NEW YORK STATE HEALTH HOMES: CARE MANAGEMENT FOR THE CRIMINAL JUSTICE INVOLVED POPULATION

A Briefing to the New York State Council on Community Re-Entry and Reintegration

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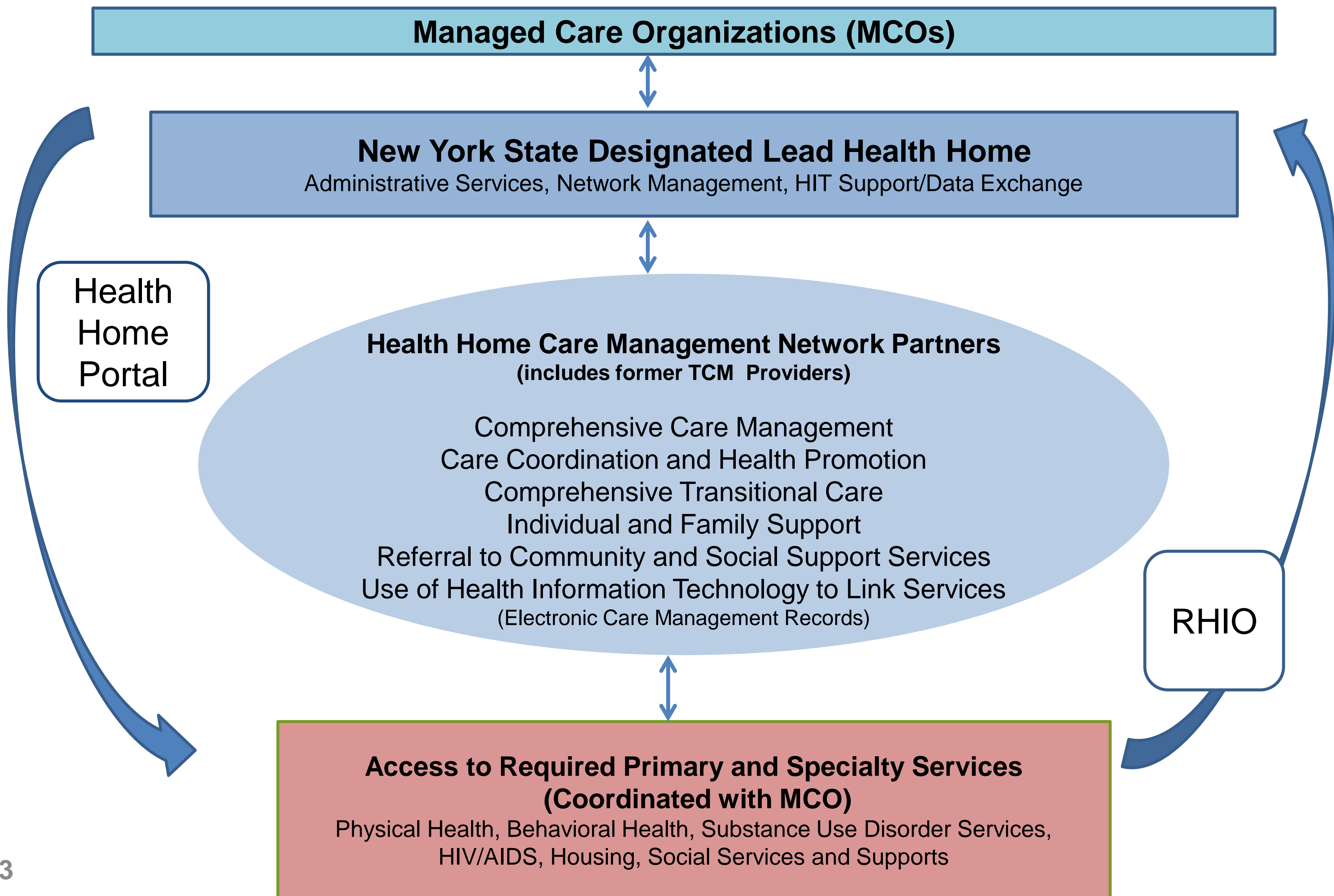
New York State Health Home Model

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)
- Community based organizations, including existing care management and housing providers

New York State Health Home Model



Health Home Care Management Services

Health home providers will be required to provide the following Health Home services in accordance with federal and State requirements:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care
- Patient and family support
- Referral to Community and Social Support Services
- Use of Health Information Technology to Link Services

Who is Eligible to be Enrolled in Health Home?

- Persons enrolled in Medicaid with:
  - At least two chronic conditions
  - One qualifying chronic condition: (HIV/AIDS) or one serious mental illness
- Chronic Conditions Include (but are not limited to):
  - Mental Health condition
  - Substance Use Disorder
  - Asthma
  - Diabetes
  - Heart Disease
  - Obesity (BMI>25)

New York State Health Home Population

- More than five million Medicaid members in New York State.
- 805,000 individuals meet the Federal criteria for Health Homes.
- Target enrollment for NYS is 446,000 (prioritizing for highest risk). Over 140,000 individuals engaged to date.
- There are 33 Health Homes serving all counties of the State (some Health Homes serve more than one county)

Criminal Justice: Health and Behavioral Health Disparities

- 53% of women & 35% of men involved in the criminal justice system report a current medical issue (National Health Care For The Homeless 2013)
- Between 60 % and 80% of all individuals under supervision have a substance use related issue (SAMHSA 2013)
- 17% of all individuals under supervision have been diagnosed with a serious mental illness, of this 17%, 75% have a co-occurring disorder (CSG 2013)
- 64% of all those in jail have some form of mental illness (OJP 2013)
- 17% are either HIV+ or living w/AIDS (National Health Care For The Homeless 2013)

Health Homes and Criminal Justice Pilots

Pilot Site

Project Partnership

HHUNY Finger Lakes, Huther Doyle

HHUNY Western, Lakeshore/ Horizon

Bronx Lebanon

Bronx Accountable Healthcare Network

Coordinated Behavioral Care

Community Healthcare Network

Brooklyn Health Home

Clinton
Franklin
St. Lawrence
Jefferson
Essex
Lewis
Hamilton
Warren
Herkimer
Oswego
Washington
Niagara
Orleans
Monroe
Wayne
Oneida
Fulton
Saratoga
Schenectady
Genesee
Ontario
Onondaga
Montgomery
Erie
Livingston
Seneca
Madison
Rensselaer
Wyoming
Yates
Cayuga
Cortland
Otsego
Schoharie
Albany
Tompkins
Chenango
Schuyler
Cattaraugus
Chautauqua
Allegany
Steuben
Chemung
Tioga
Broome
Delaware
Greene
Columbia
Ulster
Dutchess
Sullivan
Orange
Putnam
Bronx
Manhattan
Queens
Brooklyn
Staten Island
Rockland
Westchester
Suffolk
Nassau

Common Themes

Each site is working with criminal justice partners to identify and engage formerly incarcerated patients.

- Sites are communicating with the criminal justice Health Home system through a mix of informal and formal partnerships
- Sites in NYC are working with Transitional Health Services at Rikers
- Multiple sites are working with Division of Parole to identify candidates
- Some sites are working with drug and mental health courts
- One site has their County Sheriff and County DA serving on the board of the lead CJHH agency, creating buy-in and collaboration
- Two sites noted leveraging relationships that already existed between the community-based agencies in their network and the criminal justice system

Proposed Metrics

- Primary
  - Linkage to Care
  - Retention/Maintenance in Care
- Secondary:
  - Clinical markers (change in HIV+ CD4 & VL, for DM, A1c)
  - Access to treatment:
  - Self-reported Wellness:
  - Emergency Department visits
  - Homeless shelter stays
- Tertiary:
  - Recidivism: Number arrested and incarcerated on new charges within 12 months of release
  - Time in correctional facility: number of days incarcerated in the year prior to index incarceration compared to number of days incarceration in the year following release from index incarceration.

Challenges

- Medicaid enrollment and eligibility obstacles
  - Delays in Medicaid enrollment verification
  - High percentage of clients without insurance
- Data sharing and HIT connectivity
- Resources
- Working with the State Prison System
  - Mobility of incarcerated population
  - Variability in release sites

Solutions: Medicaid Eligibility

- Pilot Project: Applications through Clinton County
  - MOU with Clinton County DSS and NYS DOCCS
  - Clinton County will review and process applications for all NYS DOCCS inmates Statewide, except for those who lived in NYC prior to incarceration.
- Enrollment through New York State of Health
  - Eligibility for Medicaid through the Exchange will be determined based on IRS tax rules, using the new Medicaid income eligibility level
  - On-line applications will begin to be received beginning October 1, 2013, including incarcerated individuals and their family members.
- Reinstatement through the New York State of Health
  - Release files trigger automatic reinstatement
  - Coverage good for five months;

Solutions: Data Sharing

Ability to share data is critical. Medicaid data is subject to strict federal and state protections and criminal justice agencies have not been allowed access to data on Medicaid recipients.

- Interagency discussions on crafting MOUs that would allow greater sharing of data between DOCCS, DCJS, and DOH/OHIP).
- Driving data sharing down to the provider/community level: use cases from parole and probation are being prepared for discussion with CMS on a more liberal interpretation of Medicaid Confidential Data (MCD) restrictions. Currently client consent is needed to communicate Health Home status to CJ agencies.

Solutions: HIT Connectivity

OCFS and DOH are developing a confidentiality agreement to allow DOH to connect NYSID numbers with Medicaid data systems to:

- Operationalize quality measures and benchmarks for the CJ involved population.
- Facilitate outreach and enrollment and track linkages of CJ involved population in Health Homes

Once the database of NYSID numbers is available in the Medicaid Data Warehouse, algorithms for an individual NYSID number and Medicaid Client Identification Numbers (CIN) records would have to be automated.

Solutions: HIT Connectivity

OHIP is developing a web-based portal: Medicaid Analytics Performance Portal (~~or~~ MAPP) -for wide scale communication and Medicaid population management

- MAPP will be the forum for building Performing Provider Systems (PPS) under DSRIP.
- MAPP will facilitate communication between Health Homes, MCOs, care management agencies, and localities to better manage high needs, high risk Medicaid enrollees-including those involved in the criminal justice system.

Solutions: Resources

- Delivery System Reform Incentive Program (DSRIP): Part of the Medicaid waiver that will allow the State to reinvest $8 billion in federal MRT savings to achieve comprehensive reform of the healthcare safety net system.
- Safety net providers will be required to form Performing Provider Systems (PPS); conduct Community Health Assessments to identify the needs in their communities including the CJ population; and select projects for ~~funding~~ based on these needs; ~~funding~~ incentive payments contingent on meeting established ~~benchmarks~~ milestones.
- These reforms will benefit the criminal justice involved population who are widely served by the safety net system~~,~~; specific community health assessments can identify opportunities to do so.

Solutions: Resources

- Health Home Development Funds: $190.6 million of the MRT waiver has been allocated to Health Home development in four key areas:
  - Workforce Training and Retraining
  - Member Engagement and Health Home Promotion
  - Clinical Connectivity and HIT Implementation
  - Joint Governance Technical Assistance
- Funds would be distributed via a rate add-on; guidance around approved uses of the funds will include improved linkages with criminal justice.

Solutions: Working with the State Prison System

- Ability to obtain member-level data with DOCCS and DCJS is critical to working with the State Prison system to identify opportunities to create better linkages with Health Homes-working on a path forward for data sharing agreements.
- DOCCS has shared a deidentified cohort of 22,000 releasees with OHIP.~~;~~ Staff are using this cohort to test and refine data matching and “hot-spotting” strategies to better target Health Home interventions that will be more fully leveraged when member-level data can be shared

DISCUSSION