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

- Health Home Assignment
- Claims and Encounters
- Medicaid Enrollment
- Health Home Tracking
- Health Home CMART
- Quality Measures
- Risk, CRG, Acuity
- Criminal Justice ID (NYSID)
- Global Functioning Scale
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

<table>
<thead>
<tr>
<th>Phase</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Design</td>
<td>Done</td>
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<tr>
<td>Development</td>
<td>In process</td>
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<tr>
<td>Provider Input</td>
<td>In process</td>
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<tr>
<td>Implementation for State Users</td>
<td>Early 2014</td>
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<tr>
<td>Plan for Provider Access</td>
<td>In process</td>
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<tr>
<td>Integration of Quality &amp; CMART data</td>
<td>As soon as data are available</td>
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<tr>
<td>Implementation of Plan for Provider Access</td>
<td>As soon as possible, expected sometime 2014</td>
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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