NYS Care Management for High Need Patients

Transforming Care through Health Homes

What is a Health Home?

- **Health Homes are intensive care management and patient navigation services for high need/cost Medicaid patients.**
  - **In NYS, Health homes must have connected under a single point of accountability all of the following:**
    - **One or more hospital systems**
    - **Multiple ambulatory care sites (Physical and Behavioral Health)**
    - **CBOs, including existing care management and housing providers**
    - **Managed care plans**
  - **Health Homes provide:**
    - **Comprehensive care management**
    - **Care coordination and health promotion**
    - **Comprehensive transitional care (e.g., inpatient discharge, jail to community)**
    - **Patient and family support**
    - **Referral to community and social support services (e.g. housing, legal, food)**
    - **Use of Health Information Technology to Link Services**

Health Homes Application Review

Applications were reviewed for:

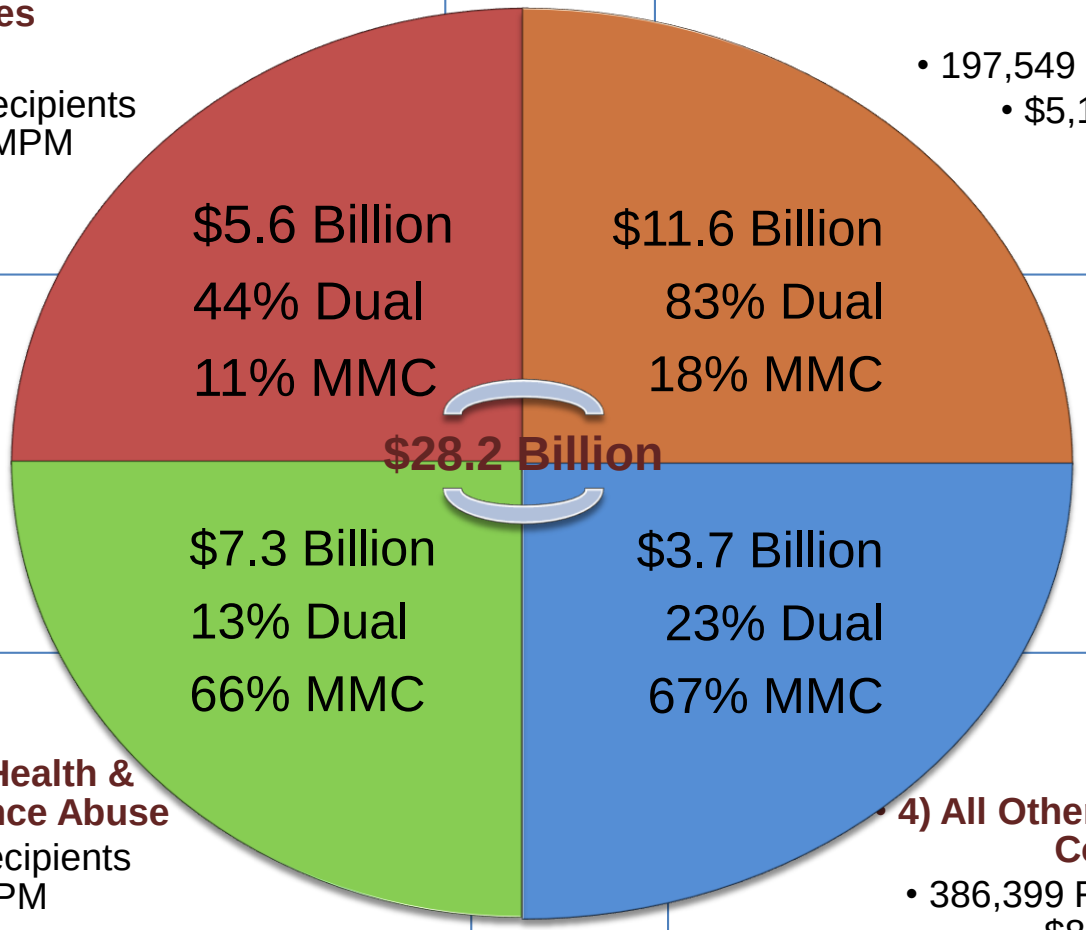
- Meeting Provider Qualifications and Standards
- Demonstrating ability to meet needs of all facets of complex populations (e.g., Mental Health, Housing, Substance Use Disorder, etc.)
- Promoting the State vision - minimize silos and concentrate volume over a few rather than many Health Home networks/systems to ensure a more limited accountability structure and more financially viable Health Homes.
- Creating choices, where applicable, between institutional led and community based led Health Homes.

Maimonides HH Vision

TODAY'S CARE	HEALTH HOME CARE
My patients are those who make appointments to see me	Our patients are those who are registered in our health home
Patients' chief complaints or reasons for visit determines care	We systematically assess all our patients' health needs to plan care
Care is determined by today's problem and time available today	Care is determined by a proactive plan to meet patient needs without visits
Care varies by scheduled time and memory or skill of the doctor	Care is standardized according to evidence-based guidelines
Patients are responsible for coordinating their own care	A prepared team of professionals coordinates all patients' care
I know I deliver high quality care because I'm well trained	We measure our quality and make rapid changes to improve it
Acute care is delivered in the next available appointment and walk-ins	Acute care is delivered by open access and non-visit contacts
It's up to the patient to tell us what happened to them	We track tests & consultations, and follow-up after ED & hospital
Clinic operations center on meeting the doctor's needs	A multidisciplinary team works at the top of our licenses to serve patients

Health Home Eligibles in NYS

(1M Medicaid Members out of 5M)



- **1) Developmental Disabilities**
- 47,760 Recipients
  $9,919 PMPM

- **2) Long Term Care**
- 197,549 Recipients
- $5,163 PMPM

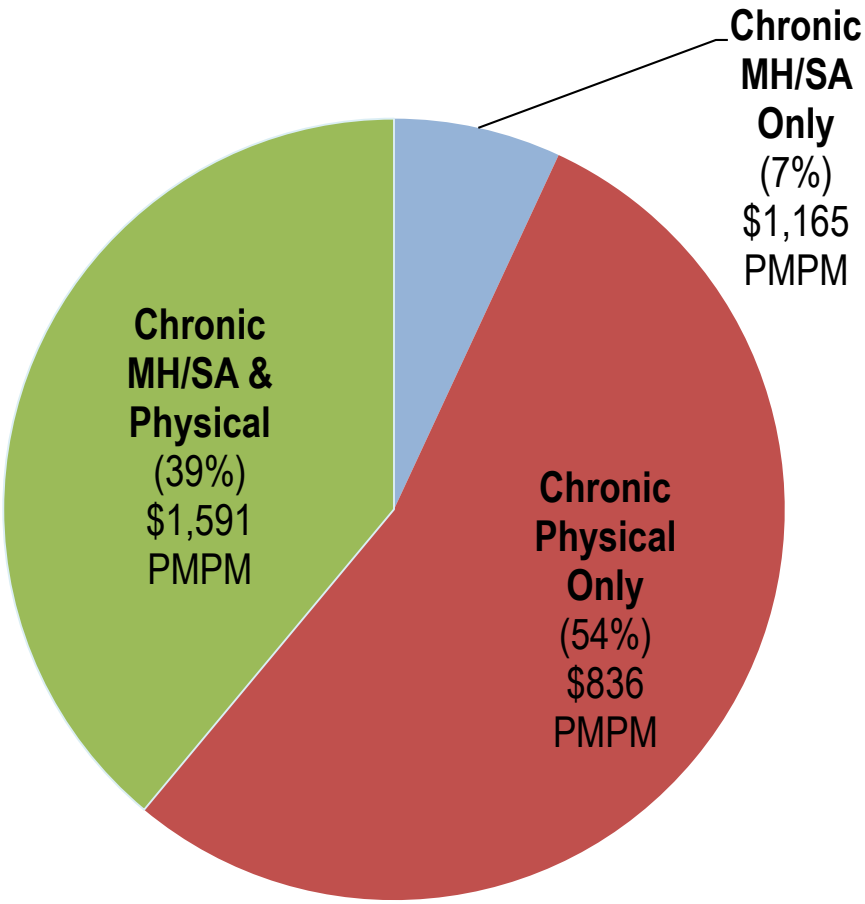
Total Complex
N=1,050,385
$2,366 PMPM
32% Dual
55% MMC

- **3) Mental Health & or Substance Abuse**
- 418,677 Recipients
  $1,540 PMPM

- **4) All Other Chronic Conditions**
- 386,399 Recipients
  $841 PMPM

Time Period: July 1, 2010 – June 30, 2011

Physical and Behavioral Health



	# Adults	Total Medicaid Spend (in Millions)	PMPM Spend
Chronic MH/SA & Chronic Physical	284,525	$5,204	$1,591
Chronic MH/SA Only	50,573	$620	$1,165
Chronic Physical Only	395,383	$ 3,714	$ 836
Total Adult	**730,481**	**$9,538**	**$1,156**

Physical and Behavioral Health: *Top 10 Chronic Conditions*

Chronic Condition	Percent of Adult Total	Total Medicaid Spend (In Millions)	Total PMPM
Hypertension	58.7	$ 5,241	$1,071
Hyperlipidemia	41.5	$ 3,757	$1,079
Diabetes	31.4	$ 2,797	$1,081
Depression	22.7	$ 2,981	$1,534
Schizophrenia	21.0	$ 3,229	$1,867
Chronic Joint and Musculoskeletal Diagnoses - Minor	17.8	$ 1,692	$1,103
Chronic Endocrine, Nutritional, Fluid, Electrolyte and Immune Diagnoses - Moderate	17.6	$ 1,669	$1,128
Asthma	17.5	$ 2,172	$1,457
Osteoarthritis	16.1	$ 1,809	$1,302
Chronic Stress and Anxiety Diagnoses	14.0	$ 1,752	$1,449

Note: Spending is overall and not condition-specific.

Health Home Highest Risk Population –

Multiple Co-occurring Complex Disease so Care MUST Be Integrated

Chronic Episode Diagnostic Categories
Health Home Eligibles Adults 21+ Years
With a Predictive Risk Score 75% or Higher (n=27,752)

Percent of Adult Recipients with Co-Occurring Condition

Condition	Total	Severe Mental Illness	Mental Illness	Subst-ance Abuse	Hyper-tension	Hyper-lipidemia	Diabetes	Asthma	Congest-ive Heart Failure	Angina & Ische-mic Heart Disease	HIV	Obesity	Osteo-arthritis	COPD & Bronch-iectasis	Epilepsy	CVD	Kidney Disease
Severe Mental Illness	43.5	100.0	**74.7**	**77.2**	33.8	28.1	23.2	34.1	6.8	8.5	9.6	14.8	23.2	13.9	20.1	31.9	10.9
Mental Illness	46.2	**70.4**	100.0	**70.9**	42.0	33.7	28.0	35.8	11.0	12.6	8.7	16.9	29.9	17.8	19.4	41.0	16.4
Substance Abuse	**54.4**	**61.9**	**60.3**	100.0	35.4	25.9	21.4	32.8	7.5	9.4	11.2	10.7	23.1	14.5	16.4	34.4	11.2
Hypertension	37.6	39.1	51.6	51.1	100.0	47.4	41.4	30.7	28.2	22.1	5.6	17.8	29.3	22.6	13.9	62.2	30.8
Hyperlipidemia	29.8	41.0	52.2	47.1	59.8	100.0	54.9	37.7	27.8	33.4	5.6	23.6	30.9	25.1	15.0	70.4	31.5
Diabetes	27.8	36.3	46.5	41.8	56.0	58.8	100.0	35.4	25.7	25.3	5.4	24.3	28.1	22.8	13.2	64.9	34.3
Asthma	28.3	52.4	58.5	62.9	40.8	39.7	34.8	100.0	15.3	17.4	12.3	22.0	34.3	33.0	16.7	47.7	18.4
Congestive Heart Failure	13.4	22.1	37.9	30.6	79.5	61.9	53.5	32.3	100.0	41.2	4.1	21.1	26.1	33.9	8.9	100.0	50.3
Angina & Ischemic HD	12.2	30.5	47.8	41.8	68.2	81.5	57.6	40.3	45.1	100.0	4.6	24.1	33.8	31.5	11.7	100.0	41.9
HIV	8.3	50.2	48.4	73.5	25.2	20.0	18.1	41.9	6.7	6.8	100.0	4.9	26.6	16.4	13.2	31.1	17.9
Obesity	12.7	50.5	61.4	45.8	52.6	55.4	53.1	49.0	22.2	23.1	3.2	100.0	39.3	25.7	16.5	60.1	27.2
Osteoarthritis	22.1	45.7	62.7	56.8	49.9	41.8	35.5	44.0	15.8	18.7	10.0	22.7	100.0	25.5	15.1	52.0	24.9
COPD & Bronchiectasis	15.5	38.8	53.0	50.6	54.7	48.1	40.7	60.1	29.2	24.8	8.7	21.0	36.1	100.0	14.0	67.2	27.0
Epilepsy	13.5	65.1	66.6	66.3	38.8	33.2	27.2	35.1	8.9	10.6	8.1	15.6	24.8	16.2	100.0	41.1	16.3
CVD	41.9	33.2	45.3	44.6	55.9	50.2	43.1	32.3	32.0	29.2	6.2	18.3	27.4	25.0	13.2	100.0	35.4
Kidney Disease	18.8	25.2	40.4	32.4	61.5	49.9	50.6	27.6	35.8	27.2	7.9	18.3	29.1	22.3	11.7	78.6	100.0
Total	**100.0**	**43.5**	**46.2**	**54.4**	**37.6**	**29.8**	**27.8**	**28.3**	**13.4**	**12.2**	**8.3**	**12.7**	**22.1**	**15.5**	**13.5**	**41.9**	**18.8**

Note: Diagnosis History During Period of July 1, 2010 through June 30, 2011.

2010 Health Home CRG Group – MH/SA Top DXs

Diagnosis Grouping	Sum of MH/SA Spend	Sum of MH/SA Recips
TOTAL	**$ 7,270,312,543**	**411,980**
Schizophrenia	$ 1,064,324,943	71,796
Schizophrenia and Other Moderate Chronic Disease	$ 987,483,578	51,021
HIV Disease	$ 896,305,908	22,252
Dementing Disease and Other Dominant Chronic Disease	$ 323,686,677	11,961
Diabetes - Hypertension - Other Dominant Chronic Disease	$ 237,735,446	11,303
Diabetes and Other Dominant Chronic Disease	$ 160,873,540	7,826
Psychiatric Disease (Except Schizophrenia) and Other Moderate Chronic Disease	$ 156,625,537	15,842
Schizophrenia and Other Dominant Chronic Disease	$ 140,336,943	5,809
Diabetes and Other Moderate Chronic Disease	$ 139,516,879	11,583
Asthma and Other Moderate Chronic Disease	$ 138,597,650	11,757
Diabetes - 2 or More Other Dominant Chronic Diseases	$ 137,828,720	4,185
Depressive and Other Psychoses	$ 136,096,859	13,809

Diagnosis Grouping	Sum of MH/SA Spend	Sum of MH/SA Recips
Two Other Moderate Chronic Diseases	$133,721,190	16,691
Moderate Chronic Substance Abuse and Other Moderate Chronic Disease	$130,702,804	10,031
One Other Moderate Chronic Disease and Other Chronic Disease	$128,258,771	16,832
Bi-Polar Disorder	$104,845,381	7,233
One Other Dominant Chronic Disease and One or More Moderate Chronic Disease	$97,316,553	6,436
Diabetes - Advanced Coronary Artery Disease - Other Dominant Chronic Disease	$90,245,930	3,303
Schizophrenia and Other Chronic Disease	$89,393,330	5,494
Chronic Obstructive Pulmonary Disease and Other Dominant Chronic Disease	$85,555,831	4,328
Diabetes and Hypertension	$83,038,235	9,638
Diabetes and Asthma	$79,170,754	5,484
Diabetes and Advanced Coronary Artery Disease	$57,899,075	3,577
Dialysis without Diabetes	$55,750,739	904

Highest Need Health Home Members - dramatically sick and costly

Calendar Year 2010 Spend for Top 100 High Cost Health Home Eligible Individuals By Category of Service *

Category of Service	Members	Medicaid FFS and Managed Care Claims	Fee for Service Paid	Managed Care Paid	Drugs Paid	Total Services and Drugs Paid
0285 INPATIENT	98	2,220	$46,003,574	$3,701,415	$0	$49,704,989
0460 PHYSICIAN SERVICES	86	22,175	$1,417,177	$779,817	$0	$2,196,995
0441 DRUGS	0	0	$0	$0	$1,557,085	$1,557,085
0287 HOSPITAL BASED OUTPATIENT SERVICES	71	4,915	$723,695	$99,012	$0	$822,707
0321 MEDICAL APPLIANCE, EQUIP, SUPPLY DEALER	23	410	$53,448	$108,714	$0	$162,161
0381 SKILLED NURSING FACILITY	7	64	$82,296	$0	$0	$82,296
0601 AMBULANCE - EMERGENCY	49	439	$62,713	$0	$0	$62,713
0288 PHARMACY	0	0	$0	$0	$53,893	$53,893
All Other Categories of Service		3,287	188,860	35,532	0	224,392
Totals	100	33,510	$48,531,763	$4,724,489	$1,610,978	$54,867,230
Total Services and Drugs Paid Per Member ==========>						$548,672

* Excludes individuals with a Primary Dx of Hemophilia, Hereditary Anemia (Including Sickle Cell)

PHASE 1 SNAPSHOT

- **Bronx:** BAHN, HHC,VNS of NY Home Care, Bronx Lebanon Hospital Ctr.
- **Brooklyn:** Maimonides, Community Health Care Network, ICL, HHC
- **Nassau:** NS-LIJ, FEGS
- **Schenectady :** VNS of Schenectady and Saratoga
- **Northern Region:** Adirondack Health Institute, Inc., Glens Falls Hospital

13 Health Homes designated, HHs, MCPs and converting CM programs **may bill** for Health Home services.

DOH, HH and MCPs developing operational policies and procedures and improving the transmission of Health Home Patient Tracking file information between NYS DOH and Health Homes and MCPs through the DOH OHIP Portal.

Phase 1 Implementation Status

- **Phase 1 Total HH Eligibles 278,000**
  - # of higher risk members 65,000
  - % of higher risk members 23%
  - # assigned to Health Homes (FFS) 5,900
  - # in outreach and engagement as of 11/12 12,000

Active Health Home Members as of December 12, 2012 by Health Home

	FFS			MCP			
Health Home Name	Active Care Management	Outreach	Total	Active Care Management	Outreach	Total	Grand Total
FEGS Health & Human Services System	1,932	12	1,944	424	17	441	2,385
Visiting Nurse Service of New York Home Care	1,102	56	1,158				1,158
Institute for Community Living-Coordinated Behavioral Care	523	7	530	39	321	360	890
Maimonides Medical Center Health Home	354	3	357	35	121	156	513
Montefiore Medical Center/Bronx Accountable Health Network	300	1	301	151	27	178	479
Visiting Nurse Service of Schenectady and Saratoga Counties, Inc	38		38	173	238	411	449
Community Healthcare Network	184	114	298				298
Bronx Lebanon-CBC Health Home	216		216	23		23	239
Adirondack Health Institute	158	42	200	26	2	28	228
New York City Health and Hospitals Corporation	30	12	42	86	7	93	135
Glens Falls Hospital	65	2	67	20	46	66	133
Health Home Partners WNY	116		116				116
North Shore-LIJ Health System	74		74	31		31	105
Grand Total	**5,092**	**249**	**5,341**	**1,008**	**779**	**1,787**	**7,128**

PHASE 2 SNAPSHOT

- **Monroe :** Anthony L. Jordan , Huther Doyle
- **Erie :** Alcohol & Drug Dependency Services, Inc., Mental Health Services Erie County -SE Corp V, Urban Family Practice,
- **Hudson Valley :** Hudson River HealthCare, Inc., Open Door Family Medical Ctr. Inc., Institute for Family Health
- **Suffolk:** FEGS,, Inc, NS-LIJ, Hudson River HealthCare
- **Staten Island :** Jewish Board of Family & Children's Services (JBFCS)
- **Queens :** Community Healthcare Network, HHC, NS-LIJ with PSCH, JBFCS
- **Manhattan**: Heritage Health & Housing Inc., Presbyterian, HHC, St. Luke's-Roosevelt Hospital Center, VNS of NY, and JBFCS

21 Health Homes designated, HHs submitting updated network partner lists, entering into Data Exchange Application Agreements (DEAA) with DOH and executing contracts with MCPs.

PHASE 3 SNAPSHOT

- **Northern Region :** Hudson River HealthCare, Inc., St. Mary's Healthcare, Samaritan Hospital, Adirondack Health Institute, Glens Falls Hospital, Visiting Nurse Service of Schenectady & Saratoga Counties,
- **Central Region:** Thomas R. Mitchell, Onondaga Care Management Services, Inc., Upstate Cerebral Palsy, Huther Doyle ,North Country Children's Clinic, St. Joseph's Hospital Health Center, Catholic Charities of Broome County, United Health Services Hospitals
- **Western Region:** Mental Health Services Erie County-Southeast Corp V, Niagara Falls Memorial Medical Center, Chautauqua County Dept. of Mental Hygiene

17 HH designated, DOH is in the final stages of designating Phase 3 HHs (Designations are still pending for Albany, Otsego, Schoharie, Delaware and Chenango counties)

Designated Phase 3 HHs working on addressing any contingencies identified in the review of their application, entering into DEAAs and MCP contracts and formalizing network partnerships

Preliminary 2011 NYC CJ Data

- Sample of 2,055 unique Medicaid IDs from NYC CJ data; 1,121 members matched to HHs
- Medicaid IDs matched to the calendar year 2011 Health Home eligible population.

Population	# of Recips
DD	14
LTC	24
MHSA	1,062
OTHER	21
Grand Total	**1,121**

Preliminary Health Home Matches

Health Home	Population				Grand Total
	DD	LTC	MHSA	OTHER	
New York City Health and Hospitals Corporation	5	8	410	4	427
Institute for Community Living-Coordinated Behavioral Care	3	3	176	3	185
Jewish Board of Family and Children's Services	3	2	106	1	112
North Shore-LIJ Health System		5	94	4	103
Visiting Nurse Service of New York Home Care		3	62	3	68
Community Healthcare Network		1	64	3	68
Bronx Lebanon-CBC Health Home	2	1	37		40
St. Luke's-Roosevelt Hospital Cener	1	1	29	1	32
Montefiore Medical Center/Bronx Accountable Health Network			29		29
Heritage Health and Housing, Inc			24	1	25
No Match to Health Home			16		16
Maimonides Medical Center Health Home			9		9
No loyalty data			6	1	7
Grand Total	**14**	**24**	**1,062**	**21**	**1,121**

Quality Measures

- Reduce utilization associated with avoidable:
  - (preventable) inpatient stay
  - (preventable) emergency room visits
- Improve Outcomes for persons with Mental Illness and/or Substance Use Disorders
- Improve Disease-Related Care for Chronic Conditions
- Improve Preventive Care

Opportunities to track CJ specific measures?