NEW YORK
state department of
HEALTH

New York State 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.

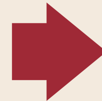
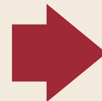
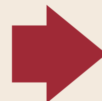
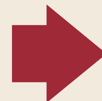
(continued)

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

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)

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

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

$5.6 Billion
44% Dual
11% MMC

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

$11.6 Billion
83% Dual
18% MMC

$28.2 Billion

$7.3 Billion
13% Dual
66% MMC

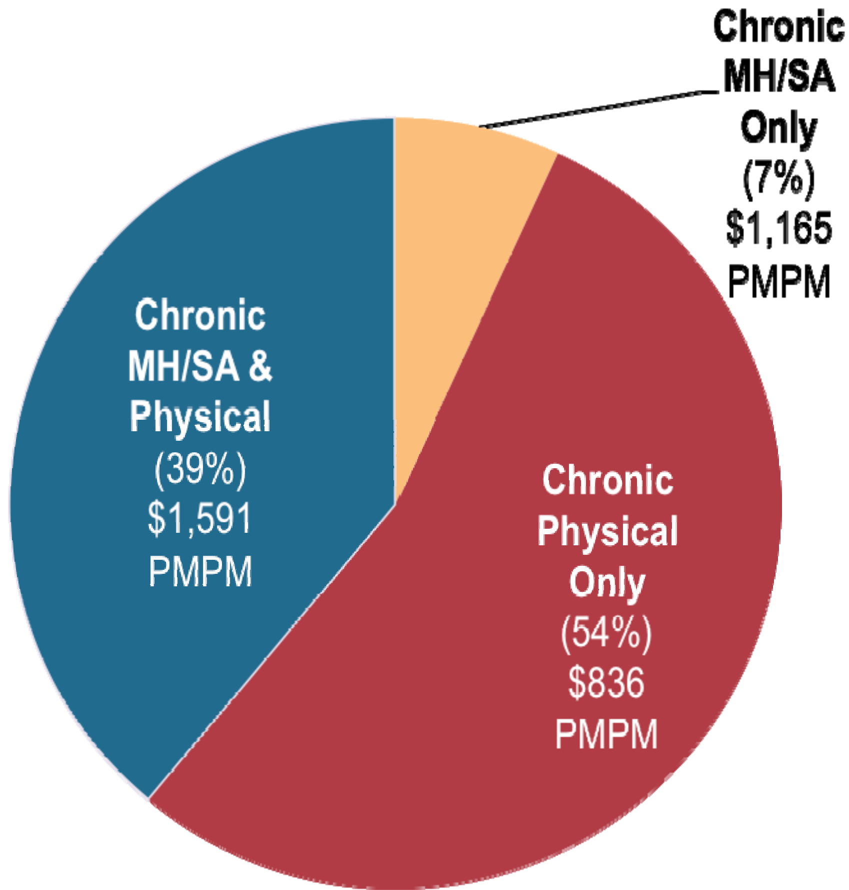
- 3) Mental Health and/or Substance Abuse
  - 418,677 Recipients
  - $1,540 PMPM

$3.7 Billion
23% Dual
67% MMC

- 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.

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

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.

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 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)

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 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 are in the process of submitting updated network partner lists, entering into Data Exchange Application Agreements (DEAA) with DOH and executing contracts with MCPs.
- DOH in discussions with CMS re: SPA approval, HH services **cannot be billed** until SPA is approved and rates are loaded

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 (pending for Albany, Otsego, Schoharie, Delaware and Chenango counties).
- Designated Phase 3 HHs are working on addressing any contingencies identified in the review of their applications ,entering into DEAAs and MCP contracts and formalizing network partnerships.
- DOH in discussions with CMS re: SPA approval, HH services **cannot be billed** until SPA is approved and rates are loaded .

Health Home Enrollment

Statewide Health Home Statistics	
Total Number of Health Homes=51 Total Health Home Eligible Individuals (MHSA and Other)	800,000
# of higher risk members[1]	165,000
% of higher risk members	21%
Phase 1 Health Home Implementation Status	
Phase 1 Total Health Home Eligibles	278,000
# of higher risk members[1]	65,000
% of higher risk members	23%
# in Outreach and Enrollment as of August 2012	1,400
# in Converting CM Slots	4,800
Total Members in Health Home	**6,200**
Projected Statewide Health Home Statistics by end of SFY 2013	
Total Health Home Eligible Individuals (MHSA and Other)	800,000
# of higher risk members[1]	165,000
# Converting CM Slots	39,000
# in Outreach or Enrollment	115,000
Total Members in Health Home	154,000
% in Higher Risk Members in Health Home	93%
[1] Based on Predictive Risk Model and Ambulatory Connectivity Measure - Higher risk means individuals more likely to end up in inpatient, nursing home (or death) and with lower outpatient visit counts.	

Assigned So Far (Total Members in Health Home: 6,200)

Enrolled By Next April (Total Members in Health Home: 154,000)

Health Home Enrollment*

	FFS			MCP			
Health Home	Enrollment	Outreach	Total	Enrollment	Outreach	Total	Grand Total
HH 1	108	1	109				109
HH2	15		15	6	205	211	226
HH 3	80	6	86				86
HH 4	810	19	829	116	32	148	977
HH 5	58	36	94				94
HH 6	407	25	432				432
HH 7	201		201				201
HH 8	53	35	88	17	59	76	164
HH 9	9		9	13		13	22
HH 10	22		22				22
HH 11	894	44	938				938
HH 12	18		18	107	250	357	375
Total	**2,675**	**166**	**2,841**	**259**	**546**	**805**	**3,646**

* As of 9-12-12

Projected Assignments by Phase

(based on July 2010/July 2011 HH Eligible Population)

Members that are not in converting TCM slots - members with a Composite Score > 125 and members with a Predictive Model Risk > 30%			
Phase	**FFS ***	**MMC ***	**Total**
Phase 1	22,781	49,062	71,843
Phase 2	25,790	55,243	81,033
Phase 3	11,639	18,139	29,778
Unmatched **	5,404	555	5,959
sub-total	**65,614**	**122,999**	**188,613**
Members in Converting TCM Slots			
Phase	**FFS ***	**MMC ***	**Total**
Phase 1	5,404	7,224	12,628
Phase 2	8,394	7,629	16,023
Phase 3	3,213	2,842	6,055
Unmatched ***	653	61	714
sub-total	**17,664**	**17,756**	**35,420**
Total	**83,278**	**140,755**	**224,033**

* MMC counts are higher as more individuals have moved to MMC.

** Members to be matched to Health Home based on loyalty.

*** Members to be matched to Health Home by Case Management Agency

Rate Increase
Pairs Chronic and Triple Chronic Populations

Projected Regional Average Health Home Payment Comparison by Base Health Status and Severity of Illness - Pairs Chronic and Triples Chronic
Excludes LTC and OPWDD Populations

			Downstate						Upstate					
Base Health Status	SMI	Severity of Illness	Eligible Recipients	Average CRG Acuity Score (with Phase I Adj)	Average CRG Acuity Score (with NEW Adj)	Ave. Monthly Payment (based on Ave. CRG Acuity with Phase I Adj)	Ave. Monthly Paymet (Ave. CRG Acuity with New Weights)	% Increase	Eligible Recipients	Average CRG Acuity Score (with Phase I	Average CRG Acuity Score (with NEW	Ave. Monthly Payment (based on Ave. CRG Acuity with Phase I Adj)	Ave. Monthly Paymet (Ave. CRG Acuity with New Weights)	% Increase
Pairs Chronic	**No**	Low	39,736	2.9200	3.0966	$67.95	$72.06	6.0%	13,270	3.4841	3.6602	$65.19	$68.48	5.1%
		Mid	20,983	5.9911	7.2789	$139.41	$169.38	21.5%	7,804	6.4872	7.6747	$121.38	$143.59	18.3%
		High	9,140	10.4891	13.8438	$244.08	$322.14	32.0%	3,045	10.8318	13.9366	$202.66	$260.75	28.7%
	Yes	Low	12,231	5.1901	10.6780	$120.77	$248.48	105.7%	5,244	5.2480	10.5974	$98.19	$198.28	101.9%
		Mid	14,357	7.6233	15.8052	$177.39	$367.79	107.3%	6,771	7.6472	15.4097	$143.08	$288.32	101.5%
		High	2,881	13.0050	25.4821	$302.63	$592.97	95.9%	1,276	12.8137	24.2513	$239.74	$453.74	89.3%
Pairs Chronic Total			**99,328**	**5.5171**	**8.3888**	**$128.38**	**$195.21**	**52.1%**	**37,410**	**6.0276**	**9.1355**	**$112.78**	**$170.92**	**51.6%**
Triples Chronic	**No**	Low	2,562	4.7862	4.9587	$111.37	$115.39	3.6%	963	5.2209	5.3808	$97.68	$100.67	3.1%
		Mid	7,762	7.2532	7.8965	$168.78	$183.75	8.9%	3,053	7.6720	8.2988	$143.54	$155.27	8.2%
		High	6,148	11.6339	13.7811	$270.72	$320.69	18.5%	2,057	12.1024	14.3990	$226.44	$269.40	19.0%
	Yes	Low	2,519	6.5921	12.5158	$153.40	$291.24	89.9%	747	6.6217	12.4206	$123.89	$232.39	87.6%
		Mid	4,266	9.1188	17.4123	$212.19	$405.18	90.9%	1,649	9.1996	17.4152	$172.12	$325.84	89.3%
		High	1,306	13.7219	25.2165	$319.31	$586.79	83.8%	530	13.7226	25.0789	$256.75	$469.23	82.8%
Triples Chronic Total			**24,563**	**8.6925**	**12.1102**	**$202.27**	**$281.80**	**39.3%**	**8,999**	**8.9715**	**12.3819**	**$167.86**	**$231.66**	**38.0%**

Health Homes Case Study

56 y/o Medicaid FFS female born in the Dominican Republic, living in the NYC

- **Background:**
  - ✓ HIV+, suffers from depression, panic attacks, diabetes, asthma, arthritis, gastrointestinal problems, and vision impairment
  - ✓ Resides in her own apartment, has two adult male children

- **Pre-Health Home Connection:**
  - ✓ Not adherent to medications, does not keep medical appointments
  - ✓ Inadequate nutritional status

- **Health Home Connection:**
  - ✓ Care coordinator schedules and manages the client's system of care, advocates for client during medical appointments and helps client maintain adherence to medication regimens
  - ✓ Client was connected to community resource such as food pantry and advocacy for legal services
  - ✓ Client has not been hospitalized or sought care in the ED since enrollment in Health Home, attends medical appointments and is adherent to medication regimens.

Health Homes Case Study

23 y/o female living in Urban Upstate NY

- **Background:**
  - ✓ Diagnosed with personality disorder, polysubstance abuse and asthma
  - ✓ She & her 2 ½ yr son reside with her mother & stepfather- has moved 3 times in the last 18 months
- **Pre-Health Home Connection:**
  - ✓ In last 2 yrs, had 3 ER visits (chest/back pain, depression, & shortness of breath) Inpt admissions for childbirth, & 2nd for depression following the ED visit, as she indicated she wished to harm her child.
  - ✓ Previous hx. of adolescent inpt admissions for mental health illness, at of ages 9, 10, 12, 15 &16
  - ✓ Not taking her medications and not engaged with primary care or mental health providers
  - **Health Home Connection:**
  - ✓ Arranged for services at mental health clinic & primary care services at family health clinic
  - ✓ Arranged for in-home parenting education program
  - ✓ Prior to first mental health clinic visit, member was arrested- Care manager was able to coordinate with jail nurse so that member received initial mental health visit while incarcerated.
  - ✓ Initially needed care manager reminders to attend medical and mental health appointments, however is now engaged in care with new providers, and is currently self reliant on keeping her appointments and is receiving care on a regular basis
- **Current Status**
  - ✓ Has had one ER visit for injuries sustained from a fall
  - ✓ Receives monthly follow- up from care manager