NY Health Home Coalition

Health Homes: A Status Update

Statewide Committee of the Regional Planning Consortia

Meggan Schilkie, Executive Director, Coalition of NYS Health Homes

AGENDA

- Overview of the Activities and Priorities of the NY Health Home Coalition
- Health Homes: Where we are Seven Years In*
  - Successes
  - Challenges
  - Outcomes
  - Vision for the Future
- Defining and Clarifying Roles and Services
  - Managed Care
  - Care Coordination
  - Care Management
- How to Collaborate with your Regional Health Home
- Q & A

**Children's Health Home services began 12/5/16.*

BRIEF HISTORY

- ACA 2703, Increased Federal Match
- Phases in across NYS – options for structuring Health Homes
- Transition of Legacy Services
- Shift from process to outcomes
- Federal context
- Constant Change
- Recent restructuring/budget cuts
- New initiatives (Penalties, Incentives, Engagement Optimization)

SUCCESSES

- Major expansion of care management capacity for high need individuals statewide
- Evolution of rate structure
- Development of some performance management data
- Partnerships across healthcare reform initiatives (e.g. DSRIP, CJ, MCOs)
- Slowly standardizing requirements, practices
- Deep partnerships with CMAs, MCOs, policymakers, etc.
- We've seen increases in the enrollment of high need/high risk members.
- Health home by health home evaluations and demonstration of value added

VALUE-ADD OF HEALTH HOMES

NY Health Home Coalition

- Quality oversight of care management network including:
  - Training
  - Chart monitoring
  - Collaborative QI projects
- Consensus feedback to the State on data collection methods
- Many lead Health Homes also operate care management programs so they have an in-depth and real-world, “on the ground” understanding of the operations, obstacles, etc. which promotes the development and implementation of realistic solutions as well as credibility within the network
- Building partnerships with key stakeholders

VALUE-ADD OF HEALTH HOMES

NY Health Home Coalition

- Dissemination of best practice development, sharing, and quality improvement
- Trusted and collegial/collaborative relationships with medical, behavioral health, and social service providers within their communities
- Billing and IT Platform support for CMAs
- Educating children's providers and families about the value of health homes serving children
- Transition of 8,000 children
- Integrating health homes into the Children's System of Care

Coalition of NYS Health Homes

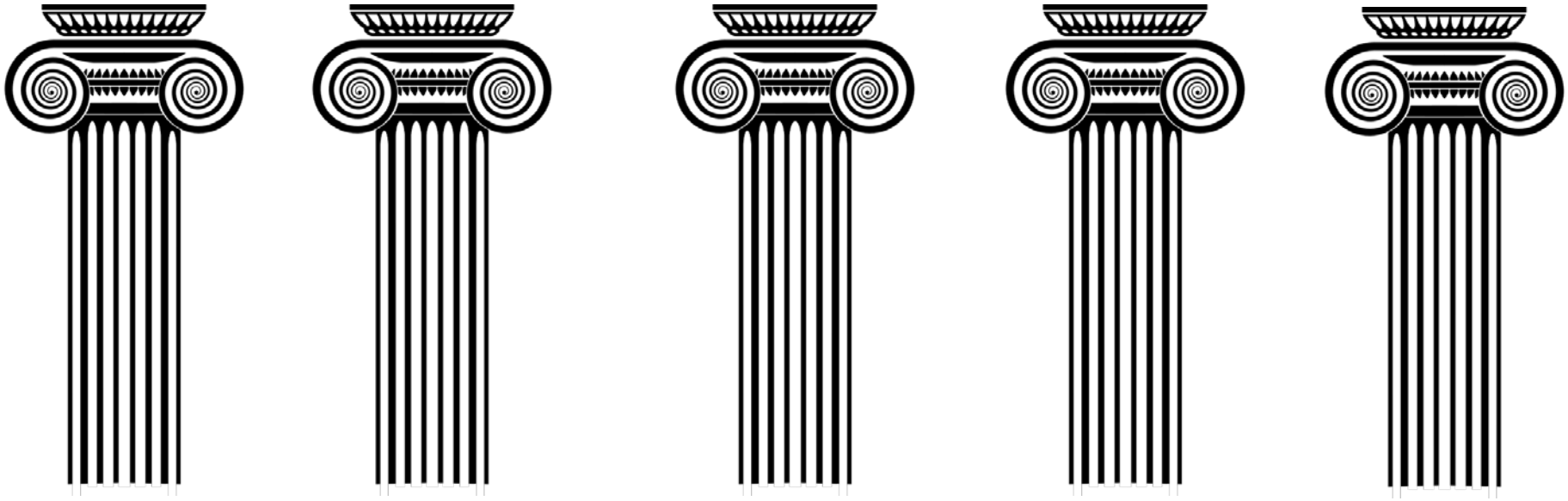
NY Health Home Coalition

Initiated in 2014; Formalized in 2015; Incorporated in 2017

Mission: The Coalition of NYS Health Homes seeks to improve the health and lives of all individuals served in health homes by enabling providers to deliver the highest quality, most cost effective care management to all.

Current Coalition Structure

NY Health Home Coalition



Member Leadership including Board and Committees

IT/Data Analysis including Affiliates/ Vendors

Advocacy and Communications through Partnerships

Statewide Representation & Geographical Diversity

Emphasis on Improving Quality of Care and Outcomes

ADVOCACY TO DATE

NY Health Home Coalition

- Elimination of harmful language in proposed State budget in 2017
- Reduction of cut in 2017 by $85M
- Reduction of cut in 2018 by $113M
  - Testimony
  - Lobbying Days
- Rate restructuring
- SED siloing
- Improvements to HML (high/medium/low) overly burdensome and ineffective acuity stratification process
- Expansion of Health Home Plus Category
- Citizens Budget Committee Report
- HH/MCO Workgroup
- Feedback on numerous policies: Children's Transformation, Disenrollment, Lost to Care, Comprehensive Assessment, ACT, IOP, SED, VBP roadmap roles

NY Health Home Coalition

- State Partners

  (SDOH incl. AIDS Inst., OMH, OASAS, OCFS)
- Advocacy Organizations
- Local Governments (LGUs) through the Conference (CLMHD) and individually
  - Need further attention to the LDSSs
- DSRIP PPSs
- Managed Care Organizations

ADVOCACY PARTNERS

- NYAPRS
- Coalition of Care Management Agencies
- Children's BH Coalition
- NYS Council of Community Behavioral Health
- Medicaid Matters
- CHCANYS
- HANYS
- COFCCA
- Coalition of BH (NYC)
- MHA of NYS

CHALLENGES

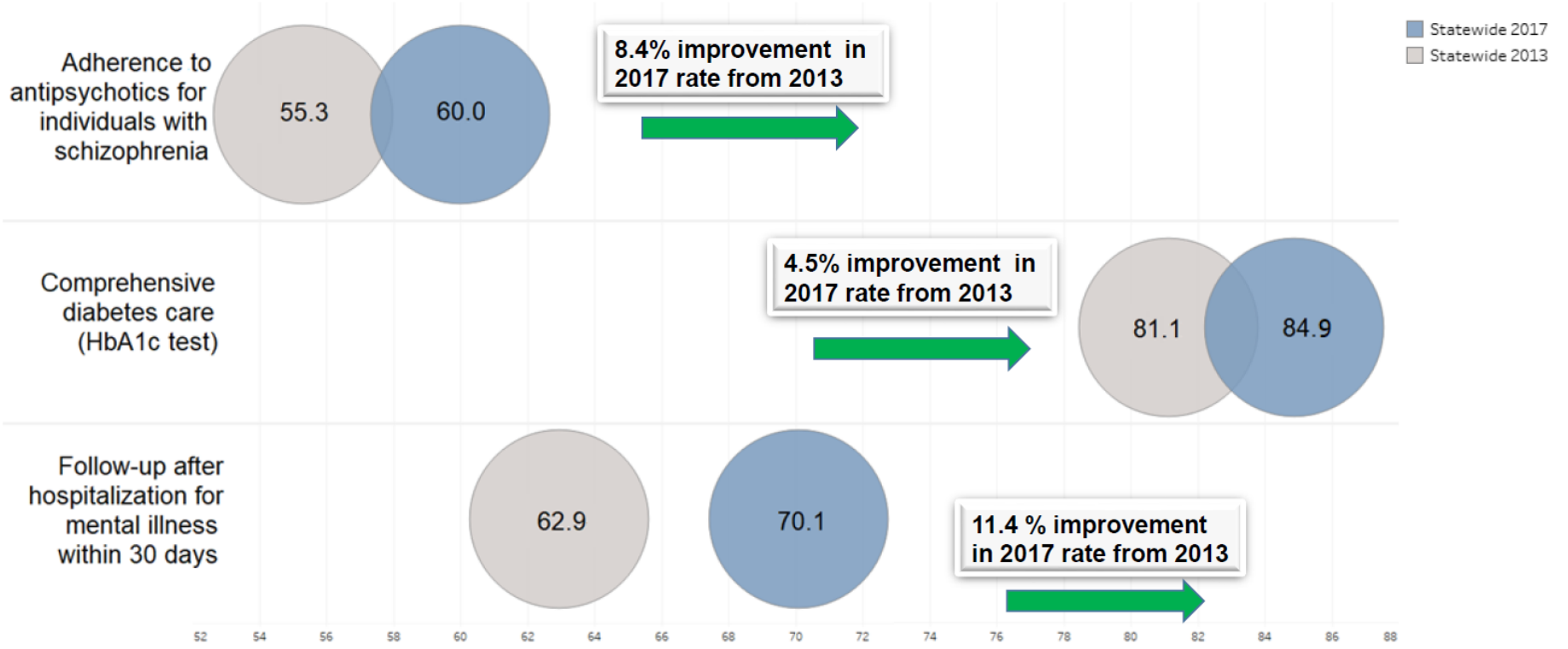
NY Health Home Coalition

- Administrative burden
- Access to data
- Variation (MCO, HH, region, LGUs, etc.)
- Limited resources/high cost of systems
- Current delays in outreach and engagement optimization
- Challenges to funding
- Limitations of available performance data

QUALITY STRATEGY

- History
- Federally required metrics
- SDOH Performance Report Cards
- Oversight, Designation visits, process
- Association with HARP/HCBS Assessments
- MCO Measures (HEDIS, et. al.) and Gaps in Care

Health Homes Improving Quality of Care for Enrolled Members



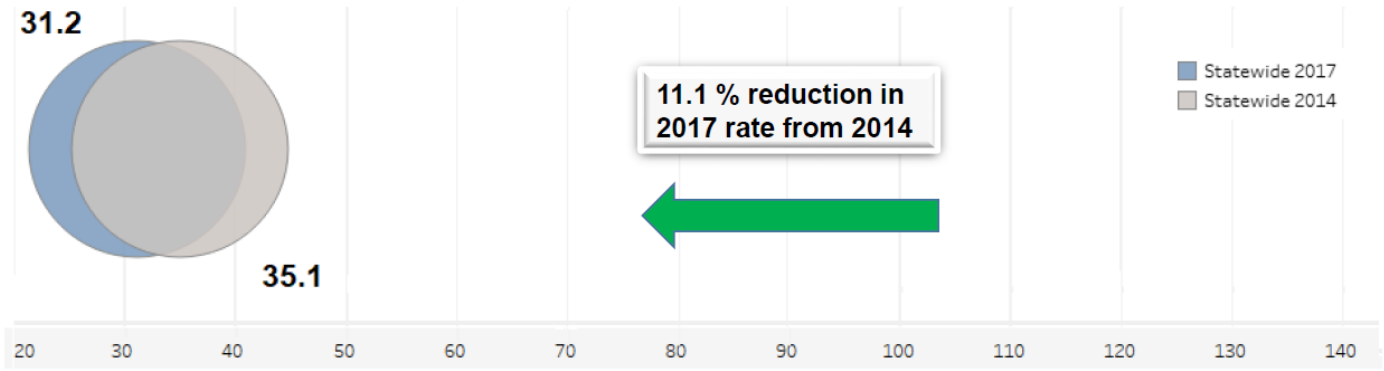
Measure Includes Adult Members 21 and Older

Measure Rate → Higher rate is better

NEW YORK STATE OF OPPORTUNITY. Department of Health

Health Homes Reducing and Avoiding High Cost Acute Care

- Plan All-Cause Readmission (PCR)
  - Number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days



Measure Includes Adult Members 18 and Older

Lower rate is better ← Measure Rate

NEW YORK STATE OF OPPORTUNITY. Department of Health

DATA BRIEFS

Potentially Preventable Emergency Visits (PPV)

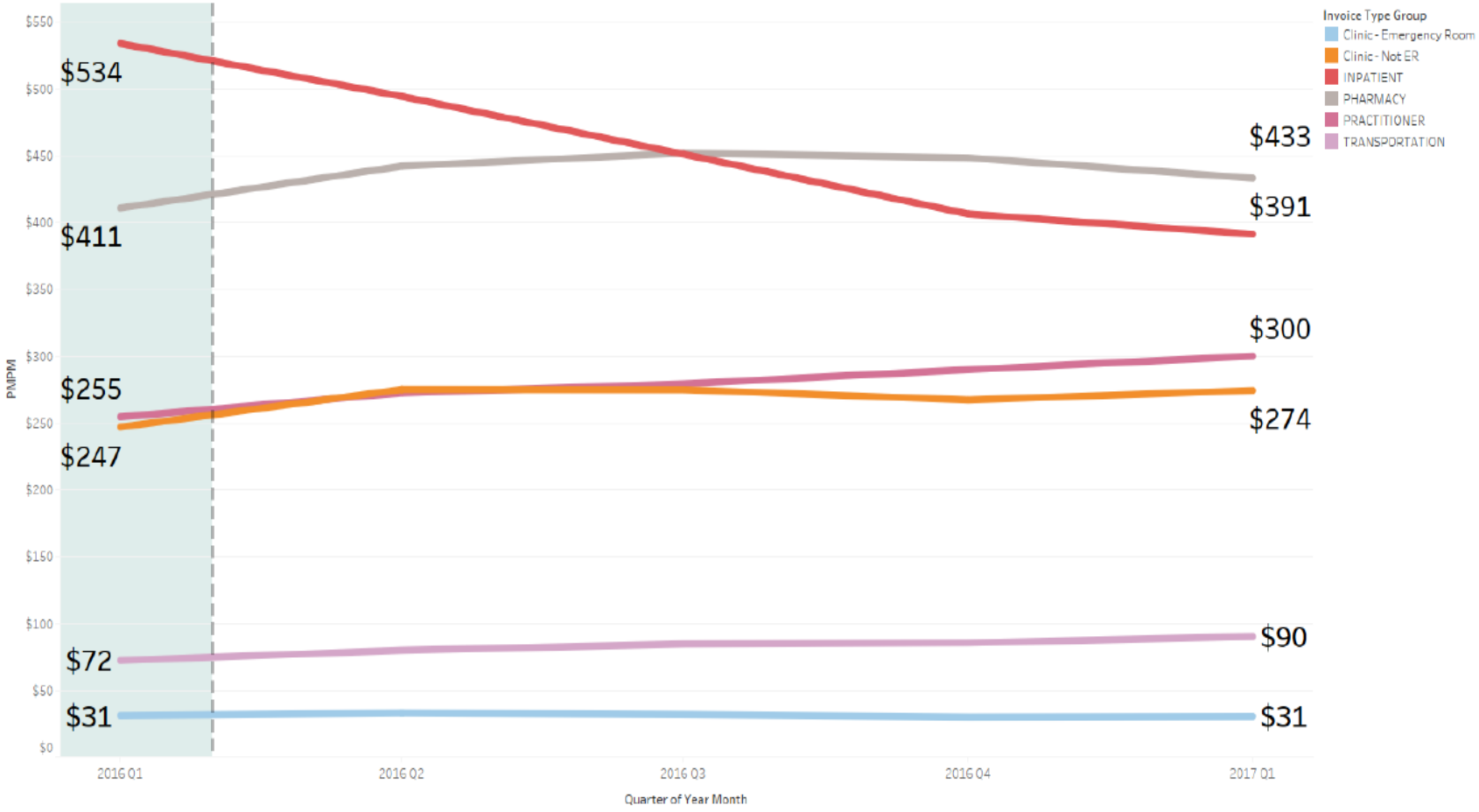
HH	CY14 Rate	CY15 Rate	72.5 Gap to Goal	10% of Gap (Improvement Target)	14-15 Improvement in the rate	14-15 Percent (%) improvement	10% of Gap (Improvement Target)	CY16 Rate	15-16 Improvement in the Rate	15-16% Percent (%) improvement	2014-2016 Improvement	14-16% % improvement
15	332.0	224.3	260	25.95	107.7	32%	15.18	142.9	81.4	36%	189.10	57%
30	123.6	97.3	51	5.11	26.3	21%	2.48	69.8	27.5	28%	53.80	44%
16	149.9	100.7	77	7.74	49.2	33%	2.82	87.8	12.9	13%	62.10	41%
14	183.4	155.2	111	11.09	28.2	15%	8.27	116.4	38.8	25%	67.00	37%
5	213.4	129.6	141	14.09	83.8	39%	5.71	135.5	-5.9	-5%	77.90	37%
7	178.0	138.6	106	10.55	39.4	22%	6.61	115.4	23.2	17%	62.60	35%
27	108.9	94.3	36	3.64	14.6	13%	2.18	72.9	21.4	23%	36.00	33%
29	118.0	97.9	46	4.55	20.1	17%	2.54	80.0	17.9	18%	38.00	32%
19	140.3	109.8	68	6.78	30.5	22%	3.73	97.3	12.5	11%	43.00	31%
25	149.5	131.8	77	7.7	17.7	12%	5.93	107.0	24.8	19%	42.50	28%
9	159.0	126.6	87	8.65	32.4	20%	5.41	113.9	12.7	10%	45.10	28%
31	182.4	158.0	110	10.99	24.4	13%	8.55	132.0	26.0	16%	50.40	28%
12	140.6	111.7	68	6.81	28.9	21%	3.92	103.9	7.8	7%	36.70	26%
17	106.4	96.9	34	3.39	9.5	9%	2.44	83.2	13.7	14%	23.20	22%
26	123.7	113.6	51	5.12	10.1	8%	4.11	100.6	13.0	11%	23.10	19%
28	124.4	113.4	52	5.19	11.0	9%	4.09	101.9	11.5	10%	22.50	18%
24	120.8	103.8	48	4.83	17.0	14%	3.13	99.4	4.4	4%	21.40	18%
22	129.0	125.6	57	5.65	3.4	3%	5.31	107.8	17.8	14%	21.20	16%
13	111.7	96.6	39	3.92	15.1	14%	2.41	94.5	2.1	2%	17.20	15%
10	126.1	114.4	54	5.36	11.7	9%	4.19	107.6	6.8	6%	18.50	15%
4	203.0	150.5	131	13.05	52.5	26%	7.80	176.9	-26.4	-18%	26.10	13%
21	105.3	96.5	33	3.28	8.8	8%	2.40	92.9	3.6	4%	12.40	12%
8	132.1	131.9	60	5.96	0.2	0%	5.94	117.6	14.3	11%	14.50	11%
11	116.3	107.9	44	4.38	8.4	7%	3.54	103.9	4.0	4%	12.40	11%
18	98.7	104.1	26	2.62	-5.4	-5%	3.16	91.6	12.5	12%	7.10	7%
6	140.3	142.0	68	6.78	-1.7	-1%	6.95	131.1	10.9	8%	9.20	7%
20	104.1	103.0	32	3.16	1.1	1%	3.05	98.7	4.3	4%	5.40	5%

Meggan Schilkie: Yello means the rate improved but not by the State required 10% of gap to goal.

Meggan Schilkie: State has established the Statewide benchmark for 2020 of 72.5 PPV/100 HH Members. This is calculated as the 90th percentile of all health home rates in this indicator in 2015.

Cohort PMPM Costs: by Service Mix

PMPM costs by service mix for the cohort over the period immediately prior to enrollment through the end of the analysis period (latest data available)



Current Goals

NY Health Home Coalition

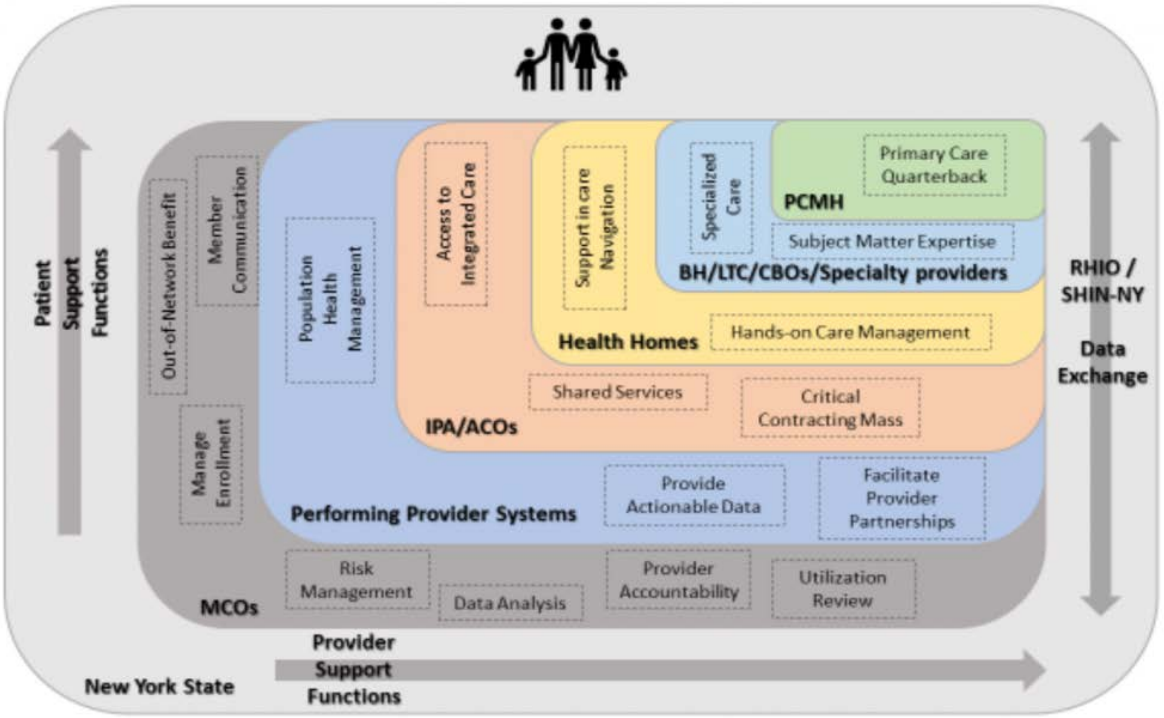
- ❑ **Improve Available Data**
- ❑ **Improve Quality of Care Management**
- ❑ **Increase Enrollment of HARP members and rate of HCBS assessments**
- ❑ **Navigate transitions including Children's Transformation (to MC)**
- ❑ **Standardize models, practices and policies and procedures**
- ❑ **Prepare for Value-Based Payments**
  - ❑ Health homes as critical partner for BHCCs, IPAs, ACOs, PPSs
- ❑ **Improve communications and understanding of health homes**
- ❑ **Expand/Improve on partnerships (MCOs, MM, Advocates and Trades)**
- ❑ **Protect the budget/global funding**

VISION FOR THE FUTURE

- Highest quality care management
  - Population health management
  - Meaningful tools and decision support
  - Major investment in workforce
  - Right people getting the right intensity of services at the right time (acuity, reimbursement, caseloads, frequency, tools)
- Health Homes as integral part of healthcare system
- Available data for all Health Homes at three levels
  - Individual/PHI that lets care managers best serve members
  - CMA level data that allows HHs to manage networks and support them with training and TA
  - Aggregate state level data for comparison, evaluation and advocacy
  - Successful partnerships with MCOs on all levels

PREPARATION FOR VBP

- DSRIP
- BHCC
- VBP Roadmap (HARP attribution)
- Role: https://www.healthmanagement.com/wp-content/uploads/Medicaid-Redesign-Team-Structural-Roadmap-03.19.2018.pdf



VALUE-BASED PAYMENTS

- Dependent on care management
- HH/MCO
- BHCCs becoming BH IPAs
- Models from around the country
- Analytics
- Partnerships

CHILDREN'S HEALTH HOME ISSUES: BIG PICTURE

- Enrollment
- Transition/transformation
- Highly intensive oversight/administrative burden
  - Reporting
  - Visits
- Eligibility
- Acuity

DEFINING AND CLARIFYING ROLES AND SERVICES

- Managed Care
  - Funds flow/payment
  - Cost management
  - Risk management
  - Provider network management
  - Gaps in Care
  - Authorization/Pre-authorization/Re-authorization
  - Utilization Management and Review
  - Quality/Outcomes (HEDIS)
- Care Management (HH core service):
  - Create, document, execute and update an individualized, patient centered plan of care for each individual
- Care Coordination (HH core service):
  - Engagement and retention in care;
  - Coordinating and arranging for the provision of services;
  - Supporting adherence to treatment recommendations;
  - Monitoring and evaluating patients' needs, including prevention, wellness, medical, specialist and BH tx, care transitions, and social and community services through the creation of an individual plan of care
  - Part of a comprehensive care management strategy
- Case Management
  - Targeted advocacy and facilitation of access to services beyond health care and including social services/social determinants (Coordination is a part of Case management/overlaps)

COLLABORATIONS WITH RPCS AND COUNTIES

NY Health Home Coalition

- Regional
- Subcommittees
  - HARP/HCBS
  - Children's Services
  - Health Home
  - Others
- Participants
  - Health Home lead reps when possible
  - MCO Reps
  - Government
  - Conference of Local Mental Hygiene Directors
  - Care Management Agencies
  - Other Advocates and Stakeholders

ASKS OF RPCS

- Continued Partnerships
- Collaboration on overcoming the HARP and HCBS enrollment and assessment barriers
- Awareness of ongoing/current efforts
- Advocacy for meaningful outcomes in performance evaluation especially for people with behavioral health needs
- Endorsement of HHs as critical partner in: ACOs, IPAs, BHCCs, HCBS (infrastructure), value-based payment arrangements, other provider networks

WEBSITE

- Follow us on Twitter @NYHealthHomes
- Is Live!

https://hhcoalition.org/

To access the slides and recording from todays webinar, please click here

www.clmhd.org/rpc