Health Home-Managed Care Plan Workgroup Meeting # 3

December 19, 2012

SUNY School of Public Health

NEW YORK state department of HEALTH

Agenda

Welcome	Jason Helgerson
Health Home Update	Greg Allen
Workgroup Report out	
◦ Operations	Stephen Rosenthal
◦ Assignment and Quality	Neil Pessin
	Peggy Leonard
◦ Discussion	Lyn Karig Hohmann
Future of Workgroups	Lauren Tobias
Q&A	Greg Allen
	Lauren Tobias

Welcome

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs
NYS DOH

Health Home Update

Greg Allen
Director
Division of Program Development and Management
OHIP, NYS DOH

Update:

- Both Phase 2 and Phase 3 SPAs are now approved.
  - We are waiting to have all Phase 3 down stream partners identified so loyalty analysis can be done and assignments provided.
  - Health Home applications for all remaining counties in Phase 3 are nearing completion.
- Phase 1 continues active outreach and enrollment. The following table represents current activity.

Phase 1 Health Home Implementation Status

- **Phase 1 Total HH Eligibles 278,000**
  - # of higher risk members 65,000
  - % of higher risk members 23%
  - # assigned to Health Homes (FFS) 5,900
  - # in outreach and engagement as of 11/12 12,000

Active Health Home Members as of December 12, 2012 by Health Home

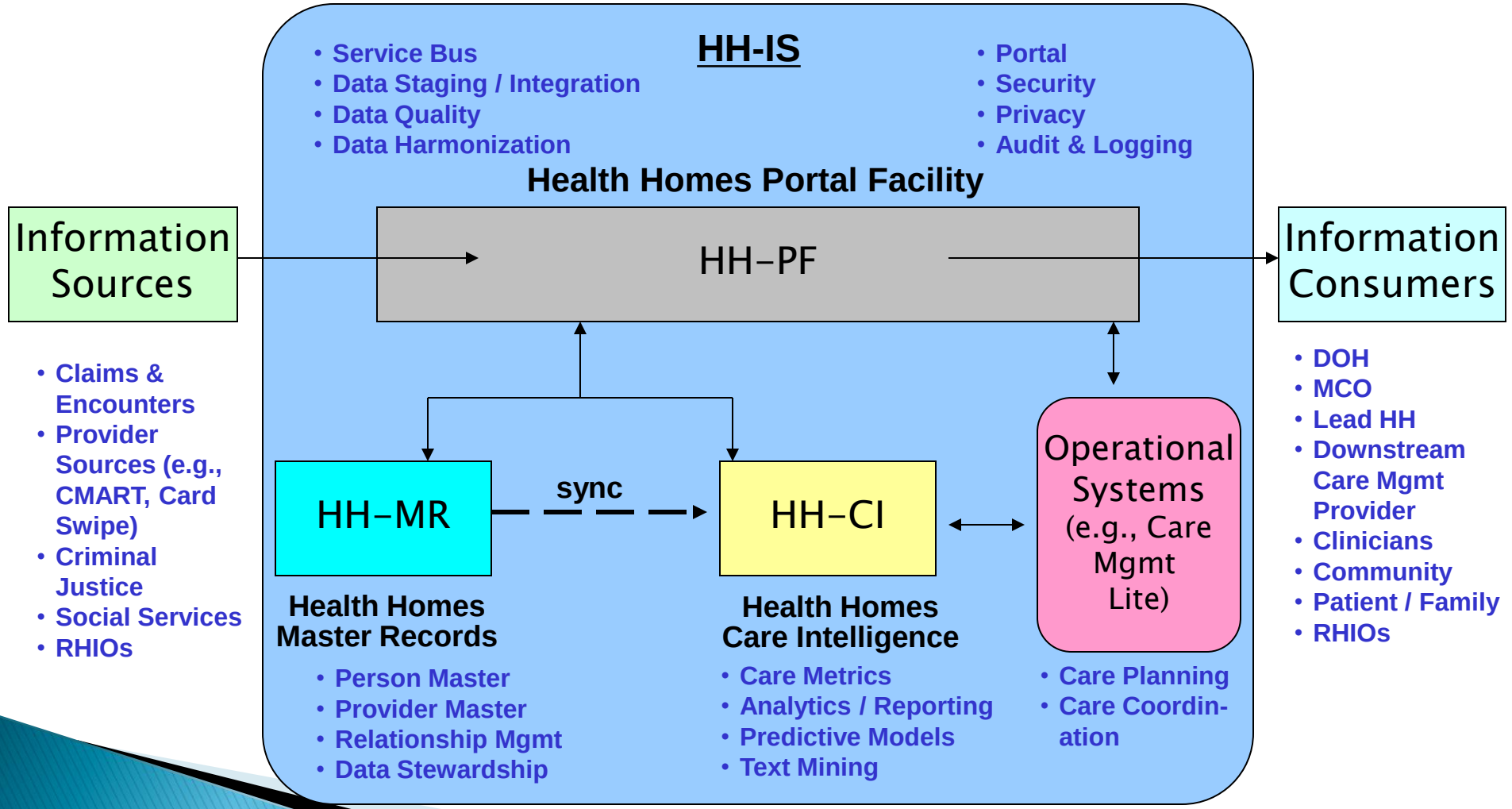
	FFS			MCP			
Health Home Name	Active Care Management	Outreach	Total	Active Care Management	Outreach	Total	Grand Total
FEGS Health & Human Services System	1,932	12	1,944	424	17	441	2,385
Visiting Nurse Service of New York Home Care	1,102	56	1,158				1,158
Institute for Community Living-Coordinated Behavioral Care	523	7	530	39	321	360	890
Maimonides Medical Center Health Home	354	3	357	35	121	156	513
Montefiore Medical Center/Bronx Accountable Health Network	300	1	301	151	27	178	479
Visiting Nurse Service of Schenectady and Saratoga Counties, Inc	38		38	173	238	411	449
Community Healthcare Network	184	114	298				298
Bronx Lebanon-CBC Health Home	216		216	23		23	239
Adirondack Health Institute	158	42	200	26	2	28	228
New York City Health and Hospitals Corporation	30	12	42	86	7	93	135
Glens Falls Hospital	65	2	67	20	46	66	133
Health Home Partners WNY	116		116				116
North Shore-LIJ Health System	74		74	31		31	105
Grand Total	**5,092**	**249**	**5,341**	**1,008**	**779**	**1,787**	**7,128**

Update:

- Health Home-Case Management Assessment Reporting Tool (HH-CMART) is nearing design completion. Training will begin shortly.
  - The Referral and Quality Workgroup has been instrumental is assisting the Department.
- Member tracking tool – the division is reviewing opportunities to streamline this tool as well as enhancing our Health Home Portal
  - The Operations Workgroup has been instrumental in identifying opportunities.

Health Homes Information System (HH-IS)

Conceptual Solution Architecture Capabilities



Update:

- Internal discussions are occurring to address administrative costs incurred by MCOs and HHs.
- We continue to work on securing infrastructure funding to support Health Home operations.
- HEAL 22 has been released. This is to provide technical support for behavioral health providers working with HH to adopt and use HIT.

Update:

- The Department is working closely with CMS on the MFFS Duals project.
  - Health Homes interested in working with Duals have been asked to submit additional information through TREO.
- 1115 Waiver –The Department continues to work with CMS on this waiver.

Managed Care- Health Home Workgroup:

- Phase 1 Health Homes and Managed Care Plans representatives met twice in late spring to find solutions to outstanding policy and operational issues.
- Outcome was the establishment of two workgroups: Operations and Assignment and Quality.
- Each workgroup consists of equal representation from HH and MCOs.
- Charges were developed and report out requested.

Workgroup Report Out:

- Operations
  - Stephen Rosenthal, BAHN
- Assignment and Quality
  - Neil Pessin, VNSNY
  - Peggy Leonard, Hudson Health Plan
- Questions and Answers
  - Lyn Karig Hohmann

Health Home & Managed Care Operational Workgroup

Summary of Deliberations
December 19, 2012
Stephen Rosenthal, Montefiore Medical Center

Purpose

To deliberate and generate consensus on mutually beneficial ways and means for all parties to effectively and efficiently communicate and work collaboratively on this endeavor. Specific focus on:

- Member Tracking Sheet
- Billing
- Reporting

Participants

- Nicholas Liguori, Amerigroup Health Plus, Co-Chair
- Stephen Rosenthal, Montefiore-BAHN, Co-Chair
- Lauren Castaldo, Metroplus
- Charlene Desaro-Raimondo, Healtfirst
- Lynda H. Karig Hohmann, NYSDOH
- Nicole Jordan-Martin, Montefiore-BAHN
- Susan Kwon, Healthfirst
- Lisa Rowe, Fidelis
- Kyle Stark, Ellis Hospital Care Central (VNS Schenectady)
- Joann Susser, NYSDOH
- David Thomas, Fidelis
- Arthur Fontanilla, Healthfirst
- Mary Pfeifer, Healthfirst
- Rick Yonkers, North Shore LIJ
- Lauren Pulver, NYSDOH

Workgroup Charges

- Charge #1:

  Evaluate existing information exchange processes among plans, providers and New York State Department of Health (NYSDOH) to determine how state can use existing data collection mechanisms to collect and exchange needed data (in lieu of the Member Tracking Sheet)

Workgroup Charges

- Results:
  - Internal reviews by each participating Health Home and Health Plan to assess existing NYSDOH or other system(s)/mechanism(s) that can fulfill the tracking sheet purpose – NONE FOUND
  - Automating the Member Tracking Sheet is slowed by ongoing changes in program requirements
  - Use of standardized file format and file exchange medium by all parties is critical

Workgroup Charges

- Charge #2:

  Create an easy and standardized conduit for modifying and submitting the Member Tracking Sheet/new process for exchanging information among all parties

Workgroup Charges

- Results:
  - Simplify the tracking sheet in accordance with Subgroup's recommendations:
    - Removal of data points that NYSDOH already has, to decrease the likelihood of unnecessary errors
    - Limit data points and transmit referrals using another file format other than Member Tracking Sheet
    - Addition of Health Home assignment to Health Plan assignment file
    - Addition of Health Plan MMIS number to Member Tracking Sheet returned to Health Home by NYSDOH
    - Add an error code to the Health Home return tracking sheet to indicate that another Health Home submitted the same referral, along with the name and MMIS number for the other Health Home

Workgroup Charges

- Results:
  - Provide additional information to streamline management of eligibility and referrals
  - Apply systems edits to prevent multiple Health homes from claiming a Member
  - Provide updated demographics to aid successful outreach and engagement efforts

Workgroup Charges

- Results:
  - Limitations of current NYSDOH OHIP Data Mart Portal:
    - Capacity to conduct batched Member search
    - Absence of updated demographic information

Workgroup Charges

- Results:
  - More comprehensive portal planned by NYSDOH (ETA unknown)
    - Informed by multiple data sources
    - Several user interfaces (i.e., consumer, Health Home, NYSDOH)
    - Multi-functional (i.e., data submission/extraction, care management tool, analytics)
    - IBM to provide technical assistance
    - Workgroup served as focus group for design concept pitched by NYSDOH and IBM, and prioritized initial development pieces (comprehensive

Workgroup Charges

- Charge #3:

  Suggest refinements to the operational processes for billing and claims

Workgroup Charges

- Results:
  - Health Homes and Health Plans were awaiting confirmation of rates; general consensus was that the approach to billing would be no different than that of billing for treatment services
  - Continue to work towards improving transparency around TCM/MATS/CIDP program billing
  - Implement system edit to prevent multiple Health Home or converting TCM/MATS/CIDP programs from billing for the same member

Workgroup Charges

- Charge #4:

  Consider how to best administer and collect data from the functional status assessment (FACT-GP) tool that will be used to adjust the member rates

Workgroup Charges

- Results:
  - FACT-GP finalized and published after the Workgroup commenced; Health Homes had not yet determined a timeline for their respective implementation
  - Also being deliberated by the Health Home and Managed Care Organization Quality and Assignment Workgroup:
    - Utility relative to adjustment and/or development (community referrals) of acuity scoring
    - Inclusion in NYSDOH Case Management Annual Reporting Tool being adapted for Health Homes program

Final Recommendations

1. Simplify the tracking sheet in accordance with the Subgroup's recommendations
2. Provide additional information to streamline management of eligibility, referrals, billing, and aid outreach and engagement efforts
3. Consolidate the Operational and Quality and Assignment Workgroups since there is overlap between the two

Final Recommendations

4. Utilize the Workgroup as ongoing consultants for the development and/or refinement of Health Home requirements, including the comprehensive portal contemplated with IBM technical assistance
5. Allow Health Homes to report all TCM/MATS/CIDP member assignments to NYSDOH via the Member Tracking sheet, irrespective of Health Plan affiliation
6. Work towards mutual transparency around converting TCM/MATS/CIDP program billing and Health Home chargebacks

Health Home and Managed Care Assignment and Quality Workgroup

Co-Chairs:
Neil Pessin – VNSNY/CCMP HH
Margaret Leonard – Hudson Health Plan

Workgroup Members:
Rosemary Cabrera – CHN (CHN HH & CCMP HH)
Henry Chung – Montefiore/BAHN
Karen Smith Hagman – Emblem Health
Michael Musci / Carlene Zincke – Wellcare
Deb Peartree – Monroe Health Plan
Madeline Rivera – Maimonides/SWBHH

Participants:
Lynda M. Karig Hohmann – DOH
Joann Susser – DOH
Jessica Fear – VNSNY/CCMP
Susan Rabinowitz – VNSNY/CCMP HH
Phil Opatz – VNSNY/CCMP HH
Grace O'Shaughnessy – VNSNY/CCMP HH
Lena Johnson – Hudson Health Plan
Karen Nelson– Maimonides/SWBHH
Nicole Jordan-Martin – Montefiore/BAHN
Elizabeth Malave – CHN (CHN HH & CCMP HH)
Ryan Wilcoxon – CHN (CHN HH & CCMP HH)
Lonnie Alison – BAHN

Workgroup Charges

The group met six times between July and November to address the following charges…

1. Develop referral criteria for determining health home service eligibility which includes assessing potential members and new members, how plans will make and identify referrals, a decision tree "rule out, rule in" criteria for referrals, and a disenrollment process
2. Create a standardized set of health home quality outcome and process measures to provide consistent benchmarks when reporting and to assess the effectiveness of the program
    - Workgroup to determine a "starter set" of measures to be immediately implemented in order to quickly assess health home services
3. Consider a process to adjust the acuity score based on actionable core pieces of data, including factors beyond the CRGs, such as history of incarceration, homelessness, and other social services

Issues & Recommendations
Charge 1: Referral Criteria

- Assignment and Outreach:
  - Patients are considered "assigned" to a HH once they appear on that entity's assignment list from DOH or from a contracted Managed Care Organization.
  - It was agreed that the 3 month clock to bill for outreach while attempting to enroll a patient is started by the Care Management organization once they indicate on the patient tracking sheet that they have begun outreach.

- <u>Referral Criteria for MCO's:</u> Prerequisite is an executed contract with Health Home and currently, a DOH assigned composite score of at least 125. The group agreed on the following criteria when determining eligibility for referral to a Health Home:
  - Patient with a HH qualifying disease who is homeless
    - Qualifying diseases: Psychiatric; HIV; Chronic Medical
  - Behavioral health condition, psychotic in nature
  - County of residence and loyalty data will determine which Health Home a patient is assigned to

Issues & Recommendations

Charges 1 and 3: Referral Criteria and Acuity Score

"Bottom Up" Community Referrals:

- Must meet Health Home eligibility criteria
- Once patient agrees to receive health home services, care manager conducts comprehensive assessment and FACT-GP.
- Acuity should be assigned based on the eligibility criteria and the additional risk factors below. Baseline acuity for bottom up referrals is 9 points, each additional risk factor equates to one or more points of additional acuity (specified below), additively.
  - Homelessness = 2 pts.
  - No PCP = 1 pt.
  - No connection to specialty doctor for their condition = 1 pt.
  - Non-adherence to treatment or medication = 2 pts.
  - Recent release from incarceration = 1 pt.
  - Recent discharge from psychiatric hospitalization = 1 pt.
  - Suicidality = 1 pt.

Further Recommendation: Acuity should be adjusted monthly to reflect reassessments and changes in functional status of the patient.

* See last slide, 'Next Steps', regarding new SMI acuity scale

Issues & Recommendations
Charge 2: Quality Outcome Measures

- Starter Set Measures:

1. Engagement rate
   - Number who consent to Health Home services / number who begin in outreach
2. Care Plan completion date
   - 30 days from the initial assessment
3. ER utilization for Health Home enrolled population
   - Within one year of enrollment
4. Patient Satisfaction Survey
5. Patient complaints and grievances

Issues & Recommendations
Charge 2: CMART Tool

Health Homes provided feedback on the following:

1. A majority of the data elements in the CMART are already being reported by the Health Homes on the patient tracking sheet.
    - Recommendation: Consolidate common data elements so they only have to be reported in one place – **DONE**

2. Several data elements are either too labor intensive or too subjective to collect and report at the present time.
    - Counts of individual care management activities performed is impractical given current system capabilities and would impose a costly administrative burden.
    - Counts of avoidable ER visits and IP stays are subject to individual Care Manager interpretation; there is no standardized definition to quantify these measures.
        - Recommendation: Health Homes should produce and transmit one quarterly CMART report including all patients, rather than individual reports for each Managed Care Organization and DOH. – **DONE**

Next Steps

- Merge Assignment & Quality Workgroup with Operations Workgroup and develop new charges.
- Review frequency of acuity score adjustment.
- Determine how / if SPOA referrals and AOT patients should be identified on patient tracking sheets
- Clarify disenrollment process for active Health Home patients who lose Medicaid eligibility and/or managed care coverage
- Adjust the bottom up community referrals model to reflect the new scale for SMI only acuity points.
- Assignment of members with composite score below 125

Contact Information

- Neil Pessin
  - Neil.Pessin@vnsny.org
- Margaret Leonard
  - MLeonard@hudsonhealthplan.org

Discussion:

- Future of the workgroups --Lauren Tobias
  - Combine to one committee?
  - Workgroup Charges?
  - Chairs and membership?
  - Addition of Phase 2 and 3?

Questions?

Greg Allen
Lauren Tobias