Western New York Care Management for High Need High Cost Populations

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Governor's Vision for Reform

"It is of compelling public importance that the State conduct a fundamental restructuring of its Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure."

- Governor Andrew M. Cuomo, January 5, 2011

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MRT Phase I

Major Reform Elements

(1) Global Medicaid Cap

- ☑ Two-year state share actual dollar cap.
- ☑ Four-year state share spending cap linked to growth in CPI-Medical.
- ☑ Industry challenge to control costs.
- ☑ “Super powers” established to ensure that cap is not exceeded.

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(2) Care Management for All

- ☑ Begins three-year phase-in to access to "care management for all" Medicaid members.
- ☑ New York is getting out of the fee-for-service (FFS) business.
- ☑ Over the next three years, new models of care management will be developed to ensure that special populations obtain the services they need (i.e., self-direction).
- ☑ Over the next three to five years, develop more "fully-integrated" care management models.

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(3) Major Expansion of PCMH and Launch of Health Homes

- ☑ Up to one million New York Medicaid members could be enrolled in PCMHs or Health Homes.
- ☑ Health Homes will be more expansive than PCMH and will target high-need/high-cost populations.
- ☑ PCMH and Health Homes will be fully-integrated with care management.

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Integrated Care Management for All
Vision for the Future

Care Management for All

- The MRT has set New York on a multi-year path to care management for all.
- Care management for all is not traditional mandatory managed care in which states rely solely on insurance companies.
- New York's vision is that virtually every member of the Medicaid program will be enrolled in some kind of care management organization.

Care Management for All

- Some care management organizations will be traditional insurance companies while others will be provider-based plans uniquely designed to meet the needs of special populations.
- New York sees full capitation as its preferred financial arrangement but is open to other financing systems, especially for special populations.

Care Management for All

- New York realizes that a period of transition is necessary to achieve its ultimate goal of fully-integrated care management for the entire Medicaid program.
- Fully-integrated means that a single care management organization would be responsible for managing the complete needs of the member (acute, long-term and behavioral care).

Care Management for All

- It will take more than three years to reach this final destination and existing care management organizations will need to evolve while new organizations will need to be created.
- New York will use a wide range of care management tools including BHOs, existing health plans, managed long-term care plans and special needs plans to ensure it reaches its goal of eliminating FFS Medicaid within three years.

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Care Management Evolution Cycle

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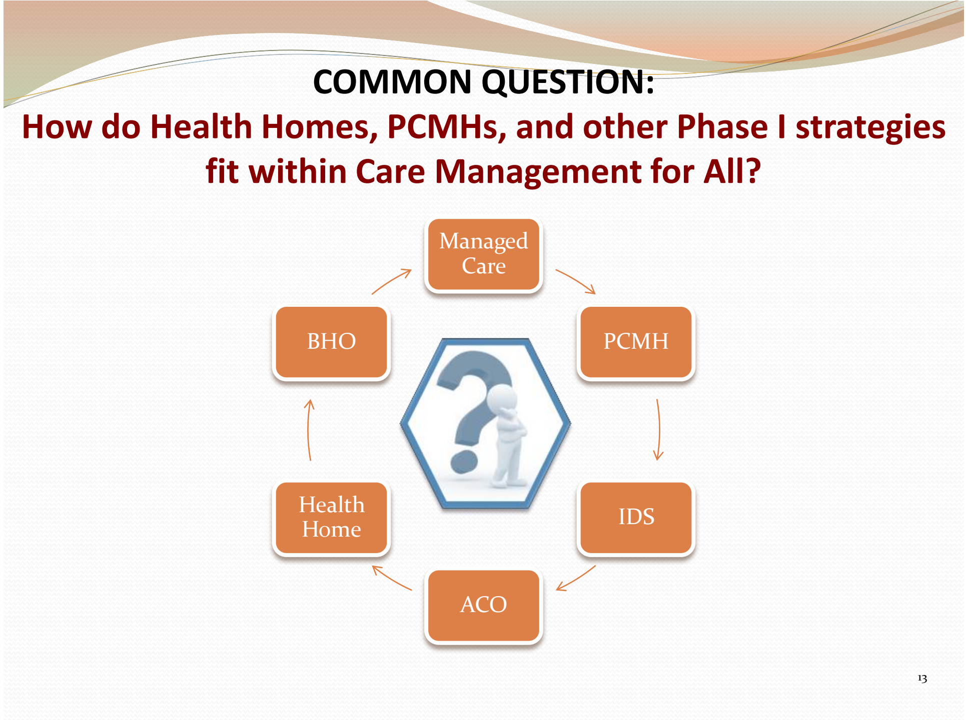
COMMON QUESTION:
How do Health Homes, PCMHs, and other Phase I strategies fit within Care Management for All?
Managed Care
PCMH
IDS
ACO
Health Home
BHO
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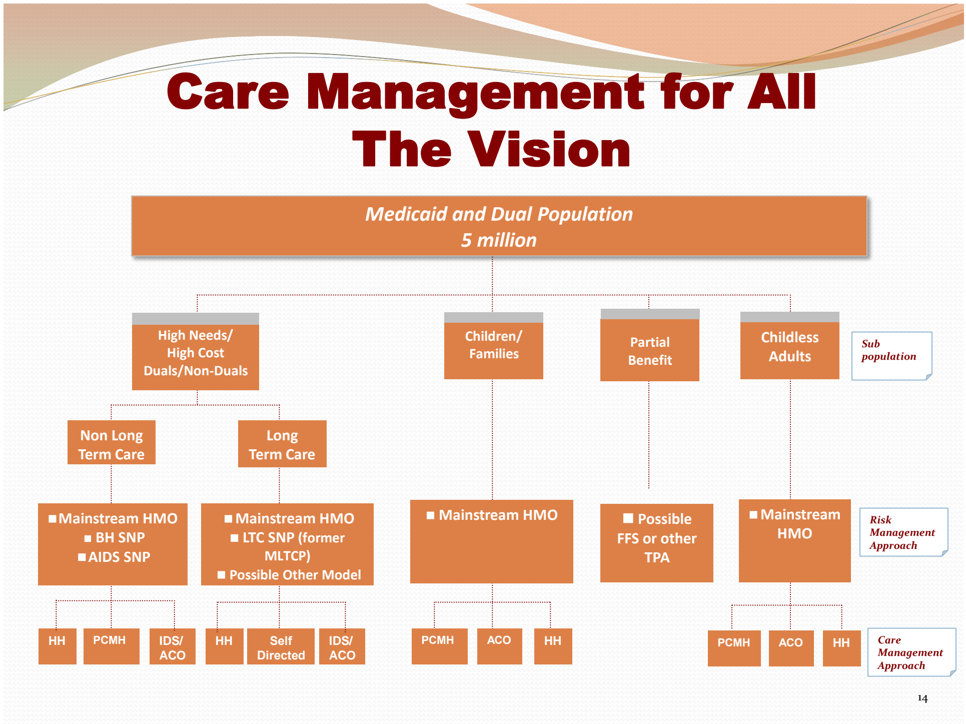
Care Management for All
The Vision
Medicaid and Dual Population
5 million
High Needs/ High Cost Duals/Non-Duals
Children/ Families
Partial Benefit
Childless Adults
Sub population
Non Long Term Care
Long Term Care
Mainstream HMO
BH SNP
AIDS SNP
Mainstream HMO
LTC SNP (former MLTCP)
Possible Other Model
Mainstream HMO
Possible FFS or other TPA
Mainstream HMO
Risk Management Approach
HH
PCMH
IDS/ ACO
HH
Self Directed
IDS/ ACO
PCMH
ACO
HH
PCMH
ACO
HH
Care Management Approach
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CMS Medicaid Director Letter

"The health home service delivery model is an important option for providing a cost-effective, longitudinal "home" to facilitate access to an inter-disciplinary array of medical care, behavioral health care, and community-based social services and supports for both children and adults with chronic conditions."

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CMS Medicaid Director Letter

"The goal in building "health homes" will be to expand the traditional medical home models to build linkages to other community and social supports, and to enhance coordination of medical and behavioral health care, in keeping with the needs of persons with multiple chronic illnesses."

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General Information

Section 2703 of the Patient Protection and Affordable Care Act (ACA)

- provides states, under the state plan option or through a waiver, the authority to implement health homes effective January 1, 2011.
- provides the opportunity to address and receive additional federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons with chronic illness.
- provides 90 percent FMAP rate for ***health home services*** for the first eight fiscal quarters that a health home state plan amendment is in effect.
- provides planning grant funds at regular FMAP for health home design and SPA preparation activities.

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Health Homes Overview

Intent - Treat the individual's physical and behavioral health condition and provide linkages to long-term community care services and supports, social services, and family services.

Purpose - Improve patient quality outcomes, reduce inpatient, emergency room, and long term care costs.

Services - Comprehensive care management, coordination and health promotion; transitional care from inpatient to other settings, referral to community and social support services, and use of health information technology to link services.

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Health Homes Overview

Beneficiary criteria - At least two chronic conditions, one chronic condition and at risk for another, or one serious and persistent mental health condition. Chronic conditions include mental health condition, substance abuse disorder, asthma, diabetes, heart disease, being overweight (BMI over 25).

Designated Providers -Physicians, clinical group practices, rural health clinics, community health centers, community mental health centers, home health agencies; interdisciplinary health teams.

Payment - flexibility in designing the payment methodology including structuring a tiered payment methodology that adjusts for severity of illness and the “capabilities” of the designated provider.

Health Home Rules

Targeting - States may provide health home services to all eligible individuals or may target services to individuals with particular chronic conditions.

States may elect to target the population to individuals with higher numbers, or severity, of chronic or mental health conditions.

Comparability - States may offer health home services in a different amount, duration, and scope than services provided to non eligible individuals

States must include all categorically needy individuals who meet the State’s criteria and this may include individuals in any medically needy group or section 1115 population.

Health Home Rules

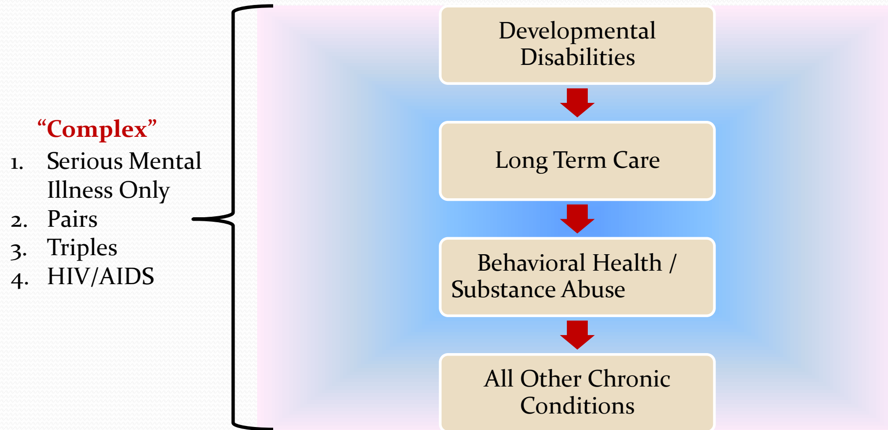
Duals - States are advised that there is no statutory flexibility to exclude dual eligible Medicare/Medicaid beneficiaries from receiving health home services.

Behavioral Health - States must consult with SAMSHA (Substance Abuse and Mental Health Services Administration) prior to the SPA submission, in addressing issues of prevention and treatment of mental illness and substance use disorders

NYS Health Home Providers

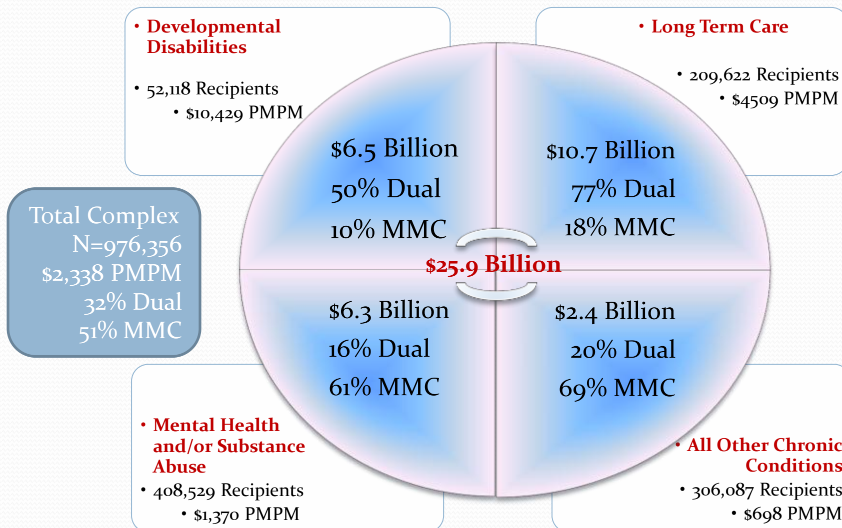
- NY will use "designated providers" for the Health Home Program
- Designated providers can be:
  - Managed Care Plans
  - Hospitals
  - Medical, mental and chemical dependency treatment clinics
  - Federally Qualified Health Centers (FQHCs)
  - Targeted Case Management (TCM) programs
  - Primary care practitioner practices
  - Patient Centered Medical Homes (PCMHs)
  - Any other Medicaid enrolled entity that meets NY's health home requirements
  - Considering adding other long term care providers
- Provider led Health Homes in NYS are high bandwidth multi-agency/institution partnerships (most often with a shared governance structure) with the mission to improve care for high need patients in a given catchment area.

Mutually Exclusive Hierarchical Selection Based on Service Utilization



* Long Term Care includes: more than 120 days of consecutive LTC needs and/or enrollment in Managed Long Term Care (PACE, Partial MLTC and MAP).

HH Populations - 2010



CRG Grouping	Category	Developmental Disabilities	Long Term Care	Behavioral Health and/or Substance Abuse	Other Chronic	Total
Serious Mental Illness Only	Expenditures	$ 61,154,098	$ 193,305,913	$ 1,358,906,853		$ 1,613,366,865
	Member Months	20,406	58,715	1,126,636		1,205,757
	Recipients	1,740	5,328	104,366		111,434
	PMPM	$ 2,996.87	$ 3,292.27	$ 1,206.16		$ 1,338.05
	Percent Dual-Eligible (%)	21.7	68.0	20.8		23.1
	Percent MMC (%)	22.4	15.1	52.5		50.2
Chronic Condition Pairs	Expenditures	$ 5,804,521,610	$ 6,940,553,624	$ 3,605,804,276	$ 1,839,489,731	$ 18,190,369,241
	Member Months	553,939	1,667,351	2,944,128	3,083,170	8,248,588
	Recipients	46,522	147,509	256,555	271,069	721,655
	PMPM	$ 10,478.63	$ 4,162.62	$ 1,224.74	$ 596.62	$ 2,205.27
	Percent Dual-Eligible (%)	51.5	81.3	14.0	20.1	32.4
	Percent MMC (%)	9.6	18.6	65.4	71.4	54.4
Chronic Condition Triples	Expenditures	$ 564,121,257	$ 2,643,508,630	$ 644,631,036	$ 144,331,580	$ 3,996,592,502
	Member Months	42,356	520,248	310,945	138,223	1,011,772
	Recipients	3,567	45,789	26,734	12,271	88,361
	PMPM	$ 13,318.57	$ 5,081.25	$ 2,073.14	$ 1,044.19	$ 3,950.09
	Percent Dual-Eligible (%)	44.6	76.3	14.5	31.9	49.9
	Percent MMC (%)	5.1	18.2	66.9	59.1	38.2
HIV / AIDS	Expenditures	$ 37,689,875	$ 910,920,370	$ 718,818,625	$ 435,060,883	$ 2,102,489,753
	Member Months	3,420	124,340	237,256	246,382	611,398
	Recipients	289	10,996	20,874	22,747	54,906
	PMPM	$ 11,020.43	$ 7,326.04	$ 3,029.72	$ 1,765.80	$ 3,438.82
	Percent Dual-Eligible (%)	20.4	27.3	13.2	16.4	17.4
	Percent MMC (%)	12.7	11.1	29.0	42.3	30.6
Total Complex	Expenditures	$ 6,467,486,840	$ 10,688,288,537	$ 6,328,160,789	$ 2,418,882,194	$ 25,902,818,362
	Member Months	620,121	2,370,654	4,618,965	3,467,775	11,077,515
	Recipients	52,118	209,622	408,529	306,087	976,356
	PMPM	$ 10,429.39	$ 4,508.58	$ 1,370.04	$ 697.53	$ 2,338.32
	Percent Dual-Eligible (%)	49.9	77.1	15.7	20.3	32.2
	Percent MMC (%)	9.7	18.0	60.5	68.8	51.2

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

Chronic Illness Demo Patient Population

Prior Diagnostic History
Patients with Risk Scores 50+*
NYC Residents

Percent of Patients with Co-Occurring Condition

		CVD	AMI	Ischemic Heart Dis	CHF	Hyper-tension	Diabetes	Asthma	COPD	Renal Disease	Sickle Cell	Alc/Subst Abuse	Mental Illness	HIV/AIDS
Cereb Vasc Dis	5.0%	**100.0%**	15.0%	49.5%	36.2%	81.6%	51.7%	35.3%	24.8%	13.7%	2.9%	56.4%	62.7%	13.7%
AMI	6.0%	12.5%	**100.0%**	80.9%	53.3%	90.1%	56.6%	40.4%	31.5%	17.4%	2.1%	55.2%	56.2%	13.5%
Ischemic Heart Dis	22.4%	11.1%	21.7%	**100.0%**	45.3%	86.9%	54.0%	42.0%	30.2%	13.2%	2.1%	53.5%	58.4%	14.0%
CHF	16.2%	11.2%	19.8%	62.8%	**100.0%**	89.5%	56.9%	42.7%	34.9%	20.7%	2.7%	48.4%	48.0%	13.4%
Hypertension	50.9%	8.0%	10.6%	38.3%	28.4%	**100.0%**	46.2%	41.0%	25.4%	11.6%	1.8%	63.1%	62.9%	20.0%
Diabetes	29.0%	8.9%	11.7%	41.8%	31.7%	81.3%	**100.0%**	41.2%	23.9%	13.0%	1.4%	55.4%	62.7%	15.6%
Asthma	36.3%	4.9%	6.7%	25.9%	19.0%	57.5%	32.9%	**100.0%**	32.5%	4.3%	2.3%	72.9%	70.0%	29.6%
COPD	20.8%	6.0%	9.1%	32.5%	27.2%	62.2%	33.3%	56.7%	**100.0%**	6.0%	1.7%	74.2%	65.6%	29.9%
Renal Disease	6.3%	10.8%	16.5%	46.7%	52.8%	93.3%	59.6%	24.3%	19.8%	**100.0%**	2.2%	36.6%	37.4%	18.0%
Sickle Cell	2.9%	5.0%	4.2%	15.7%	14.9%	31.3%	14.0%	28.2%	12.3%	4.7%	**100.0%**	48.9%	50.7%	15.0%
Alc/Subst Abuse	72.8%	3.9%	4.5%	16.5%	10.7%	44.1%	22.0%	36.4%	21.2%	3.2%	2.0%	**100.0%**	70.9%	33.4%
Mental Illness	66.2%	4.7%	5.1%	19.7%	11.7%	48.3%	27.4%	38.4%	20.6%	3.6%				

* High Risk of Future Inpatient Admission
Source: NYU Wagner School, NYS OHIP, 2009.

Children and Health Home

- Out of the Behavioral Health and Chronic (n = 715K) Medical Cohorts in 2009:
  - Just under 74,000 members were 0-20 years old
  - Approximately 41,000 were in NYC
  - 38,000 had a primary diagnosis in the Mental Disorders spectrum

Top 25 Diagnosis for HH Children (Age 0 – 20)

Diagnosis	Unique Recipients
OTHER UNKNOWN AND UNSPECIFIED CAUSE OF MORBIDITY AND MORTALITY	55,369
NOT AVAILABLE	27,926
ATTENTION DEFICIT DISORDER WITH HYPERACT	11,265
ROUTINE INFANT OR CHILD HEALTH CHECK	10,403
UNSPECIFIED EPISODIC MOOD DISORDER	6,225
UNSPECIFIED DELAY IN DEVELOPMENT	4,170
ASTHMA,UNSPECIFIED TYPE, UNSPECIFIED	3,792
OPPOSITIONAL DEFIANT DISORDER	3,575
DENTAL EXAMINATION	3,538
BIPOLAR DISORDER, UNSPECIFIED	3,414
DEPRESSIVE DISORDER, NOT ELSEWHERE CLASS	3,241
ACUTE UPPER RESPIRATORY INFECTIONS OF UN	3,110
ACUTE PHARYNGITIS	3,000
UNSPECIFIED DISTURBANCE OF CONDUCT	2,805
NEED FOR PROPHYLACTIC VACCINATION AND IN	1,964
POSTTRAUMATIC STRESS DISORDER	1,889
UNSPECIFIED PSYCHOSIS	1,869
ROUTINE GENERAL MEDICAL EXAMINATION AT A	1,845
ABDOMINAL PAIN, UNSPECIFIED SITE	1,608
ANXIETY STATE, UNSPECIFIED	1,555
ATTENTION DEFICIT DISORDER WITHOUT MENTI	1,539
UNSPECIFIED VIRAL INFECTION	1,529
UNSPECIFIED HYPERKINETIC SYNDROME	1,516
ASTHMA, UNSPECIFIED TYPE, WITH (ACUTE) E	1,506
UNSPECIFIED OTITIS MEDIA	1,446

Role of Managed Care Plans

- Managed Care plans should contract with State approved community lead Health Homes if available
- Managed Care plans roles include:
  - Responsible for assigning their members to Health Homes
  - Provide administrative support for Health Homes as necessary
  - Provide care management in parts of the state with gaps in access to care management or to provide members a choice in a county/region
  - See Managed Care Roles and Responsibilities chart on website.

Rate and Patient Consent Updates

- Rates-updated Rates have been posted to web
  - Increased all rate cells
  - Increase $ for admin
  - Increase to HIV rate cells
  - Reduce Malignancy and Catastrophic CRG cells

- Patient Consent-
  - New Draft available on website soon;
  - revised form expected to address:
    - 'Literacy' concerns;
    - Operational issues with RHIOs

Health Home Data

- See County summary data on HH website by population, diagnosis, age and category of service
  - http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/population_information.htm Quality Measures
- Acuity, predictive model, loyalty and attribution data are all finalized and being formatted for distribution.
- Sharing Recipient Specific Data with plans on HH population
- Will be sharing phase one county summary information with chosen lead applicants shortly

Quality Measures

NY will be using quality measures that fall into the following categories:

- Measures collected from claims and encounters
- Measures currently collected by managed care plans
- Measures per NQF and/or meaningful use measures
- New measures that meet federal reporting requirements

Health Home Quality Measures

Goal 1: Reduce utilization associated with avoidable (preventable) inpatient stays

- Ambulatory care sensitive conditions **OR** Preventable Quality Indicators
  - Age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, under age 75.
- Plan- All Cause Readmission **OR** Potentially Preventable Readmissions
  - (HEDIS 2012 – Use of Services) For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Health Home Quality Measures (cont'd.)

- Care Transitions: Transition Record Transmitted to Health Care Professional
  - Percentage of patients who are discharged from an acute inpatient setting to home or any other site of care for whom a transition record (Diagnosis/problem list, medication list with OTC and allergies, identified follow up provider, cognitive status, and test results or pending results) was transmitted to the accepting facility or to the designated follow up provider within 24 hours of discharge (National Quality Measures Clearinghouse).

HH Quality Measures (cont'd.)

Goal 2: Reduce utilization associated with avoidable (preventable) emergency room visits

- (HEDIS 2012 – Use of Services) The rate of ED visits per 1,000 member months. Data is reported by age categories.
- Data Source: Claims

HH Quality Measures (cont'd.)

Goal 3: Improve Outcomes for persons with Mental Illness and/or Substance Use Disorders

- Mental Health Utilization
- (HEDIS 2012 – Use of Services) The number and percentage of members receiving the following mental health services during the measurement year.
  - Any service
  - Inpatient
  - Intensive outpatient or partial hospitalization
  - Outpatient or ED

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HH Quality Measures (cont'd)

Goal 3: Improve Outcomes for persons with Mental Illness and/or Substance Use Disorders

- Identification, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- (HEDIS 2012 – Use of Services) This measures the percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received the following:
  - Initiation - an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis Inpatient
  - Engagement - Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.

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HH Quality Measures (cont'd.)

Goal 3: Improve Outcomes for persons with Mental Illness and/or Substance Use Disorders

- Follow Up After Hospitalization for Mental Illness
- Follow up After Hospitalization for Alcohol and Chemical Dependency Detoxification
- Antidepressant Medication Management
- Follow Up Care for Children Prescribed ADHD Medication
- Adherence to Antipsychotics for Individuals with Schizophrenia
- Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

HH Quality Measures (cont'd)

- **Goal 4: Improve Disease-Related Care for Chronic Conditions**
  - Use of Appropriate Medications for People with Asthma
  - Medication Management for People With Asthma
  - Comprehensive Diabetes Care (HbA1c test and LDL-c test)
  - Persistence of Beta-Blocker Treatment after Heart Attack
  - Cholesterol Testing for Patients with Cardiovascular Conditions

HH Quality Measures (cont'd)

- **Goal 5: Improve Preventive Care**
  - Adult BMI Assessment
  - Screening for Clinical Depression and Follow-up Plan
  - Chlamydia Screening in Women
  - Colorectal Cancer Screening

HH Phases

- **Phase I** - 10 counties:
  - Bronx, Clinton, Kings (Brooklyn), Essex, Franklin, Hamilton, Nassau, Schenectady, Warren, Washington
  - Selected HHs have been announced.
  - Implementation is scheduled for January 8, 2012
- **Phase II** – 16 Counties:
  - Albany, Dutchess, Erie, Manhattan, Monroe, Orange, Putnam, Queens, Rensselaer, Richmond (Staten Island), Rockland, Saratoga, Suffolk, Sullivan, Ulster, Westchester,
  - HH application due date for **Phase II counties only is February 1, 2012**.
  - ***UPDATED*** Implementation is tentatively scheduled for April 1, 2012.
- **Phase III** – 36 Counties:
  - Alleghany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Columbia, Cortland, Delaware, Fulton, Genesee, Greene, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Niagara, Ontario, Oneida, Onondaga, Orleans, Oswego, Otsego, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Wayne, Wyoming, Yates
  - HH application due date for **Phase III counties only is April 21, 2012**.
  - ***UPDATED*** Implementation is tentatively scheduled for July 1, 2012.

Open Implementation Issues

- Final SPA Submission- briefing CMS with State HH Team - DOH, OMH, OASAS and Aids Institute and NYC DOHMH
- Working through TCM transition issues – patient assignment issues etc.
- Awaiting final CMS quality measures
- Data sharing with Plans and chosen HH networks
- Weighing possibility of starting implementation with FFS members
- NYS Health Home Website (links to many relevant materials):

http://nyhealth.gov/health_care/medicaid/program/medicaid_health_homes/index.htm

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Questions?

- Join the Health Home Listserv and get updated health home information. Go to: http://nyhealth.gov/health_care/medicaid/program/medicaid_health_homes/index.htm.
- Questions or comments regarding NYS implementation of Health Homes can be directed to hh2011@health.state.ny.us.

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