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

✚ 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

✚ 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

Initiated in 2014; Formalized in 2015; Incorporated in 2017

Infrastructure established

Successful Advocacy and Lobbying Efforts

Standardization, Processes, Workflows and Models

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

- 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

- 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
PARTNERSHIPS

✚ 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

✚ 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

Adherence to antipsychotics for individuals with schizophrenia:
- 2013: 55.3%
- 2017: 60.0%
- Improvement: 8.4% improvement in 2017 rate from 2013

Comprehensive diabetes care (HbA1c test):
- 2013: 81.1%
- 2017: 84.9%
- Improvement: 4.5% improvement in 2017 rate from 2013

Follow-up after hospitalization for mental illness within 30 days:
- 2013: 62.9%
- 2017: 70.1%
- Improvement: 11.4% improvement in 2017 rate from 2013

Measure Includes Adult Members 21 and Older

Measure Rate → Higher rate is better
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.

Lower rate is better

Measure Rate

Measure Includes Adult Members 18 and Older
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**Potentially Preventable Emergency Visits (PPV)**

Meggan Schilkie: Yellow 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

- 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)
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 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

**Care Management (HH core service):**
- Create, document, execute and update an individualized, patient centered plan of care for each individual

**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

✚ 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
Follow us on Twitter @NYHealthHomes
Is Live!

https://hhcoalition.org/

To access the slides and recording from today's webinar, please click here

www.clmhd.org/rpc