

Health Home / Managed Care Work Group

May 16, 2014

*New York State Health Home Managed Care
Update*

Discussion Topics

- ❑ Update Health Homes Enrollment and Billing Statistics
- ❑ Waiver Resources
 - ❑ DSRIP
 - ❑ Health Home Development Funds
- ❑ Refining and Simplifying Health Home Rates
 - ❑ High, Medium Low Methodology and Refining Acuity
- ❑ Resolving Denied Claims for “Duplicative” Services
- ❑ Behavioral Health Transition for Adults and Children
- ❑ Status of Tailoring Health Homes to Serve Children
- ❑ Health Home Managed Long Term Care Guidance
- ❑ Supportive Housing Regional Training/ Housing RFA Schedule
- ❑ Health Home Plus

Health Homes Enrollment

Statewide Health Home Enrollment Statistics
(Based on Jan 2012 to March 2014 claims as of 3.26.14)

Health Home Service	Members
Converting Members in <i>Active Care Management</i>	46,636
Converting Members in <i>Outreach</i>	7,293
New Members in <i>Outreach</i>	120,749
New Members in <i>Active Care Management</i>	49,275
Total # Health Home Members to Date (Unique Count)	183,581

Health Homes Billing

Total Health Home Claims

(w/ Date of Service Between Jan 2012 and March 2014 as of 3.26.14)

Rate Summary	Unique Recipients w/MA Claims	MA Claim Count	MA Services Paid
Health Home Care Management (Converting)	46,636	425,525	\$241,169,063
Health Home Outreach (Converting)	7,293	13,694	\$6,837,021
Health Home Outreach (New)	120,749	284,982	\$37,721,433
Health Home Services (New)	49,275	231,521	\$48,085,221
Totals	183,581	955,722	\$333,812,738

Health Homes and Waiver Resources

- Health Homes will play a key role in the implementation of the Waiver to implement \$8 billion in resources over five years
 - \$6.92 billion for Delivery Service Reform Incentive Payments (DSRIP)
 - \$190.6 million Health Home Development Funds
 - \$645.9 million for 1915i Services that will flow to Plans who contract for those services

(Waiver resources also include \$500 million of Interim Access Assurance Fund (IAAF) and \$245 million in Long Term Care Workforce Strategy funds that will flow to Plans)

Key Components of DSRIP Plan and Health Homes

- ❑ Transformation of the health care safety net at both the system and state level.
- ❑ Key focus on reducing avoidable hospitalizations by 25% over five years.
- ❑ Statewide initiative open to large public hospital systems and a wide array of safety-net providers.
 - Under Safety Net Provider Definition - Health Homes can participate as Vital Access Providers and “Non-Qualifying” providers.
- ❑ Payments are based on performance against process and outcome milestones.
 - Provides will develop projects based upon a selection of CMS approved projects from three domains (System Transformation, Clinical Improvement, Population-Wide Strategy Implementation (the Prevention Agenda).
- ❑ Health Homes will be key players in achieving reduction in avoidable hospitalizations and as eligible providers that will be required to work together to develop DSRIP projects
- ❑ Collaboration! Collaboration! Collaboration!

DSRIP Performing Provider Systems (PPS) Local Partnerships to Transform Delivery System

Partners should include:

- ❑ *Hospitals*
- ❑ *Health Homes*
- ❑ *Skilled Nursing Facilities*
- ❑ *Clinics & FQHCs*
- ❑ *Behavioral Health Providers*
- ❑ *Home Care Agencies*
- ❑ *Other Key Stakeholders*

Responsibilities must include:



May 15, 2014 (Yesterday!): Non-Binding Performing Provider System Letter of Intent Due
Detailed DSRIP Schedule of Events Available on DOH DSRIP Website
List Serve Available

DSRIP Care Management Projects

Domain: System Transformation

- ❑ 2.a.i) Create Integrated Delivery Systems that are focused on Evidence Based Medicine and Population Health Management
- ❑ 2.a.iii) Health Home At-Risk Intervention Program – Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services.
- ❑ 2.b.i) Ambulatory ICUs
- ❑ 2.b.vi) Transitional supportive housing services

DSRIP Schedule of Key Dates

July 15 - August 1	DSRIP Planning Design Grant awards made
August 22	Draft DSRIP Project Plan application released; public comment period begins
September 22	Public comments on draft DSRIP Project Plan application due
October 1	Final DSRIP Project Plan application released
December 16	DSRIP Project Plan application due
December 18	DSRIP Project Plan applications are posted to web, public comment period begins

Health Home Development Funds and 1915(i) Resources for HARP/HH Members

- ❑ Health Home Development Funds (\$190.6 million over 5 Years).
 - Member Engagement and Health Home Promotion
 - Workforce Training and Retraining
 - Clinical Connectivity – HIT Implementation
 - Joint Governance Technical Assistance and Implementation Funds
- Funds will be distributed through a CMS State Plan approved rate add-on ...
- Department working with CMS to advance SPA for approval
- ❑ 1915(i) funds (\$645.9 million) will flow through plans for the development of targeted pilot for assessment, network development, and person-centered planning for community based services for individuals with SMI /SUD.
 - Will impact members that qualify for HARP and are enrolled in Health Home

Simplifying and Refining the Health Home Payment Methodology

- ❑ Goals:
 - ❑ Simplify and refine payment methodology
 - ❑ Implement new payment methodology prior to January 1, 2015 transition to Managed Care and the 2 year period for mandated government rates
 - ❑ Refine the methodology to address weakness in the acuity measure within the “High, Medium, Low” rate structure discussed with HH/MCO Work Group at previous meetings

Proposed Approach for Developing Simplified and Refined HH Payment Methodology

- ❑ HH MCO Subcommittees (Financial Feasibility, CRG/Acuity, Criminal Justice) and State Agency Partners have worked to develop approaches to refine acuity measure....Progress has been made but need to develop approach that facilitate efforts to move forward soon with recommendations
- ❑ Proposal: These Subcommittees have agreed to bring together a small group of representatives to reach consensus on a handful of measures to refine acuity that can be recommended to the HH MCO Work Group for comment
- ❑ Proposed parameters for developing proposal
 - ❑ Identify data that addresses the key weaknesses of the current acuity measure (e.g., homelessness)
 - ❑ Identify 4-6 data measures that can be “operationalized” quickly and easily in the rate setting structure and do not require complex and time consuming data collection efforts

Proposed Approach for Developing Simplified and Refined HH Payment Methodology

- ❑ Based on feedback and subcommittee discussions to date the following proposals are being made for consideration by the HH MCO Work Group:
 - The set of rates for “Other Conditions” is not necessary and would be eliminated
 - Refined methodology would have two sets of low-medium-high rates, HARP and non-HARP.
 - An additional High level tier will be developed for AOT e.g., Health Home Plus
 - Outreach would be paid at a flat rate to be determined (i.e., outreach would not be based on acuity)

Proposed Approach for Developing Simplified and Refined HH Payment Methodology

- ❑ Proposed payments (as discussed at previous meetings) for AOT and High, Medium, Low Care Management Services:

	HARP		non-HARP	
Tier	Downstate	Upstate	Downstate	Upstate
High	\$479	\$417	\$383	\$333
Medium	\$311	\$271	\$249	\$217
Low	\$125	\$108	\$62	\$54
AOT	\$800	\$700		

Next Steps

- ❑ Within the parameters discussed in these slides, work with HH/MCO subgroups to identify 4-6 data-driven factors that can be easily captured to inform the acuity levels and develop a methodology for assigning members to Low, Medium, High tiers.
- ❑ Subcommittee completes its work by the end of June and reports back to HH/MCO Work Group
- ❑ Submit SPA to CMS in July 2014 to implement new rate structure

Proposed Resolution of Denied Health Home Claims for “Duplicate” Services

- ❑ The entity with the denied claim for Health Home services shall submit the TCNs of the denied claims along with an attestation that Health Home services were provided and that payment was not received from the Health Home and/or Managed Care Plan.
- ❑ DOH will review the denied claim submissions and recommend for reimbursement.
- ❑ Reimbursement of denied claims will be:
 - Limited to a maximum of three months per member
 - State only payment
 - Issued through an offline payment

Behavioral Health Transition

❑ **What's Been Going On (Refresher)**

- Transition of all BH FFS State Plan Services to Medicaid Managed Care
- Add new Home and Community Based Services (1915 c and 1915i) to MCO scope of benefits
- Establish new MCO product line for adults with significant MH and SUD treatment needs called Health And Recovery Plan (HARP)

❑ **What's New**

- Request for Qualification (RFQ) sent out to MMC Plans March 21, 2014
- RFQ responses from NYC due June 6, 2014
- Plans will demonstrate via RFQ that they have the expertise to administer full continuum of mental health/SUD services for adults, either in the MMC Plan, in partnership with a BHO, or by establishing a HARP
- Mercer Training on the RFQ tool on May 19th and 20th for DOH/OMH/OASAS staff
- Teams across 3 agencies including subject matter experts will evaluate

Health Homes and HARP Plans

- ❑ Proposal: Expand the Health Home MCO Work Group to include plans participating and engaged in HARP discussions
- ❑ To address capacity issues and smooth transition of enrollment of HARP members in Health Homes, State will work with Plans to and Health Homes now to begin to enroll HARP eligible members in Health Homes
- ❑ Work with Plans and Health Homes to develop standards to help Plans and Health Homes understand roles, expectations and effectively care manage the intense needs of HARP members
 - ❑ Starting point NCQA standards modified and the current Administrative Services Agreement between Health Home and Plans
 - ❑ Appropriate standards probably reside in the middle

Behavioral Health Transition and Health Home

- ❑ Key Dates
 - ❑ BH Transition for Adults in NYC—January 1, 2015
 - ❑ BH Transition for Adults ROS—July 1, 2015
 - ❑ BH Transition Children—January 1, 2016

- ❑ BH and Health Home (it's all connected)
 - ❑ HH & HARP eligible Adults will receive Health Home Care Coordination
 - ❑ HH eligible Children will receive HH Care Coordination
 - ❑ BH Providers serving children will be afforded the opportunity to become part of a HH network, prior to the January 1, 2016 transition

Expanding Health Homes to Meet the Special Needs of Children with Complex Needs

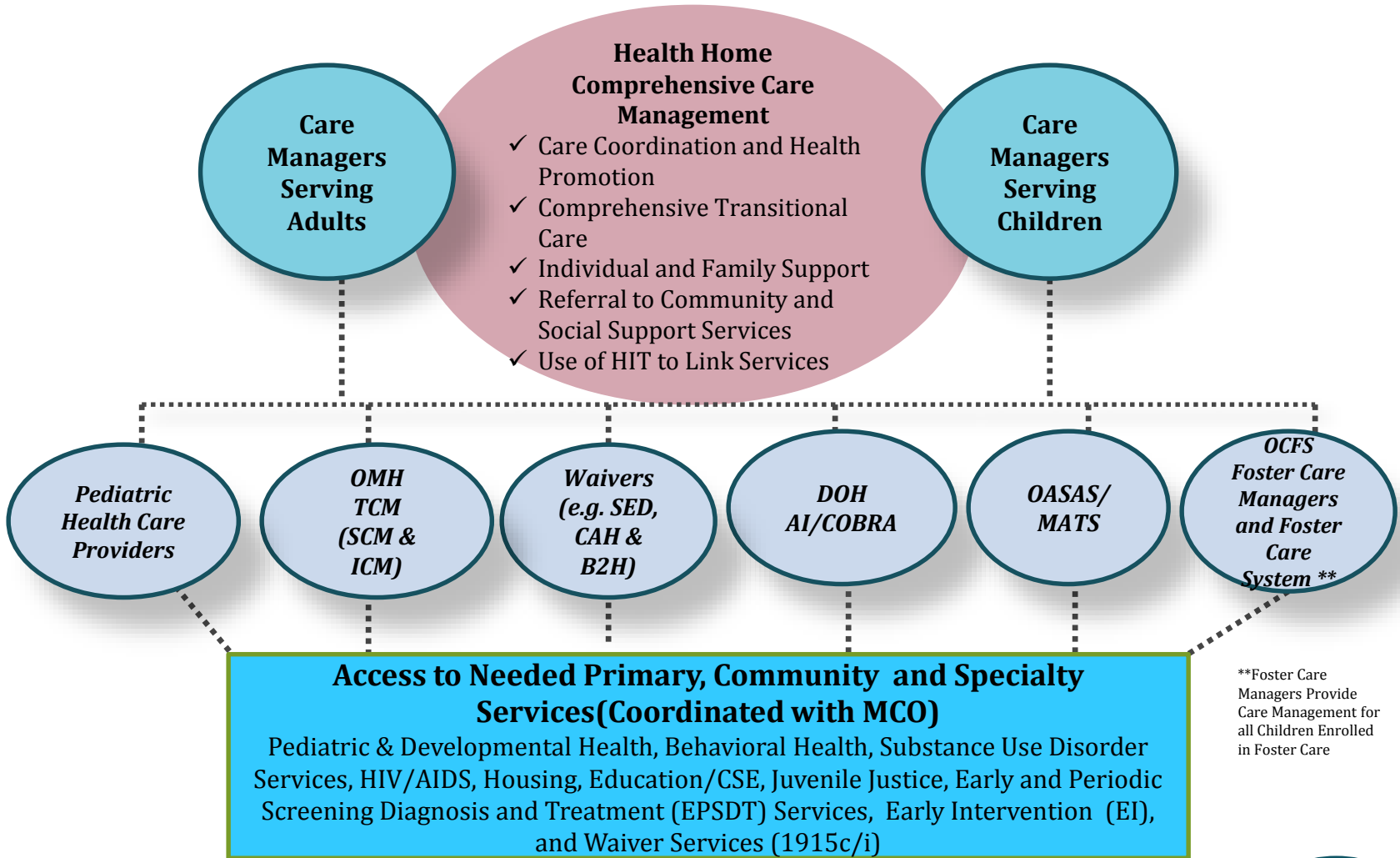
Enrolling Children in Health Homes

- ❑ The Department of Health in partnership with OCFS, OMH and OASAS, has begun to work with stakeholders to expand and tailor the Health Home model to serve children.
- ❑ It is expected that the Health Home eligibility requirements will be modified and existing Health Homes (or new Health Homes) may choose, via an application process, to meet expanded network and other requirements to serve children.

New York State Health Home Model for Children

Managed Care Organizations (MCOs)

Health Home Administrative Services, Network Management, HIT Support/Data Exchange



**Foster Care Managers Provide Care Management for all Children Enrolled in Foster Care

Network Requirements

- Lead Health Home
- Downstream & Care Manager Partners
- Primary, Community and Specialty Services

Note: While leveraging existing Health Homes to serve children is the preferred option, the State may consider authorizing Health Home Models that exclusively serve children.

Tailoring Health Homes for Children Collaboration and Building Networks

- ❑ Health Home Eligibility Criteria
 - Must be conditioned-based
 - Goal: SED, Foster Care, Medically Fragile Children / children with complex needs
- ❑ Network Requirements: Tailor and expand to include providers with expertise serving children with complex needs
- ❑ Tailor Delivery of Six Core Services Health Home Services to meet the unique needs of children
- ❑ Health Homes serving children will operate across regions (i.e., areas or regions of service that are different than the county-based regions served by existing Health Homes)
 - Goal: approve enough well qualified Applicants to achieve sufficient access to Health Home services for all Health Home eligible children in New York State.
- ❑ Collaboration partnerships, networking and network development discussions are HAPPENING!!!

Tailoring Health Homes for Children Collaboration and Building Networks

Anticipated Schedule for Enrolling Children in Health Homes

Review Health Home Children's Model with Stakeholders - MRT Children's Work Group, HH-MCO Work Group	October 2013
Collaborate with Stakeholders to Refine Health Home Model and Develop Health Home Application for Children	November 2103 - March 2014
<i>Draft Application for Health Homes Serving Children Made Available - Working Document - Opportunity to Provide Feedback</i>	<i>May/June 2014</i>
Comments on Draft Application	July 2014
Final Application for Health Homes Serving Children Made Available	August 2014
Anticipated Due Date for Submission of Applications for Health Homes Serving Children	September 2014
Health Home State Agency Team Review and Approval of Applications	October 2014
Begin Enrolling Children in Health Homes Phase-in based on Application Approvals and Network Readiness	January 2015
Behavioral Health Services for Children in Managed Care	January 2016

Proposed Guidance on Health Home and MLTC Services

- ❑ An integral component in the Department's move towards Care Management for All is the mandated enrollment of dual eligible individuals ages 21 and over receiving more than 120 days of community-based long term services and supports into Managed Long Term Care plans (MLTCP).
- ❑ At this time, Health Home services are not part of the MLTCP benefit package and the care coordination services provided by MLTCP are different and distinct from those care management services provided by Health Homes.
- ❑ While the Department is not prioritizing individuals enrolled in MLTCP for enrollment in Health Homes, it is possible that a Health Home may encounter (e.g., through outreach or referral) a member that meets Health Home eligibility requirements (i.e., qualifying diagnosis and appropriate level of risk) and is enrolled in a MLTCP; or is enrolled in a Health Home and is subsequently enrolled in a MLTCP.

Proposed Guidance on Health Home and MLTC Services continue

- In either case, the Health Home and the MLTCP can continue to serve the member and each provider may bill (i.e., The Health Home may bill for Health Home care management payment and the MLTCP may bill its premium) for their respective services.
- Health Homes and MLTCPs should enter into agreements that define their respective care management and coordinator roles and establish a collaborative working relationship that is in the best interests of the member.
- MLTCPs are responsible for coordination with the Health Home and are not responsible for Health Home management or performance or for any services outside the scope of their contractual benefit.
- The Department's Division of Long Term Care is currently developing a template for such agreements for use by the Health Homes and MLTCPs.

Housing and Health Homes

Social Determinants of Health

- ❑ MRT Affordable Housing Resources - \$222 million over two years (2014-15 and 2015-16) and includes funding for capital projects, rental subsidies and pilot projects.
- ❑ The Pilot Projects are primarily focused on targeting housing funds to high cost, high utilizers of Medicaid, including those enrolled or eligible for Health Homes.
 - Health Homes Supportive Housing Pilot – RFA due May 23, 2014, provides funds for rental subsidies and services and to identify best practices, procedures and methods for Supportive Housing Providers to collaborate with Health Homes.
 - OMH Supported Housing Services Supplement.
 - Health Home HIV + Rental Assistance Pilot Project.
 - Other: Homeless Senior Placement Pilot Project, Step-Down/Crisis Residence Capital Conversion, Nursing Home to Independent Living Rapid Transition, Senior Supportive Housing Pilot Project.

Bringing Health Homes and Housing Providers Together

Six Regional workshops have been conducted Statewide (the last one is May scheduled for 21, 2014 Hudson Valley region) to provide training to Health Homes and Housing Providers on:

- ❑ Identifying and accessing the various types of housing resources available
- ❑ Roles and Responsibilities of Health Homes and HH Care Managers
- ❑ Roles and responsibilities of Housing Case Managers
- ❑ Developing collaborative relationships between HH Care Managers and Housing Case Managers, ***encouraging housing providers to join the networks of Health Homes***

Shifting Focus of Health Homes from Start Up to Performance

The Department is developing a plan to provide Plans, Health Homes, and Care Managers access to the Health Home Module/data:

- Stage 1: Pre-Portal Access: Provide “static” Health Home Performance Reports – focusing initially on operational metrics, MCO and HH list management, aligning billing and tracking data
 - *New DOH Health Home Performance Team will Assist with Data Distribution and Review*
- Stage 2: Portal Access: Provide access to Health Home performance data using preconfigured, interactive dashboards

Health Home Performance: Use of Inpatient and ED Down, Primary Care Up



MRT 89: Health Home

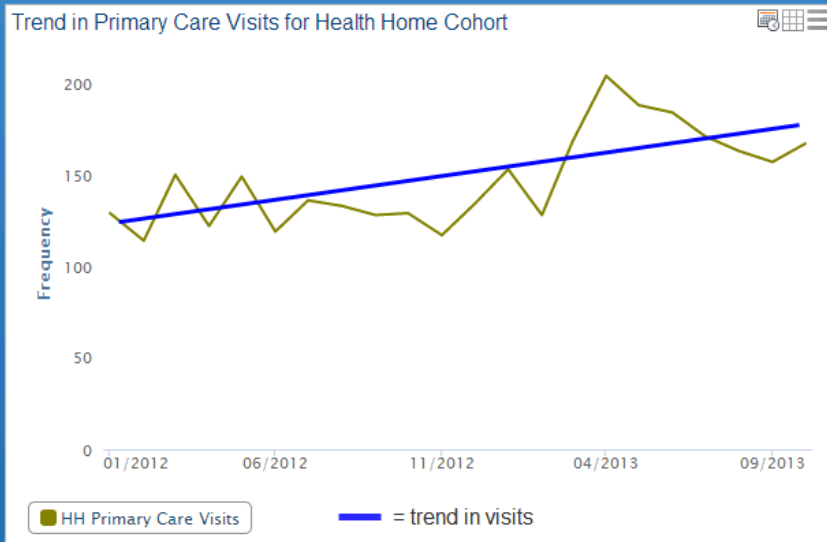
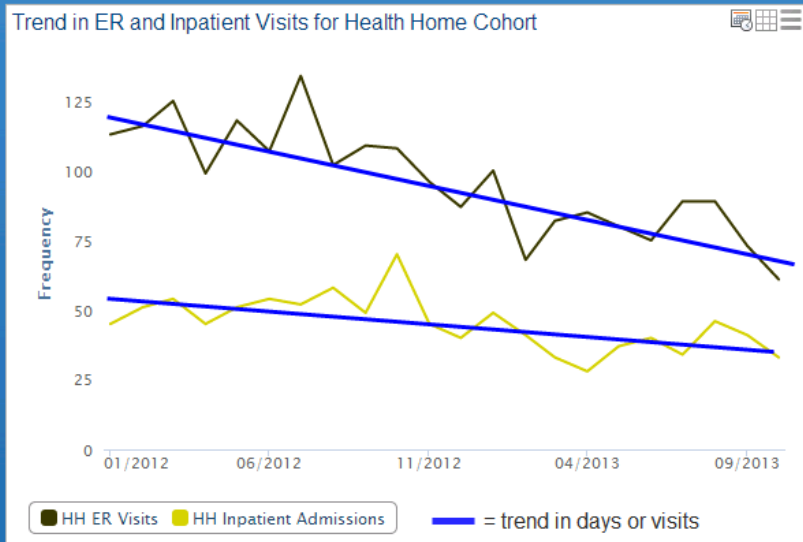
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Health Home Name
All Members

HH MC Plan Name
All Members

Impact of Health Home on Service Utilization:
Cohort of Members Enrolled from 11/2012 - 12/2013 with Prior Medicaid Enrollment and No Prior Case Management



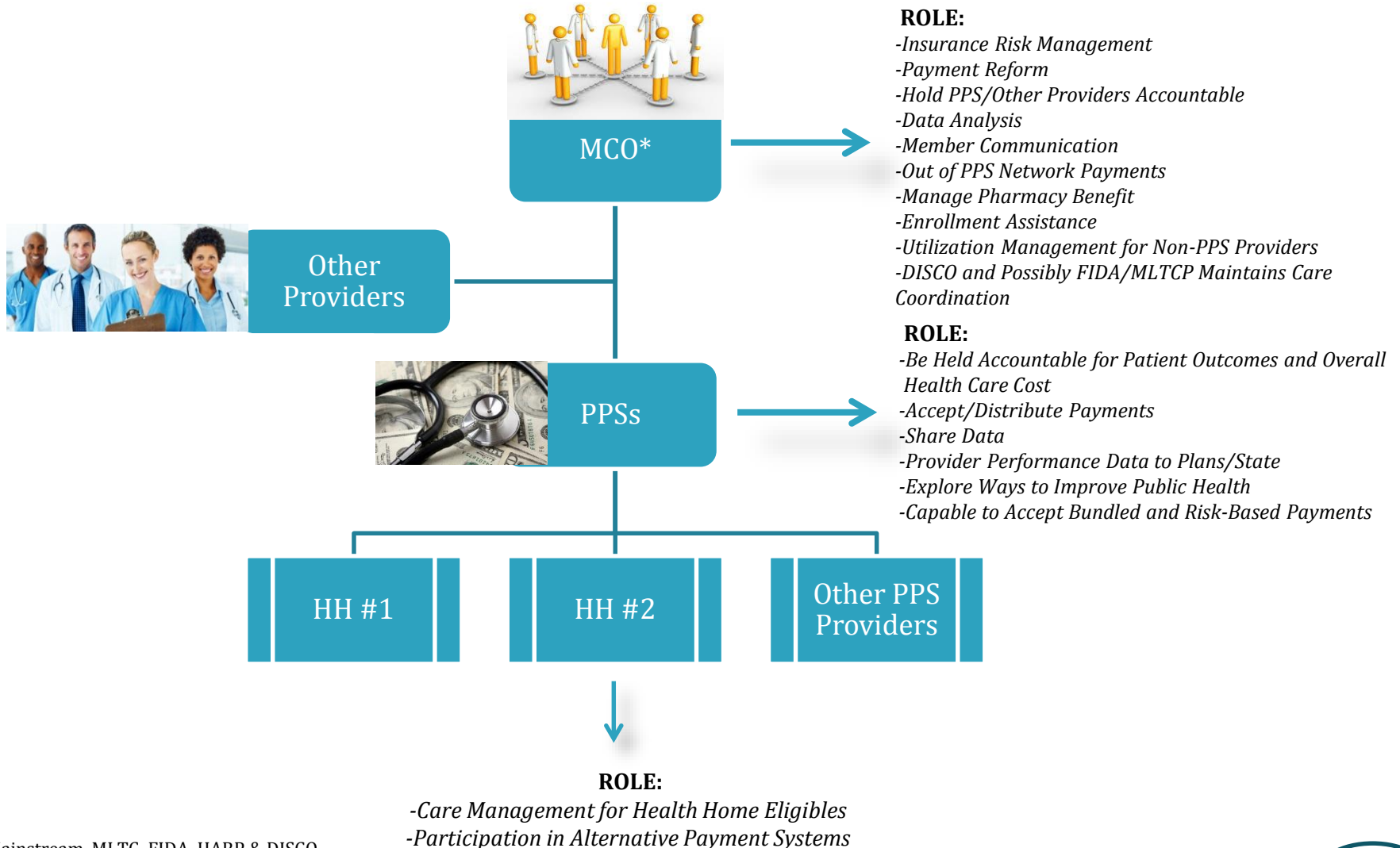
The Future of Health Homes and New Challenges

- ❑ Health Homes are and will remain an integral part of the State's vision for:
 - ❑ Care Management for All
 - ❑ DSRIP Performing Provider Systems
 - ❑ The transition of behavioral health to Managed Care/HARP Plans
- ❑ Health Home will be tailored to serve the unique needs of special needs children (Medically Fragile Children, SED, Foster Care), enrollment will begin in 2015
- ❑ Health Homes will become contractually required Managed Care Plan providers and will provide care management services for high needs, high risk populations as they move into Plans and the Behavioral Health benefit moves into Managed Care.

The Future of Health Homes and New Challenges

- ❑ Health Homes will need to manage and tailor operations to performance measures and outcomes and link quality outcomes to best practices.
- ❑ More advanced Health Homes could potentially become Accountable Care Organizations (ACOs) receiving sub-capitated rates from Managed Care Plans
- ❑ Under the umbrella of the Plans, DSRIP Performing Provider Systems and Health Homes will remain important fixtures beyond the 6-Year DSRIP Program

How The Pieces Fit Together: MCO, PPS & HH



*Mainstream, MLTC, FIDA, HARP & DISCO