<b>Provider Office Changes</b> When the provider office or facility has moved, changed ownership, merged with another group etc.	When there are any major updates within your practice, please make sure you update us in a timely manner by sending the changes to <a href="mailto:pfmemails@monroeplan.com">pfmemails@monroeplan.com</a>  **Important changes include new practitioners, new service locations, TIN changes, NPI updates, remit address updates, termed practitioners, etc.
<b>Provider Roster Updates</b>	To ensure accurate and current practice data is captured, please send updated provider practice rosters to Monroe Plan at <a href="mailto:pfmemails@monroeplan.com">pfmemails@monroeplan.com</a>
<b>Medicaid ID (MMIS)</b>	To see Medicaid patients, providers must enroll with NYS and have an MMIS number. To enroll, go to the eMedNY site, <a href="#">Provider Enrollment Page</a> , and navigate to your provider type to print and review the instructions and enrollment form
<b>Attestations</b>	We will begin requesting Provider Attestation Forms, HIV Attestation Forms, and Ownership Disclosure Attestations beginning in April 2022. Please keep an eye out for this request and return it in a timely manner!

## WE'VE NEVER LOOKED BETTER.

### THE NEW MONROEPLAN.COM

**We've redesigned our website to showcase all that Monroe Plan offers our community, our members. and our customers.**



**A NEW, FRESH LOOK**

We cleaned house and hung some new pictures. We think you'll like it!

**ENGAGING NEW CONTENT**

Reorganized & refreshed content to appeal to current partners and attract new customers & employees!

**MORE UPGRADES TO COME**

We are not finished yet. We'd love your feedback as we plan to keep making improvements!

**CHECK OUT THE ALL NEW [WWW.MONROEPLAN.COM](http://WWW.MONROEPLAN.COM) TODAY!**