NY Health Home Coalition

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NYS Department of Health
Office of Health Insurance Programs
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Dear Peg,

For several years now, we have worked together to build the state's health home program around a common vision of the role that health homes would play in the state, our shared understanding of the short- and long-term benefits of health homes, and a joint commitment to performance improvement. We are deeply grateful for the extensive work your team has undertaken to develop performance measures, collect and analyze available data and share that data with health homes as well as a larger network of stakeholders. We think this is an excellent start to more performance-driven care management. To make the data increasingly actionable, we're recommending some additional collaboration to provide meaningful context and to ensure the data is used for performance improvement and ultimately for the benefit of all health home-enrolled members in New York State.

Together, we have achieved measurable success in serving this complex population. At the statewide level, we have seen important reductions in avoidable utilization rates, in tandem with the important increases in primary care. We are committed to continuing along this path.

At the same time, the real work associated with understanding the relationship between the diversity of the population, and the intersection of chronic conditions and disability, poverty, geography, social needs and health and health outcomes is really beginning. We are not alone in pioneering this landscape, as the need to address the social determinants of health (SDOH) for our members through targeted interventions and strategies is taking health care by storm.

Some data is absolutely better than no data. At the moment, this data is just that – data, and not information. This data does NOT:

- Take into account how long people were enrolled in health homes
- The acuity or risk adjustment of the populations served by each health home
- Acknowledge that it could be comparing two totally different groups of people between years

- Take into account the major increase in enrollment across the time period that the outcomes reflect. During this time, health homes were taking on more and more high need individuals who, newly enrolled, had not had their care managed previously.

The fundamental question is, "What actions, applied to what members, under what circumstances, produce what results?" The information provided in the report only address the last part of these questions. Without the first three parts, these data are not yet useful in developing targeted plans for improvement. Below we suggest ways to leverage it for this purpose. We also feel it is critical to acknowledge that this analysis required an investment of major resources by SDOH and for that we are grateful. We propose going forward to combine resources, specifically leveraging the Coalition, our IT/Data Committee, our vendor partners and potential new funding sources to support further analysis and do NOT expect SDOH to shoulder the full burden for this alone.

We also totally recognize that the available data is limited to that which has been collected. It therefore has limitations which are unavoidable. We also recognize that there are existing demands on the system to meet reporting requirements including on plans and the State around HEDIS and QARR measures. Health homes are both willing and determined to help move the needle on these critical measures in collaboration with you and our plan partners. Additionally, we think it is important to acknowledge the need to build a more complete system of outcomes that measure recovery and rehabilitation - the social determinants outcomes. Research is clear that if we improve these outcomes, we decrease costs to the system and health outcomes also improve. Health Homes are in the position to measure the attainment of safe and stable housing, employment, education, social support, peer empowerment, Patient Activation Measures (PAM) and other domains of functioning that stand as proxies for better health.

The real work that we want to undertake will be challenging, as there is much variation in the size of our health homes and in the medical and social needs of health home enrollees. In CY 2016, for example, the smallest health home had 408 enrollees while the largest one had 12,181 enrollees, all compared to statewide average of 4,431 enrollees. It is highly unlikely that these two health homes share the same risk, which is why the state's use of the average as a performance benchmark does not help us to better understand the variation across health homes. As we all know, the use of the average never tells the full story. Understanding what works and what does not work will require a careful account of what's happening within the health home based on additional and complimentary data.

Analyzing the Data at the Health Home Level

To improve its suitability for public consumption, we need to develop a better methodology for reflecting the factors affecting performance and to jointly evaluate together potential uses for the data as well as the unintended consequences of the data being taken out of context.

The data prepared by the state does not stratify the population by demographics, medical and social needs, or any other way, yet the stratification of the population is critical to making valid comparisons across health homes. We would welcome a discussion about the State's goals for the analysis and reporting of the data.

We must move beyond the "raw" data that you have provided, and engage in a process of evaluation to establish best practices, and to advance this model to other populations who are not currently enrolled in the health homes population.

We believe that the road that we must go down today is to evaluate what is happening at the health home level to create a shared understanding of how the factors – and the real-life situations – that matter are considered by the state's policy leaders

We respectfully request a meeting with you to discuss this matter further. Additional information to inform that discussion is included below.

Sincerely,

The Coalition of NYS Health Homes

Our View of the Data

We do appreciate the time and effort that SDOH put in to prepare the CY 13-16 data on health home performance and we have taken some time to analyze the data on the 31 health homes. We now share these points with SDOH to underscore our concerns about the data as released. **The conclusion that we reach is that the raw data by itself does not support a greater understanding of the performance of the health homes. Transparency is an important goal, when conveying an important message. In this case, however, it is not clear what the message is and how the data will be used by non-health home entities.**

Additional questions to be posed regarding the source data for health homes and additional data sources that could be used to supplement this data:

- How do these outcomes relate to care management activities (frequency, type, and intensity of engagement)?
- How are social determinants of health (and outcomes related to SDOH) being accounted for?
- How do outcomes differ by population?
- How do outcomes differ by length of enrollment in the program? Is there a point at which the impact of care management is seen? What happens after that point? How long are the outcomes sustained? What are the pre-post outcomes?
- How can we isolate the effect of care management on outcomes?
- Are the members in the numerators for "poor outcomes" also the members that are stratified as medium or high for payment?
- Will we receive member-level and CMA-level data? These are critical for developing any type of action plan.

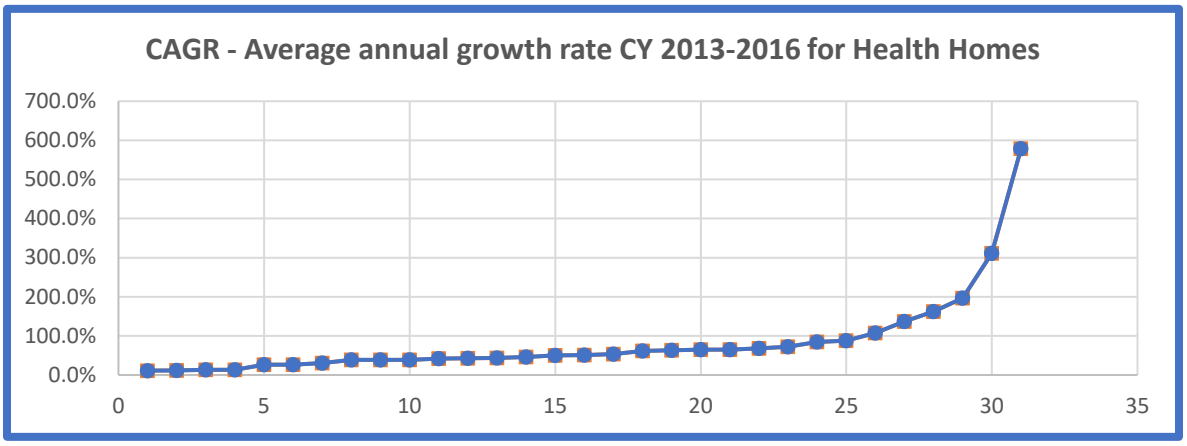
How can we work together to determine whether low rates of preventive screenings are a result of poor care management, versus a result of inadequate access to primary care in a given ZIP code? If engagement in primary care is high, but certain screening rates are low for a given health home, what are the implications of that finding? If the members are going to the doctor, does a low screening rate reflect poorly on the care manager? Or the PCP? Or is there another explanation?

Overall, The Coalition is concerned about the "consequences" of publicizing these data in a vacuum. There are no baselines, there is no accounting for who comprises the population, or for other externalities. How will the State address health homes that do not demonstrate improvement in a certain timeframe? How will MCOs interpret these data and use them for decision making about assignments and payment?

We also think it is inappropriate to include the re-designation level in the scorecard, given everything the State has acknowledged about the flaws and inconsistencies in the process.

Health Home Enrollment Growth

Between CY 2013-2016, the state's health home program grew from 41,252 to 136,788, or by an average annual growth rate of 49.1 percent. The growth in heath homes, however, varied greatly. The graph below shows the range of the average annual growth rate across health homes. Low to high range: 11.2 to 578.5.



NY Health Home Performance Goal

We appreciate the way in which the NY DOH has outlined the 28 measures for the health homes, and the methodology for measuring performance. We examined the data across health homes and found remarkable variation that creates deep concerns about showing any data that compares health homes. This graph shows the potentially preventable emergency room visit rate (PPV) across health homes for which NY DOH has established a benchmark performance target of 101.86 (NY HH AIT). The range shown in this graph moves from 69.8 to 224.9 across the 31 health homes, and the statewide average of 105.1. Note that the health homes at the high range have a rate that is more than 3 times greater than the rate at the low range.