NEW YORK STATE | Department of Health | Office of Health Insurance Programs

NYS Health Home Performance Management and Quality Measures

May 10, 2017

Welcoming Remarks

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Office of Health Insurance Programs

Health Home Performance Management

- The Health Home Program is at a critical juncture in the landscape of Medicaid Redesign, DSRIP and Value Based Payments
- A little over two years from now (October 2019), payments for Health Home will be part of the Managed Care Plans' capitated rates and Health Homes will be required to negotiate care management rates with the Plans
- Value Based Payments will be implemented across the Medicaid System
- The ability to provide and demonstrate value – evaluated by performance measures and health outcomes – will determine the ability of your Health Home to be successful and thrive in a value based payment Medicaid program

Health Home Performance Management

- Successful Performance Management will require concerted and tactical efforts by Lead Health Homes to actively monitor performance measures and manage practices, processes and providers to ensure Health Home care management is providing value and improving health outcomes
- The DOH is committed to being your Performance Management partner and has worked to develop a Performance Management Program to provide the tools needed to successfully become value based, outcome driven enterprises

Agenda

- Performance Management Program
- Measure Selection Process
- Clinical and Process Measure
- Evaluation
- Timeframe and Reporting Methods
- Next Steps
- Questions/Feedback

Performance Management Program

- The Health Home Performance Management Program (PM) provides a formal framework for Health Homes (HH), Care Management Agencies (CMAs), Managed Care Plans (MCPs) and the State to work together to improve health outcomes of Health Home members
- The PM program builds upon and includes the triennial re-designation process which focuses on determining compliance with minimum standards
- The PM program will now include specific measures that lead to short term and longer term performance outcomes to achieve the vision of health, well being, and recovery for Health Home members
- The PM Program includes performance improvement support on an ongoing basis
- The PM program is a single program and includes all designated Health Homes (those serving adults and/or children)

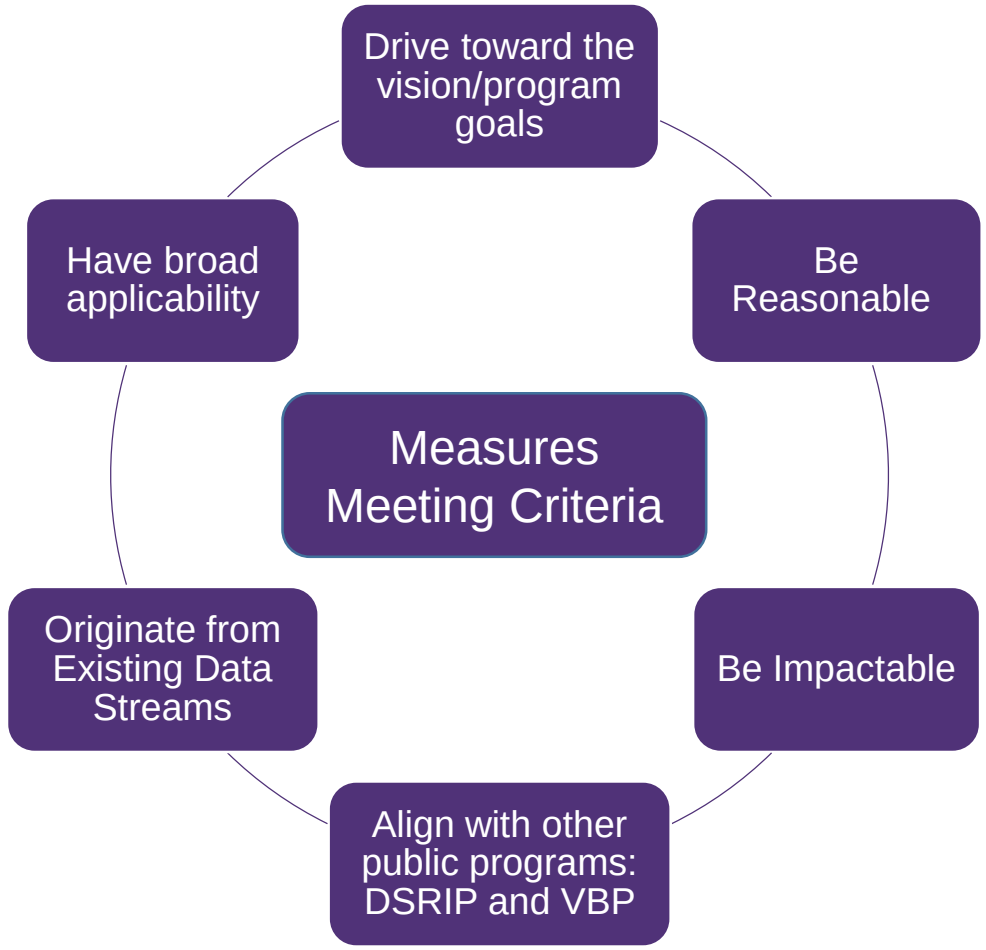
Health Home Performance Management Efforts

On April 5, 2016 DOH communicated to the Health Home community that three Performance Management activities would be implemented:

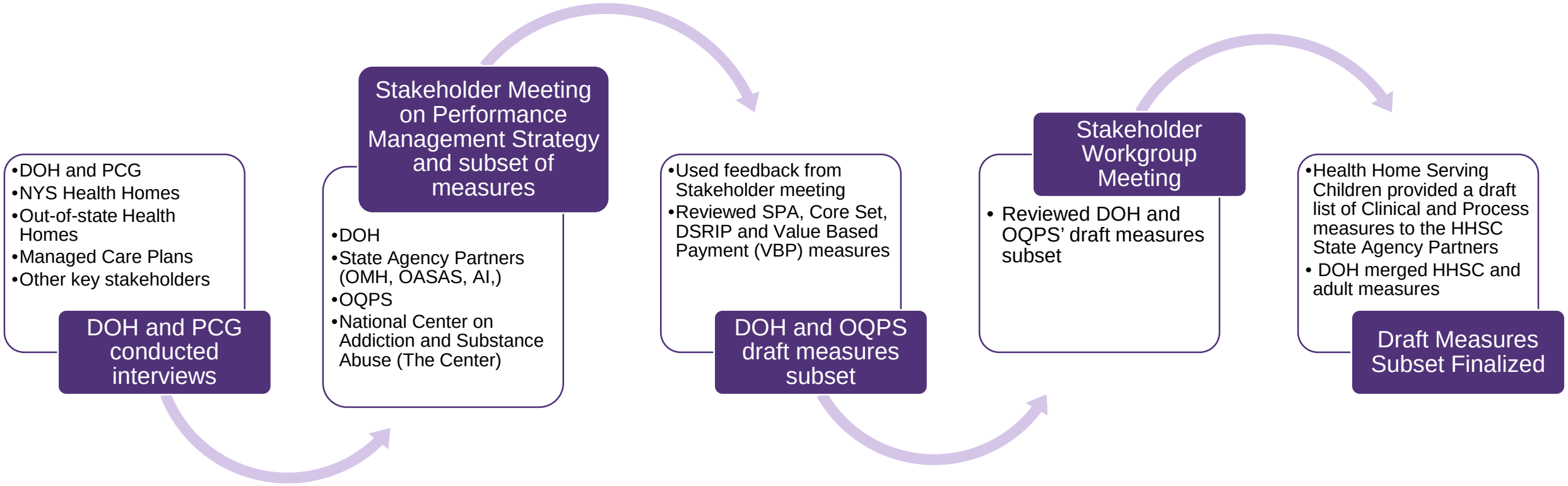
1. Continue Health Home Triennial Re-designation Process (Provide Site Visit feedback, including Performance Improvement Plans (PIPS)
2. Develop Performance metrics around HARP members
3. Implement “Clinical” Quality Measures and monitoring, reflecting Health Home State Plan Amendment (SPA) Measures, and be in alignment with DSRIP and HARP measures

Performance Measures Selection Process

- To successfully implement the third activity, “Clinical” Quality Measures and Monitoring, it was determined that a defined list of measures meeting key criteria must be identified.
- A clearly defined set of measures would help provide focus for rapid-cycle improvement efforts
- PCG and DOH facilitated a process that included Health Home interviews and meetings with State Agency Partners, which culminated in the identification of a set of “qualities” that would drive selection of the subset.
- It is expected that we will add and modify measures as data and new measures are developed or made available



Measure Selection Process



Achieving Goals by Focusing on Performance Measures

Vision

- Health
- Well-Being
- Recovery

Long-Term Goals

- Increase PCP Use
- Decrease ED Utilization
- Decrease Inpatient & SNF Admissions & Readmissions

Short & Mid-Term Drivers

Access to, and engagement in:

- Primary & Preventive Care
- Condition Specific Care & Management
- Care Management & Transitional Care
- Community-Based Services & Supports

Performance Measures

SPA Evaluation

Re-designation Process

Foundation: Health Home Organizational Capabilities / Operations

Short and Mid-Term Drivers
Three Categories of Performance Measures

Primary & Preventive Care

- Primary Care Utilization
- Medication Management & Adherence
- Adult Body Mass Assess.
- Well Child/Care visits

Condition Specific Care

- IET Alcohol & Drug Dependence
- Mental Health Utilization
- Medication Management- asthma
- Adherence to Mood Stabilizers
- Comprehensive Care for people living w/HIV/AIDS
- F/U After Hosp. for MI
- F/U After Hosp. for alc / chem dependency

Care Management & Transitional Care

- Plan All-Cause Readmission
- P: At-Risk – Lost to Follow-Up
- P: Response to ED
- P: Inpatient Discharge Contact
- F/U After Hosp. for MI
- F/U After ED for alc/other drug dependency
- F/U After ED for MI

Measuring Linkages to Community Based Services and Supports

- Linking members to community based services and supports, including HCBS services for HARP members (and eventually children) is critical and important part of person-centered planning for Health Home members
- Other than identifying how many members are receiving Medicaid billable services (e.g., HCBS services for HARP members) there are no existing measures that meet design criteria to measure access and engagement to community based services in general
- Monitoring access, engagement and performance could be done at the Health Home level

Clinical and Process Measures

NYS Health Home Measure Subset						
A/C	**Measure ID**	**Measure Title**	**Measure Definition**	**Guidance Document**	**Measure Steward**	**Data Source**
A	ABA	Adult Body Mass Index (BMI) Assessment	Percentage of Health Home enrollees ages 18 to 74 who had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year. Data is reported by age categories (18-64, 65 -74, total).	Core Set of Health Care Quality Measures	NCQA	QARR- member level
C	AP use	Multiple Concurrent Antipsychotic Use in Children and Adolescents	Percentage of children and adolescents 1–17 years of age who were on two or more concurrent antipsychotic medications	HHSC Application	NCQA	Administrative
A/C	FUA-7 day/FUA-30 day	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence	Percentage of emergency department (ED) visits for members 13 -64 years of age with a principal diagnosis of alcohol or other drug (AOD) dependence, who had a follow up visit for AOD. Two rates are reported: 1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit. 2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit.	NYS Health Home SPA	NCQA	Administrative
A/C	FUH-7day/FUH-30 day	Follow Up After Hospitalization for Mental Illness	The percentage of discharges for treatment of selected mental illness disorders for members 6 - 64 years of age who had an outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health provider within 7 days and within 30 days of discharge.	Core Set of Health Home Quality Measures	NCQA	Administrative

Always check DOH Health Home website for most recent version of Measure Subset (link)

Clinical and Process Measures

NYS Health Home Measure Subset						
A/C	**Measure ID**	**Measure Title**	**Measure Definition**	**Guidance Document**	**Measure Steward**	**Data Source**
A/C	FUM-7 day/FUM-30 day	Follow-up After Emergency Department Visit for Mental Illness (FUM)	Percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness. Two rates are reported: 1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit. 2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit. Data is reported by age categories (0-17, 18-64, 65 and older, total)	NYS Health Home SPA	NCQA	Administrative
A	HIV/AIDS-Engaged in Care HIV/AIDS-Viral Load HIV/AIDS-Syphilis Screening	Comprehensive care for people living with HIV/AIDS	Percentage of members living with HIV/AIDS who received the following services: (A) two outpatient visits with primary care with one visit in the first six months and one visit in the second six months, (B) viral load monitoring, and (C) Syphilis screening for all who 18 and older	NYS Health Home SPA	NCQA	Administrative
A/C	IET-Initiation IET-Engagement	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Percentage of Health Home enrollees age 13 and older with a new episode of alcohol or other drug (AOD) dependence who: (a) Initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis (b)	Core Set of Health Home Quality Measures	NCQA	Administrative
C	MetMon	Metabolic Monitoring for Children and Adolescents on antipsychotics	The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing	HHSC Application	NCQA	Administrative

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Clinical and Process Measures

NYS Health Home Measure Subset						
A/C	**Measure ID**	**Measure Title**	**Measure Definition**	**Guidance Document**	**Measure Steward**	**Data Source**
A	MMA-50%/MMA-75%	Medication management for people with asthma	Percentage of members age 5 to 64 who were identified as having persistent asthma and were dispensed appropriate medications in amounts to cover: 1) at least 50% of their treatment period and 2) at least 75% of their treatment period.	NYS Health Home SPA	NCQA	Administrative
A/C	MPT	Mental health utilization	Percentage of members receiving any (inpatient, intensive outpatient, partial hospitalization, outpatient, ED) mental health service during the measurement year.	NYS Health Home SPA	NCQA	Administrative
C	P: AssignC	Members without outreach	Number and Percentage of children in assignment without outreach/enrollment segment by CMA by HH	Process Measure	Salient	MAPP
A	P:AssignA	Members without outreach	Number and Percentage of adults who are referred to the health home during the measurement period and do not receive outreach in two months by CMA by HH	Process Measure	Salient	MAPP
A/C	P: At-Risk	At Risk - Lost to Follow-up	Of all enrolled members, the percent without a single completed intervention in over 60 days.	Process Measure	OQPS	CMART
A/C	P: Dis f/u	Inpatient Discharge Contact	Percentage of inpatient discharges which occurred during the measurement period in which a care manager met with the patient within 48 hours of discharge.	Process Measure	OQPS	CMART, Administrative

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Clinical and Process Measures

NYS Health Home Measure Subset						
A/C	Measure ID	Measure Title	Measure Definition	Guidance Document	Measure Steward	Data Source
A/C	P: ED f/u	Response to ED	Of all ED visits which occurred during the measurement period, the percent in which a care manager completed an intervention with the member within 48 hours of the ED visit.	Process Measure	OQPS	CMART, Administrative
C	P: Timeline R-A	Time from HH referral to O/E	Average time from HH referral to outreach/enrollment segment for all children's Health Home members (from MCO, Health Home, CMA)	Process Measure	Salient	MAPP
A	PCR	Plan All-Cause Readmission Rate	The number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days of discharge and the predicted probability of an acute readmission for enrollees age 18 and older. Data is reported by age categories (18-64, 65 and older, total).	Core Set of Health Care Quality Measures	NCQA	Administrative
A	PQI-92	Chronic Condition Hospital Admission Composite— Prevention Quality Indicator	The total number of hospital admissions for chronic conditions per 100,000 Health Home enrollees age 18 and older. Data is reported by age categories (18-64, 65 and older, total)	Core Set of Health Care Quality Measures for Medicaid Health Home Programs	AHRQ	Administrative
C	PsychCare	Use of First-Line Psychosocial Care for Children and Adolescent on Antipsychotics	The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment	HHSC Application	NCQA	Administrative
C	WC:3-6	Well-Child Visits in the 3rd, 4th, 5th & 6th Year	The percentage of children, ages 3 to 6 years, who had one or more well-child visits with a primary care provider during the measurement year	HHSC Application	NCQA	Administrative
C	WC:Ad	Adolescent Well-Care Visits	The percentage of adolescents, ages 12 to 21 years, who had at least one comprehensive well-care visit with a primary care provider during the measurement year	HHSC Application	NCQA	Administrative

Always check DOH Health Home website for most recent version of Measure Subset (link)

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Clinical and Process Measures

- Stratifications
  - Adult and Children's Health Home
  - HIV, SMI and SUD
  - HARP
  - Age based on measure

- Maintaining a list of possible future measures
  - DOH, State Agency Partners and OQPS will review
  - Suggestions by Health Homes welcome

Evaluation Measures Required by CMS in the State Plan

- DOH will collect and report the following quality measures to determine the effect of the Health Home program on reducing:
  - Hospital Inpatient Utilization (Salient Dashboards)
  - Hospital cost per member per month
  - Emergency Room Utilization (Salient Dashboards)
  - Emergency Room cost per member per month
  - Skilled Nursing Home Admission
  - Skilled Nursing Home cost per member per month
  - PCP Utilization (Salient Dashboards)

Other MAPP Data DOH Will Provide

- Enrollment
- Disenrollment
- High Medium and Low and clinical and functional indicators (homeless, criminal justice involved)
- Members who opt out of HH

Timeframe and Reporting Methods

Report/Measure	Description	Report time period	Month – Responsible party	Report sent to
Clinical Measures	All subset clinical measures except for ABA (BMI)	**Bi-annual** Jan-June 2017 (6 m lag)	January 15, 2018 and annually thereafter, OQPS posts in Open Data July 15, 2018 and annually thereafter DOH Data Analyst – send via email DOH posts on HH website	Health Homes DOH State Agency Partners MCPs
Clinical Measures	ABA (BMI) only	**Annual** Jan – Dec 2017 (6 m lag)	July 15, 2018 and annually thereafter, DOH Data Analyst sends via email OQPS posts annually in Open Data DOH posts on HH website	Health Homes DOH State Agency Partners MCPS

Timeframe and Reporting Methods

Report/Measure	Description	Report time period	Month – Responsible party	Report sent to
Process Measures	All subset process measures	**Quarterly** (w/ 3 month lookback)	July 15, 2017 and monthly thereafter, DOH Data Analyst sends via email OQPS posts annually in Open Data DOH posts on HH website	Health Homes DOH State Agency Partners MCPS
CMART data	All CMART data submitted to OQPS	**Quarterly** (w/ 3 month lookback)	July 15, 2017 and monthly thereafter, DOH Data Analyst sends via email OQPS posts annually in Open Data DOH posts on HH website	Health Homes DOH State Agency Partners

Next Steps

- Share regular Performance Management Reports starting in July 2017
- Finalize segmentation strategy and provide performance improvement support
- Utilize measures subset for Learning Collaboratives and Health Home support
- Update existing Performance Dashboards and add new Performance and Cost Dashboards
- Follow-up on DSRIP dashboard access and export capability

Quality Measures Information

- Visit the Health Home Assessment, Process and Quality Measures webpage: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/index.htm
    - Statewide Health Home Quality Measures (SPA)
    - Health Home Core Set
    - Health Home Measure Subset

Questions/Feedback

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