CHCS Center for Health Care Strategies, Inc.

Improving the quality and cost-effectiveness of publicly financed health care

# Medicaid Health Homes: The National Landscape

National Health Policy Forum Meeting

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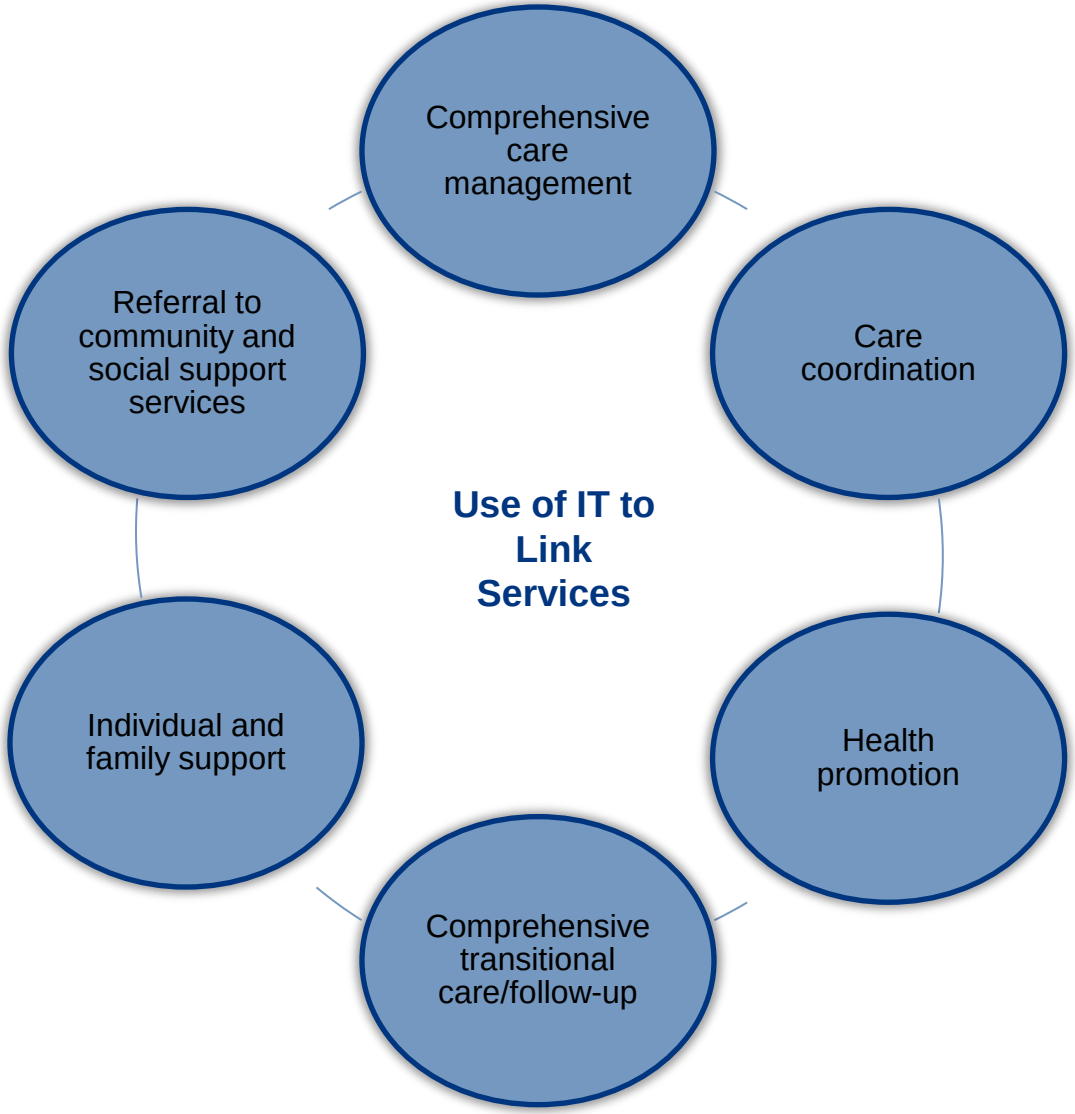
# Health Home Basics

- New state plan option created under ACA Section 2703
- Overall goal: improve integration across physical health, behavioral health and long term services and supports
- Opportunity to pay for "difficult-to-reimburse" services, e.g., care management, care coordination
- Flexibility for states to develop models that address an array of policy goals
- Significant state interest in evidence-based models to improve outcomes and reduce costs
- States receive an enhanced 90/10 federal match for the first eight fiscal quarters of the health home benefit

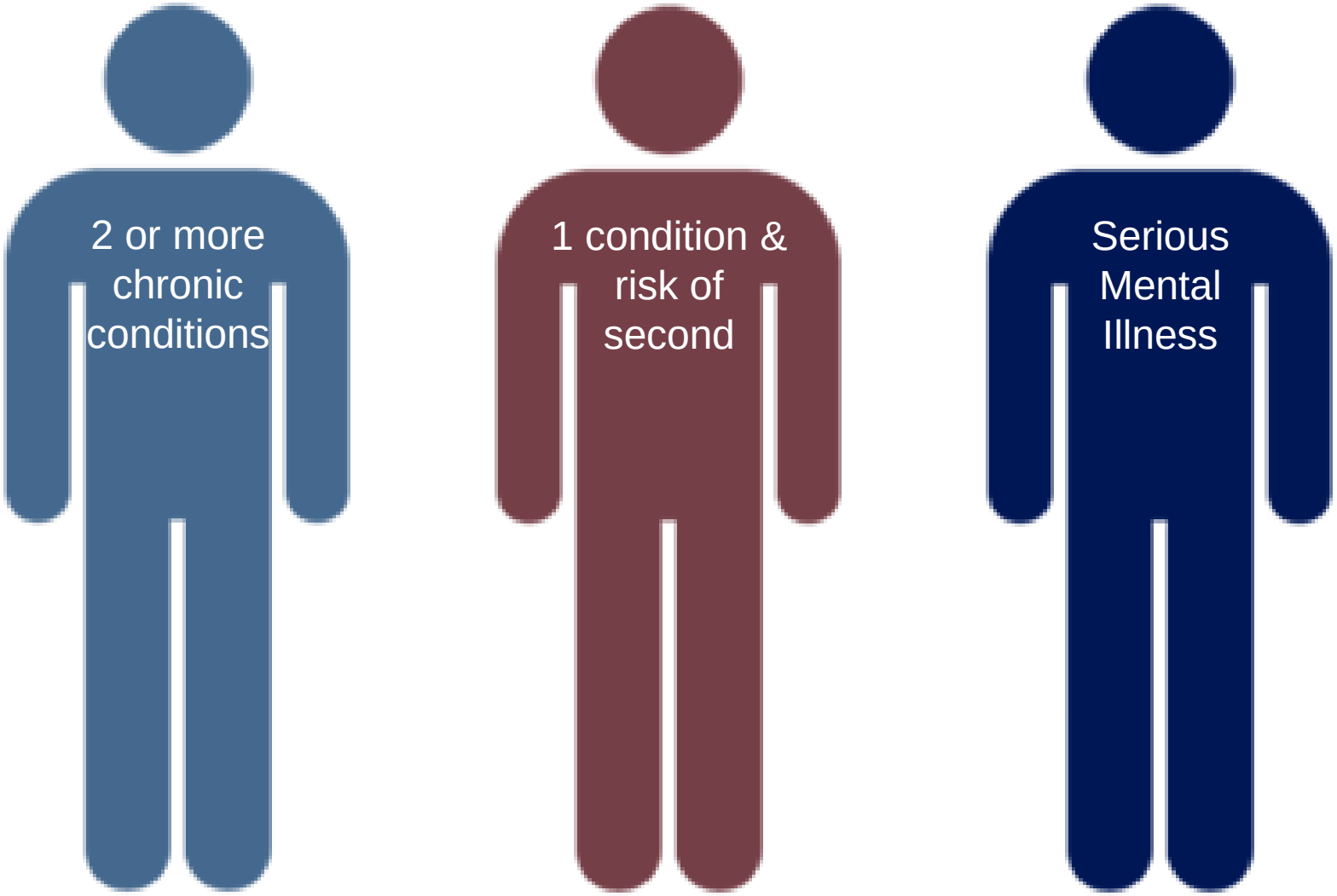
# What are health home services?



# What are health home services?

- All six services must be provided
- Do not include medical/direct treatment services
- Do not need to be provided “within the walls”
- Not limited to primary care

# Who can receive services?



# Targeting health home populations

## Targeting Do's

- By condition
- By geography
- By severity/risk
- By certain eligibility categories

## Targeting Don'ts

- By age
- By delivery system
- By dual-eligibility status

# Related to, but not the same as medical home

- Medical home can be foundation
- Health homes expand on traditional medical home models by:
  - Focusing on patients with multiple chronic and complex conditions;
  - Coordinating across medical, behavioral, and long-term care; and
  - Building linkages to community and social supports.
- Focus on outcomes, including reductions in: hospital admissions, ED visits, and admissions to LTC facilities

# Who can provide services and what must they do?

- Who can provide services?
  - Designated providers
  - Teams of health care professionals
- What requirements must be met?
  - State-defined
  - Key minimum federal standards include:
    - Provide quality-driven, cost-effective, culturally appropriate, person/ family-centered services
    - Develop a person-centered care plan that coordinates/integrates clinical/non-clinical health care needs/services
    - Establish a continuous QI program

# How are services reimbursed?

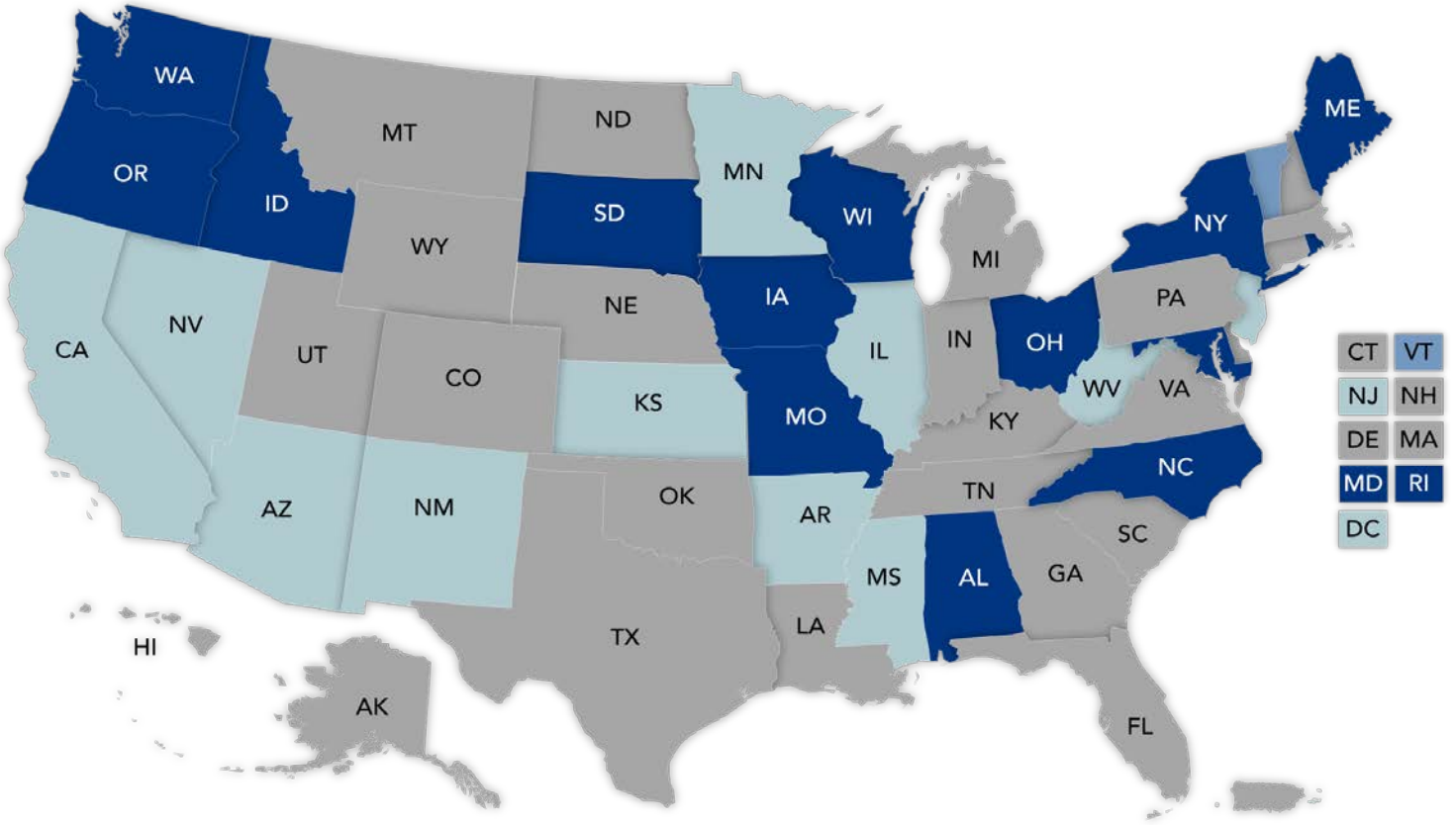
- Significant flexibility for states around payment methods
- Per member per month (PMPM) and case rates most common
- Can tier by patient severity or by provider capabilities
- Can flow payment through a lead entity (e.g. health plan) or pay directly from state to health home providers
- Can include resources for beneficiary engagement

# How are outcomes measured?

- Quality Measures
  - Core health care quality measure set (listed)
  - State selected measures
- Evaluation Measures
  - Hospital admissions
  - Emergency room visits
  - Skilled nursing facility admissions

1. Adult BMI Assessment
2. Ambulatory Care - Sensitive Condition Admission
3. Transition Record Transmitted to Health care Professional
4. Follow-up After Hospitalization for Mental Illness
5. Plan- All Cause Readmission
6. Screening for Clinical Depression and Follow-up Plan
7. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
8. Controlling High Blood Pressure

# State Health Home Activity




| | | |
|---|---|---|
| | **Approved Health Home State Plan Amendment (SPA)** | Alabama, Idaho, Iowa, Maine, Maryland, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island, South Dakota, Washington, Wisconsin |
| | **Health Home SPA "On the Clock" (officially submitted to CMS)** | Ohio (2nd SPA), Vermont (response to Request for Additional Information (RAI) pending) |
| | **Approved Health Home Planning Request** | Alabama, Arizona, Arkansas, California, District of Columbia, Idaho, Kansas, Maine, Maryland, Minnesota, Mississippi, Nevada, New Jersey, New Mexico, North Carolina, Washington, West Virginia, Wisconsin |
| | **No Activity** | Alaska, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Indiana, Kentucky, Louisiana, Massachusetts, Michigan, Montana, Nebraska, New Hampshire, North Dakota, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Wyoming |

# The Ticking Clock…

Date indicates when the state's enhanced federal match ends.

| DATE | STATE |
|---|---|
| 10/2013 | Oregon |
| | Rhode Island (two SPAs) |
| | North Carolina |
| 1/2014 | Missouri (two SPAs) |
| | New York (SPA #1) |
| 4/2014 | New York (SPA #2) |
| 7/2014 | New York (SPA #3) |
| | Iowa (primary care SPA) |
| | Alabama |

| DATE | STATE |
|---|---|
| 10/2014 | Ohio |
| | Wisconsin |
| 1/2015 | Idaho |
| | Maine |
| 7/2015 | Iowa (SPMI SPA) |
| | Washington |
| | Rhode Island |
| | South Dakota |
| 10/2015 | Maryland |

# Approved Health Home Models

| Primary Care Focus | SMI/SED/SUD Focus | Broad: Primary Care and SMI/SED |
|---|---|---|
| • Iowa | • Iowa | • Alabama |
| • Maine | • Maryland | • Idaho |
| • Missouri | • Missouri | • New York |
| • North Carolina | • Ohio | • Oregon |
| • Wisconsin | • Rhode Island | • South Dakota |
| | | • Washington |

# Key Considerations

- Significant flexibility in how models are developed
- Models must be free from duplication of services and payment with other Medicaid-funded services
- Cannot target by age; however health homes can be tailored to different needs across the age continuum
- Models should demonstrate true integration across primary and behavioral health
- Operational challenges for dual eligibles
- Timeframe for ROI given initial unmet service needs
- Ability to develop targeted and sustainable models

# Health Home Information Resource Center

- One-on-one technical support to states
- Peer-learning collaboratives
- Webinar
- Online library of hands-on tools and resources, available at:

  http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html