NEW YORK
state department of
HEALTH

New York State Care Management for High Need Patients

Transforming Care through Health Homes

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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 connect 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.*

(continued)

What is a Health Home?

Health Homes provide:

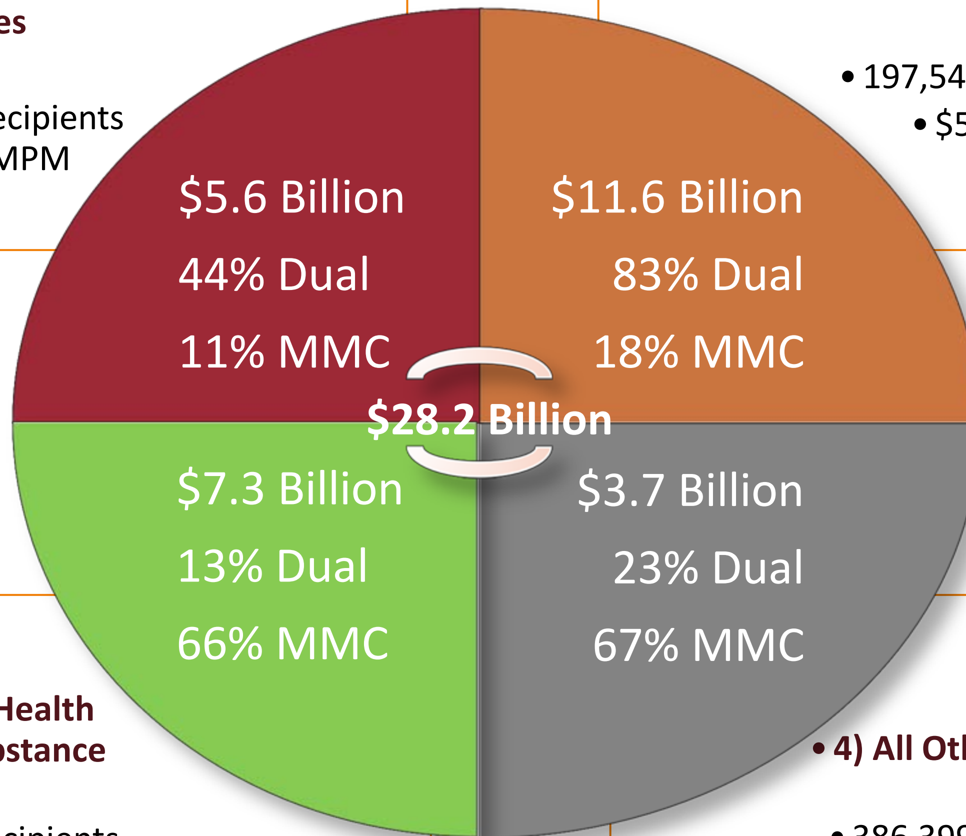
- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care (e.g., inpatient discharge, jail to community)
- Patient and family support
- Referral to community and social support services (e.g. housing, legal, food)
- Use of Health Information Technology to link services

Health 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 and/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

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.

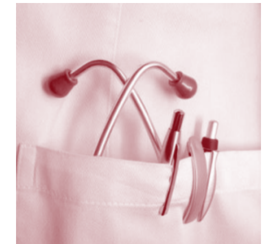
2010 Health Home Clinical Risk Groups:
Behavioral Health Population

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	97	3,163	$37,155,041	$4,154,558	$0	$41,309,599
0441 DRUGS	0	0	$0	$0	$1,934,145	$1,934,145
0460 PHYSICIAN SERVICES	79	18,668	$946,230	$690,887	$0	$1,637,116
0287 HOSPITAL BASED OUTPATIENT SERVICES	72	6,104	$715,936	$208,217	$0	$924,153
0521 LPN	0	84	$0	$400,435	$0	$400,435
0321 MED APPLIANCE, EQUIP, SUPPLY DEALER	27	249	$46,384	$116,941	$0	$163,325
0381 SKILLED NURSING FACILITY	10	92	$99,589	$0	$0	$99,589
0601 AMBULANCE - EMERGENCY	57	543	$73,192	$0	$0	$73,192
0288 HOSPITAL PHARMACY	0	0	$0	$0	$54,117	$54,117
All Other Categories of Service		4,040	$185,490	$75,808	$0	$261,299
Totals	100	32,943	$39,221,863	$5,646,846	$1,988,262	$46,856,970
Total Services and Drugs Paid Per Member =======================>						$468,570
* Excludes individuals under 18 years of age and individuals with a Primary Dx of Hemophilia, Hereditary Anemia (Including Sickle Cell)						

Most Readmission $ for Medical Reasons for Patients with Underlying BH DX

All Readmissions* ($814M)

Patients without MH/SA $149M

Patients with MH/SA $665M 82%

Readmissions for Patients with MH/SA Conditions ($665M)

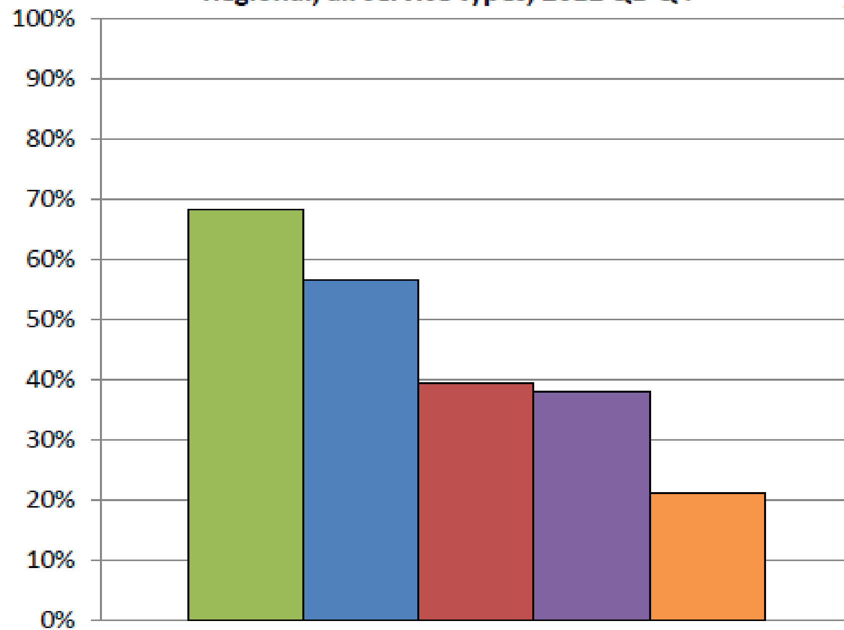
MH/SA medical readmission $395M 59%

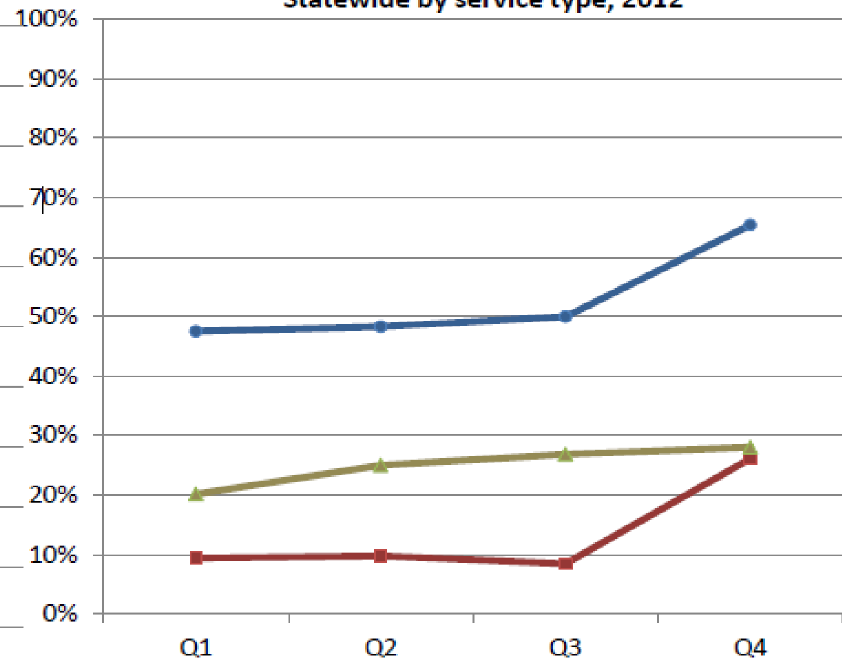
MH/SA readmission $270M

*Readmissions within 30 day from original admission date

Care Coordination Varies but Poor Overall Between Hospital and Outpatient

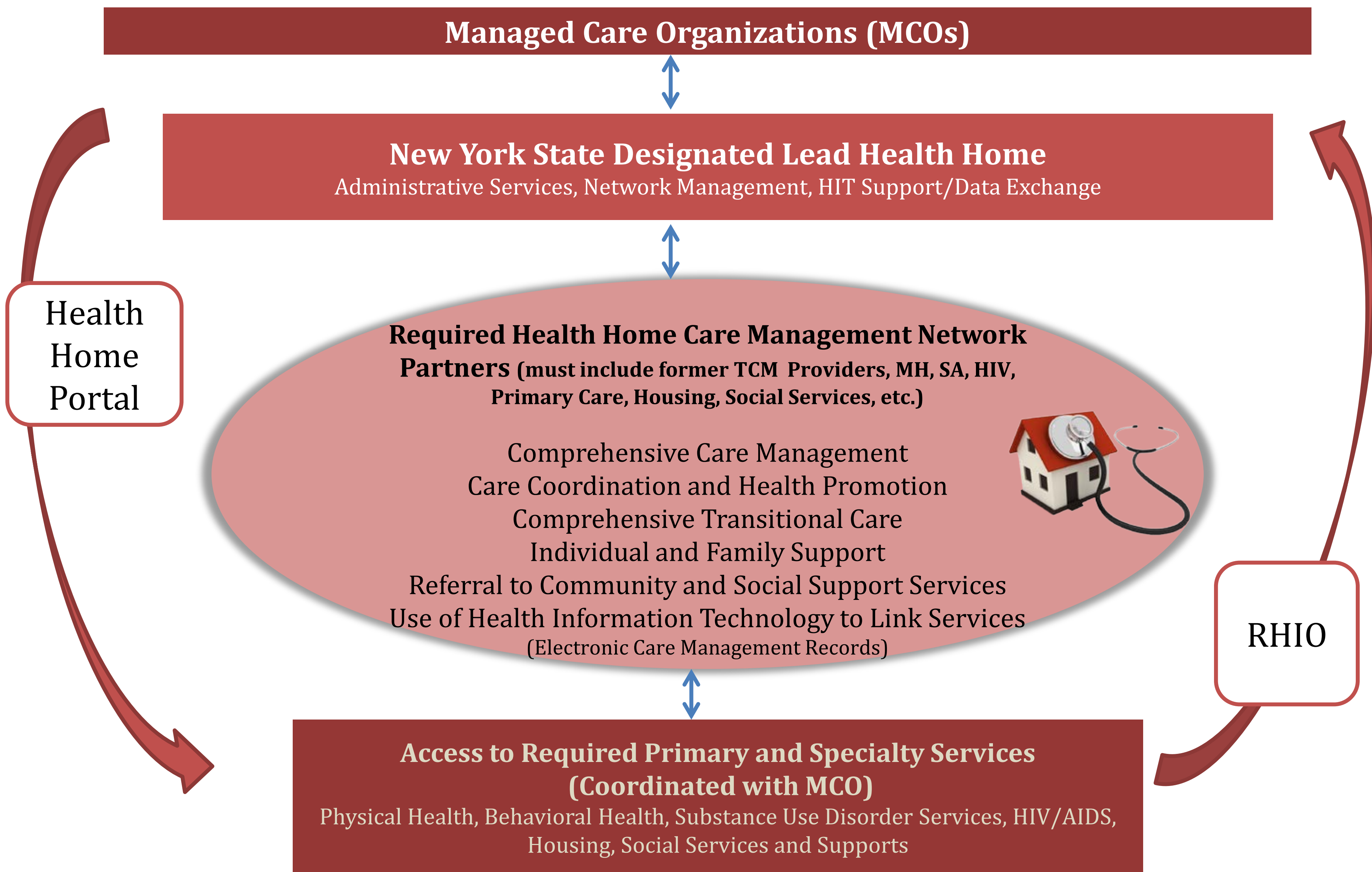
2012 rates of inpatient provider contacting outpatient provider, based upon # of discharges*





*Data submitted by BHOs

New York State Health Home Model



How Eligible Members are being Identified and Assigned

New York State Health Home Analytical Products:

- **CRG Based Attribution** – *For Cohort Selection.*
- **CRG Based Acuity** – *For Payment Tiers.*
- **Predictive Model** - Predicts future negative events (Inpatient, Nursing Home Death) using claims and encounters – *For Assignment Priority.*
- **Ambulatory Connectivity Measure** – *For Assignment Priority.*
- **Provider Loyalty Model** – Establishes Patient Connectivity to Existing Care Management, Ambulatory (including BH), ED and Inpatient – *For Matching to Appropriate HH and to Guide Outreach activity.*

Health Home Assignments: Managed Care Workflow

New York State Team
- Conduct analysis and identify plan Health Home candidates based on acuity/loyalty/risk
- Compile lists of candidates, send to plan via the Health Commerce System (HCS)
- Provide Payment

Managed Care Plan
- Conduct analysis and assign members to Lead Health Homes
- Re-post monthly file with Health Home assignment to HCS and send welcome letters
- Submit claim for non-TCM slots for payment to eMedNY
- Disburse payment to Lead Health Home

Lead Health Home
- Receive member assignments
- Assign members to downstream providers for outreach and engagement
- Report outreach and engagement, enrollment, participant data*, associated rate code
- Disburse payment to downstream providers

Downstream Provider Partner
- Begin outreach and engagement
- Report outreach and engagement, enrollment, participant data*, associated rate code
- Receive payment

*Care management process metrics, functional status, and dates

Statewide Health Home Enrollment Statistics

(Based on Jan 2012 to November 2013 Claims)

32 HHs in 58 Counties Designated under 3 Phases effective 1/1/12, 4/1/12, 7/1/12		
Converting Members	# of HH Recipients Engaged in Outreach	5,400
New Members	# of HH Recipients Engaged in Outreach	80,853
Converting Members	# of HH Recipients Engaged in Active Care Management	39,931
New Members	# of HH Recipients Engaged in Active Care Management	32,965
	Total # HH Recipients (Distinct Count)	132,582
Total Health Home Eligible Individuals (MHSA and Others)		805,000
	# of Higher Risk Members	446,000
Higher Risk members are identified based on predictive risk model and ambulatory connectivity measure; e.g., those with lower ambulatory connectivity and those more likely for inpatient, nursing home or death		
	% of Higher Risk members	55%
	% of Higher Risk members	29.73%

Health Home Payment and Tracking

- Billing rates are based on acuity scores, which will be adjusted based upon a functional assessment (FACT-GP - including housing status) of Health Home members done at engagement and annually thereafter.
- A Health Home Member tracking system collects details not collected in claims – e.g., where the member is being served and what services have been delivered.

Health Home Payments by Base Health Status and Severity of Illness

			Downstate			Upstate		
Base Health Status [1]	Serious Mental Illness [2]	Severity of Illness [3]	Eligible Recipients [4]	Average Acuity Score [5]	Average Monthly Payment [6]	Eligible Recipients [4]	Average Acuity Score [5]	Average Monthly Payment [6]
Single SMI/SED	Yes	Low	15,989	6.6993	$155.89	7,231	6.6775	$124.93
		Mid	7,261	9.3623	$217.86	3,621	9.0329	$169.00
		High	292	22.1821	$516.18	68	21.9944	$411.52
Single SMI/SED Total			23,542	7.7127	$179.48	10,920	7.5539	$141.33
Pairs Chronic	No	Low	39,736	3.0966	$72.06	13,270	3.6602	$68.48
		Mid	20,983	7.2789	$169.38	7,804	7.6747	$143.59
		High	9,140	13.8438	$322.14	3,045	13.9366	$260.75
	Yes	Low	12,231	10.6780	$248.48	5,244	10.5974	$198.28
		Mid	14,357	15.8052	$367.79	6,771	15.4097	$288.32
		High	2,881	25.4821	$592.97	1,276	24.2513	$453.74
Pairs Chronic Total			99,328	8.3888	$195.21	37,410	9.1355	$170.92
Triples Chronic	No	Low	2,562	4.9587	$115.39	963	5.3808	$100.67
		Mid	7,762	7.8965	$183.75	3,053	8.2988	$155.27
		High	6,148	13.7811	$320.69	2,057	14.3990	$269.40
	Yes	Low	2,519	12.5158	$291.24	747	12.4206	$232.39
		Mid	4,266	17.4123	$405.18	1,649	17.4152	$325.84
		High	1,306	25.2165	$586.79	530	25.0789	$469.23
Triples Chronic Total			24,563	12.1102	$281.80	8,999	12.3819	$231.66
HIV/AIDS	No	Low	5,997	5.4996	$127.97	752	5.4517	$102.00
		Mid	5,160	10.5293	$245.02	815	9.5101	$177.93
		High	1,424	18.9814	$441.70	160	17.6933	$331.04
	Yes	Low	192	5.5550	$129.26	36	5.5029	$102.96
		Mid	3,713	10.4834	$243.95	450	9.6692	$180.91
		High	507	20.1222	$468.24	65	19.3610	$362.24
HIV/AIDS Total			16,993	9.6825	$225.31	2,278	8.9943	$168.28
Grand Total			164,426	8.9816	$209.00	59,607	9.3305	$174.57

Health Home Metrics

- Care management process and functional data will be collected via the DOH Care Management Assessment Reporting Tool (CMART).
- NYS State Plan Amendment (SPA) identifies claims-based outcome measures, including service utilization (ED, inpatient, preventive services, follow-up after inpatient services, chronic disease management and medication compliance).

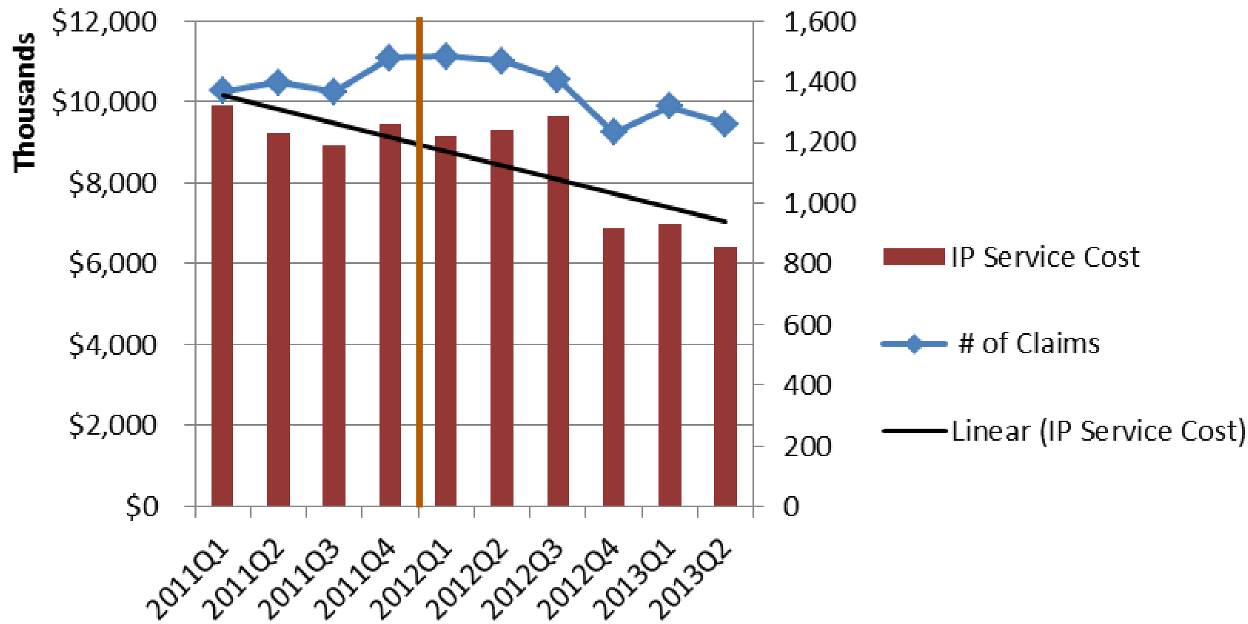
Critical Aspects – Making this Work, Work

- **Integration** - Service and Care Management – Silos Guarantee Continued Failure. Link primary care and behavioral health…work patients and dollars through health plans not around them.
- **Shared Responsibility** – Care management without Risk and Reward might not work.
- **Respect for Precursor Programs** – Legacy TCM programs given priority and rate protection etc.
- **Housing** – The best care model won't work if people don't have a safe place to live.
- **Sustainability** – Build through phases; Need to budget for expiration of 90/10; message HH as "permanent feature" of Medicaid redesign; leverage structure for other efforts (e.g., Olmstead, BH carve-in to managed care); drive infrastructure dollars through HH; promise gainsharing & distribute through health home.

Unsolved Challenges

- Fully Resourcing Start Up and Administration – Waiver?
- Health Plans versus Providers, Provider Versus Provider
- Right sizing payment…how much is too much? – is the rate ever high enough – Medicaid ROI?
- Moving past FFS - Gain sharing, Risk sharing
- Gainsharing attribution

Inpatient Service Cost for a Subset of Health Home Enrolled Members



*** Includes individuals continuously enrolled in Medicaid with no case management services in calendar 2011 who enrolled in Health Home Services in the first nine months of 2012. N = 3,653 individuals.**

ER Service Cost for a Subset of Health Home Enrolled Members

Thousands

$300
$250
$200
$150
$100
$50
$0

2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0

Visits

2011Q1 2011Q2 2011Q3 2011Q4 2012Q1 2012Q2 2012Q3 2012Q4 2013Q1 2013Q2

ED Service Cost
Visits
Linear (ED Service Cost)

*** Includes individuals continuously enrolled in Medicaid with no case management services in calendar 2011 who enrolled in Health Home Services in the first nine months of 2012. N = 3,653 individuals.**

Health Home Vision *.....Maimonides Medical Center*

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