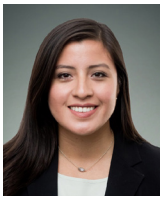
COPE HEALTH SOLUTIONS

The evolution and future of the NY health home program



Authors: Catherine Castillo, Senior Consultant, Tony Shi, Intern, Evan King, Executive Vice President

Background

In 2010, the Affordable Care Act provided states the option to implement a "health home" (HH) care management model, with the goal of improving care coordination, reducing costs and improving health outcomes for high-need Medicaid members with chronic conditions. In an attempt to bridge resource gaps for a particularly complex segment of the population, the HH model creates a dedicated source of funding to cover the intensive care management services required to manage the clinical and psychosocial needs of this population.

Building on the key parameters set by CMS, states who choose this option design a HH program that targets their population's specific needs and leverages existing models and infrastructure. To date, 20 states have submitted applications to CMS, received approval and implemented HH programs; many more are currently in the planning stage.

The Original New York HH Program

Since the New York HH program was launched in 2012, some program elements have not changed with relation to member eligibility, participating entities, referral channels and payment.

There are two main mechanisms by which eligible members are identified and referred. In "top-down" enrollment, the State identifies a list of target members using claims data and then assigns eligible members to specific HH providers based on existing relationships with primary care providers or geography. The HH provider is then responsible for conducting outreach to locate, educate, screen and officially enroll the member. Alternatively, there is a "bottom-up" enrollment process, where providers can identify eligible members in the community or clinical settings and then refer them to a HH provider for assessment and enrollment. The State reimburses HH providers on a per member per month (PMPM) basis for outreach activities and for active management once the member is enrolled. As of December

2016, the program has enrolled 262,520 eligible members.[1]

There are two types of HH providers: Health Home "leads" and Care Managed Agencies (CMAs). The HH leads are agencies responsible for overall administration of HH services, including billing the State and disbursing funds to CMAs, assigning members to CMAs, establishing standards of care and monitoring performance. CMAs are agencies and teams of frontline providers who deliver services directly to members, including comprehensive care management. These teams include nurse care managers, care coordinators and various support staff. Each CMA may contract with multiple HH leads and vice-versa. In many cases, HH leads have ownership of a CMA. There are also cases where health systems own HH leads and CMAs.

Evolution of the NY HH Program

Over the past five years, the State has worked with HH providers to continuously identify both best practices and barriers to success. These discussions have led to various changes and additions to the program that address payment, targeting of special populations and integration of HH providers into the broader care continuum. While some of these changes have had the desired impact of resolving the program's inefficiencies, others have resulted in further financial pressure and logistic challenges. Below, we summarize key changes and their impact to date.

- *Payment Tiers:* Originally, members were stratified using a risk acuity score derived from claims data. However, the claims data was relatively outdated by six to nine months and did not account for patients' psychosocial risk factors. As of December 2016, members are stratified into three risk levels – high, medium and low – using a more comprehensive assessment conducted by care managers, which can be updated monthly.[2] The PMPM reimbursement increases with each risk level to theoretically cover the cost of providing more services to higher risk members.[3] However, the changes are not accompanied by guidance on how services should vary accordingly. While the assessment is a better measurement of member risk level, CMAs are concerned about financial sustainability under the new tiers. In practice, CMAs are not able to assess members monthly, so the risk level and associated PMPM often does not reflect their current needs. CMAs are also reportedly unable to cover the costs of providing services that meet members' needs with the current PMPM rates.

- *Funds flow:* Managed Care Organizations (MCOs) initially received a three percent portion of each PMPM to cover costs related to member eligibility assessment and assignment. Over time, many HH leads and CMAs took on these responsibilities, in part due to the implementation of the Medicaid Analytics Performance Portal (MAPP) billing system, which streamlined the process and required less input from MCOs to identify members. As of April 2016, the State adjusted the billing guidance so that MCOs no longer receive a portion of the PMPM. Now that HH leads receive the full PMPM, payments to downstream CMAs have increased. Bypassing the MCO also allows CMAs to receive funds more rapidly to cover the costs of providing services.

- *Legacy provider rates:* Before the HH program, the State established specialized care management services for the targeted care management (TCM) populations (e.g., COBRA HIV/AIDS and OMH[4]). Referred to as "legacy providers," the entities who provided those services were able to become

[1] NYSDOH: Eligibility Requirements: Identifying Potential Members for Health Home Services
[2] NYSDOH: Schedules of Key Dates, Recent Events, Inquiries and Reminders
[3] Currently, the PMPM rate for outreach is $135. Upstate providers receive a PMPM of $360, $234, and $58 for active management of high, medium, and low-risk members, respectively. Downstate, the rates are higher: $383 (high), $249 (medium), and $62 (low).
[4] COBRA refers to the Consolidated Omnibus Budget Reconciliation Act, which provides employees the right to pay premiums for and keep the group health insurance that they would otherwise lose after they reduce their work hours, quit their jobs, or lose their jobs. OMH refers to the New York State Office of Mental Health.

HH leads or CMAs. However, legacy providers were accustomed to delivering intensive care management services at a higher cost. To help with the transition, the State reimbursed the legacy providers with a higher PMPM based on the rates they previously received. As of December 2016, the higher legacy provider rates have ended and transitioned to regular HH rates[5], which poses a challenge to CMAs who must now reconcile their service offering with a reduced revenue stream.

- *Targeted programs for special populations:* Over time, the State has identified a need to further segment the program to better target services to the eligible population's wide array of medical and psychosocial needs. In 2014, the Health Home Plus program was created to provide more intensive care management for members with severe mental illness and a history of treatment noncompliance or criminal offense. Other similar subprograms include the Health and Recovery Plan program, which manages care for members with significant behavioral health and substance use disorders, and the Adult Home program, which targets individuals with serious mental illness transitioning from an adult home to a community setting. In December of 2016, the State deployed a specialized Health Homes Serving Children program for children under 21 with serious emotional disturbances or complex traumas. By narrowing the focus of these subprograms, members are able to receive more targeted services, the care manager to member ratio can be adjusted to allow for more intensive care and reimbursement rates have been increased to reflect the shift in provider resource allocation.

- *Integration of HHs to the broader care continuum:* It has become clear that HH providers need to integrate within the broader care continuum to increase enrollment. HH leads report significantly higher success with bottom-up enrollment – anecdotally, they achieve a conversion rate of less than 30 percent via top-down enrollment, compared to upwards of 80 percent through bottom-up referrals – and the State is making moves to bolster this process. In February of this year, the State issued a memorandum[6] to hospitals, reminding them of the mandate that requires them to establish a HH referral process for eligible members seeking care in the emergency department. While this is not a new regulation, the State's letter clearly puts the onus on the hospitals, and they are now mobilizing to meet the mandate. Hospitals are facing challenges in determining which staff will be responsible for assessing and enrolling members, establishing the necessary IT infrastructure and identifying a funding source for these transformations. Hospitals must also design procedures that align with the referral process of each HH lead they refer to, which can vary significantly.

The Future of Health Homes in New York

Since its inception, the NY HH program has undergone significant changes as part of an ongoing effort to increase the value and sustainability of services. As the program enters its sixth year, we anticipate that it will continue to evolve as HH leads and CMAs refine their business models and seek strategic partnerships to strengthen their referral networks. Key to these changes will be continuing to adapt their member base, aligning their reimbursement model and services with value-based payment strategies of large health systems, bolstering their capabilities to deliver integrated services and readily document and share data and outcomes. Below, we summarize upcoming changes and our key projections for the future of the HH program.

- *Changes to the outreach PMPM:* By the end of the year, the State plans to reduce the outreach PMPM to achieve more savings. In response, CMAs will need to restructure their outreach and enrollment model, including their staffing and caseloads to function under the stricter financial constraints. Some CMAs have already begun to do so by developing outreach teams made up of

[5] NYSDOH: Health Home Program Updated Billing Guidance
[6] NYSDOH: DHDTC DAL 17-04 - Hospital Requirements for Making Referrals to Health Home

nonclinical (and thus lower-cost) staff who are dedicated to engaging referred members, converting them to enrollees and assigning them to a care manager.

- *Increased focus on outcomes:* Both the State and HH providers are pushing for more data to track enrollee outcomes and avoidable utilization to quantify the impact of the program and justify its continued funding. Although HH leads and CMAs are not direct providers of care, they are evaluated using clinical outcomes measures because they support adherence to treatment and connect members to providers who do have direct control. In 2016, the State released a dashboard in MAPP that enables HH leads to compare their own performance on these measures against their peers. The same is available at the CMA level. We expect that as the State completes re-designation of HH leads this year, the overall program's cost efficiency and individual quality assurance and improvement programs will be more closely monitored.

- *Consolidation of the market:* HH leads and CMAs are increasingly aligning to specific health systems. Many of the State's largest systems already have ownership of a HH lead and CMA. Meanwhile, many of those who do not own one have entered into agreements with CMAs to deploy outreach staff into specific facilities to increase bottom-up enrollment. For as long as members identified in these facilities can be "self-referred" to a specific HH lead, internal networks will tighten even further. HH leads are also likely to be pushed out of the market if they do not secure access to an ambulatory network, without which their ability to integrate with the broader care continuum and impact member outcomes will be severely limited. Furthermore, the State has stopped accepting applications for new HH leads, capping the number in the market. From this, we can infer that the market is saturated and likely to shrink over time.

- *Expansion of CMA offering:* As mentioned, some CMAs are already contracting directly with health systems to provide outreach staff on-site. For this reason, we expect more CMAs to enter into contracts directly with hospitals to help them meet the HH referral mandate from the State. Eventually, we anticipate that forward-thinking CMAs will begin to seek contracts with MCOs, or even be absorbed by them, to become providers of highly specialized care management services for the MCOs' highest-risk members. However, there is an even more pressing need for HH providers to reevaluate their long-term strategy. As the State moves to distribute the majority of Medicaid payments through value-based arrangements, there is a likelihood that the dedicated funds for the HH program may be terminated. To survive in this scenario, CMAs will also need to broaden their functionalities to manage all risk tiers of members, not just the HH-eligible population.

With these and other potential changes on the horizon, HH providers must continue to adapt. CMAs and HH leads will need to adjust their models to drive expanded enrollment and right-size their teams to better target services by patient risk level, all while continuing to improve quality. Strategic partnerships with health systems will be key to growing referral networks in the short-term, and necessary for long-term integration within the comprehensive care management models under value-based payments. Lastly, the ability to collect and share data and outcomes will greatly support CMAs and HHs in quantifying their value as partners in the effort to improve patient outcomes and reduce costs.

About COPE Health Solutions

COPE Health Solutions is a national health care consulting firm with extensive experience in health care and population health strategy, including Medicaid waivers and DSRIP. We are currently working with multiple health systems in the state of New York to integrate Health Home services into their broader population health strategy and financial model, with the ultimate goal of optimizing system performance under risk-based agreements.

With corporate offices in Los Angeles, New York and Seattle, the COPE Health Solutions team is

comprised of a diverse range of subject matter experts who can assist health systems, managed care plans, and frontline providers become successful in value-based payment environments. For more information, please contact info@copehealthsolutions.com.