Health Homes Today and Tomorrow

New York State Department of Health
Office of Health Insurance Programs

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Agenda

1. Health Homes National Landscape
2. NYS Health Homes Overview
3. NYS Health Homes and DSRIP
4. Health Homes Tomorrow – Children’s Health Homes
5. State Performance System for Health Homes
Health Homes National Landscape

Section 2703 Health Home Basics

• New Medicaid state plan option created under ACA Section 2703
• **Overall goal:** Improve integration across physical health, behavioral health, and long term services and supports
• Opportunity to pay for “difficult-to-reimburse” services, e.g., care management, care coordination
• Flexibility for states to develop models that address an array of policy goals
• Significant state interest in evidence-based models to improve outcomes and reduce costs
• States receive an enhanced 90/10 federal match for the first eight fiscal quarters of the health home benefit
Federal Rules Health Home Eligibility

To be eligible to be part of a Health Home, a person must be enrolled in Medicaid and have:

- **Two or more** chronic conditions; or
- **One** single qualifying chronic condition and at risk of another; or
- **Serious Mental Illness (SMI)**

**Chronic conditions** include (but are not limited to):

- Alcohol and substance abuse
- Mental health condition
- Cardiovascular disease
- Metabolic disease
- Respiratory disease
- Obesity BMI > 25

*Sec. 2706. STATE OPTION TO PROVIDE HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS.*

(a) State Plan Amendment. Title XIX of the Social Security Act (42 U.S.C. 1396a et seq.), as amended by sections 2201 and 2305, is amended by adding at the end the following new section:

> “Sec. 1945. STATE OPTION TO PROVIDE COORDINATED CARE THROUGH A HEALTH HOME FOR INDIVIDUALS WITH CHRONIC CONDITIONS.—

**State Health Home Activity**

- **Alabama, District of Columbia, Idaho, Iowa (2), Kansas, Maine (2), Maryland, Michigan, Missouri (2), New Jersey (2), New York, North Carolina, Ohio, Oklahoma (2), Rhode Island (3), South Dakota, Vermont, Washington, West Virginia, Wisconsin**

Note that Oregon has withdrawn its Medicaid health home state plan amendment and is no longer providing services under a 2706 SPA.
Approved Health Home Models

- **Chronic Medical Condition Focus**
  - Iowa
  - Maine
  - Missouri
  - North Carolina
  - Wisconsin

- **SMI/SED/SUD Focus**
  - DC
  - Iowa
  - Kansas
  - Maine
  - Maryland
  - Michigan
  - Missouri
  - New Jersey
  - Ohio
  - Oklahoma
  - Rhode Island
  - Vermont
  - West Virginia

- **Broad Focus Including Chronic Medical and SMI/SED**
  - Alabama
  - Idaho
  - **New York**
  - Rhode Island
  - South Dakota
  - Washington

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Lessons from Early Adopting States

1. The option offers significant flexibility to advance state-defined policy goals
2. Policy goals should drive target population selection, program design and payment method
3. Services should be defined to effectively engage with and care for people with complex needs
4. Providers need support in their transformation to the Health Home model
5. Access to real-time data is critical for effective care coordination
NYS Health Homes Overview

NYS View - Before Health Homes: Targeted Case Management (TCM)

• The TCM program was created to promote optimal health and wellness for Medicaid beneficiaries diagnosed with severe mental illnesses. They were designed to be:
  • Patient-centered in their approach
  • Based on creating clinical linkages
  • Coordinated with essential community resources

• Case managers worked to give patients control over their health and wellbeing, and engage them in the community, in order to avoid entering an institution while other options remained viable. Primary focus SMI and HIV.

• The TCM program was the predecessor to NYS’s current Health Homes, with the conversion from TCM to Health Homes taking place in 2012
**New York State Health Home Model**

**Managed Care Organizations (MCOs)**

**New York State Designated Lead Health Home**
Administrative Services, Network Management, HIT Support/Data Exchange

**Health Home Care Management Network Partners**
(includes former TCM Providers)
- Comprehensive Care Management
- Care Coordination and Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support
- Referral to Community and Social Support Services
- Use of Health Information Technology to Link Services
  (Electronic Care Management Records)

**Access to Required Primary and Specialty Services**
(Coordinated with MCO)
Physical Health, Behavioral Health, Substance Use Disorder Services, HIV/AIDS, Housing, Social Services and Supports

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**HEALTH HOMES BY REGION**

**Western Region:** HHUNY Lakeshore Behavioral Health; HHUNY Chautauqua County, Greater Buffalo United Healthcare Network; Health Home Partners of Western NY; Niagara Falls Memorial

**Central Region:** Catholic Charities of Broome County; Central NY Health Home Network; Greater Rochester Health Home Network; HHUNY Author Doyle, HHUNY Onondaga Case Management Services; St. Josephs Hospital; Bassett Hospital, UHS Hospitals

**Northern Region:** Adirondack Health Institute; Samaritan Hospital; VNS of NE NY; Hudson River Health Care; St. Mary's Hospital

**Hudson Valley:** Hudson River HealthCare; Open Door Family Medical Centers; Institute for Family Health

**New York City:** Bronx Lebanon Hospital; Montefiore Hospital (BAHN); VNSNY; Community Healthcare Network; St. Luke’s-Mt. Sinai; CBC; Heritage Health and Housing; HHC; Queens Coordinated Care; Maimonides (Southwest Brooklyn Health Home), North Shore LIJ, NY Presbyterian

**Long Island:** FEGS; Hudson River Healthcare; North Shore LIJ
Health Homes Today – Studying Pre & Post Health Home enrollment

- Currently enrolled more than 150,000 eligible Medicaid beneficiaries, out of a predicative risk model target of 500,000.

- In a recent study, the Department examined changes in cost and utilization metrics for Medicaid enrollees pre and post-Health Home enrollment

- Total cost increased by $19.5M ($137M to $156.5M) when comparing pre and post enrollment periods for a group of 12,756 patients.

- PMPM cost increased by $255 or 14.2% ($1,791 pre vs $2,046 post)
  - New Care Management (HH) costs constituted 69% of the total change in PMPM cost ($176 of $255)

- Cost Impacts by Category of Service (PMPM change):
  - Inpatient: -$92
  - Health Home / Care Management: +$176
  - Pharmacy: +$85 (mostly psych and hep c meds)
  - Mental Health: +$29 / Substance Abuse: +$12

- Changes in utilization per 1,000 member months (MM) followed changes in cost with the exception of ED utilization
  - Inpatient Admissions: -9% Per 1,000 MM (PMPM cost -14%)
  - Primary Care Visits: +10% Per 1,000 MM (PMPM cost +16%)
  - Emergency Department Visits: +4% though PMPM cost -1%

- 30% of Health Homes had decreases in PMPM costs for ‘traditional’ health care services. 12% had decreases in total PMPM costs including Care Management fees

- Next Steps - Robust independent outcome and process evaluation underway by Columbia University.
Health Homes Today – PMPM Results

Key Observations

- PMPM cost increased by 14.2% or $255 from $1,791 to $2,046

- Changes in PMPM cost as a % of total cost reflected in a small number of categories:
  - Inpatient -9%
  - Health Home/ Care Management +9%
  - Pharmacy (Rx) +2%

NOTE: Total costs (including Health Home costs) rose from $137M to $156.5M for the cohort of 12,756 members

Legend: ER = Emergency Room, SUD = Substance Use Disorder, MH = Mental Health, Rx = Pharmacy, HH/CM = Health Home/ Care Management

NYS Health Home and DSRIP
DSRIP Explained

• Overarching goal is to reduce avoidable hospital use – ED and inpatient— by 25% over 5+ years of DSRIP
• This will be done by developing integrated delivery systems, removing silos, enhancing primary care and community-based services, and integrating behavioral health and primary care.
• Built on the CMS and State goals in the Triple AIM
  • Improving Quality of Care
  • Improving Health
  • Reducing Costs

Performing Provider Systems (PPS)

• Partners should include:
  • Hospitals
  • Health Homes
  • Skilled Nursing Facilities
  • Clinics & FQHCs
  • Behavioral Health Providers
  • Home Care Agencies
  • Physicians/Practitioners
  • Other Key Stakeholders
The 25 PPSs that Cover the State

Health Homes & DSRIP

- Health Homes fit into the DSRIP Program by being integral parts of Performing Provider Systems (PPSs), together with a majority of healthcare providers in the State serving the Medicaid beneficiaries.

- Health Homes are particularly critical to DSRIP's success because they provide care management services to the high-utilizing, chronically ill population of Medicaid members who are driving more than 50% of avoidable costs.

- Successful engagement of patients into Health Homes (and subsequent successful engagement of Health Homes into DSRIP) will be pivotal in meeting DSRIP's ambitious transformation goals for the State's healthcare system.
DSRIP’s Vision – how the pieces will fit together between MCOs, PPSs, & HHs

**PPS ROLE:**
- Be Held Accountable for Patient Outcomes and Overall Health Care Cost
- Accept/Distribute Payments
- Share Data
- Provider Performance Data to Plans/State
- Explore Ways to Improve Public Health
- Capable to Accept Bundled and Risk-Based Payments

**MCO ROLE:**
- Insurance Risk Management
- Payment Reform
- Hold PPS/Other Providers Accountable
- Data Analysis
- Member Communication
- Out of PPS Network Payments
- Manage Pharmacy Benefit
- Enrollment Assistance
- Utilization Management for Non-PPS Providers
- DISCO and Possibly FIDA/MLTCP
  Maintains Care Coordination

**HH ROLE:**
- Care Management for Health Home Eligible Individuals
- Support all reforms and help link systems through integrated care management
- Participation in Alternative Payment Systems

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Health Homes Tomorrow – Children’s Health Homes
Children’s Health Homes

- Health Homes were originally designed to manage the care adults with chronic illnesses, but the State is now moving towards providing the same integrated care management to chronically ill children, as well.

- The principles of serving children in Health Homes are as follows:
  - Use care coordinators to work with families and children with complex health needs
  - Ensure continuity of care from service to service (education, foster care, juvenile justice, child-to-adult care)
  - Adopt child-specific measures to monitor quality and outcomes

- The eligibility requirements will be adjusted to better suit children, as well
  - Based on current modified eligibility, 234,000 children in the State are eligible to be enrolled in Health Homes

Expanding the Health Home Program to include Children

- The State will leverage existing Health Homes to serve children, as well as authorize new Health Home models to exclusively serve children

- Existing Health Homes were given the opportunity to apply with an expanded network to serve children

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<th>Children’s Health Homes – Existing Health Homes</th>
<th>Children’s Health Homes – New Health Homes</th>
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<td>1. Catholic Charities of Broome County</td>
<td>1. Montefiore Medical Center Partnership, including:</td>
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<td>2. Greater Rochester Health Home Network</td>
<td>- Montefiore Medical Center</td>
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<td>3. Central New York Health Home Network (CNYHHN)</td>
<td>- Healthcare Network Health Home</td>
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<td>4. North Shore LIJ Health Home</td>
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<td>6. St. Mary’s Healthcare</td>
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<td>7. Niagara Falls Memorial Medical Center</td>
<td>2. Children’s Health Homes of Upstate New York (CHHUNY)</td>
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<td>10. VNS – Community Care Management Partners</td>
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Expanding the Health Home Program to include Children – Timeline:

• Applications for expanding Health Home services are now complete.

• Readiness activities, webinars and trainings will continue through to December 31st, 2015

• January 1st 2016: Enrollment of eligible children into designated Health Homes begins

State Performance System for Health Homes
Medicaid Analytics and Performance Portal (MAPP)

MAPP – Health Home Performance Dashboards
MAPP – Tracking Health Home Enrollment

MAPP – Tracking Enrollment Performance
MAPP – Tracking ER Utilization

MAPP – Tracking Inpatient Utilization
Regional Health Information Organizations (RHIOs)

- Providing data that is timely, accurate, and easily accessible to support population health analysis and inform decision-making is critical to Health Home performance. It is therefore critical that providers make clinical data available to other providers by connecting with their Regional Health Information Organization (RHIO)
- As of July 1, 2015 the RHIO completed their certification process and have now become Qualified Entities (QE).
- QEs are devoted to developing and deploying interoperable health information technology and analytics to facilitate patient-centric care across health settings

**QE Core Minimum Services:**
- Patient Record Lookup (Community)
- Patient Record Lookup (Statewide)
- Secure Messaging Direct
- Consent Management
- Notification (Alerts)
- Identity Management & Security
- Provider and Public Health Clinical Viewer
- Public Health Integration
- Result Delivery

Statewide Health Information Network of New York (SHIN-NY)

- The SHIN-NY is a “network of networks” that links New York’s nine QEs throughout the State.
- With patient consent, the QE allows those records to be accessed securely by other healthcare providers
- As part of the SHIN-NY, QEs will be able to exchange records between each other, creating a statewide network of health information

*This “network of networks” is the keystone of the State’s strategy of safely and securely sharing accurate and useful health data through the DSRIP Program*
Lessons Learned from the Health Home Program thus far

1. Patient engagement is hard – even when you specifically pay for it

2. Managing care for children with complex needs is particularly difficult because multiple systems are always involved – thus the need for Children’s Health Homes in New York State

3. Building the relationship between Health Homes, Managed Care Organizations, and the system at large takes time and commitment

4. Having Health Home capacity makes engaging in larger reforms easier

5. Data drives everything

6. You can pay for process for a while, but moving to paying for outcomes is critical

Questions?

DSRIP e-mail: dsrip@health.state.ny.us

Health home email app: https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action