

# Health Homes for Children with Chronic Conditions

August 15, 2012

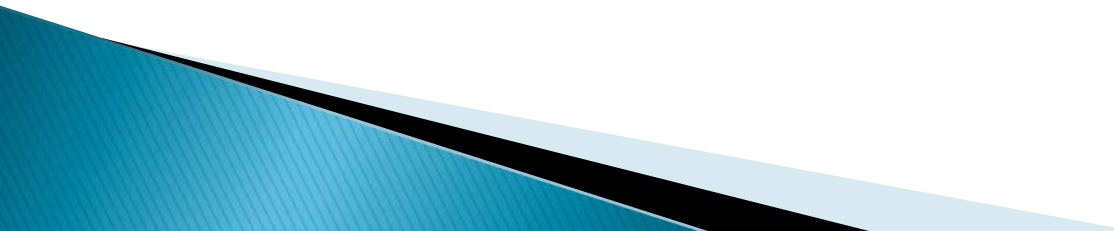
# What is the Focus of Today's Discussion?

- ▶ Provide an overview of the progress of the Health Homes for Children's Work Group and draft programmatic recommendations
- ▶ Discuss issues and concerns related to medically fragile children (MFC)
  - What is the best way to deliver care coordination to MFC?
    - Should care coordination for MFC be provided as part of Health Homes or should it remain separate?
  - How are their needs the same or different from those children with chronic conditions but not necessarily of the same medical complexity?
  - How are the care coordination needs different for MFC receiving most of their care in their home versus institutional settings?
- ▶ Provide DOH feedback on MFC's issues related to Health Homes

# Progress on Developing Health Homes for Children with Chronic Conditions

- A DOH interagency workgroup (involving OCFS, OMH, OASAS) has been meeting (February 2012 through present) to discuss eligibility, provider infrastructure and standards and evidenced-based quality
- Working draft of preliminary programmatic recommendations has been developed and will be presented to the Office of Health Insurance Programs (OHIP)
- Stakeholders will be engaged to discuss and update draft prior to finalization of recommendations

# **A Snapshot of NYS Medicaid Enrolled Children with Chronic Conditions**



# Complex Medicaid Populations: Children 0 to 20 Years

## • 1) Developmental Disabilities

• 11,524 Recipients  
\$3,859 PMPM

\$527 Million

0.63% Dual

26% MMC

## • 2) Long Term Care

• 2,387 Recipients  
• \$11,025 PMPM

\$310 Million

70% Dual

11% MMC

**\$2.3 Billion**

\$1.0 Billion

0.20% Dual

67% MMC

\$412 Million

0.38% Dual

80% MMC

## • 3) Mental Health and/or Substance Abuse

• 50,510 Recipients  
\$1,769 PMPM

## • 4) All Other Chronic Conditions

• 24,085 Recipients  
\$1,499 PMPM

Total Complex  
N=88,506  
\$2,234 PMPM  
32% Dual  
63% MMC

# Pediatric Inpatient Admissions by Age Group, DRG and Percent, July 2010 – June 2011

## Less than one year:

▶ Bronchiolitis & RSV pneumonia	12.0%
▶ Seizures	6.7%
▶ BPD and other chronic respiratory	4.9%
▶ Malnutrition & failure to thrive	4.2%
▶ Other pneumonia	3.6%
▶ Respiratory system with ventilator	3.3%
▶ Infections upper respiratory tract	2.9%
▶ Non-bacterial gastroenteritis	2.3%

# Pediatric Inpatient Admissions by Age Group, DRG and Percent, July 2010 – June 2011

## 1 – 5 years:

▶ Asthma	13.3%
▶ Seizures	9.1%
▶ Other pneumonia	7.8%
▶ Bronchiolitis & RSV pneumonia	5.7%
▶ Non-bacterial gastroenteritis	3.4%
▶ Infections of upper respiratory tract	3.1%
▶ Sickle cell anemia crisis	2.7%
▶ Chemotherapy	2.6%
▶ Major hematologic/immuno	1.6%

# Pediatric Inpatient Admissions by Age Group, DRG and Percent, July 2010 – June 2011

## 6–20 years:

Bipolar disorders	23.0%
Major depressive disorders	8.7%
Childhood behavioral disorders	6.8%
Schizophrenia	3.8%
Sickle cell anemia crisis	3.7%
Asthma	3.1%
Depression except major depressive	3.0%
Seizure	2.8%
Adjustment disorder & neurosis	2.4%
Diabetes	2.3%



# Federal Background



# Health Homes Goals

Per the Centers for Medicare and Medicaid Services:

- ▶ Improve the experience of care
- ▶ Improve the health of population
- ▶ Reduce costs without harm to individuals, families or communities
  
- ▶ The Health Home model expands upon the medical home model to build linkages to community and social supports for individuals with chronic illnesses and to enhance coordination and integration of primary, acute, and behavioral (mental health and substance) care.

# Federal Health Homes Eligibility Criteria

Medicaid eligible individual having:

- two or more chronic conditions;
- one condition and the risk of developing another;  
*or*
- at least one serious and persistent mental health condition.

Note: HIV/AIDS has been added in New York State as a single qualifying condition.

# Working Draft –

- » Preliminary Programmatic Recommendations for Children's Health Homes

# Preliminary Programmatic Recommendations for Health Homes for Children – Conditions Eligibility

- ▶ Two chronic medical conditions, including but not limited to:
  - Asthma
  - Diabetes
  - Obesity (BMI at or above 95<sup>th</sup> percentile for children of same age and sex)
  - Hypertension
  - Conditions that present uniquely in childhood: i.e. very low birth weight < 1500 Grams, bronchopulmonary dysplasia, fetal alcohol syndrome
  - Congenital and genetic conditions
  
- ▶ Substance abuse disorders (includes dependency) when paired with a chronic medical condition or serious mental illness
  
- ▶ Note: Group emphasized the importance of identifying conditions in their earliest manifestations to prevent progression:
  - Prediabetes
  - Family Hypercholesterolemia

# Preliminary Programmatic Recommendations for Health Homes for Children – Conditions Eligibility (continued)

- ▶ One serious mental illness (encompasses serious emotional disturbance and serious, persistent mental illness)
- ▶ One HIV/AIDS diagnosis
- ▶ One serious chronic condition at risk for another
  - Autism spectrum disorder
  - Cystic fibrosis
  - Diabetes Type 1
  - Sickle cell disease
  - Other genetic conditions screened for by NYSDOH or identified by other genetic testing, resulting in a shorter lifespan
  - Females, ages 19 years and under, any chronic condition and a pregnancy – from pregnancy identification through 24 months after pregnancy has ended (regardless of how the pregnancy ends)
  - Others – for discussion

Note: The group noted that a robust community referral process to facilitate timely identification and assessment of children eligible for health homes is necessary

# Preliminary Framework for Provider Infrastructure, Services and Standards

- ▶ Provider networks that include pediatric medical and dental specialists across multiple disciplines that have the expertise and experience in serving children and their families in order to effectively provide the six children's health home services.
  - Comprehensive care management
  - Care coordination and health promotion
  - Comprehensive transitional care
  - Patient and family support
  - Referral to community and social supports
  - Use of health information technology to link services above as feasible and appropriate
- ▶ Provider networks that have linkages to community supports and organizations that have experience assisting families and youth navigate the systems of care.

# Areas in Need of Further Review and Discussion Related to Infrastructure, Services and Standards

- ▶ Identification & implementation of a pediatric-specific, developmentally appropriate functional assessment tool to be utilized at key points of engagement
- ▶ Individualized care planning and management using a family-centered, developmental approach with inclusion of all care givers (birth, adoptive, kinship foster and non-kinship foster family and step parents)
- ▶ Determination about whether the frequency of care plan review and updates should be specified for children; and if so, the specifics of the frequency for review and updates



# Areas in Need of Further Review and Discussion Related to Infrastructure, Services and Standards

- ▶ Scope and initiation of transition planning, including transition from pediatric to adult providers and transition at key events in the child's life, i.e. home to school, home to independent living
- ▶ Consents for children and adolescents in special circumstances (including but not limited to children whose parents have relinquished parental rights to the local Department of Social Services and adolescents seeking treatment for reproductive health, STDs or HIV/AIDS).
- ▶ Intersection of health homes with other relevant NYSDOH services, including service coordination for children enrolled in the Early Intervention Program and Nurse Family Partnership for pregnant/postpartum adolescents

# Areas in Need of Further Review and Discussion Related to Infrastructure, Services and Standards

- ▶ Intersection with other service systems and existing waiver programs under the oversight of OMH and OCFS (including OMH Home & Community-Based Services Waiver and Targeted Supportive & Intensive Case Management Programs, and OCFS Bridges to Health Services Waiver for Children in Foster Care with SED, developmental disabilities or medically fragile).
- ▶ The intersection of medically fragile children with health homes

# Comments and Questions

- ▶ Do the care coordination needs of medically fragile children differ from children with chronic conditions generally?
- ▶ Do the care coordination needs differ for medically fragile children receiving care in their community versus care in institutional based settings?

# Comments and Questions

- ▶ If medically fragile children were to receive care coordination within Health Homes, what types of providers does NYSDOH need to ensure are included within their networks?

# Next Steps

- ▶ August 2012 – A working draft of programmatic recommendations and your input today will be discussed with staff of the Office of Health Insurance Programs (OHIP), Division of Program Development and Management.
- ▶ Process and timeline to finalize draft of recommendations will be discussed with OHIP.