

What Will BHOs, Health Homes and Managed Care Mean to You?

NYAPRS Capital District Regional Forum

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www.nyaprs.org

Thanks!

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- **Joan Erney**, J.D. Business Development and Public Policy officer, Community Care Behavioral Health
- **Michael W. Cole**, LCSW, Director of Community Services, Columbia County Department of Human Services
- **Katherine Maciol**, LCSW-R, Commissioner of Mental Health, Rensselaer Co
- **Stephen J. Giordano**, Ph.D., Acting Director, Albany Co. Department of Mental Health
- **Dan Godfrey**, LCSW-R, Director of Clinical Services, ClearView Center, Inc.
- **Anthony Falco**, LCSW, Director of Planning and Evaluation, Rehabilitation Support Services

New York Association of Psychiatric Rehabilitation Services (NYAPRS)

A statewide coalition of people who use and/or provide community mental health recovery services and peer supports that is dedicated to improving services, social conditions and policies for people with psychiatric disabilities by promoting their recovery, rehabilitation, rights and community integration and inclusion.

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Unprecedented Pace of Change

- **October:** Managed care plans took over the Medicaid pharmacy benefit
- **January:** Regional Behavioral Health Organizations began efforts to improve hospital discharge and community services follow up plans for hospitalized 'high needs' individuals
- **January-June:** Medicaid beneficiaries are being assigned to new coordinated Health Home networks
- **2013-4:** Medicaid mental health, substance use and medical services are put into some form of managed care

Why are Changes Coming to Your Medicaid Healthcare?

- US and New York state budgets can no longer keep up with Medicaid's rising costs
- At the same time, too many Medicaid beneficiaries don't get or participate in enough of the right kind of healthcare
- As a result, too many spend too much time in expensive visits to emergency rooms and hospitals

Ultimate Goal of These Changes

- Improving health care outcomes
- Improving service quality, coordination and accountability
- Reducing the runaway cost of care

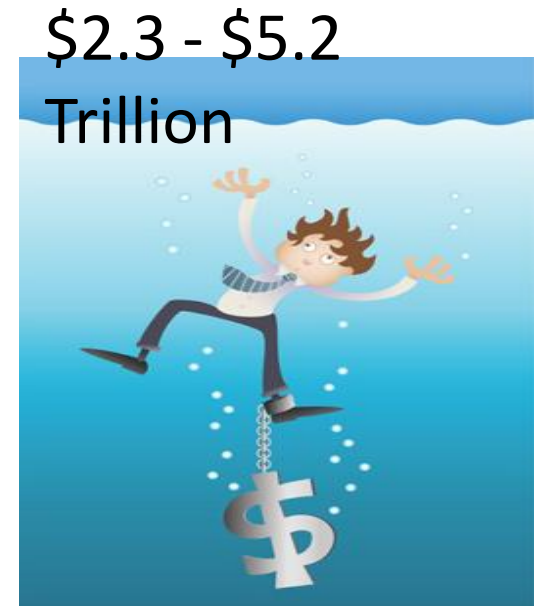
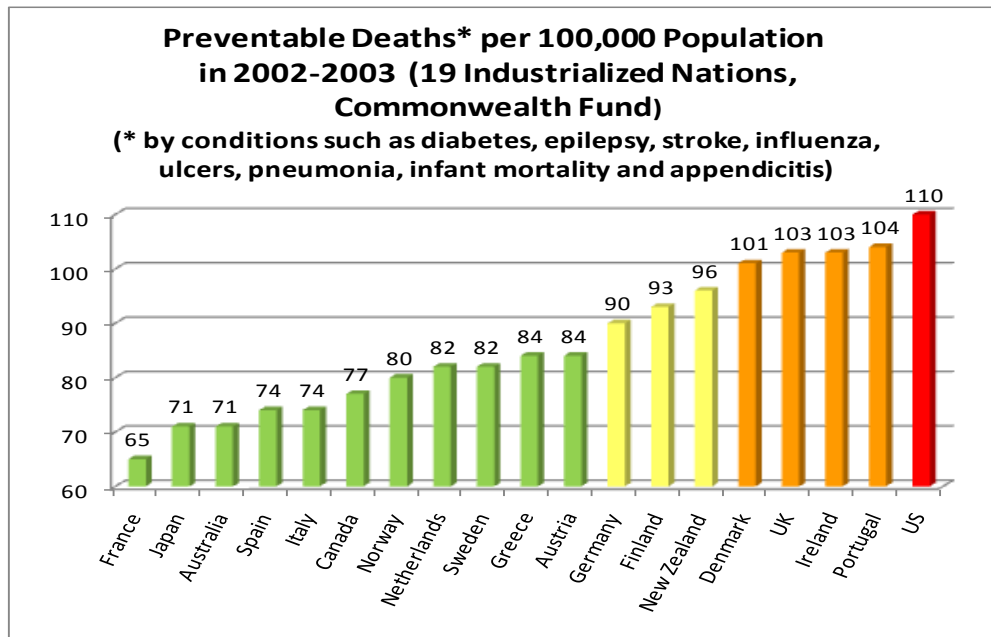
The U.S. has a *Sick Care System* not a *Health Care System*

- Half of Americans have one or more chronic health conditions (155+ million)
- Over half of these people receive their care from 3 or more physicians
- In total, treating chronic health conditions consumes 75%+ of the \$2.5 trillion we spend on healthcare each year in the U.S.
- In large part due to the fact that money doesn't start flowing in the US healthcare system until after you become sick



America's Healthcare System at the Brink

"The American healthcare system is a dysfunctional mess." (Ezekiel Emanuel, MD, Chair of the Department of Bioethics at the Clinical Center of the National Institutes of Health)



"As much as 30% of health care costs (over \$700 billion per year) could be eliminated without reducing quality": Big focus for Nat./State Budget Cutters

SAMHSA on Affordable Care Act: Major Drivers

- **More people** will have insurance coverage
- **Medicaid will play a bigger role in MH/SUD** than ever before
- Focus on **physical and behavioral health care coordination and integration**
- Major emphasis on **home and community based services** and less reliance on institutional care
- **Preventing** diseases and promoting **wellness**

SAMHSA on Affordable Care Act: Major Drivers

- **Person centered individualized care**
- **Outcomes:** improving the experience of care, improving quality and outcomes while ‘bending the cost curve’
- *Decrease overuse and underuse of services*
- *Electronic healthcare Records*
- *Health Homes and Accountability Care Organizations*

NY's Behavioral Healthcare System Funding

- The publically funded mental health system alone serves over **600,000 people** and accounts for about **\$7 billion** in annual expenditures. Approximately **50 percent of this spending goes to inpatient care.**
- The publicly funded substance use disorder treatment system serves over **250,000** individuals and accounts for about **\$1.7 billion** in expenditures.

NY's Behavioral Healthcare System

Fragmentation, Lack of Accountability

- Despite the sizable amount of funding, care to the neediest patients often suffers from a **lack of comprehensive care coordination and accountability** for the provision of **quality** care and for improved **outcomes** for consumers.

NY's Behavioral Healthcare System

Overuse of Costly Institutional Services

- In NYS, Medicaid fee-for-service readmission rates to psychiatric inpatient units are **20% within 30 days of discharge.**
- The **majority of preventable admissions** to any Article 28 Medicaid fee-for-service reimbursed inpatient beds are from **people with behavioral health conditions**; the **majority are for chronic physical health conditions.**

NYS Backdrop: High Cost of Medicaid Care for New Yorkers w/ Multiple 'Chronic' Conditions

- New York's Medicaid program serves almost 5 million beneficiaries at a cost of over \$50 billion annually.
- ***20% of Medicaid beneficiaries (1,029,621) account for 75% of the program's expenditures: \$31.1 million***
- Average cost per year: \$30,195 which is 15 times higher than the average beneficiary

NYS Backdrop: High Cost of Medicaid Care for New Yorkers w/ Multiple ‘Chronic’ Conditions

- These beneficiaries have “multiple co-morbidities, are medically complicated and require services across multiple provider agencies. Due to their multiple and intensive needs, their care can often be fragmented, uncoordinated and at times duplicative. “
- ***Over 40% of these beneficiaries are diagnosed with mental illness and chemical dependency.***

HH Eligibles by County and Age with Spending

New York State Medicaid

Health Home Eligible Recipients: Phase I Counties

June 1, 2010 through May 31, 2011 Service Period

Phase I Location	0-18 Years		19+ Years		Total	
	Recip	PMPM	Recip	PMPM	Recip	PMPM
BRONX	10,026	\$ 1,665	98,403	\$ 1,402	108,429	\$ 1,426
BROOKLYN	10,091	\$ 1,513	147,559	\$ 1,115	157,650	\$ 1,141
CLINTON	400	\$ 1,375	2,918	\$ 815	3,318	\$ 883
ESSEX	123	\$ 1,515	840	\$ 890	963	\$ 969
FRANKLIN	220	\$ 1,605	1,434	\$ 956	1,654	\$ 1,043
HAMILTON	13	\$ 2,324	76	\$ 966	89	\$ 1,176
NASSAU	1,837	\$ 1,759	21,179	\$ 1,092	23,016	\$ 1,145
SAINT LAWRENCE	338	\$ 2,022	3,584	\$ 1,100	3,922	\$ 1,177
SARATOGA	510	\$ 1,099	3,842	\$ 856	4,352	\$ 884
SCHENECTADY	851	\$ 1,352	4,533	\$ 1,025	5,384	\$ 1,077
WARREN	275	\$ 1,262	1,570	\$ 920	1,845	\$ 971
WASHINGTON	282	\$ 1,234	1,539	\$ 886	1,821	\$ 940
Phase I Total	24,966	\$ 1,578	287,477	\$ 1,200	312,443	\$ 1,231

Note: Data include Behavioral Health and/or Substance Abuse and Other Chronic Condition recipient classification cohorts. Persons with Developmental Disabilities and the Long Term Care recipient cohorts have been removed from Phase I analyses. PMPM \$ = (Total Medicaid Spend / Total Medicaid Member Months)

* Updated HH Attribution from June 1, 2010 through May 31, 2011 – County as of last date of Medicaid Eligibility. Saratoga and St. Lawrence have been moved out of phase one.

Phase One Population Information by County

Average Amount Paid per Claim/Prescription for Top Ten Categories of Service that Contribute to Overall Spend by County for Dates of Service 7/1/10 to 6/1/11

Phase 1 County	Drugs	Inpatient	D&TC	Hospital Outpatient	OMH Rehabilitative Services	Case Management Services	Skilled Nursing Facility	Physician Services	Transportation	Home Health Agency Professional Services
BRONX	\$ 5,474	\$ 6,743	\$ 125	\$ 140	\$ 990	\$ 160	\$ 1,599	\$ 27	\$ 60	\$ 107
BROOKLYN	\$ 4,464	\$ 6,081	\$ 112	\$ 155	\$ 867	\$ 175	\$ 1,494	\$ 19	\$ 60	\$ 124
CLINTON	\$ 3,462	\$ 4,098	\$ 135	\$ 118	\$ 495	\$ 519	\$ 1,208	\$ 28	\$ 69	\$ 83
ESSEX	\$ 3,771	\$ 4,229	\$ 120	\$ 120	\$ 556	\$ 485	\$ 370	\$ 34	\$ 45	\$ 87
FRANKLIN	\$ 3,876	\$ 5,116	\$ 151	\$ 141	\$ 910	\$ 391	\$ 1,359	\$ 34	\$ 65	\$ 115
HAMILTON	\$ 3,451	\$ 8,793	\$ 69	\$ 86	\$ 756	NA	\$ 1,925	\$ 25	\$ 117	\$ 140
NASSAU	\$ 3,405	\$ 5,253	\$ 128	\$ 126	\$ 1,051	\$ 276	\$ 1,363	\$ 19	\$ 91	\$ 107
SAINT LAWRENCE	\$ 3,621	\$ 4,787	\$ 117	\$ 354	\$ 881	\$ 246	\$ 892	\$ 33	\$ 100	\$ 96
SARATOGA	\$ 3,367	\$ 2,950	\$ 112	\$ 88	\$ 1,085	\$ 309	\$ 476	\$ 21	\$ 53	\$ 65
SCHENECTADY	\$ 3,512	\$ 3,149	\$ 86	\$ 122	\$ 926	\$ 170	\$ 1,072	\$ 27	\$ 41	\$ 65
WARREN	\$ 2,779	\$ 4,571	\$ 81	\$ 104	\$ 938	\$ 336	\$ 1,287	\$ 31	\$ 53	\$ 86
WASHINGTON	\$ 3,356	\$ 3,844	\$ 84	\$ 85	\$ 1,144	\$ 424	\$ 1,226	\$ 25	\$ 37	\$ 117

NYS Ranks 50th in Avoidable Hospital Readmissions

- NYS Department of Health estimated that \$800 million was spent last year on 'avoidable Medicaid hospital readmissions.'
- ***70% of these involved beneficiaries with mental health, substance use and major medical conditions.***
- 65% of admissions for this group were for medical reasons.

NY's Behavioral Healthcare System

Overuse of Costly Institutional Services

- The **overuse of inpatient detoxification and SUD inpatient rehabilitation services** by a small number of individuals results in poor outcomes and high Medicaid costs.
- There is an **over-reliance on state hospitals, adult homes and nursing homes** partly due to the system's inability to assign responsibility for integrated community care.

NY's Behavioral Healthcare System

Housing, Economic Instability

- The **unemployment rate** for people with serious mental illness is extremely high, around **85%** based on national surveys.
- Serious mental illness and substance use disorders confer significant risks of **homelessness**.

NY's Behavioral Healthcare System

Poor Health Outcomes

- People with serious mental illness **die 15 - 25 years earlier** on average than the rest of the population.
- There **are few examples of co-location** of physical and behavioral health services in New York, though co-location is a recognized best practice.
- **Early intervention for psychiatric disorders (usual onset in early twenties) is infrequent** and not promoted under the current regulatory and financing approach.

Big Stakes for Communities of Color

- Compared to non-Hispanic whites with SMI, African Americans and Latinos with major MH diagnoses face serious health inequities due to:
 - Higher rates of obesity, diabetes, metabolic syndrome, and cardiovascular disease
 - Poorer access and quality of medical care

NYS Medicaid Redesign Team

Key Initiatives

- **Global Cap:** state share cap, CPI growth cap
- From FFS to **Managed Care** for all: payment for outcomes not for visits
- 1 million to **Health Homes** for “high-need/high-cost groups, fully integrated w managed care
- **Pharmacy Carve-in to Managed Care**
- **Contract with BHOs** to begin transition to care management for behavioral health services with 2014 goal **being full integration of physical and behavioral health**
- **‘Super’ 1115 Medicaid waiver**

NYAPRS Advocacy at the Table

- **Medicaid Redesign Team**
- **Behavioral Health Work Group**
- **Affordable Housing Work Group**
- **Health Homes Advisory Group**
- **Peer Services Work Group**
- **Pharmacy into Managed Care Group**
- **People First Steering Committee**

Focus of NYAPRS Medicaid Advocacy

- Services must promote **recovery and wellness, health literacy and 'self management'**
- In an atmosphere of such great change in expectations and options, beneficiaries must be **guaranteed Informed choice, privacy and other basic rights protections**, supported by **peer advocates and/or enrollment brokers**, with **consumer access to personal electronic records** that prominently features **advance directives**.
- Health outcomes/savings from hospital/ER diversion come heavily from addressing **social determinants of health** like social, housing, economic status.

Focus of NYAPRS Medicaid Advocacy

- Hence, there must be significant **reinvestment** of Medicaid savings into **peer services, housing, rehabilitation/ employment services expansion**.
- **Peer run services** should play prominent roles in BHO, health homes and managed care re-designs.
- **Open access to medications of choice**
- Crucial importance of **cultural competence** and other strategies to address health disparities
- Inclusion of **1915.i self direction** and **1915.k Community First Choice** options in 'super waiver'

2011 NYAPRS Budget Advocacy

Priority #1

- Helping to lead a coalition of 41 state and regional advocacy groups to avoid seeing Medicaid mental health and substance use services going directly to the coordination of managed care plans.

2011 NYAPRS Budget Advocacy

Priority #1: Background

- Most Medicaid beneficiaries already get their healthcare through Medicaid managed care plans....but not their mental health and detox services, which are ‘carved out’ and paid for via fee for service.
- To make quick savings, the state wanted to fold all of those services into the managed care health plans and let the plans direct those dollars to approved providers for approved services.

The Alternative: Regional BHOs

- We backed an alternative OMH/OASAS proposal to bring in specialty managed care groups called Behavioral Health Organizations.
- BHOs have considerable recent experience in funding and favoring recovery, wellness and peer support services.

OMH/OASAS: Role of BHOs

- Monitoring BH inpatient length of stay;
- Reducing unnecessary behavioral health inpatient hospital days (working with hospitals for a prompt, effective discharge plan)
- Improving rates of engagement in outpatient treatment post discharge (working with outpatient providers to coordinate with good discharge plan and to implement an effective community plan that results in....)

OMH/OASAS: Role of BHOs

- Reducing behavioral health inpatient readmission rates;
- Better understanding of the clinical conditions of children diagnosed as having a Serious Emotionally Disturbance (SED); and
- Profiling provider performance.

BHOs will Review:

- All fee-for-service admissions to OMH-licensed psychiatric units (all ages) in general hospitals (Article 28 hospitals)
- Fee-for-service children and youth admitted to OMH licensed private psychiatric hospitals (Article 31 hospitals)
- Fee-for-service direct admissions to OMH State-operated children's psychiatric centers or children's units of psychiatric centers
- Fee-for-service OASAS Certified Part 816 Inpatient Detoxification Services (Article 28/32)
- Fee-for-service OASAS certified hospital (Art 28/32) or freestanding (Article 32 only) Part 818 Chemical Dependence Inpatient Rehabilitation Services

Regional BHO Awardees

- New York City Region: OptumHealth
- Hudson River Region: **Community Care Behavioral Health**
- Central Region: Magellan Behavioral Health
- Western Region: New York Care Coordination Program
- Long Island: ValueOptions and North Shore LIJ Health System

Additional BHO Focus?

- Define, engage and link cohorts of disengaged or high risk individuals to appropriate treatment.
- Review outpatient engagement for post-discharge follow-up care.
- Suicide prevention for high need/high risk populations discharged from inpatient settings.
- Reducing costs for people with high cost physical and behavioral health conditions.
- Behavioral health emergency diversion/inpatient diversion.

In 2014

- We move from FFS to a fully capitated and integrated managed care system:
 - Special Needs Plans
 - Integrated Delivery Systems
 - Behavioral Health Organizations

In 2014

- State Medicaid dollars flow to managed care groups who authorize services in approved provider networks according to approved service plans.
- Moving from current state regulations and reimbursement systems
- Greater flexibility to pay for peer services, employment, housing, rehab....based on evidence based outcomes
- Depends on what's in the RFP and contract!

Maximizing Peer Services

- Promote acknowledgement and respect for the unique contributions **and value of peers in delivering services that help people, promote wellness and decrease costs.**
- Facilitate ways to accommodate Medicaid funding for peer services, such as **waivers, grants and funding for programs rather than for the position itself.** Funding for training and education, certification, and leadership development would strengthen the peer workforce.

Maximizing Peer Services

- Establish an **accreditation process for peer-run agencies** which would professionalize their activities and require that supervision be provided by a trained peer to preserve the unique, whole health/wellness approach that peers provide.
- **Incorporate peer services into health homes** as a required element in health home applications, given the recognition that peer services are evidence-based practices which can improve outcomes while being cost effective.

Special Role, Value of Peer Services

- Start where the person is
- Promote hope and shared responsibility
- Form strong engaging personal relationships
- Focus on wellness and successful community living
- Promote improved self care and advocacy
- Help prevent relapses and provide alternatives to costly emergency room visits and hospitals
- Are innovative and cost effective

Some Data on Peer Services Effectiveness

NYAPRS Peer Bridger 2008 Data on Reducing Re-Hospitalizations

In 2008, the Peer Bridger Project worked with 251 individuals and 190 of those consented to the release of their hospitalization data. After a preliminary review of this data, ***136 of these individuals were not re-hospitalized in the state psychiatric centers in 2008.***

72% percent of the people we worked with were able to stay out of the hospital for the following year.

Some Data on Peer Services Effectiveness

Peer Bridger Replications

- Peer Bridger model adapted by OptumHealth in several states with the following results.
- Tennessee: reduced average number of hospital days per month from **7.42 to 1.98**, a **73.3% decrease**.
- Wisconsin: reduced average number of hospital days from **.86 to .48**, a **44.1% decrease**.

Some Data on Peer Services Effectiveness

NYAPRS Peer Wellness Coaching:

One Person's Outcomes

- Clean for 1 year
- Relapsed 1 year post rehab-went back to rehab-now clean
- 2009-prior to enrollment: **7 inpt stays** (4 different facilities) **\$52,282**
- 2010-1 detox, 1 rehab (referred by the CIDP team) **\$20,650.**
- 2011-1 relapse with detox/rehab no claim yet.

Some Data on Peer Services Effectiveness

PEOPLE Inc Peer Crisis Diversion Services Continuum

- Hospital Diversion House
- Warm Line
- In-Home Peer Companionship
- Social Structure (Nights Out)
- Emergency Department Advocacy

Benedictine Hospital Onsite Peer Services

In 2007, 60% (1,473 of 2,472) of individuals assisted by peer advocates were able to be stabilized or referred elsewhere without admission.

- Clinic Advocacy

NYS Academy of Peer Services

- Funded by NYS Office of Mental Health
- Led by University of Medicine and Dentistry of NJ and NYAPRS, in conjunction with peer partners
- Focus on helping peer programs to transition to **recovery centers** (wellness, community inclusion)
- Focus on administration and management, best practice peer services, appeal and effectiveness of peer programs and services in the NYS health and mental health care reform environment
- Oscar Jimenez, NYAPRS director
oscarj@nyaprs.org

Pharmacy into Managed Care

- 2011-12 budget agreement approved a proposal from the Medicaid Redesign Team (MRT) to move pharmacy from Fee for Service to the control of managed care plans, for those individuals who get their health care via Medicaid managed care plans.
- That meant that beneficiaries will generally get access only to those drugs that are on each plan's approved list (formulary).
- Advocates have pushed for open access for previously protected classes like mental health, AIDS/HIV, organ-transplant and epilepsy-related meds.

Pharmacy into Managed Care

- According to DOH, 19 of the 20 plans will continue open access to these medications; 15 will do so on an indefinite basis and 4 will continue open access for 12 months of study.

September DOH Medicaid Update

Q8. I do not see my drug on my plan's formulary or list of covered drugs and I've been on this drug for a while; can I stay on it?

ANSWER: If you've been on the drug for a while, you may be able to stay on that drug. For example, many **plans will continue to cover antipsychotics, immunosuppressants, antiretroviral therapy, anticonvulsant and antidepressant drugs for their members that are already on these drugs.** You should contact your plan to find out if the drug you are on is one that your plan will continue to cover for you, **even though it may not be on their list of covered drugs.**

Health Homes

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

Heath Homes Goal

- The health home provider will be **accountable for reducing avoidable health care costs**, specifically preventable hospital admissions/readmissions, skilled nursing facility admissions and emergency room visits and meeting quality measures.

Health Home Network Leader

- Health home providers can either **directly provide, or subcontract** for the provision of, health home **care coordination** services.
- The **health home provider remains responsible** for all health home program requirements, including services performed by the subcontractor.
- Health homes coordinate services to **network partners who continue to bill Medicaid**

Health Home Network Requirements

- Preferred health home applications will include an integrated health care and community provider network that includes
 - managed care plans
 - hospitals
 - community based organizations,
 - targeted case management providers
 - mental health and substance abuse services providers.

HH Program Requirements

- **Coordination of care** and services post critical events, such as emergency department use, hospital inpatient admission and discharge;
- **Language access/ translation capability;**
- **24 hour 7 days a week telephone access to a care manager;**

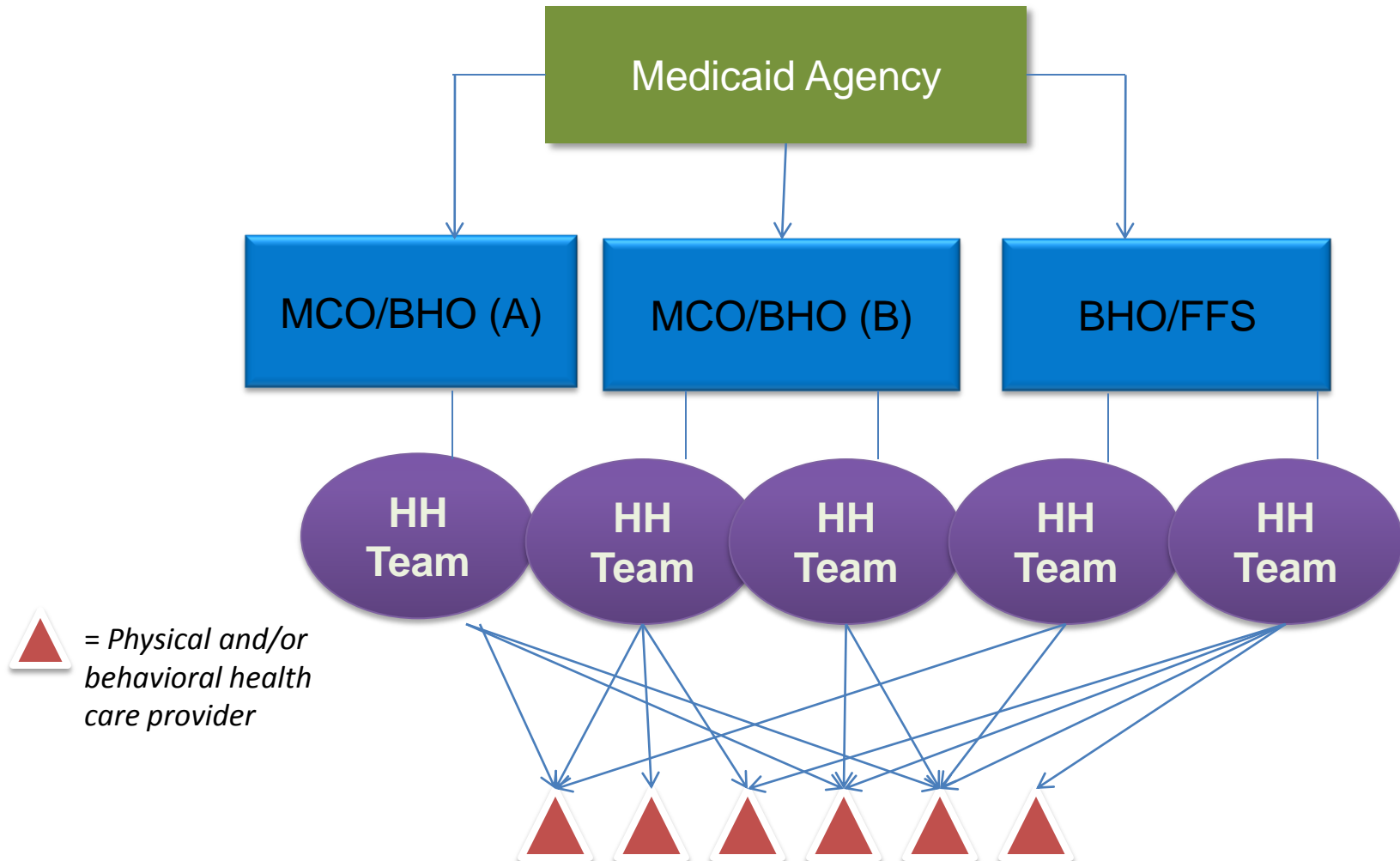
HH Program Requirements

- **Crisis intervention;**
- **Links to acute and outpatient medical, mental health and substance abuse services;**
- **Links to community based social support services-including housing;**
- **Beneficiary consent** for program enrollment and for sharing of patient information and treatment.

HH Proposals Must Demonstrate

- **A strong plan to deploy tiered care management plan for:**
 - Low need- stable individuals in ambulatory care with episodic crisis or inpatient need
 - Intermediate need individuals- not as connected to ambulatory care, more frequent emergency room and inpatient use
 - High need individuals- such as those serviced by OMH and HIV/AIDS COBRA TCMs and the MATS program.

Examples of Structuring Health Homes In Managed Care Delivery System



Updated Phase-in plan for Health Home Applications

- **Phase I - 10 counties:**
 - Bronx, Clinton, Kings (Brooklyn), Essex, Franklin, Hamilton, Nassau, Schenectady, Warren, Washington
 - 21 applicants were conditionally approved as Phase 1 Medicaid Health Homes and began operations on

Updated Phase-in plan for Health Home Applications

- **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 15, 2012.**
- ***UPDATED*** Implementation is tentatively scheduled for April 1, 2012

Updated Phase-in plan for Health Home Applications

- **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

Pre-Health Home Changing Trends

Emergency Services (diversion)

Inpatient Services (diversion)

PH

CDT

Clinic

IPRT

PROS

Clubs

Employment

Peer Services

Recovery Ctr

ACT

Case Management

Housing

Life in the Era of Health Homes

Health Home Applicant

IT System (subcontract?)

Managed Care Plan(s)

Case Manager/MATS/COBRA to Care Manager, More Positions

Peer Services (bridging, wellness, diversion, recovery centers)

Hospital(s) and Emergency Services

General Practitioners Specialists

PROS MH Clinics

Housing and Employment Linkages

Visiting Nurse Service of Schenectady County

- **Lead Partners:** Ellis Hospital, Hometown Health Center, Capital District Physicians Health Plan
- **Medical Services:** Belvedere Health Services; Volunteer Physicians Project of Schenectady
- **Behavioral Health/Housing Services:** Capital District Psychiatric Center; Clearview Center; Conifer Park; Hope House; McPike Addiction Treatment Center; Mohawk Opportunities; New Choices Recovery Center; Northeast Parent and Child Society; Parsons Children and Family Service; Rehabilitation Support Services; Carver Counseling Center; Schenectady County Chapter ARC

Visiting Nurse Service of Schenectady County

- **AIDS Services:** AIDS Council of Northeastern New York; Catholic Charities AIDS Services
- **Housing/Social Services:** Catholic Charities Senior Services in Schenectady; Schenectady City Mission; Schenectady Community Action Program; Schenectady County Department of Social Services; Schenectady Municipal Housing Authority

Glens Falls Hospital

- **Hospitals:** Glens Falls Hospital, Saratoga Hospital
- **Medical Services:** Adirondack Medical Services; Hudson Headwaters Health Network
- **BH Services:** Adirondack Samaritan Counseling Center; Warren/Washington Association for Mental Health; Catholic Charities; Liberty House; Warren/Washington County Ofc. of Community Svcs.
- **Home Care:** Saratoga County Public Health; Warren County Public Health; Washington County Public Health

Rehabilitation Support Services

- **Counties:** Dutchess, Ulster, Orange, Sullivan, Westchester, Schoharie, Otsego, Delaware, Chenango, Tioga, Schenectady
- **Health Plans:** Hudson River HealthCare; Hudson Health Plan;
- **Hospitals:** Albany Medical Center; Bon Secours Charity Health System; Orange Regional Medical Center; Ellis Medicine; St. Francis Hospital
- **Medical Providers:** Orange County Department of Health; Carver Community Center; The Institute for Family Health; Greater Hudson Valley Health Family Health Center;

Rehabilitation Support Services

- **BH Providers:** Hudson Valley Mental Health; Mental Health America of Dutchess County; Mental Health Association in Ulster County; Mental Health Association in Orange County; Albany County Department of Mental Health; Mohawk Opportunities; Alcoholism and Drug Abuse Council; Broome County Mental Health Department; Occupations; Capital Area Peer Services; Orange County Department of Mental Health; Chenango County Department of Mental Hygiene; Otsego County Community Services Board; ClearView Center; Parsons Child & Family Center;

Rehabilitation Support Services

- **BH Providers:** Conifer Park; PEOPLE; Crystal Run Village Recovery Center; Delaware County Drug & Alcohol Clinic; New Choices Recovery Center; Delaware County Mental Health Clinic; Rehabilitation Support Services; Friends and Advocates for Mental Health; Sullivan County Department of Community Services; Tioga County Department Of Mental Hygiene; New Hope Manor; Northeast Career Planning; Gateway Community Industries; Schoharie County Department of Community Services; NAMI Of Orange County; Arms Acres; Friends of Recovery - Delaware & Otsego (FOR-DO)

Rehabilitation Support Services

- **Disability Services:** Action Toward Independence; Independent Living; Sullivan County ARC; Lexington Center; Orange AHRC; Epilepsy Society of Southern NY; Inspire, CP Center;
- **AIDS Services:** AIDS Council of Northeastern New York; AIDS-Related Community Services (ARCS); Catholic Charities AIDS Services;

Rehabilitation Support Services

- **Home Health Services:** Always There Family Home Health Services; Independent Home Care; Living Resources Certified Home Health Agency;
- **Housing:** Multi-County Community Development Corp.; Homeless & Travelers Aid; Safe Homes of Orange County; Safe Harbors of the Hudson;

Rehabilitation Support Services

- **Misc:** Maternal-Infant Services Network of Orange, Sullivan; Opportunities for Otsego; Catholic Charities Community Services of Orange County; Catholic Charities of the Diocese of Albany; Regional Economic Community Action Program, Inc. (R.E.C.A.P.); Delaware County Office for the Aging; Restorative Management Corporation' Delaware Opportunities; Dispute Resolution Center; Family Empowerment Council; First Transit; Warwick Area Migrant Farm Community; Honor EHG; Jewish Family Services of Orange County; Youth Advocate Programs;

Expected Impact on Beneficiaries

- Most people will likely be **auto assigned** into health homes that include their case management program and provider
- DOH will assign FFS members to Provider-led Health Homes; Health Homes will send enrollment letters to their assigned FFS members
- Managed Care Plans will assign plan members who qualify for Health Home services to Provider-led Health Home; Plans will send enrollment letters to their members

Expected Impact on Beneficiaries

- Health home coordinators will have and share with provider systems **up to date information about beneficiaries' past and current health issues, their providers and their response and follow up with medications and treatments**
- More attention, help needed to protect beneficiary rights and choices
- They will likely be asked to participate in fresh new health/BH assessments and to help shape new goal and treatment plans

Expected Impact on Beneficiaries

- **Unmet needs** will be identified and referrals will be made and coordinated to new or 'better' health care providers
- Everyone will be focused on **averting avoidable ER and hospital visits.**

Consent Process

- The assigned Health Home is required to secure patient consent forms to officially enroll all Health Home members in a Health Home program
- The signed consent form allows their patient information to be shared with Health Home partners, including a Regional Health Information Organization (RHIO), if applicable
- Final consent form has been posted on the Health Home website

Disenrollment or Changing Health Homes

- Members who decide to disenroll from Health Homes must sign a disenrollment form
- Members who choose to be in a different Health Home should notify their Plan or assigned Provider-led Health Home
- Members who either cannot be located or refuse to sign the patient consent or disenrollment form must be disenrolled either immediately or after the three (3) month Outreach and Engagement period as appropriate

Health Home Reimbursement

- Health homes will be paid a **per member per month (PMPM) care management fee** that is adjusted based on **region, enrollment volume, case mix and patient “functional status.”**
- There will be a 10% quality withhold (w CMS approval)
- Health Home providers will be eligible to receive 15% of **shared savings.**
- **Most network providers will not receive HH \$ but bill previous funding sources.**

Health Home Rates

- Health Home rate variables:
 - caseloads (which will vary from 12-1 at highest intensity end and 140-1 at lowest intensity end)
 - case management cost and
 - member ‘acuity.’
- The care management rates in the current chart are regional, paying 24.37% more for the downstate region in comparison to the upstate region.

Outreach and Engagement Payments

- **Existing** case management slots (i.e., OMH TCM, COBRA, MATS) will bill at 100% of the approved PMPM rate for Outreach and Engagement
- For **new** Health Home members, case management fee will be paid in two increments: outreach and engagement or active case management
 - Outreach and engagement for new members will be paid at a reduced percentage (80%) of the active care management PMPM

Outreach and Engagement Payments and Time Period

- The outreach and engagement PMPM will be available for the three (3) months. If outreach and engagement is unsuccessful, the provider may not bill again for three (3) months from the conclusion of the outreach and engagement period
- All Health Home outreach and engagement activities are billable under the monthly PMPM as long as one of the six (6) core services are provided in the billed quarter
- Once a patient has been assigned a care manager and has consented, the full active case management PMPM may be billed on the first day of that month

Assignment and Billing

For Fee-for-Service Members

- State Designated Health Homes will bill eMedNY PMPM Rate Codes:
 - 1386- Health Home Services
 - 1387- Outreach & Engagement – for up to 3 months initially, additional 3 months allowed, 3 months after last claim
 - **Subcontractors** bill the State Designated Health Home

Projected Health Home Payments

Projected Average Health Home Payments - Sample Populations

Patient #	Base Health Status	Dx Description	Severity of Illness	Acuity Score	Downstate Monthly Payment	Upstate Monthly Payment	Previous		
							Acuity Score	Downstate Monthly Payment	Upstate Monthly Payment
1	Pairs Chronic	Diabetes and Hypertension	Low	1.6947	\$39	\$32	0.8114	\$17	\$13
2	Pairs Chronic	Diabetes and Asthma	Low	4.6947	\$109	\$88	4.0729	\$83	\$67
3	Triples Chronic	Diabetes - Hypertension - Other Dominant Chronic Disease	Low	5.7894	\$135	\$108	5.3524	\$110	\$88
4	Triples Chronic	Congestive Heart Failure - Diabetes - Cerebrovascular Disease	Mid	6.0001	\$140	\$112	7.4909	\$153	\$123
5	Single SMI/SED	Conduct, Impulse Control, and Other Disruptive Behavior Disorders	Low	6.3574	\$148	\$119	5.6522	\$116	\$93
6	Pairs Chronic	Schizophrenia and Other Chronic Disease	Mid	7.1434	\$166	\$134	6.9474	\$142	\$114
7	Pairs Chronic	Asthma and Other Moderate Chronic Disease	Mid	7.1434	\$166	\$134	8.3686	\$171	\$138
8	Single SMI/SED	Schizophrenia	Mid	7.9093	\$184	\$148	7.9318	\$163	\$131
9	Pairs Chronic	Diabetes and Advanced Coronary Artery Disease	High	8.818	\$205	\$165	7.0289	\$144	\$116
10	HIV/AIDS	HIV Disease	Mid	10.0992	\$235	\$189	10.0992	\$207	\$166
11	Triples Chronic	Cystic Fibrosis	Low	10.1255	\$236	\$189	5.6337	\$115	\$93
12	Triples Chronic	Diabetes - 2 or More Other Dominant Chronic Diseases	High	10.8664	\$253	\$203	12.3349	\$253	\$203
13	Triples Chronic	Brain and Central Nervous System Malignancies	High	11.1186	\$259	\$208	21.1181	\$433	\$348
14	Triples Chronic	Non-Hodgkin's Lymphoma	High	11.1186	\$259	\$208	11.7499	\$241	\$194
15	Single SMI/SED	Schizophrenia	High	16.6197	\$387	\$311	16.6288	\$341	\$274
16	HIV/AIDS	HIV Disease	High	17.7378	\$413	\$332	17.7378	\$363	\$292

Phase one HH Eligibles by Plan by County*

Type	Name	Bronx	Brooklyn	Clinton	Essex	Franklin	Hamilton	Nassau	Saint Lawrence	Saratoga	Schenectady	Warren	Washington	Grand Total
AIDS SNP	AMIDA CARE SN	1,025	1,557											2,582
	METPLUS SN	1,570	1,517											3,087
	NY PRESB SYS SELECT	2,136	1,322											3,458
AIDS SNP Total		4,731	4,396											9,127
HMO / PHSP	AFFINITY HEALTH PLAN	11,230	4,254					1,618						17,102
	AMERIGROUP NY CDPHP	600	3,652					1		1,606	1,594	4	334	4,252
	EXCELLUS			1		1			313					315
	FIDELIS HC NY	8,567	13,954	826	376	150	44	2,304	1	908	1,213	479	539	29,361
	GHI HMO SELECT	1									1			2
	GHI PPO					2			1					3
	HEALTHFIRST	19,488	16,607					2,279						38,374
	HEALTHPLUS	4,096	13,139					1,122						18,357
	HIP	5,136	9,199					3,400						17,735
	METROPLUS	13,465	13,090											26,555
	NEIGHBORHOOD	3,297	6,604					1						9,902
	UNITED HEALTHCARE C	796	17,660					2,735						21,191
	WELLCARE	1,757	3,031											4,788
	HMO/PHSP Total		68,433	101,190	827	376	153	44	13,460	315	2,514	2,808	483	873
MEDICAID ADVANTAGE	AFFINITY PROVIDER	22	4											26
	FIDELIS PROVIDER	80	169								11			260
	GHI HMO SELECT	8	9					1						18
	HIP ADVANTAGE	124	230					86						440
	LIBERTY HEALTH ADVAI	14	14					1						29
	MANAGED HEALTH INC	13	17											30
	METROPLUS PROVIDER	17	16											33
	SENIOR WHOLE HEALTH OF NY									15	37	17	2	71
	TOUCHSTONE/PRESTIGI	27	51											78
UNITED HEALTHCARE COMM PLAN	1	1											1	
MEDICAID ADVANTAGE Total		305	511					88		15	48	17	2	986
FFS Total		24,934	41,462	2,091	464	1,281	32	7,631	3,269	1,313	1,677	1,070	664	85,888
Grand Total		98,403	147,559	2,918	840	1,434	76	21,179	3,584	3,842	4,533	1,570	1,539	287,477

* Updated HH Attribution from June 1, 2010 through May 31, 2011 – Plan enrollment as of last date of Medicaid Eligibility Saratoga and St. Lawrence have been moved out of phase one.

From Case Management to Care Management

- Care managers will have **more responsibility** and authority to coordinate a broader array of healthcare (e.g. MH, SU, medical conditions)
- They will be able to **do more** than ‘assess, link and monitor’, e.g. transportation, individualized support
- **More slots** will be needed beyond existing case management/MATS to serve 900,000 health home eligible beneficiaries.

DOH Health Home Quality Measures

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

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

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

Goal 4: Improve Disease-Related Care for Chronic Conditions

Goal 5: Improve Preventive Care

We Must Look and Incentivize Outcomes Beyond Adherence to Treatment and Medication

- Housing stability
- Economic stability
- Social connection
- Involvement in Peer Support

NYAPRS/NYSCCBH

Health Workers Retraining Initiative Proposed Training Curriculum

- Support Resources: Recorded Webinars; Live Webinars; Mentoring and Tutoring; ICM Manual; Pre and Post Assessment on Skills and Outcomes
- Proposed Training Format/Schedule: Training program will continue for 2 year period: Training will begin in April 2012
- 48 Hours of training to complete course; 24-30 Hours in Classroom regionally located; 18-24 hours of Web Training; Additional Web Training available as support resources; Student should complete course within six months from start

Financial Pressures, Healthcare Reform Can Speed the Pace of Wellness and Recovery Promotion...

- If we do more than simply save dollars by diverting people from ERS and hospitals and are successful...
- at truly helping people meet their health and personal goals via a more responsive and person directed health care and supports

.....Or Are We Back to the Medical Model?

- We have helped advance mental health systems by infusing recovery, rehabilitation, rights and peer support approaches and values.
- In integrating with the healthcare system and its illness, medication and patient based emphases, we must be strong and persistent in infusing these values into those systems by demonstrating that they need us and them to succeed.

Challenges for Peers

- Find/Sustain Hope
- Develop/Articulate Dreams and Goals
- Develop Self Advocacy and Recovery Self Management Skills (WRAP)
- Know/Exercise Your Rights (Advance Directives)
- Build/Sustain Contact with Personal Supports and Community Contacts/Resources
- Prepare for More Risks, Responsibilities
- Strengthen Stamina and Endurance
- Have/Find Faith
- Explore Alternative Forms of Healing

Challenges for Providers

- Train and Sustain Staff Belief in Recovery
- Train and Sustain Staff Competencies on Promoting Rehabilitation Readiness and Person Centered Planning
- Active Engagement and Outreach, Customer Satisfaction in Competitive Environment
- Firm Up Documentation Skills
- Firm Up Good Outcome Systems
- Get Ready for Electronic Records
- Get Entrepreneurial with New Partners and Payers
- Focus on wellness, prevention, employment, community integration

MRT Phase II Recommendations

- Reinvest savings from reduced hospital and ER into peer support, housing, employment.
- Peer services: valued, recommended for health homes, flexible funding, accreditation
- Health homes: recovery, reduced force
- Pharmacy: continuity for 'protected classes'
- Unfreeze, expand supported housing

2012-3 Executive Budget Proposal

- Supported Housing Reinvestment fund
- Kingsboro reinvestment commitment
- Olmstead focus: enhanced housing for 5k+ adult/nursing home/state PC residents
- Hikes to PROS, Cuts to CDT, sheltered work
- \$3m: more managed care enrollment brokers
- \$6m: mh provider electronic records prep
- \$1.25m: raise mh response in primary care
- \$1.25m: 'first break' recovery centered responses

NYAPRS is Poised to Help!

Members Services and OMH funded Technical Assistance

- *Grassroots Advocacy January 31, 2012 Legislative Day*
- *Member Briefing March 1, 2012*
- *Service Transformation:* incorporating recovery, rehabilitation and wellness; PROS and Peer Services TA; Health Home Learning Collaborative edyeschwartz@nyaprs.org
- *Community and Economic Development:* incorporating employment and asset development, Employment Networks TA, We can Work/Save, Peer Employment Support kellys@nyaprs.org
- *Peer Services:* incorporating peer outreach, engagement, bridging and wellness coaching TA, forensic PS tanyas@nyaprs.org
- *Annual Conference Exec Seminar PROS Academy Regional Forums*
- *Cultural Competence:* chackum@nyaprs.org

www.nyaprs.org

Join our E-news week day list! bobbif@nyaprs.org

NYAPRS Upcoming Events of Note

- March 1: **Member Briefing** Holiday Inn Wolf Road, Albany
- March 28-9: **Annual Executive Seminar**, Hotel Albany (formerly Crowne Plaza), Albany
- April launch of **Care Management Training**
- September 19-21: **NYAPRS 30th Annual Conference**, Hudson Valley Resort, Kerhonkson, NY