Opportunities for ILCs in the NYS Health Home Initiative

August 18, 2011

Webinar Logistics

- During today's presentation, all participants will be in a "Listen Only" mode. However, you may submit questions to the speaker at any time by typing the question in the Chat feature located to the lower left of your screen. Questions will be answered as time allows.

- We will also conduct a live Question and Answer session at the end of the webinar, should you want to ask your questions directly to the speaker. We'll follow-up with instructions later in the presentation.

- As a reminder, today's presentation and call is being recorded.

Outline

- Overview of what's happened already in 2011
- What is a health home?
  - Federal health care reform
  - NYS implementation
- Who will be served by a health home?
- What will a health home look like?
- How will the health home be reimbursed?
- Other Medicaid Redesign Team initiatives to restructure services and reduce costs
  - Mandatory Managed Care
  - Behavioral Health Organizations
- Where do ILCs fit in the health home initiative?

Before we get to health homes, let's review the most recent history.

- Andrew Cuomo elected in November 2010

- Executive Budget/Executive Order in January 2011 to create a Medicaid Redesign Team (MRT), and reduce Medicaid spending by about $2.8 billion

- March 2011 – MRT agrees on over 200 initiatives to restructure the Medicaid program
  - **"Care management" will be implemented for all who can benefit over the next three years.**
  - **Small cohort of Medicaid enrollees who consume disproportionate share of Medicaid spending will be targeted for aggressive interventions to rationalize their care away from hospitals and emergency rooms.**

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**

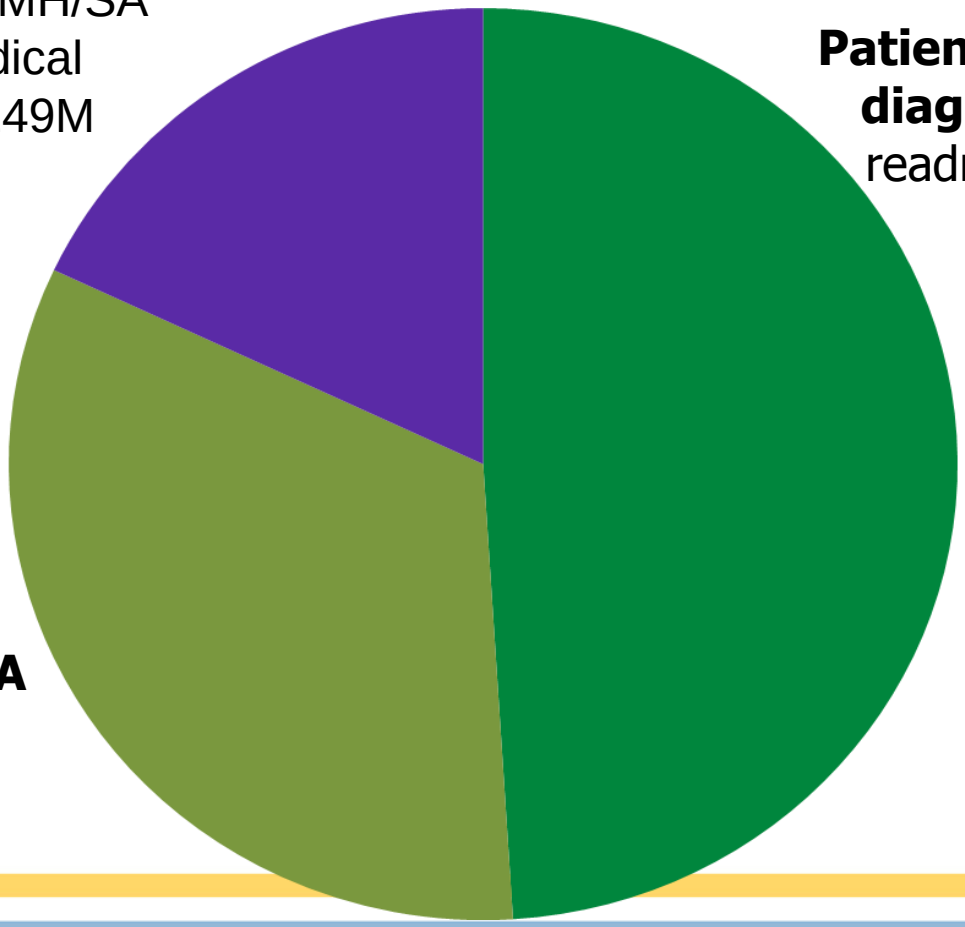
***** FFS Only Non-Dual Recipients excludes Medicaid recipients with any MMC member months of eligibility during CY2009.**

The Need for Integrated Care: Potentially Preventable Readmissions (PPR's)

NYS Costs $814M (2007)

Patients **without** MH/SA diagnosis, medical readmission $149M

Patients with MH/SA diagnosis, medical readmission $395M



Patients with MH/SA diagnosis, MH/SA readmission $270M

What is a health home?

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.

How is New York planning to implement health homes?

- State option to provide health home services to Medicaid beneficiaries with chronic conditions became effective on January 1, 2011.

- NYSDOH submitted a draft State Plan Amendment to CMS on June 30, 2011 to implement health homes for individuals with chronic conditions.

http://www.health.state.ny.us/health_care/medicaid/program/medicaid_health_homes/docs/nys_health_home_spa_draft.pdf

Health Home Application

- It's happening now – application process was posted on August 1st.

- On DOH's website:

http://www.health.state.ny.us/health_care/medicaid/program/medicaid_health_homes/

- DEADLINE for Health Home Applications: October 3, 2011, Letters of Intent Due COB September 1, 2011

- Health Homes implementation – November 1, 2011

Who can become a health home?

- 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

Health Home Applicants

- NY health home applicants must :
  - have strong medical, behavioral, and social service community providers connections
  - use multi-disciplinary teams of medical, behavioral , targeted case management (TCM), and social services providers that can assure appropriate and timely access to services.
  - Must be enrolled (or be eligible for enrollment) in the NYS Medicaid program and agree to comply with all Medicaid program requirements.
  - Can either directly provide, or subcontract for the provision of, health home services. Responsible for all health home program requirements, including services performed by the subcontractor.

Who will be served by a health home?

- 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 (Serious Emotional Disturbance will be excluded from initial HH group)
- substance abuse disorder
- asthma
- diabetes
- heart disease,
- being overweight (BMI over 25)
- HIV/AIDS
- Hypertension

Populations

State of Medicaid Spending: High Cost Enrollees

975,000 Patients with Multiple Chronic Illnesses

I/Developmental Disability

- 52K Recipients
- **$6.4B/$10,500 PMPM**

Issues: Very High Cost - Waiver and FFS Expense is Growing Rapidly

Long Term Care

- 209K Recipients
- **$10.5B/$4,500 PMPM**

Issues: High Cost; Lack of Management; High Intensity LTC and IP Services without coordination

Behavioral Health

-408K Recipients

- **$6.3B/$1,400 PMPM**

Issues: High Cost; Socially Unstable, Lack of Services Management; Lack of BH and Physical Health Care Coordination

Chronic Medical

-306K Recipients

- **$2.4B/$695 PMPM**

Issues: High Cost; Lack of Services Management; Lack of Physical Care Coordination

What will a health home look like?

- *"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."*

CMS Medicaid Director Letter on November 16, 2010 Re: Health Homes for Enrollees with Chronic Conditions https://www.cms.gov/smdl/downloads/SMD10024.pdf

From the SPA language

- "NY health homes will use multidisciplinary teams of medical, mental health, chemical dependency treatment providers, social workers, nurses and other care providers led by a dedicated care manager who will assure that enrollees receive needed medical, behavioral, and social services in accordance with a single plan of care."

- Optional team members may include:
  - nutritionists/dieticians,
  - pharmacists,
  - outreach workers including peer specialists and other representatives as appropriate to meet the enrollee needs (housing representatives, entitlement, employment).

How will health homes operate?

- Individuals will be able to choose a health home provider and can choose to opt out of a health home assignment altogether, however DOH expects health home networks will work hard to engage, satisfy and retain high need enrollees.

- The State reserves the right to assign beneficiaries to a specific health home.

- There will be only one care plan for each patient enrollee. All members of the health home team will report back to the care manager on patient status, treatment options, actions taken, and outcomes.

How will health homes be reimbursed?

- Health home providers will be paid a per member per month (PMPM) care management fee that is adjusted based on region, enrollment volume, case mix, and in the near future, patient functional status.

- A case finding PMPM payment, at a reduced amount, is available for the first few months to reimburse for outreach and engagement. Once a patient is assigned a care manager and enrolled in the health home program, the active care management fee may be billed.

- Quality Incentive-The active care management fee will be paid in two installments with the final installment paid once the health home provider meets state quality metrics.

- If the state achieves service savings, after a year, it is expected that health home providers will be able to participate in a shared savings pool.

Health Home Reimbursement (continued)

- DOH recently communicated that health home funding is only going to the one single health home applicant organization.
- The process for subcontracting with health home providers and reimbursement for services is still up in the air.
- DOH expects health homes to “pay fairly downstream.”

Other MRT initiatives targeted at the health home enrollee

- There are three simultaneous MRT initiatives targeting individuals with chronic health and behavioral health conditions:
  - Behavioral Health Organizations (BHOs)
  - Mandatory enrollment in Managed Care
  - Health Homes

- How do they all interact, or better stated, how will they interact?

Behavioral Health Organizations (BHOs)

- Targeted to persons with serious mental illness and/or substance dependence who have a history of multiple psychiatric admissions/readmissions, emergency service use, dependence relapses and detoxifications, incarceration, and homelessness.
- Not managed care per se – the BHO in the first three years is intended to reduce fee for service utilization for the "carved out" (of managed care) Medicaid behavioral benefit.
- BHOs not intended to interact with beneficiaries directly; rather, with inpatient/outpatient providers to improve their effectiveness.

BHOs

- BHOs will develop provider “report cards” to grade provider performance and responsiveness.
- Goal eventually is to convert the “carved out” fee for service benefit into a managed care premium, paid either directly to a BHO or a managed care organization.
- One BHO will be selected for each OMH region.
- No company is planned to be awarded more than one BHO designations.
- Applications were submitted on August 5th.
- OMH decisions expected August 19th.
- BHOs scheduled to go live on October 1st.

Expansion of Medicaid Managed Care mandatory enrollment and benefit changes

- Medicaid Managed Care (MMC) plans serve only non-dual Medicaid recipients.
  - August 1, 2011- personal care became a benefit for MMC.
  - October 2011 - pharmacy becomes a plan benefit for MMC.
  - January 2012 - Personal emergency response (PERS) becomes a MMC benefit.
  - July 2012 – Consumer Directed Personal Assistance in MMC benefit.
  - October 2012 – nursing home placement becomes MMC benefit and non-dual nursing home residents enroll in MMC.

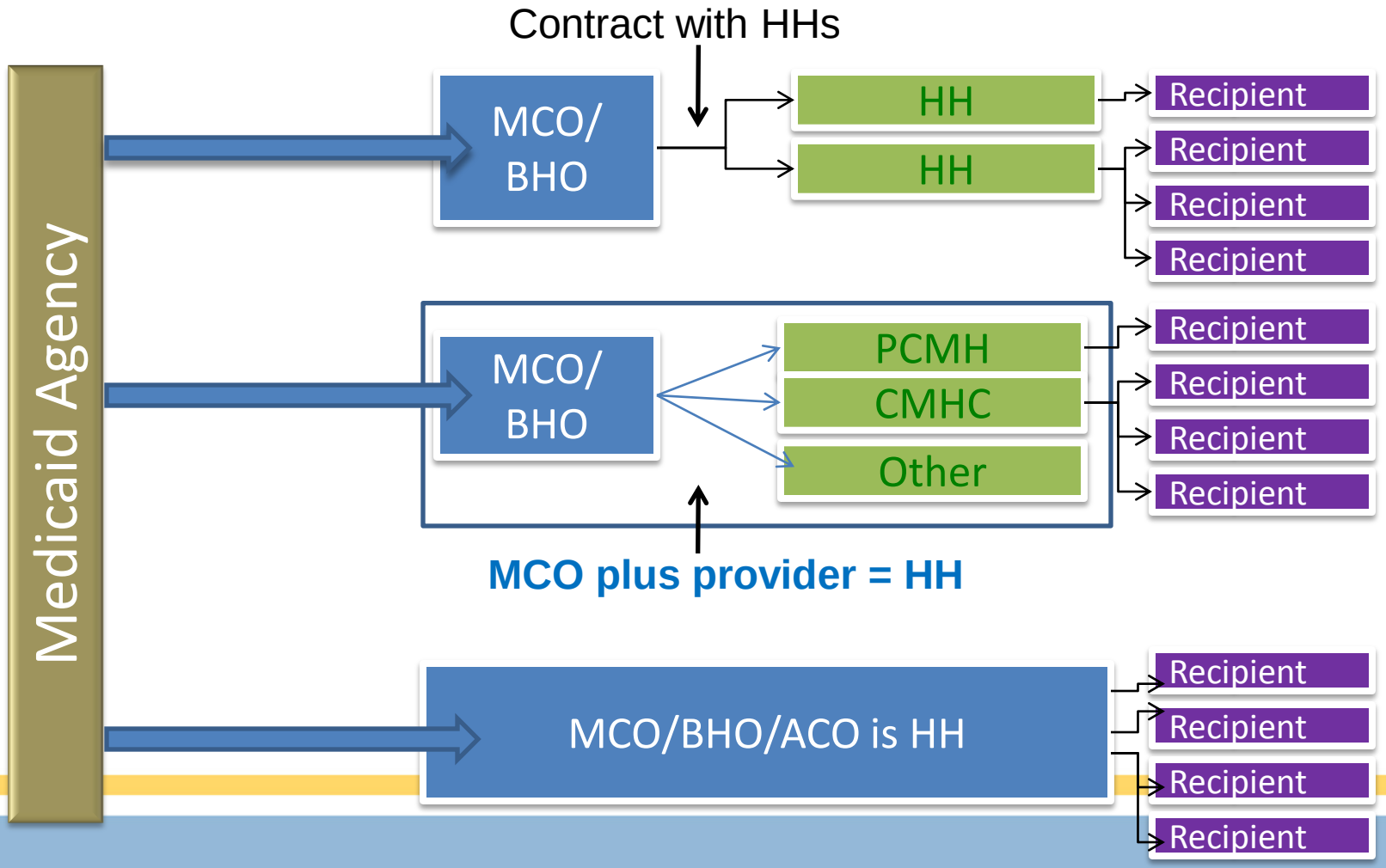
Managed Long Term Care Population

- Managed Long Term Care (MLTC) plans currently serve individuals who are eligible for Medicare and Medicaid (duals) as well as non duals.
  - In the future, primary target population for MLTC will be dual eligible.
- April 2012 begins mandatory enrollment of dual eligibles in New York City who require community based long term services in MLTC or care coordination model.
- Upstate expansion will be county by county, as sufficient MLTC plan and care coordination model capacity is developed.
- July 2012 – Consumer Directed Personal Assistance in MLTC benefit.

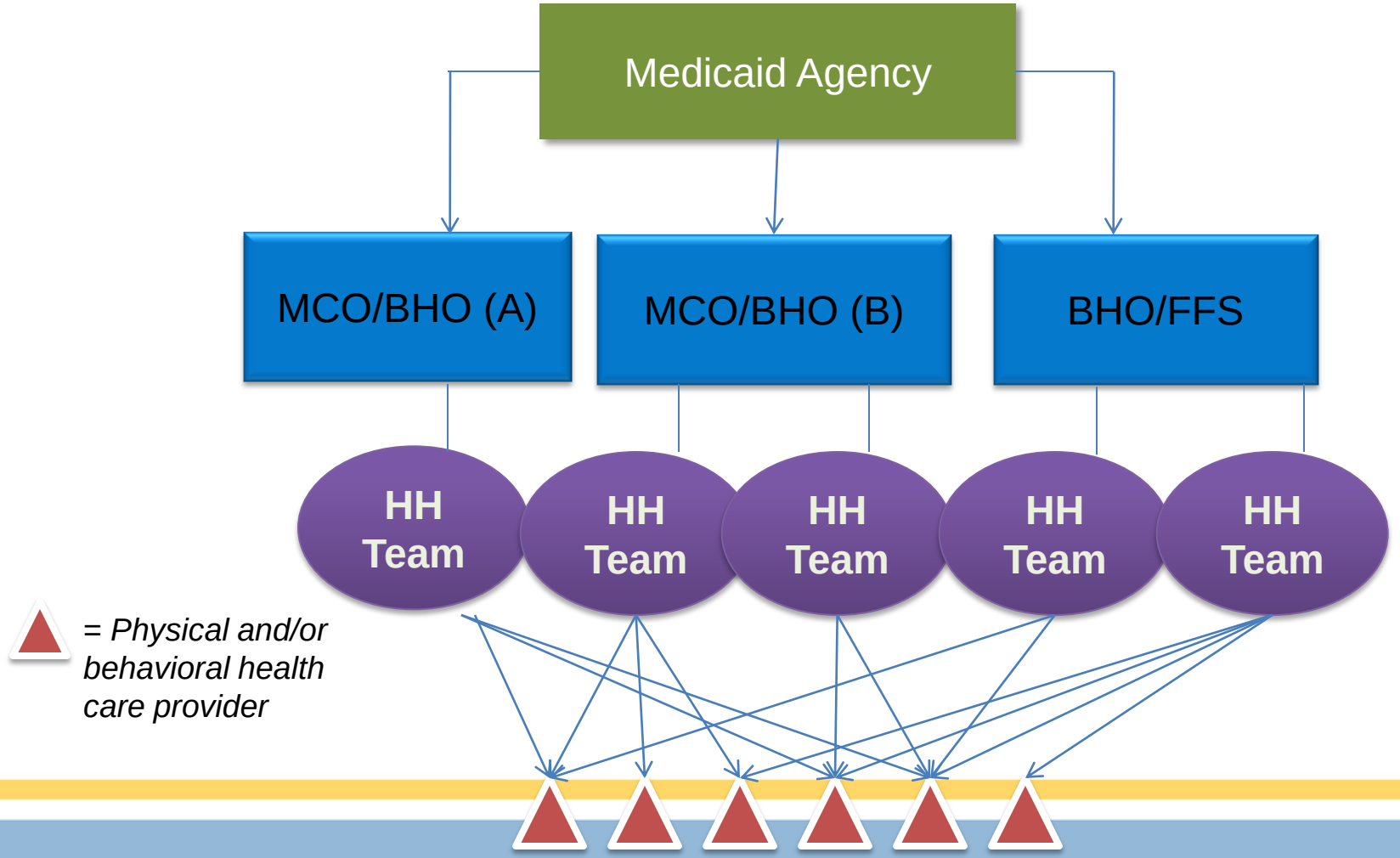
Excluded from Initial Mandatory Enrollment

- Several groups are not eligible to enroll in MLTC or care coordination models until program features and reimbursement rates are developed.
- These include people in:
  - Traumatic Brain Injury (TBI) Waiver
  - Nursing Home Transition and Diversion (NHTD) Waiver
  - Assisted Living Program (ALP)
  - Office of People with Developmental Disabilities (OPWDD) Wavier

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



Examples of Structuring Health Homes In Managed Care Delivery System



DOH 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

ILCs and Health Homes

- Health home providers are required to provide health home services that include referrals to community based organizations and social service providers.
- Health home applicants must include in their application their plans to refer individuals to community based organizations and social support services providers for public assistance support services, housing services, etc.
- DOH has repeatedly stressed the need for peer services for all people with disabilities and housing assistance.
- Applications are due October 3rd. ILCs must connect with potential health home providers NOW!

What should your center be doing for a role in this rapidly changing Medicaid managed care system?

- Identify and build relationships with likely health home applicants and other health home providers in your region.
  - Let these organizations know that your “optional” services are “mandatory” if they are to succeed.
  - Sell yourself as the peer service expert – discuss not only what you currently do, but what you can and are willing to do.
  - Let these organizations know the wide range of populations served by your center.
  - To the extent possible, quantify the value you bring to the health home.
- Health home reimbursement is finite, with many competing interests – you’ve got to be able to sell yourself convincingly.
- Similar process for MLTC population down the road.

Additional Information

- DOH website for Medicaid Health Homes

http://www.health.state.ny.us/health_care/medicaid/program/medicaid_health_homes/

- State Medicaid Director's Letter 10-024 re Health Homes

https://www.cms.gov/smdl/downloads/SMD10024.pdf

- State Plan Amendment Draft

http://www.health.state.ny.us/health_care/medicaid/program/medicaid_health_homes/docs/nys_health_home_spa_draft.pdf

- MRT Behavioral Health Reform Work Group, Health Homes presentation by Greg Allen 7/12/11

http://www.health.state.ny.us/health_care/medicaid/redesign/behavioral_health_reform.htm

Questions?

- If you would like to ask a question, please select the “Raise Hand” button on the top left of your screen.
- Once your name has been called, please press the ‘Star’ key followed by the ‘7’ on your telephone keypad to open your line and ask your question.
- If you are listening to the audio portion only and would like to ask a question, after web-based questions have been answered, we will open the telephone lines for additional questions from audio-only listeners.