Medicaid Redesign Team Behavioral Health Work Group

New York State Health Home Federal Rules and Potential Models

July 12, 2011

NEW YORK state department of HEALTH

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."*
- *"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."*

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.

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.

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.

Health Home Application

- States required to describe all designated providers, composition of teams, and methods used to assure providers adhere to standards.
- State support health home provider services (i.e. coordination and access to services, use of IT to link services) must be defined.
- Requires a comprehensive description of the rate-setting policies that assure health home payment method is consistent with the goals of efficiency, economy, and quality of care.

Health Home Application

- States set initial quality measures until CMS releases a core set of quality measures.

- CMS requires states to collect and report information required for state and CMS evaluation including tracking of avoidable hospital admissions, cost savings, and monitoring of use of HIT. Additional guidance forthcoming.

Health Home Approval

- CMS expects to work closely with states prior to submission.
- No time limit for SPA submission to receive 90% FMAP. 8 Quarters are rolling.
- States may need to amend SPA to come into compliance with final regulatory requirements.
- CMS encourages states to consider utilizing technologies to provide health home services and improve care coordination. Further guidance will be forthcoming in the future.

State of Medicaid Spending: High Cost Enrollees

Pairs, Triples and HIV/AIDS groups account for 18 percent of member months and 52 percent of spend

Entire Medicaid Clinical Risk Grouping (FFS, Managed Care & Dual-Eligible)	Recipients	Pct Total Member Months	Sum Total Claim Expenditures CY2009	Pct Total Claim Expenditures	Total Claim PMPM
Healthy/Acute	3,603,376	62.45	$ 9,164,421,559.54	19.81	$ 272.49
Minor Chronic	71,971	1.54	$ 455,060,231.31	0.98	$ 549.88
Single Chronic	816,569	16.44	$ 9,114,948,953.60	19.70	$ 1,029.40
Pairs Chronic	**721,655**	**15.32**	**$ 18,153,765,366.16**	**39.24**	**$ 2,200.88**
Triples Chronic	**88,361**	**1.88**	**$ 3,987,101,629.39**	**8.62**	**$ 3,940.70**
Malignancies	27,913	0.53	$ 912,990,577.07	1.97	$ 3,169.31
Catastrophic	34,237	0.71	$ 2,379,368,897.94	5.14	$ 6,244.47
HIV / AIDS	**54,906**	**1.14**	**$ 2,092,172,707.13**	**4.52**	**$ 3,422.09**
Total	**5,418,988**	**100.00**	**$ 46,259,829,922.14**	**100.00**	**$ 858.97**

State of Medicaid Spending: High Cost Enrollees

147,889 Fee-for-Service (FFS)Pairs, Triples and HIV/AIDS Enrollees cost $6.9B in 2009

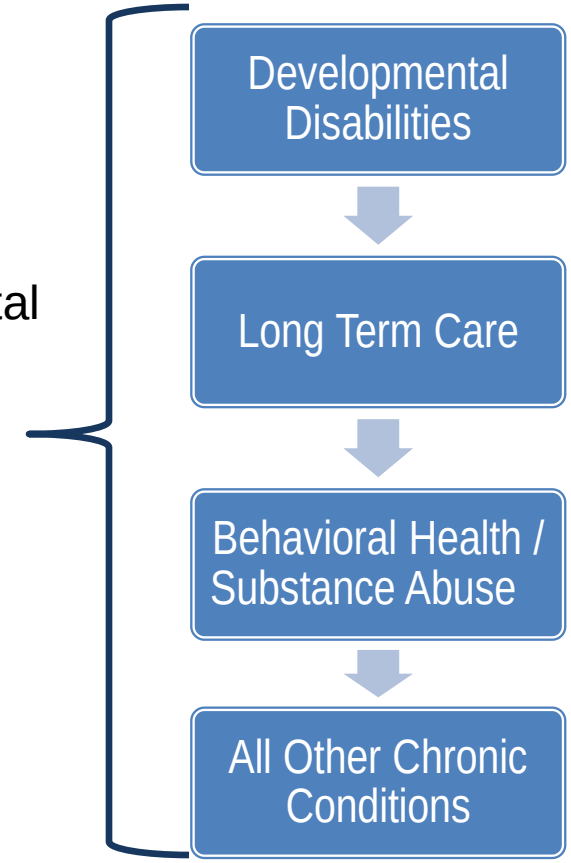
Clinical Risk Grouping for FFS-Only Non-Dual Eligible Recipients***	Recipients	Pct Total Member Months	Sum Total Claim Expenditures CY2009	Pct Total Claim Expenditures	Total Claim PMPM
Healthy/Acute	685,922	67.02	$ 1,145,627,952.09	9.49	$ 251.84
Minor Chronic	37,866	3.70	$ 292,866,238.28	2.43	$ 772.35
Single Chronic	135,991	13.29	$ 2,299,827,552.72	19.05	$ 1,788.58
Pairs Chronic	**106,050**	**10.36**	**$ 4,422,143,460.78**	**36.64**	**$ 3,840.82**
Triples Chronic	**14,166**	**1.38**	**$ 1,039,970,105.52**	**8.62**	**$ 6,528.78**
Malignancies	5,720	0.56	$ 337,435,792.73	2.80	$ 6,894.61
Catastrophic	10,035	0.98	$ 1,112,572,535.35	9.22	$10,044.17
HIV / AIDS	**27,673**	**2.70**	**$ 1,420,175,935.10**	**11.77**	**$ 4,666.04**
Total	**1,023,423**	**100.00**	**$ 12,070,619,572.57**	**100.00**	**$ 1,510.96**

***** FFS Only Non-Dual Recipients excludes Medicaid recipients with any MMC member months of eligibility during CY2009.**

Mutually Exclusive Hierarchical Selection Based on Service Utilization

"Complex"

1. Serious Mental Illness Only
2. Pairs
3. Triples
4. HIV/AIDS



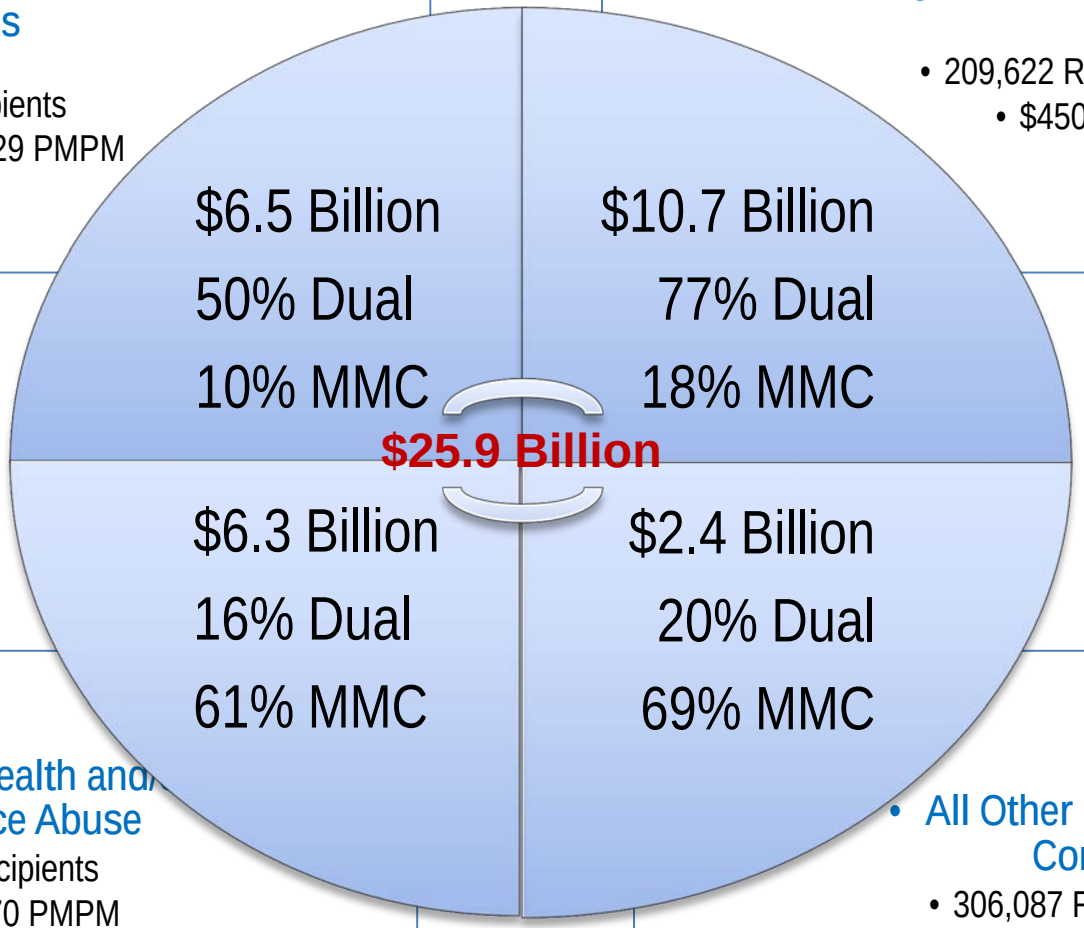
* Long Term Care includes: more than 120 days of consecutive LTC needs and/or enrollment in Managed Long Term Care (PACE, Partial MLTC and MAP).

Populations

- Developmental Disabilities
  - 52,118 Recipients
    - $10,429 PMPM

- Long Term Care
  - 209,622 Recipients
    - $4509 PMPM

Total Complex
N=976,356
$2,338 PMPM
32% Dual
51% MMC



- Mental Health and Substance Abuse
  - 408,529 Recipients
    - $1,370 PMPM

- All Other Chronic Conditions
  - 306,087 Recipients
    - $698 PMPM

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

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.

Primary Care Use of High Cost Patients

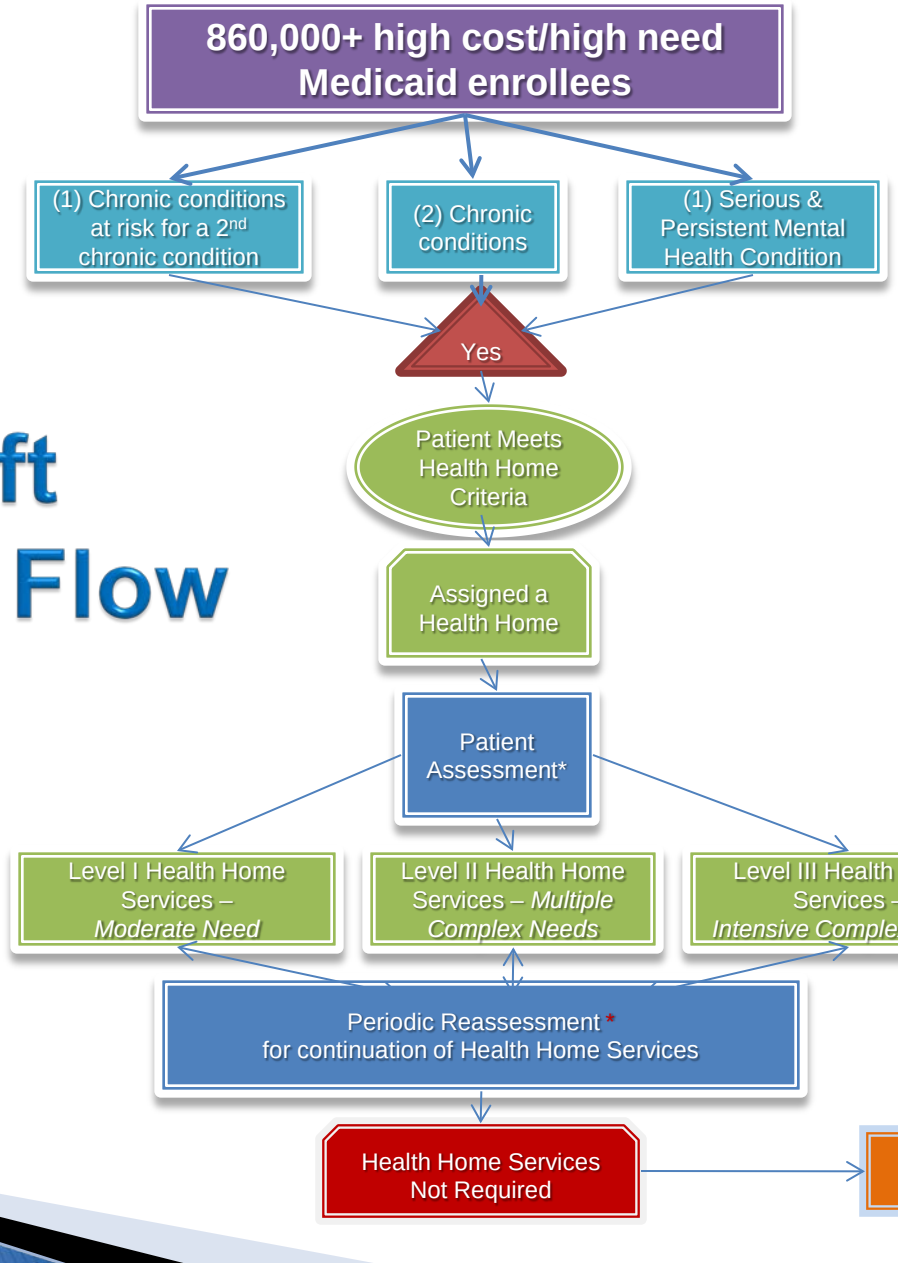
"Medical Home" for Patients with Risk Score ≥50
Based on Prior 2-Years of Ambulatory Use

"Medical Home" Status	All NYS	Number of PC/Spec/OB Providers Touched
Loyal	48.9%	2.80
OPD/Satellite	25.1%	2.97
D&TC	15.0%	2.55
MD	8.8%	2.71
Shopper	18.8%	5.39
Occasional User	13.3%	1.18
No PC/Spec/OB	19.0%	0.00
Total	100.0%	2.54

51%

Source: NYU Wagner School, NYS OHIP, 2009.

Draft Patient Flow



***Medically and Behaviorally Complex**

***Non-Compliant with Treatment Health Literacy Issues**

***ADL Status**

***Inability to Navigate Health Care System**

***Social Barriers to Care**

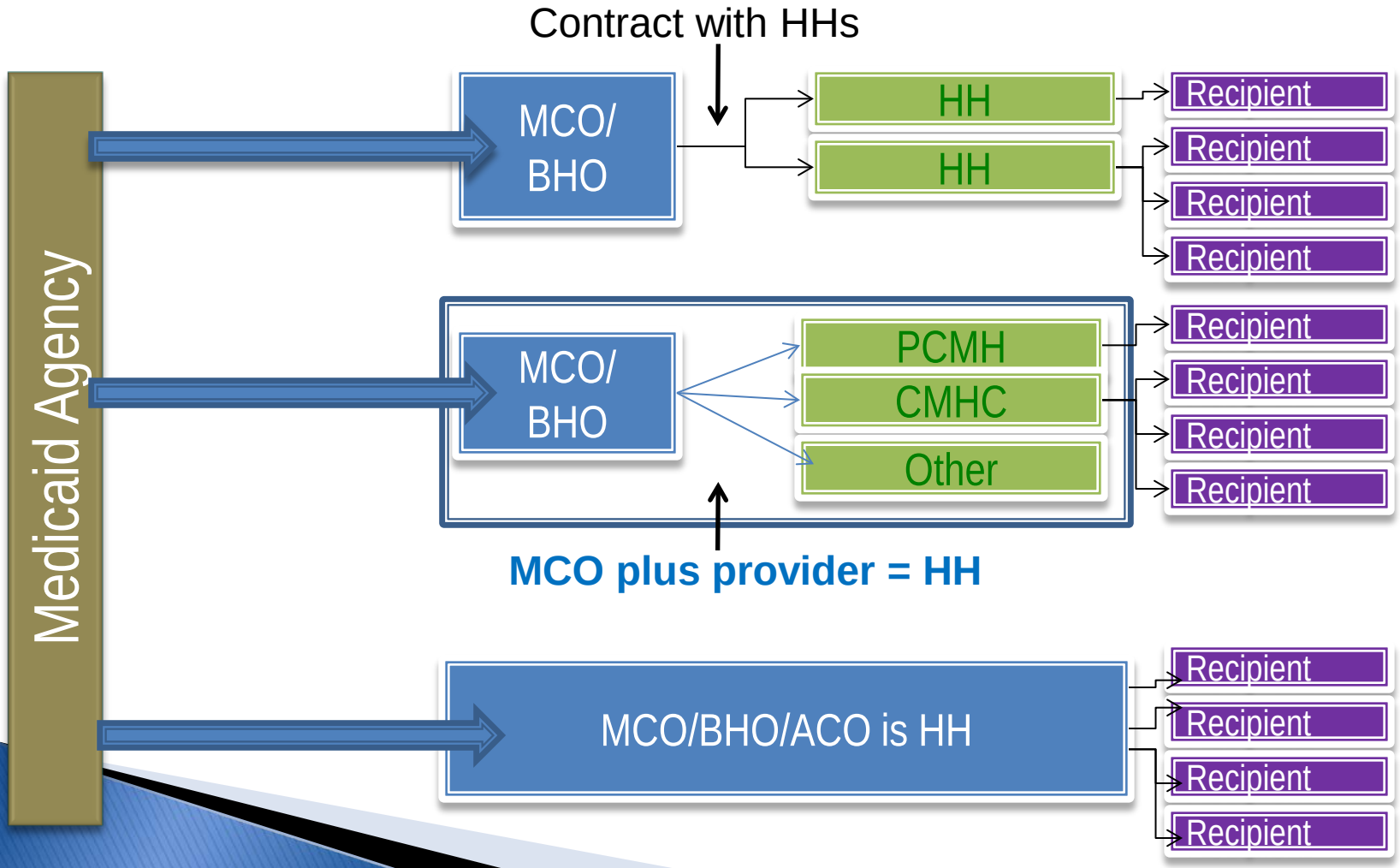
***Homelessness**

***Temporary Housing**

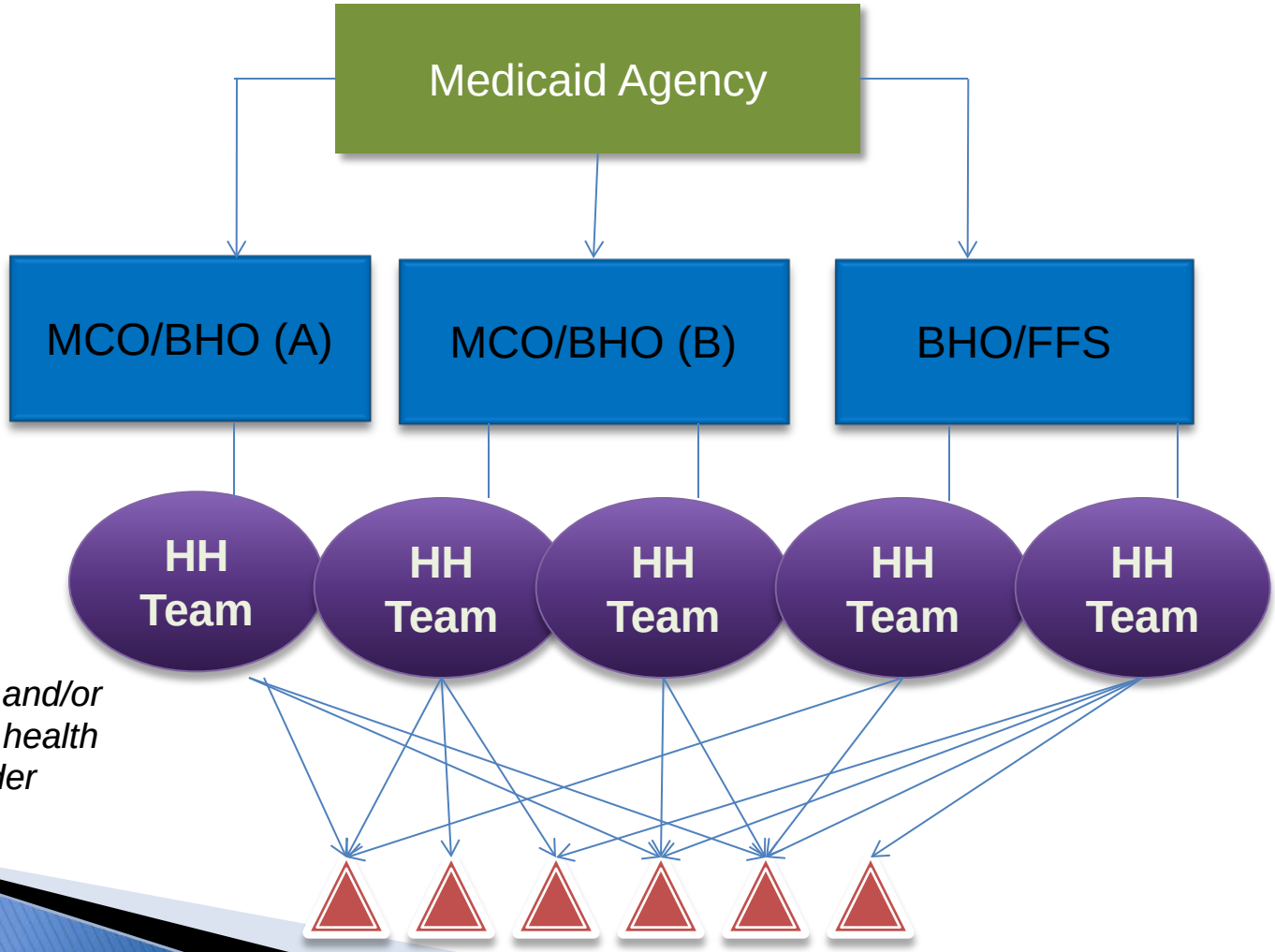
***Lack of Family or Support System Food , Income**

***Need assistance applying for Entitlement Programs**

Examples of Structuring Health Homes (HH) In Managed Care Delivery System



Examples of Structuring Health Homes In Managed Care Delivery System



= *Physical and/or behavioral health care provider*

Implementation Status

- Enrollment target – October 2011.
- Broad Expert Group assisted with development of Interim Health Home Provider Qualifications.
- CMS and SAMSHA consults occurred with DOH, OMH, OASAS and the Aids Institute.
- Draft quality measures have been developed with state stakeholders – out for review by Expert Group.

(continued)

Implementation Status

- Draft finance model has been developed with state agencies – out for review by Expert Group.
- Draft state plan has been submitted for CMS feedback.
- NYS Health Home Web site (links to many relevant materials): http://nyhealth.gov/health_care/medicaid/program/medicaid_health_homes/index.htm.

Issues Under Consideration

- Finalizing roles for health plans/BHOs in the delivery of home health systems.
- Changing how care management is currently provided (e.g., extending it out to the point of care).
- Leveraging existing health plan infrastructure (e.g., data and reporting, provider networks, etc.).
- Patient Assignment Algorithms
- Conversion of TCM Programs
- Shared Savings
- Shared Risk