

## New York's Chronic Illness Demonstration Project: Lessons for Medicaid Health Homes

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*Russell Wells, who lives in Mount Vernon, NY, has diabetes, high blood pressure, neuropathy, bipolar disorder and a history of stroke and alcohol and drug abuse. He has lived on the streets and served time in jail. But now the 58-year-old says he's doing much better medically and socially thanks in part to a Medicaid case management demonstration called Westchester Cares Action Program.*

The Westchester-based program is one of six projects around New York State that participated in the recently completed, three-year Chronic Illness Demonstration Project (CIDP), which was part of the *Rethinking Care Program*, a national initiative developed by the Center for Health Care Strategies and funded by Kaiser Permanente. The New York State Health Foundation also supported the New York CIDP initiative.

The Action Program, run by nonprofit, Tarrytown-based Hudson Health Plan, provided a multidisciplinary care team, including an on-the-street peer support worker, that helped Wells develop and follow a personal care plan and arrange medical appointments. While Wells already had some needs provided through a separate homeless housing program, many other clients also received help from the Action Program with housing, transportation, and mental health and chemical dependency services.

“They have contact with me twice a month, and the nurse comes and talks with me and asks how I’m doing and whether I need anything,” Wells says.

“And they have a crisis hotline, so there’s an around-the-clock person I can talk to. Sometimes I need that.”

The goal of the New York demonstration was to improve care for high-need, high-cost Medicaid fee-for-service beneficiaries like Wells who account for about half the state’s \$54 billion annual Medicaid expenditures. Under the CIDP model, a care coordinator connected beneficiaries to strong primary and preventive care as well as needed mental health and substance abuse services. It was hoped that this coordination would lower Medicaid costs by reducing preventable hospitalizations and emergency department use.

While the final state evaluation will not be done until early 2013, Hudson officials say their own preliminary data show that Action Program clients in the program for at least two years experienced a 45 percent reduction in

### IN BRIEF

Through the *Rethinking Care Program*, the Center for Health Care Strategies partnered with four states – Colorado, Pennsylvania, New York, and Washington -- to test new strategies to improve health care quality and control spending for Medicaid’s highest-need, highest-cost populations. This profile details the experiences of New York’s *Chronic Illness Demonstration Project*, which included six regional pilots across the state focused on improving care for Medicaid beneficiaries with chronic physical and behavioral health needs. For more information about the *Rethinking Care Program*, visit [www.chcs.org](http://www.chcs.org).

the number of hospital admissions and a 15 percent decrease in ER visits, compared with two years prior to enrollment.

“We’re hoping there’s a cost saving, [though] we know that getting these beneficiaries on the path of primary and preventive care and correct medications and lab services might increase spending,” at least initially, says Denise Spor, a Medicaid specialist with the state Department of Health.

### **Lessons for New York’s Health Homes Model**

The CIDP initiative is serving as a model for New York State’s much larger Medicaid “health home” program for high-need beneficiaries. The health home initiative – supported by enhanced federal Medicaid funding available under the Affordable Care Act – aims to eventually extend similar case management services to nearly one million of the state’s five million Medicaid beneficiaries, in both the fee-for-service and managed care programs.

Through the CIDP initiative, “we’ve learned a lot about the importance of care management for these individuals,” says Ms. Spor, who is co-managing the health home initiative. “Those who connected with the care manager appeared to stabilize and show improvement.”

But state officials and providers also learned a great deal about the challenges of running a comprehensive case management program for Medicaid beneficiaries with complex health and social needs. Those challenges included a shortage of housing and behavioral health resources for clients, difficulties in arranging timely medical appointments, medical record privacy rules, lack of ability to quickly share patient information among providers,

and inadequate payment. Another problem from the start was simply locating and contacting the beneficiaries, many of whom were homeless and who have mental health or chemical dependency disorders.

“Because of the complexity of these patients, you had to be a really savvy care manager and you had to really develop trust,” Ms. Spor says. “And if they’re in the street and need assistance with shelter and food, you need to address the social service needs first before starting with medical issues.”

### **Genesis of CIDP**

CIDP originated when New York State passed legislation allowing the health commissioner to solicit proposals from provider organizations to set up case management programs for high-risk beneficiaries in Medicaid fee-for-service. The health department then selected six projects that showed they could deliver the needed array of care management services. Besides the Westchester Cares Action Program, they were:

- New York Health and Hospitals Corporation (HHC), serving three New York City boroughs;
- Institute for Community Living, in two boroughs;
- UnitedHealthcare of New York, in two boroughs;
- Federation Employment and Guidance Services, in Nassau County; and
- UB Family Medicine in Erie County.

Other than HHC, the demonstration sponsors were not hospital systems and did not necessarily have medical providers working directly for them. They were paid a per-patient per-month case management fee of about \$300, with Medicaid paying separately for

each beneficiary’s standard health care benefits. The state agreed that if an organization participating in CIDP saved Medicaid money while meeting quality performance measures, the sponsor would receive up to a 50 percent share of savings to the extent savings is available out of the saving pool for the second and third years of the program. The actual shared savings totals, if any, will not be known until all claims have been analyzed.

The progress of the CIDP initiative was accelerated through a provider learning collaborative, facilitated by CHCS with support from the New York State Health Foundation and Kaiser Permanente

Community Benefit. Through this learning collaborative, representatives from the six CIDP pilot sites routinely met to share best practices and address common challenges.

### Multi-Disciplinary On-the-Street Care Management

The participating CIDP programs assigned nurses, social workers, and peer specialists – people who previously had experienced social and medical issues similar to those of the clients – to locate and contact potential clients identified by statistical analysis to be at risk of high health care costs. They often had to search the streets, homeless

## Overview of Chronic Illness Demonstration Projects in New York

Title	Type of Organization	Geographical Region	Key Elements of Intervention
<b>Pathway to Wellness</b> Institute for Community Living, Inc. (ICL)	Not-for-profit human services	Sections of Northern Manhattan	<ul style="list-style-type: none"> <li><b>Care Management (CM) Team:</b> Clinical care coordinators, field care managers (FCM), peer support specialists; regular case reviews with medical consultant</li> <li><b>Distinct Feature:</b> Participating providers offer same /next day appointments; extensive use of peer support specialists</li> </ul>
<b>Hospital 2 Home</b> NYC Health and Hospitals Corporation (HHC)	Public hospital health care system	Sections of Manhattan, Brooklyn, and Queens	<ul style="list-style-type: none"> <li><b>CM Team:</b> Social work supervisor (lead), community-based care managers (CBCM), chronic disease registry coordinators, HHC clinical staff, housing coordinator</li> <li><b>Distinct Feature:</b> Patient Alert System in 3 hospitals notifies CBCM when enrollee is in the building; Use of housing coordinator</li> </ul>
<b>Live Healthy Care Management Program</b> OptumHealth, of UnitedHealthcare	Insurance company	Sections of Queens	<ul style="list-style-type: none"> <li><b>CM Team:</b> Behavioral nurses, clinical nurses, social workers, peer support specialists</li> <li><b>Distinct Feature:</b> Virtual office place—staff do not have central office</li> </ul>
<b>Nassau Wellness Partners</b> Federated Employment & Guidance Services, Inc. (FEGS)	Not-for-profit health & human services system	All of Nassau County	<ul style="list-style-type: none"> <li><b>CM Team:</b> Clinical care coordinators, FCMs, peer support specialists; regular meetings with medical consultant</li> <li><b>Distinct Feature:</b> Nurses provide medical <i>and</i> behavioral expertise to teams</li> </ul>
<b>Westchester Cares Action Program</b> Hudson Health Plan	Non-profit HMO	All of Westchester County	<ul style="list-style-type: none"> <li><b>CM Team:</b> Nurse supervisor, FCMs, integrated care coordinators, peer support specialist</li> <li><b>Distinct Feature:</b> Use of INTERMED-Complexity Assessment Grid (IM-CAG) for assessment and intervention.</li> </ul>
<b>Healthy Partners of Erie</b> SUNY Buffalo Family Medicine, Inc.	Medical school faculty practice plan	All of Erie County (includes City of Buffalo)	<ul style="list-style-type: none"> <li><b>CM team:</b> Nurse care manager, practice enhancement assistant (PEAs), social service coordinator</li> <li><b>Distinct Feature:</b> Emphasis on telephonic nurse care management</li> </ul>

shelters, and drug clinics to find them, though many were not found. Then staffers explained the program to them and asked them to sign up. Nearly all those who were personally reached did enroll, says Peggy Leonard, director of the Westchester Cares Action Program.

The Action Program care manager would then do a comprehensive patient assessment and work with the client to develop a personalized health plan, following up with the person weekly. The care manager would do an assessment every six months, or after a hospitalization or ED visit. The care manager was responsible for making sure the client's needs – including medical, housing, behavioral health, addiction, food, education, and vocational training – were promptly addressed. They coordinated with physicians, social workers, behavioral health providers, and others.

Action Program surveys found high patient and staff satisfaction, though the street outreach work was often grueling and it wasn't easy to hire the right people who can deal with the complexities of the patient population. To address potential stress, staffers met regularly with a psychologist or psychiatrist. "It's intense work, which can be very gratifying and very disturbing," says Georganne Chapin, CEO of the Hudson Health Plan. She contrasts that with the traditional approach. "It's easier to stay detached when you're doing the work over the phone rather than marching on the streets with clients retrieving possessions from the last place they slept."

HHC's demonstration had many of the same positive experiences and challenges, says Rachel Davis, HHC's

assistant director for the program.<sup>1</sup> The hospital system, however, enjoyed a major advantage over the other CIDP projects in being able to assign specific primary care physicians and a psychiatrist to work with the care managers and clients. Primary care physicians at HHC's Bellevue and Woodhull hospitals were assigned to participate in the weekly CIDP case conference and worked closely with the care managers.

On the other hand, as a hospital system HHC faced the dilemma that by successfully preventing avoidable hospitalizations and ER visits for these high-utilizing Medicaid patients, it was losing revenue. "By shifting utilization patterns, we're potentially reducing the volume of patients coming into our hospitals," Ms. Davis says. "But there will be efficiency gains in the hospital system by appropriately rerouting patients from the emergency room to primary care, and decreasing the number of avoidable inpatient admissions. Regardless of the financial implications, there is buy-in from HHC leaders that this is the correct way to treat patients."

### **Timely Information Exchange**

Sharing patient information quickly is key to coordinating services among different provider organizations. But like the Action Program, HHC had to overcome hurdles in sharing data with medical, behavioral health, and other providers outside its own system. That was partly due to federal patient privacy rules and partly to outside providers not having compatible electronic health records. Ms. Davis, whose organization, HHC, will serve as a Medicaid health home in four New York City boroughs, acknowledges that it will be a heavy lift for health home organizations to be

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<sup>1</sup> Effective December 3, 2012, Ms. Davis left HHC to join CHCS.

## CIDP Lessons Inform New York’s Health Home Approach

Coordinating care for chronically ill Medicaid beneficiaries with complex medical and social needs is a tough job. New York State officials and participating programs and providers learned many lessons from the Chronic Illness Demonstration Project that are being applied to the state’s new Medicaid health home initiative.

Here are key takeaways:

- 1. It was generally hard for case managers to access medical, mental health, and substance abuse providers for their clients.** As a result, New York’s health home initiative is seeking to establish much closer connections from the outset between the organizations responsible for case management and provider organizations, because it is critical to be able to get prioritized appointments. There will even be efforts to locate medical and behavioral health providers in the same setting.
- 2. Appropriate housing is in short supply for clients, many of whom are homeless.** The state’s health homes initiative will focus on patient housing needs in various ways, including incorporating housing providers into their health home network.
- 3. There were many hurdles in getting organizations to share patient data.** This was due to federal privacy rules and lack of capacity to exchange electronic data between organizations. The state has developed a standard consent form to be signed by patients that hopefully will allow health home providers to share information. The state also plans to use regional health information organizations as vehicles for improved data exchange.
- 4. Given the intensity of the job, it was difficult to hire the right people to do community-based case management with clients.** Plus, there was considerable turnover. Moving forward, the state is offering health home participants a workforce training initiative that prepares case managers to provide more coordinated, patient-centered care. There will be a particular emphasis on training peer support specialists.
- 5. It can take months to locate high-cost, high-risk beneficiaries.** The demonstration programs did not get paid for this work and lost money on that. In contrast, the health home initiative will pay case managers 80 percent of the per-patient per-month fee for a three-month period during the outreach phase.
- 6. Case managers’ efforts to coordinate services sometimes ran into resistance, territoriality, and misunderstandings from provider organizations.** Extensive education was required to build good relationships with other organizations. This includes being clear on everyone’s role from the beginning and building consistent mechanisms for communication.

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- Denise Spor, Medicaid Specialist, New York State Department of Health

technically capable of sharing patient data as fully as the state hopes within 18 months of launch. Nevertheless, she thinks it is a challenge that will help everyone move forward.

“I’m so excited for the [information technology] implications,” Davis says. “This is pushing HHC to innovate on data management and come up with new systems and new resources for patients. It’s a wonderful catalyst in a lot of ways.”

### **Next Steps for New York Health Homes Roll-Out**

Drawing heavily on lessons from its CIDP experience, New York State is now rolling out its Medicaid health home program in three phases, by county. It currently is targeting high-cost adult beneficiaries with substance abuse and mental health problems and/or multiple chronic conditions. Roll-out of the first phase began in early 2012, with all counties phased in during the months that followed.

While the state originally said the first round of health homes could potentially enroll nearly one million people, it’s now expected the program will focus on a narrower group of beneficiaries and be much smaller, though Spor was not able to provide an estimated enrollment.

The state is selecting health home sponsors that have pulled together a wide range of service providers, including hospitals, physicians, housing programs, and behavioral health specialists. The Hudson Health Plan, for example, is part of collaborative of 25 organizations called the Hudson Valley Care Coalition, with a family health center as the nominal leader. Health plans by themselves are not allowed to serve as health.

“This is all about real collaboration among all different kinds of providers,” Hudson Health Plan’s Chapin says. “It’s a hugely important integration of acute care, mental health, and substance abuse providers. These are people who haven’t previously sat at the same table.”

A major source of initial funding is the Medicaid health homes provision of the Affordable Care Act, which allows the federal government to offer states an enhanced 90 percent matching contribution for case management services, for up to eight quarters of a beneficiary’s enrollment. The match covers patient assessment, development of a care plan, care coordination, transitional care, community service referrals, and use of IT. It does not apply to standard Medicaid health care benefits.

Ms. Spor says the state will do some things differently in the health home program as a result of lessons learned during the CIDP initiative. One change is that unlike the CIDP projects, health homes will receive an outreach and engagement payment for locating and contacting eligible beneficiaries. CIDP sponsors said they were hurt financially by not receiving care management fees until they found and signed up clients, which could take months.

“Our CIDPs were our learning laboratory, our trailblazers, who helped us go forward with the health home initiative,” Ms. Spor says, expressing satisfaction that most of the sponsors now are participating in health homes. “They were 24/7 dedicated to clients.”

Ms. Chapin hopes the state health home initiative keeps its focus on overall improvement in the lives of its clients and on broader savings in social costs, not just on Medicaid costs. For example,

Russell Wells has been able to reconnect with his adult children and do volunteer work at the local church because he has stabilized his medical and mental health conditions with help from the Westchester Cares Action Program. “I

never thought about giving back before, but now I give more than I receive,” he says. “I feel good about that.”

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### About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. In collaboration with state and federal agencies, health plans, providers, and consumer groups, CHCS pursues innovative and cost-effective strategies to better serve Medicaid beneficiaries.

This spotlight is a product of CHCS' *Rethinking Care Program*, which is developing and testing new strategies to improve health care quality and control spending for Medicaid's highest-need, highest-cost populations. The *Rethinking Care Program* is made possible by Kaiser Permanente Community Benefit, with additional funding from the New York State Health Foundation. For more information about the *Rethinking Care Program*, as well as tools for improving care management for Medicaid beneficiaries with complex needs, visit [www.chcs.org](http://www.chcs.org).