SALIENT HHS

Salient's Health Home Module for NYS

Presentation to HH/MCO Consolidated Work Group

November 15, 2013
1 Commerce Plaza
Albany, NY

Background

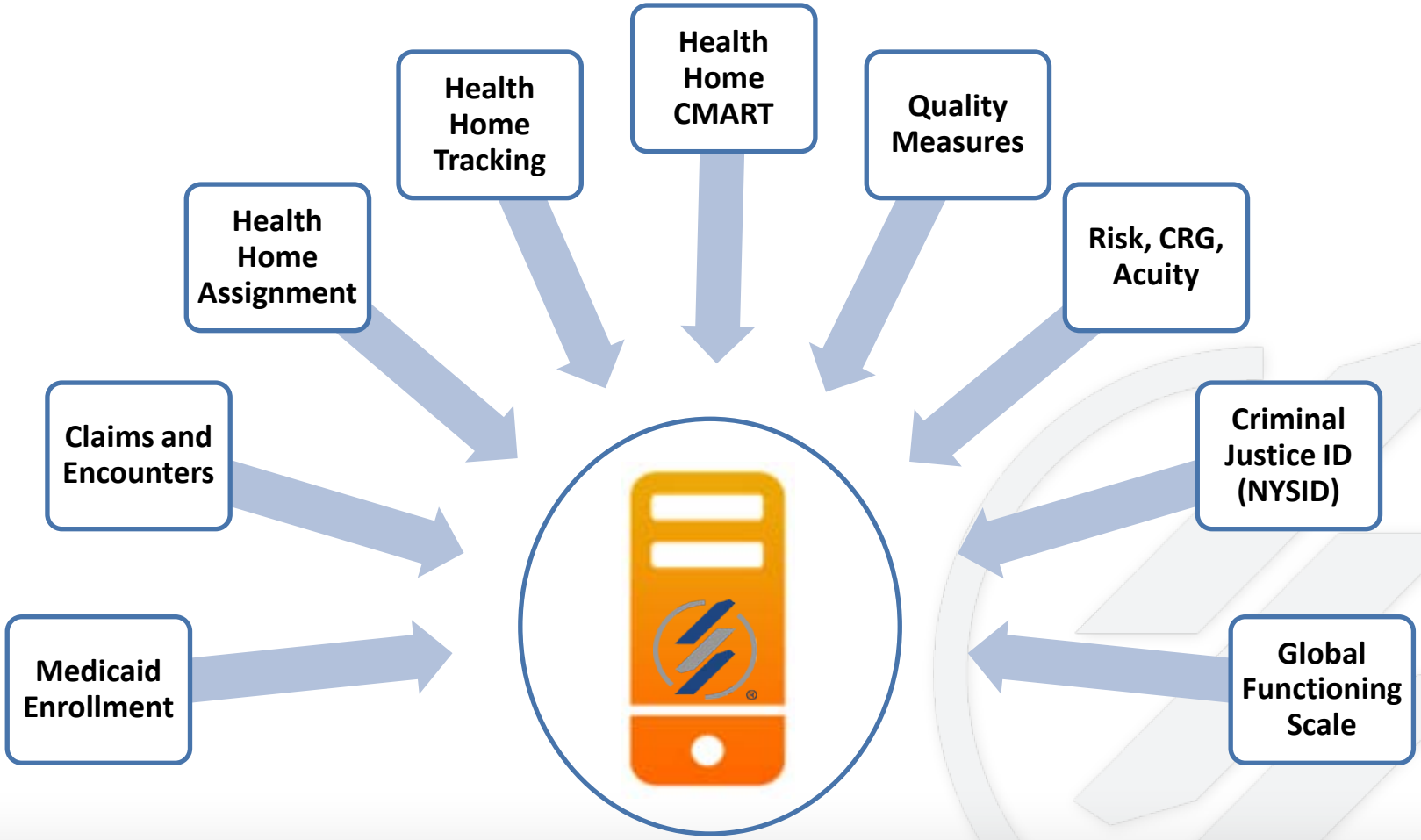
- Salient's Medicaid software system is used by NYS to help manage the program and track the redesign process
- Users include: DOH, OMH, OASAS, OPWDD, OMIG, DOB, OSC, Legislature; a dozen counties and NYCDOHMH, and other health care stakeholders
- NYS system includes all paid Medicaid claims and encounters from April 1, 2005 - updated weekly
- Salient now under contract to: 1) add features specific to Health Homes to allow NYS to monitor and evaluate the initiative; 2) develop a plan for provider access to this Health Home data

Meeting Goals

- Provide overview of Health Home enhancements
- Get your feedback
- Discuss priority data needs

Salient Health Home Module

Integrating multiple data sources and types



Cross Cutting Views

- **The new Health Home features will allow users to look at Health Home data by**
  - MCO, Health Home, Care Management Organization
  - Geography
  - Age, gender, and other demographics
  - Disease state
  - Service type
  - Clinical Risk Group, acuity, disability status
  - And many other variables and patient attributes

How will data be used?

- **Continuous Program Oversight** - to identify whether the health home program is progressing towards its goals and at what pace
- **Performance Profile/"Scorecard"** - to profile how well each health home is doing
- **Trigger Events** - to identify at-risk health home enrollees
- **Payment Integrity** - to detect improper health home payments
- **Gain-sharing** - potentially assist with shared saving analysis
- **Ad hoc Analyses**
- ***And for providers*** - to help understand their caseload, costs and utilization and better manage care and their business

What data will be included in Health Home Module? Examples include…

- **Enrollment**
  - Count of enrollees, beneficiaries in outreach, disenrollees, and related rates
- **Enrollment Performance**
  - Time from assignment to outreach, outreach to enrollment, beneficiaries in outreach but not enrolled
- **ER Use**
  - Count of ER visits, # ER users, rate per member month
  - Lists of high ER users
- **Inpatient Use**
  - Count of inpatient admissions, # admissions per member month, average length of stay
  - Lists of high inpatient users

And more…

- **Primary Care**
  - Count of primary care visits, rate per member month
- **Ambulatory Behavioral Health Use**
  - Count of Ambulatory Behavioral Health visits, rate per member month
  - List of BH enrollees with no regular service use
- **Cost**
  - Average costs and claims per HH enrollee
- **Care Management Activity**
  - Quarterly data: counts of outreach, interventions, and core services - and rates per member month
- **Quality Measures**
  - Wave 1: largely inpatient and behavioral health measures driven by federal reporting requirements

Process

Phase	Status
Design	Done
Development	In process
Provider Input	In process
Implementation for State Users	Early 2014
Plan for Provider Access	In process
Integration of Quality & CMART data	As soon as data are available
Implementation of Plan for Provider Access	As soon as possible, expected sometime 2014

Discussion Questions

- **Which providers need data?**
  - MCOs
  - Health Homes
  - Care Management Organizations
- **Who are the data users in each entity?**
- **What data are highest priority for providers?**
  - Measures
  - Frequency
  - Summarization levels