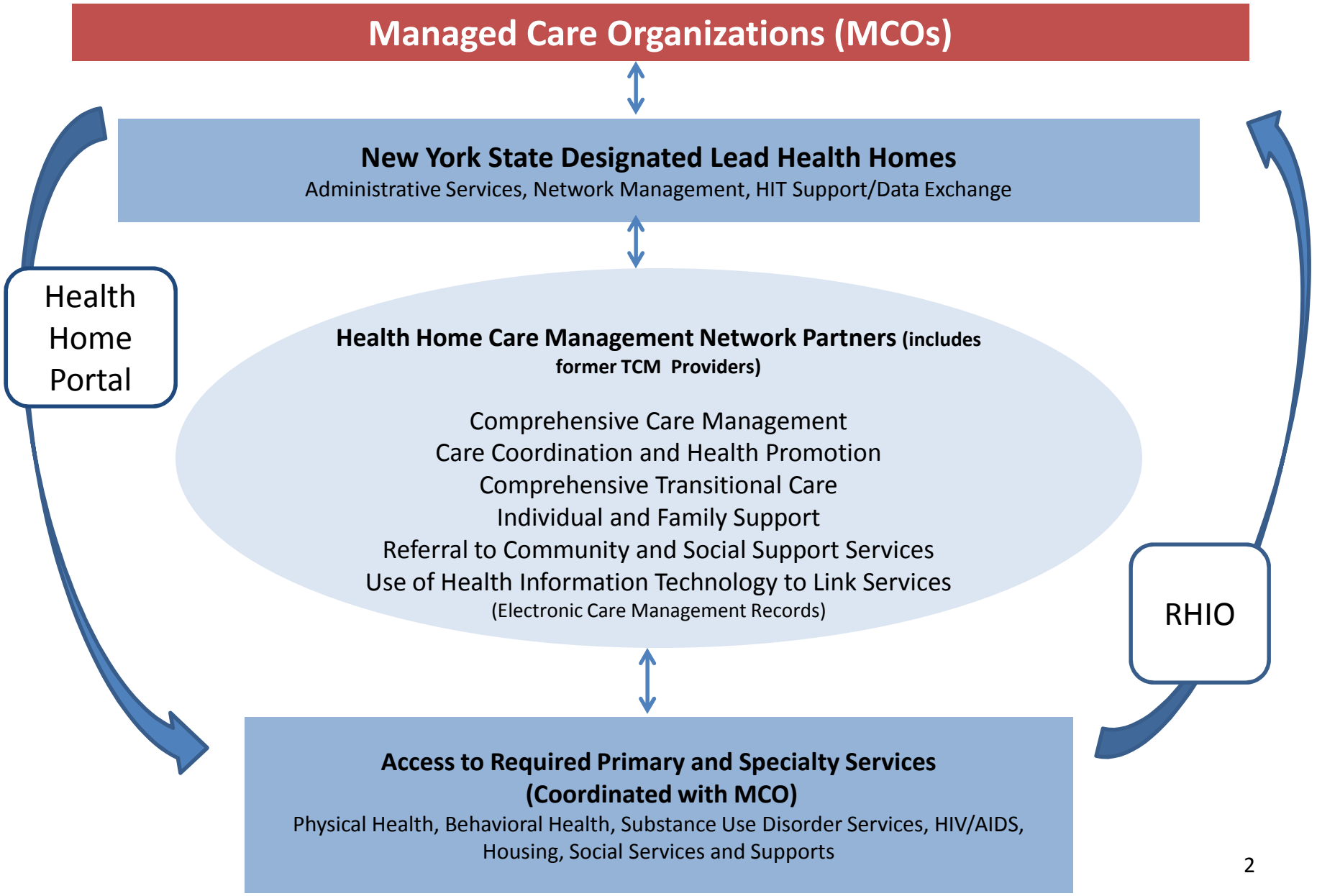
New York Health Homes Learning Collaborative Meeting #4

Health Homes Update
September 26, 2013

NEW YORK
state department of
HEALTH

New York State Health Home Model



New York State Health Home Population

- More than five million Medicaid members in New York State.
- 805,000 individuals meet the Federal criteria for Health Homes.
- Target enrollment for NYS is 446,000 (prioritizing for highest risk).
- There are 32 Health Homes serving 58 counties. (Some Health Homes serve more than one region).

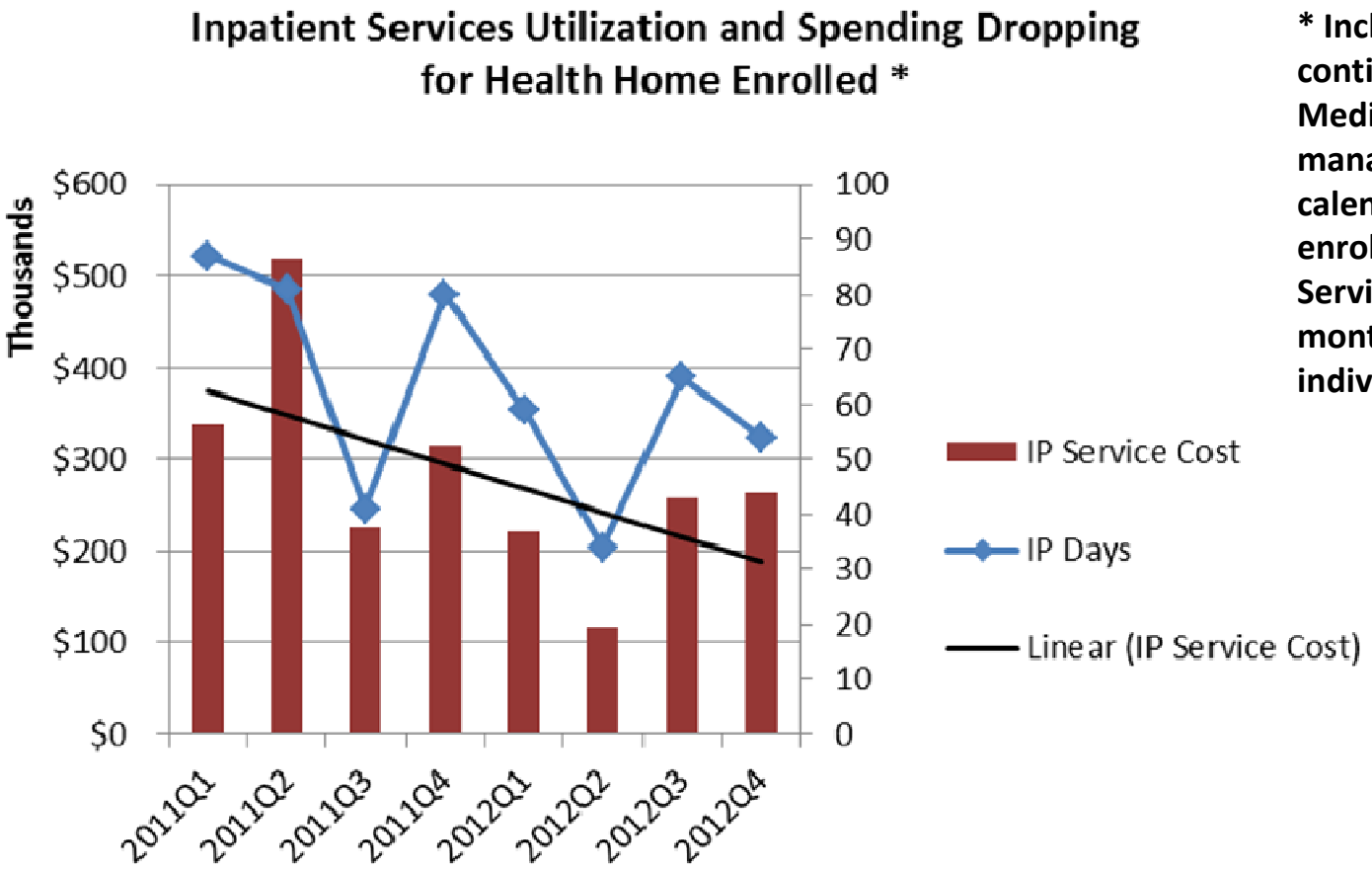
19 Percent of High Risk Members are Enrolled in Designated Health Homes

Statewide Health Home Enrollment Statistics (Based on January 2012 to August 2013 Claims)		
48 HHs (32 Unique Entities) Designated under 3 Phases effective 1/1/12, 4/1/12, 7/1/12		
Converting Members	# of HH Recipients Engaged in Outreach	3,674
New Members	# of HH Recipients Engaged in Outreach	41,863
Converting Members	# of HH Recipients Engaged in Active Care Management	34,572
New Members	# of HH Recipients Engaged in Active Care Management	20,348
	Total # HH Recipients (Distinct count)	83,765
Total Health Home Eligible Individuals (MHSA and others)		805,000
	# of Higher Risk Members Higher risk members are identified based on predictive risk model and ambulatory connectivity measure; e.g.,those with lower ambulatory connectivity and those more likely to die or have an inpatient or nursing home admission)	446,000
	% of Higher Risk Members	55%
	% of Higher Risk Members Enrolled or in Outreach	19%

Health Home Billing Exceeds $179 Million

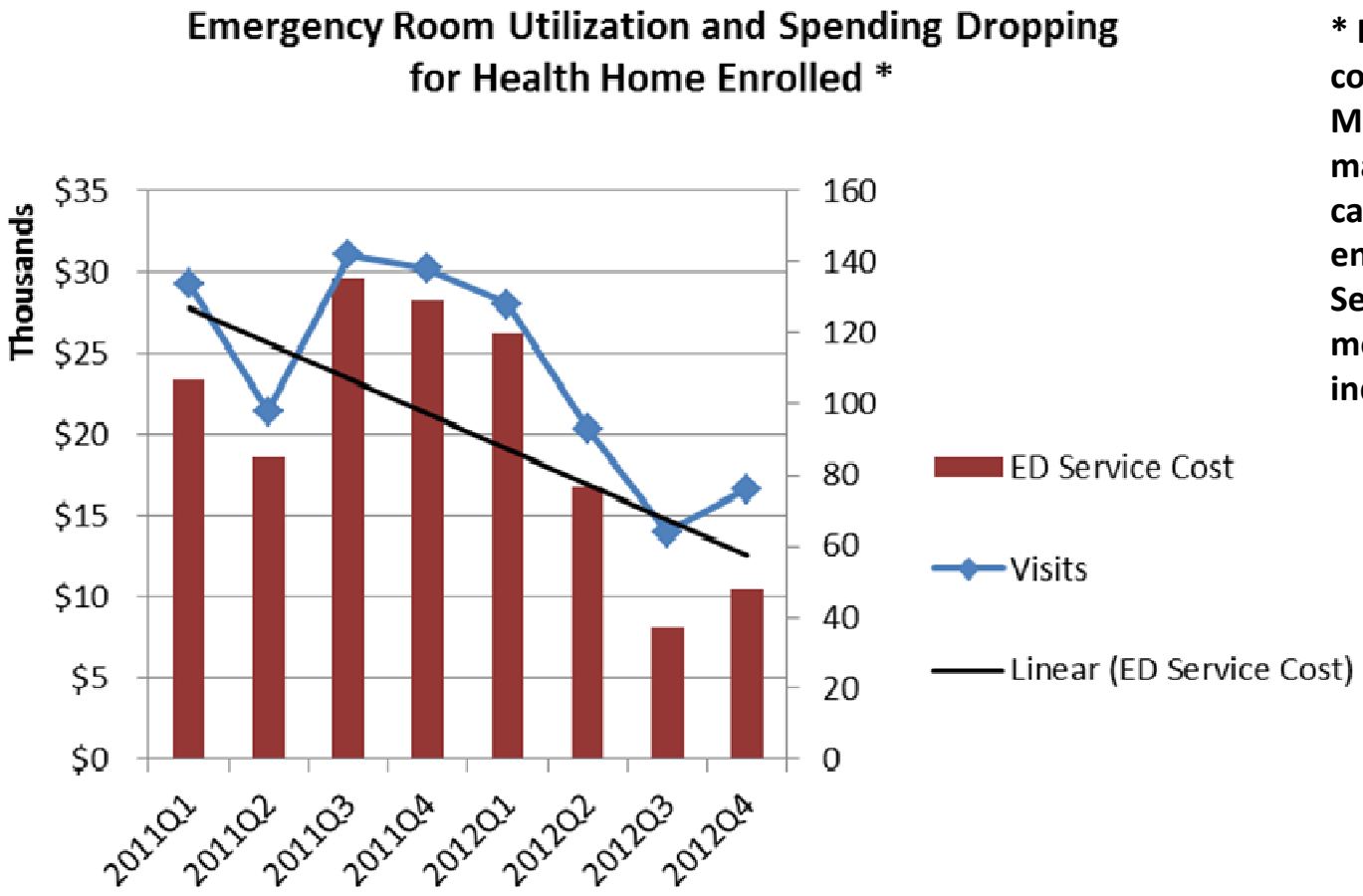
Total-to-Date Health Home Claims with DOS between Jan. 2012 to Aug. 2013 (9/12/13)			
Rate Summary	Unique Recipients w/MA Svc Claims	MA Service Claim Ct	MA Svcs Paid
Health Home Case Mgmt Svcs (Converting)	34,572	256,827	$149,633,779
Heatlh Home Outreach (Converting)	3,674	6,649	$3,206,911
Health Home Outreach (New Slots)	41,863	77,180	$11,673,220
Health Home Services (New Slots)	20,348	69,038	$14,907,221
Totals (Rate Summary)	83,765	409,694	$179,421,131

Early Process and Performance Measures



*** Includes individuals continuously enrolled in Medicaid with no case management services in calendar 2011 who enrolled in Health Home Services in the first six months of 2012. N = 194 individuals.**

Early Process and Performance Measures



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HEALTH HOMES

Meeting the Challenges

Health Homes: Meeting the Challenges

Challenge: Involve Stakeholders

A Health Home Managed Care Workgroup will work with the State to address implementation issues; seven subgroups have been formed:

- Assignment and Referral
- Criminal Justice
- Clinical Risk Group Analysis
- Contracting
- Financial Feasibility
- Behavioral Health Transition
- Start-Up Grants

Next Meeting of the Health Home Managed Care Workgroup on September 27, 2013.

Health Homes: Meeting the Challenges

Challenge: Increase Volume and Assignments

- In January 2013 about 60,000 Health Home eligible members in Phase 1 and 2 counties were prioritized for assignment by Health Home (FFS: 25%) and Managed Care Plans (75%) and posted to Health Home Tracking System assignment files.

In May 2013:

- Assignments released to designated Phase 3 Health Homes.
- Criteria used to prioritize members for assignment were adjusted bringing the total assigned members to approximately 446,000 (82% MC and balance FFS).

Health Homes: Meeting the Challenges

Challenge: Contracting Issues Continue to Be Resolved

- DOH and its State Implementation Partners facilitate one to one conversations between Health Homes and parties as needed.
- Health Home and Managed Care Plan contracts are being executed on an ongoing basis - there are now 118 approved contracts between Health Homes and Managed Care Plans.
- Contracts are being executed between Health Homes and their network partners, allowing assignments to flow.
- OMH State and County operated TCM programs are entering into contracts with Health Homes; mechanism for payment of Health Home administrative fees has been established .

Health Homes: Meeting the Challenges

Challenge: Resource Health Home Implementation

- $2 million of "Stage I" Health Home Implementation Grants have been awarded to 22 of 32 distinct Health Homes
  - As required by statute, SFY 13-14 spending must be funded from savings identified under the Global Spending Cap.
  - To the extent additional savings can be identified in the current year, Stage II Grants (not to exceed $15 million) may be allocated in SFY 13-14.
  - The Budget includes $15 million for grants in 2014-15.
  - Goal was to distribute limited resources as widely and effectively as practical.
- MRT Waiver Update

Health Homes: Meeting the Challenges

Challenge: Enroll Additional Populations

Enrolling Children into Health Homes

- Over next several months Department will be working with OMH, OASAS and Stakeholders to identify issues and proposed parameters and protocols for the enrollment of children into Health Homes.
- Issues and proposed protocols will be collaboratively developed and addressed with stakeholders.

Health Homes: Meeting the Challenges

Challenge: Enroll Additional Populations

Adult Home Settlement

- The Department will be working with Health Homes and Managed Long Term Care Plans to help implement an initiative to link Adult Home residents to care management and supportive housing.
- Project will begin in Brooklyn and Queens, briefings to be held with Health Homes and Managed Long Term Care Plans shortly.

Health Homes: Meeting the Challenges

Challenge: Health Home MRT Projects

- Hospital Referrals to Health Homes
  - ACA requires Hospitals to refer eligible individuals to Health Homes
  - The Department is working with hospital associations and stakeholders to develop guidance and procedures for hospitals to meet CMS referral requirements
- Oversight Grievance/Complaints and Incident Reporting
  - Agency staff developing a proposed process for discussion with stakeholders
- Shared Savings SPA
  - Department has begun initial discussions with CMS

Health Homes: Meeting the Challenges

Challenge: Current Health Home Landscape is Under Transition

- Health Home SPA allows converting TCM programs to bill legacy rates for two years (extended from one year); legacy providers will no longer bill directly for their Health Home patients. Billing will shift from legacy providers to Health Home for FFS members or to Managed Care Organizations (MCOs)for Plan members.

- Legacy rates are scheduled to transition to Health Home Rates on:
  - January 1, 2014 – Phase 1
  - April 1, 2014 – Phase 2
  - July 1, 2014 – Phase 3

- The target dates for carving the behavioral health benefit into Managed Care have been moved from April 1, 2014 to allow more time for the transition of behavioral health services into Managed Care and for the creation of HARPS (Health and Recovery Plans)
  - January 2015 – New York City
  - July 2015 – Rest of State (ROS)

Health Homes: Meeting the Challenges

Challenge: Current Health Home Landscape is Under Transition

- Under Care Management for All, Health Home PMPM rates will be negotiated between the MCOs and Health Homes (after a probable period of State mandated rates).

- Health Homes will serve expanded populations which currently do not receive care coordination services and for which there are no existing "legacy" Medicaid resources to reallocate to Health Homes:
  - HARP Beneficiaries beyond historic legacy capacity will be enrolled in Health Homes
  - OASAS HARP and non-HARP recipients who may need Health Home services
  - The projected increased costs for this expanded Health Home population will need to be accommodated under Global Spending Cap

Health Homes: Meeting the Challenges

Challenge: Ensuring a Smooth Transition

- The State clearly wants TCM providers to be financially stable as they transition into managed care.

- The State understands that significant unplanned drops in provider revenue related to HH rate changes cannot be tolerated if we are to keep our critically needed care management workforce in place for the move to managed care.

- While the State does desire a more streamlined and unified rate setting structure any transition plan will be mindful of the revenue impact on all care management providers.

Health Homes: Meeting the Challenges

Challenge: Ensuring a Smooth Transition

The State Agency Implementation Team is working on recommendations for the consideration of stakeholders:

- Extend the current Health Home legacy rates (or an agreed upon replacement, e.g., tiers of rates) until January 2015 and allow legacy providers to bill directly until such time.
- Adjust Managed Care Premiums to include a 3% Health Home administrative fee (HH rates remain intact)
- Between now and January 2015, modify and simplify the current Health Home rate structure to better align rates with levels of service intensity.
- Require Plans to pay Health Homes the “modified” Health Home rate (i.e., mandated Government rate) for a transition period of two years (2015 and 2016)
- Implement initiatives to facilitate better service planning and coordination between Health Homes, downstream care managers and MCOs - this will likely include targeted waiver resources when available

HEALTH HOMES

Behavioral Health Transition

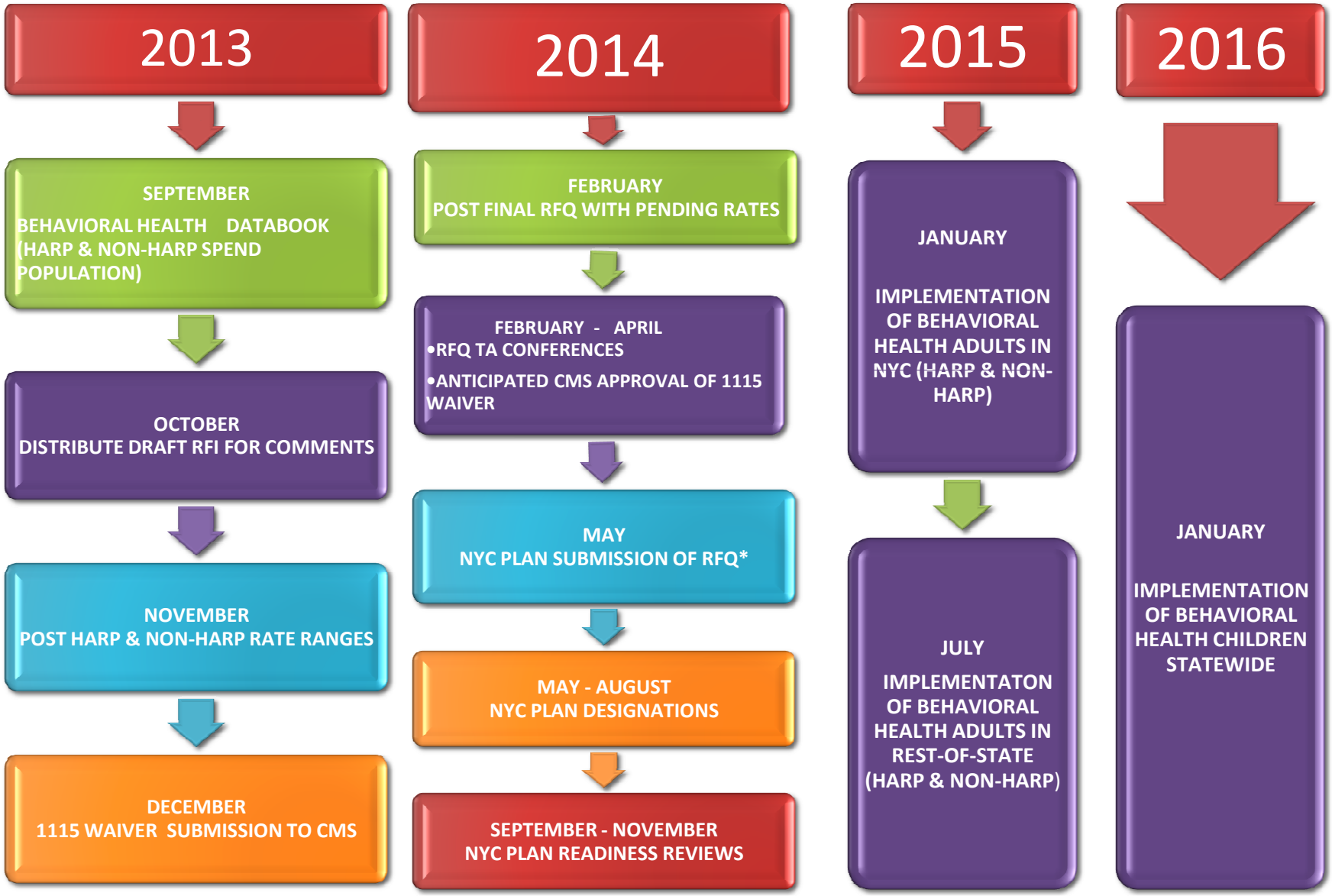
Behavioral Health Transformation
Guiding Principles of Redesign

- Do No Harm
- Person-centered care management
- Integration of physical and behavioral health services
- Recovery oriented services
- Patient/consumer choice
- Ensure adequate and comprehensive networks

Behavioral Health Transformation
Guiding Principles of Redesign

- Tie payment to outcomes
- Track physical and behavioral health spending separately
- Reinvest savings to improve services for behavioral health populations
- Address the unique needs of children, families & older adults

Behavioral Health Transformation Implementation Timeline



Behavioral Health Transformation
Design for Managed Behavioral Health

Behavioral Health services will be managed by:

- Qualified Health Plans meeting rigorous standards (perhaps in partnership with BHO).
- Health and Recovery Plans (HARPs) for individuals with significant behavioral health needs.

Calendar Year 2011 HARP/Non-HARP Population

Summary of analysis for HARP and Non-HARP population during CY 2011

Datasource : Salient and DataMart

Group			Recipients	Expenditure	Eligible Months	PMPM Expenditure
HARP	Non-Duals / Age 21 and over/ OPWDD Excluded		**137,742**	**$ 3,851,214,942**	**1,522,658**	**$ 2,529**
	Duals	MLTC enrolled	41	$ 911,830	486	$ 1,876
		MLTC eligible	178	$ 8,819,949	2,101	$ 4,198
		All other Duals	4,123	$ 97,031,652	45,458	$ 2,135
	Total		**142,084**	**$ 3,957,978,373**	**1,570,703**	**$ 2,520**
NON-HARP*	Non-Duals / Age 21 and over/ OPWDD Excluded		**207,771**	**$ 2,940,798,859**	**2,129,963**	**$ 1,381**
	Duals	MLTC enrolled	6,309	$ 106,640,455	75,368	$ 1,415
		MLTC eligible	25,096	$ 1,194,825,146	296,156	$ 4,034
		All other Duals	154,224	$ 6,126,307,448	1,750,217	$ 3,500
	Total		**405,239**	**$ 11,680,425,188**	**4,392,590**	**$ 2,659**
Total (HARP + Non-HARP)	Non-Duals / Age 21 and over/ OPWDD Excluded		**345,513**	**$ 6,792,013,801**	**3,794,806**	**$ 1,790**
	Duals	MLTC enrolled	6,350	$ 107,552,285	75,854	$ 1,418
		MLTC eligible	25,274	$ 1,203,645,095	298,257	$ 4,036
		All other Duals	158,347	$ 6,223,339,100	1,795,675	$ 3,466
	Total		**547,323**	**$ 15,638,403,561**	5,964,592	**$ 2,622**

* Members not meeting HARP special needs criteria but having OMH or OASAS diagnosis and/or service in CY2011.

Calendar Year 2011 Services for the HARP and Non-HARP Populations

Service Group	Total HARP Non dual Dollars (in Billions)	Total Non-Harp Non dual Dollars (in Billions)	Total Dollar for BH Non dual pop (in Billions)
INPATIENT	$1.65	$0.78	$2.43
MANAGED CARE	$0.65	$0.64	$1.29
CLINIC	$0.57	$0.62	$1.18
HOME HEALTH	$0.31	$0.10	$0.41
NURSING HOME	$0.19	$0.44	$0.62
PRACTITIONER	$0.20	$0.24	$0.44
TRANSPORTATION	$0.06	$0.04	$0.09
PRIVATE DENTIST	$0.02	$0.03	$0.05
REFERRED AMBULATORY	$0.01	$0.01	$0.02
DENTAL CLINIC	$0.01	$0.01	$0.02
DURABLE MED EQUIP	$0.02	$0.02	$0.03
LABORATORY	$0.02	$0.03	$0.06
EYE CARE	$0.00	$0.00	$0.01
CHILD CARE	$0.00	$0.00	$0.00
UNDEFINED PROFESSIONAL	$0.00	$0.00	$0.00
ICF/MR	$0.00	$0.00	$0.00
PHARMACY	$0.79	$0.62	$1.42
Total without Cap Payment	$3.85	$2.94	$6.79

Behavioral Health Transformation
Qualified Behavioral Health Plan vs. HARP

Qualified Behavioral Health Plan

- Medicaid eligible
- Benefit includes all Medicaid covered services
- Organized as a benefit within Medicaid Managed Care
- Management coordinated with physical health benefit management
- Performance metrics specific to behavioral health

Health And Recovery Plan (HARP)

- Eligible based on utilization patterns or functional impairment
- Benefits include all current Medicaid covered services PLUS 1915i-like services
- Benefit management built around expectations of higher needs HARP patients
- Performance metrics specific to 1915i, and higher needs population

Behavioral Health Transformation
1915i-like Services in the HARP

Proposed Menu of 1915i-like Home and Community-Based Services

- Psychosocial rehabilitation
- Community Psychiatric Support and Treatment (CPST)
- Residential Supports/Supported Housing
- Crisis Intervention
- Peer Supports
- Habilitation
- Respite/Crisis Respite
- Case Management
- Supported Employment
- Education Support Services
- Self-Directed Services
- Non-Medical Transportation
- Training and Counseling for unpaid caregivers
- Family Support and Training

Behavioral Health Transformation
Draft Network Requirements

- Contract with any OMH, OASAS provider serving at least five of their members in any of their counties (under review to tailor by program type)
- Contract with State operated OMH providers as “Essential Community Providers”
- Allow members to have a choice of at least two providers of each Behavioral Health specialty service
- Continue to pay government rates for ambulatory services currently in place for 24 months
- Comply with all mandatory network requirements for 24 months from contract implementation

Behavioral Health Transformation Progress Report

Completed Tasks

Finalized List of State Plan Services to be added to scope of benefits including:

- *PROS, ACT, CPEP, CDT, IPRT, Partial Hospitalization, TCM*
- Opioid Treatment
- Outpatient Chemical dependence rehabilitation
- Clinic
- Inpatient (SUD and MH)

Behavioral Health Transformation Progress Report

Completed Tasks (continued)

- Identified proposed 1915i-like services for HARPs.
- Provided Plans with member specific files and specific information on services and volume.
- Established initial network requirements.
- Selected functional assessment tool.
- United Hospital Fund/Center for Health Care Strategies (UHF/CHCS) facilitated a small group consulting session with National experts from other States to learn from their successes and challenges.
- On September 10th UHF/CHCS also hosted a small group roundtable discussion for Plans and Providers. Plans/Providers have requested that these sessions will continue regionally, throughout the State.

Behavioral Health Transformation Progress Report

In Progress

Follow up with recommendations from 9/10/13 Plan/Provider session:

- Consider NYS Plan/Provider standard contract template.
- Consider adoption of OMH/OASAS certification for Plan credentialing.
- Review DOH/OMH/OASAS regulations that may impede Plan flexibility and increase cost.
- Establish Plan/Provider subcommittees to facilitate information sharing and to take responsibility for Regional Technical Assistance Sessions.

Behavioral Health Transformation Progress Report

In Progress

- Set premiums.
- Finalizing draft 1115 Waiver amendment for submission to CMS.
- Finalizing draft RFI and RFQ.
- Release RFI to Plans with data book for input from stakeholders.

Behavioral Health Transformation
Open Issues

- Defining final adequate network and ensuring access
- Assessments and Conflict Free Case Management
- Finalizing transitional and payment provisions for legacy services
- Setting new rates for the 1915i-like services
- Obtaining approval from CMS
- Other details

QUESTIONS?