Health Homes: Perspectives from the Leaders

February 26, 2014

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CALIFORNIA HEALTHCARE FOUNDATION

California Improvement Network

Better Ideas for Care Delivery

Today's Speakers

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CHCS Center for Health Care Strategies, Inc.

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

Medicaid Health Homes: Overview and Update on National Activity

February 26, 2014

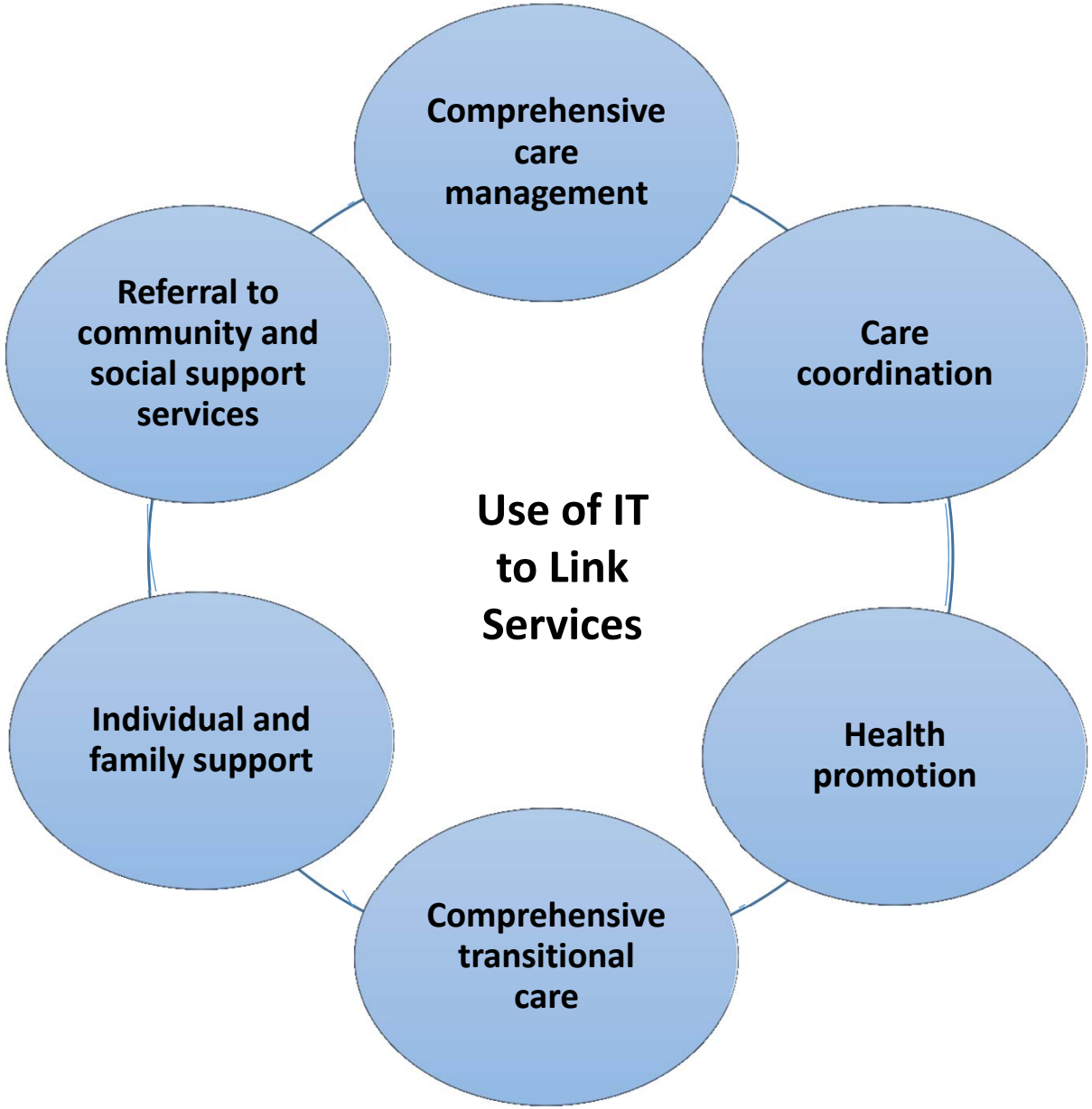
Allison Hamblin, Vice President

Center for Health Care Strategies

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?



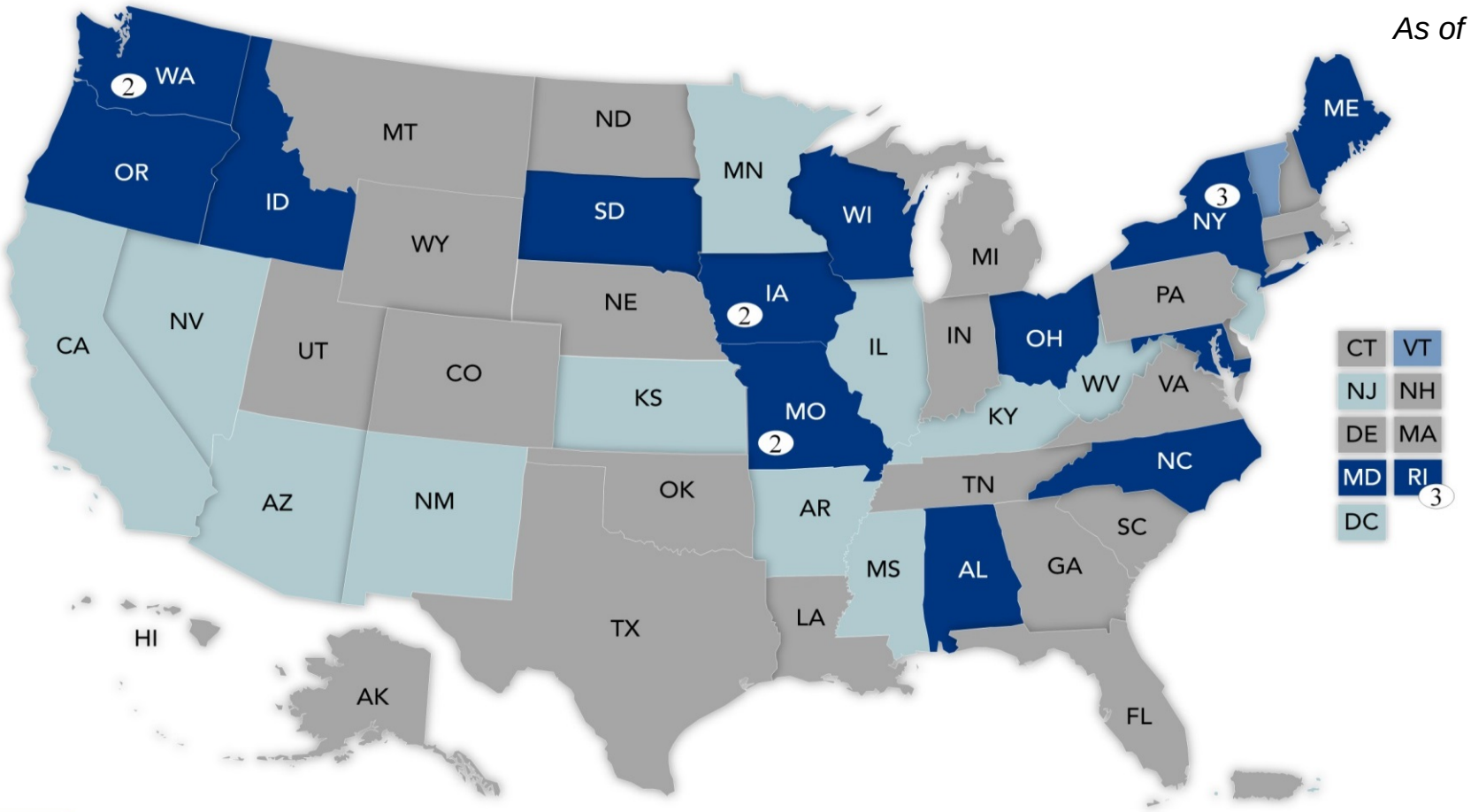
What Are Health Home Services?

- 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?

State Health Home Activity

As of February 2014



	Approved Health Home State Plan Amendment (SPA) (where (#) = number of approved SPAs if more than one exists)	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)	Iowa (3rd SPA), Maine (2nd SPA), Ohio (2nd SPA), Vermont (response to Request for Additional Information (RAI) pending), Wisconsin (2nd SPA)
	Approved Health Home Planning Request	Alabama, Arizona, Arkansas, California, District of Columbia, Idaho, Kansas, Kentucky, Maine, Maryland, Minnesota, Mississippi, Nevada, New Jersey, New Mexico, North Carolina, Washington, West Virginia, Wisconsin
	No Proposed SPA Submitted to CMS*	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

*Some states may be in the planning phase.

SOURCE: Developed by the Center for Health Care Strategies for the Centers for Medicare & Medicaid Services' Health Home Information Resource Center. See http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html.

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

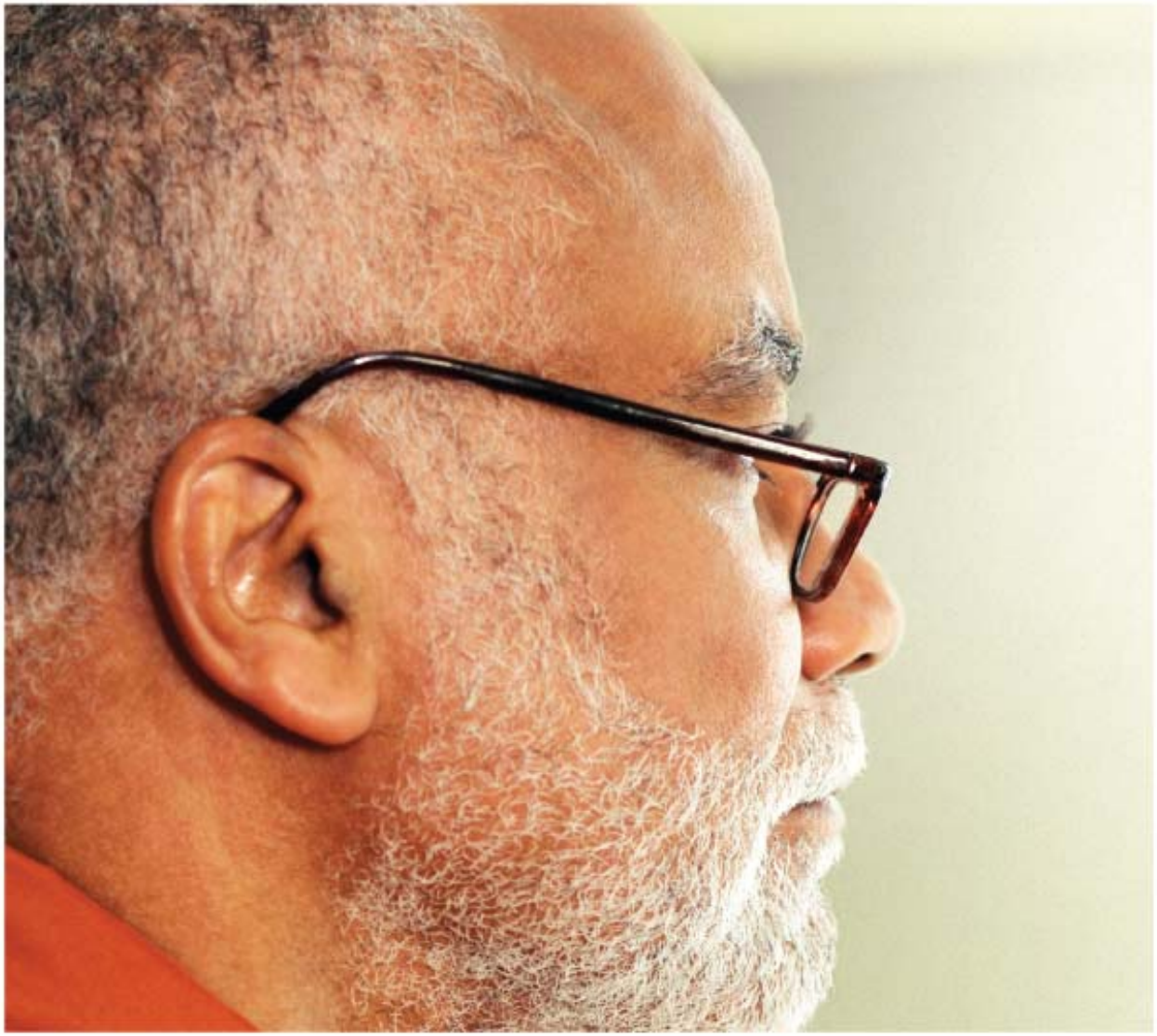
Lessons from Early Adopting States

- Option offers significant flexibility to advance state-defined policy goals
- Policy goals should drive target population selection, program design and payment method
- Services should be defined to effectively engage with and care for people with complex needs
- Providers need support in their transformation to health home model
- Access to real-time data is critical for effective care coordination

Health Home Information Resource Center

- One-on-one and group technical support to states
- Webinars
- 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



Health Homes

The Washington Way

HealthPath Washington

February 26, 2014

Washington State Health Care Authority

Washington State Department of Social & Health Services

Washington's Medicaid Program

- Health Care Authority and Department of Social and Health Services: Shared responsibility for Medicaid program
- Most populations enrolled in managed care (last group included people with eligibility related to disability and blindness, July 2012)
- Five managed care organizations

Health Homes

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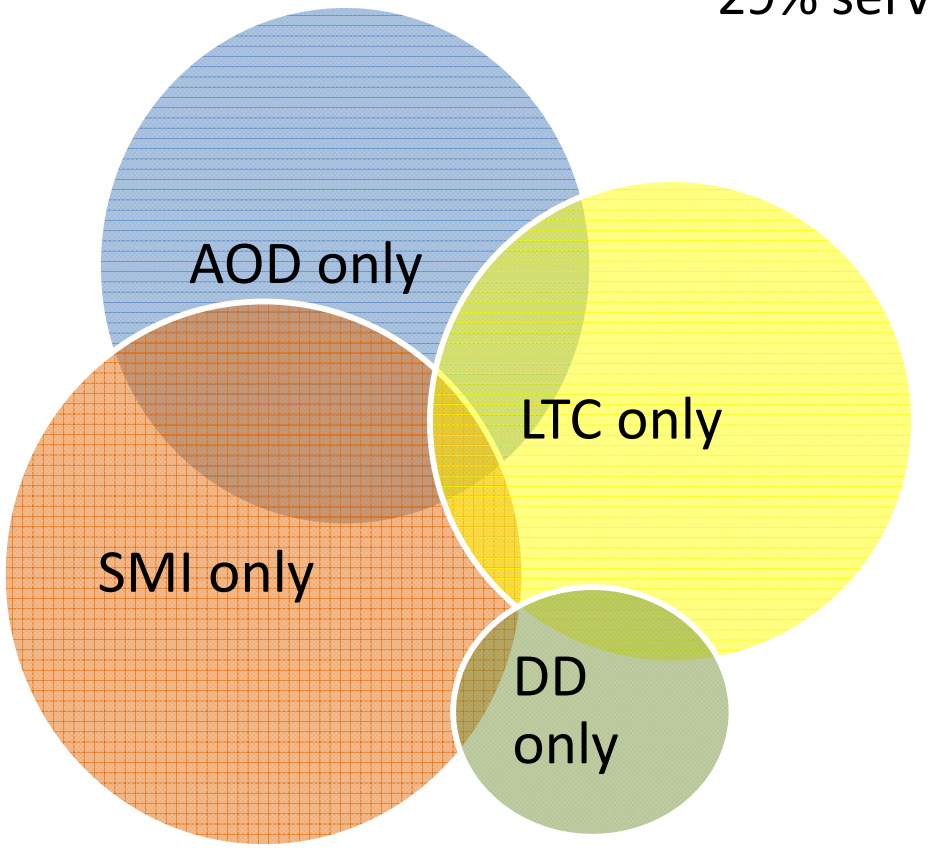
Making the Case

Washington State Health Care Authority

Washington State Department of Social & Health Services

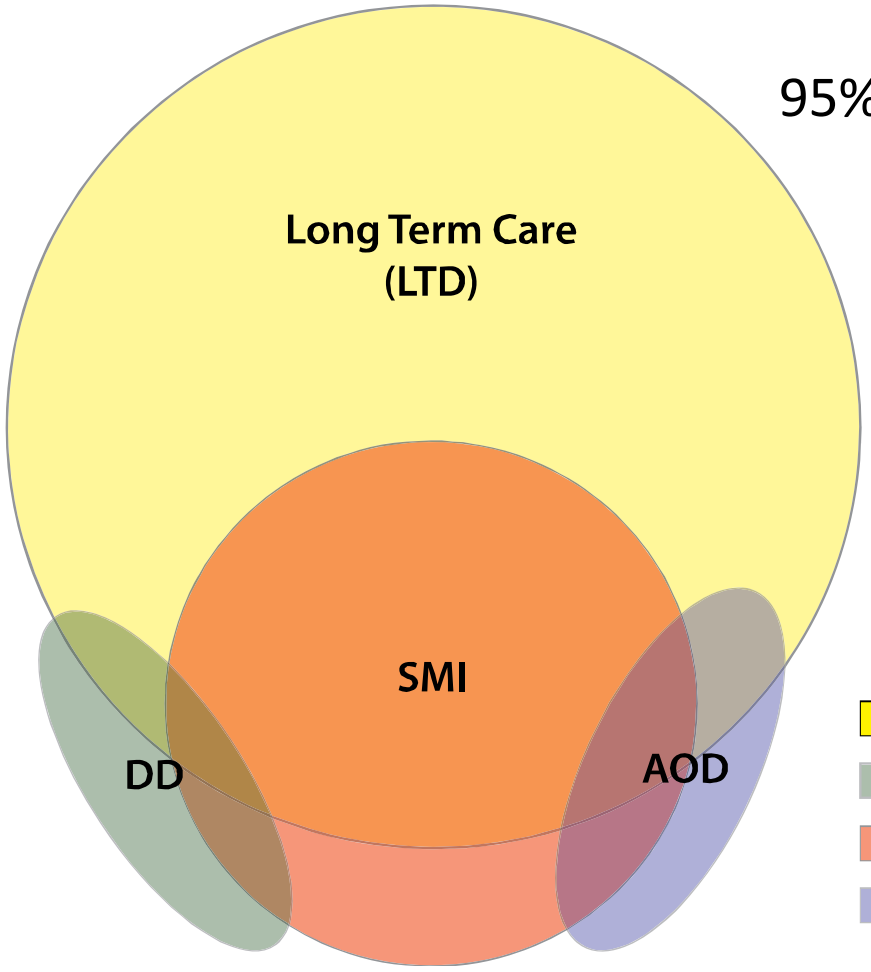
Service Needs for High Risk/High Cost Medicaid-Only Beneficiaries Overlap

29% served by ALTSA



Service Needs Overlap for High Risk/High Cost Beneficiaries Who Are Eligible for Medicare & Medicaid

95% served by ALTSA



LTD Long Term Care

DD Developmental Disabilities

SMI Serious Mental Illness

AOD Alcohol and Drug Abuse

Sources that Inform Washington's Health Home Model

- Federal law – Section 2703, Affordable Care Act
- State law – SSB 5394 (passed in 2011)
- Stakeholder feedback during "duals" planning
  - Improve coordination and align incentives
  - Single point of contact and intentional care coordination
  - Improve on what works, including flexibility to allow for local variances based on population need and provider networks

Health Homes

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Implementation Approach

Washington State Health Care Authority

Washington State Department of Social & Health Services

Goals

- Establish person-centered health action goals designed to improve health, health-related outcomes and reduce avoidable costs
- Coordinate across the full continuum of services
- Organize and facilitate the delivery of evidence-based health care services
- Ensure coordination and care transitions
- Increase confidence and skills for self-management of health goals
- Single point of contact responsible to bridge systems of care

Focus on High-Risk Enrollees

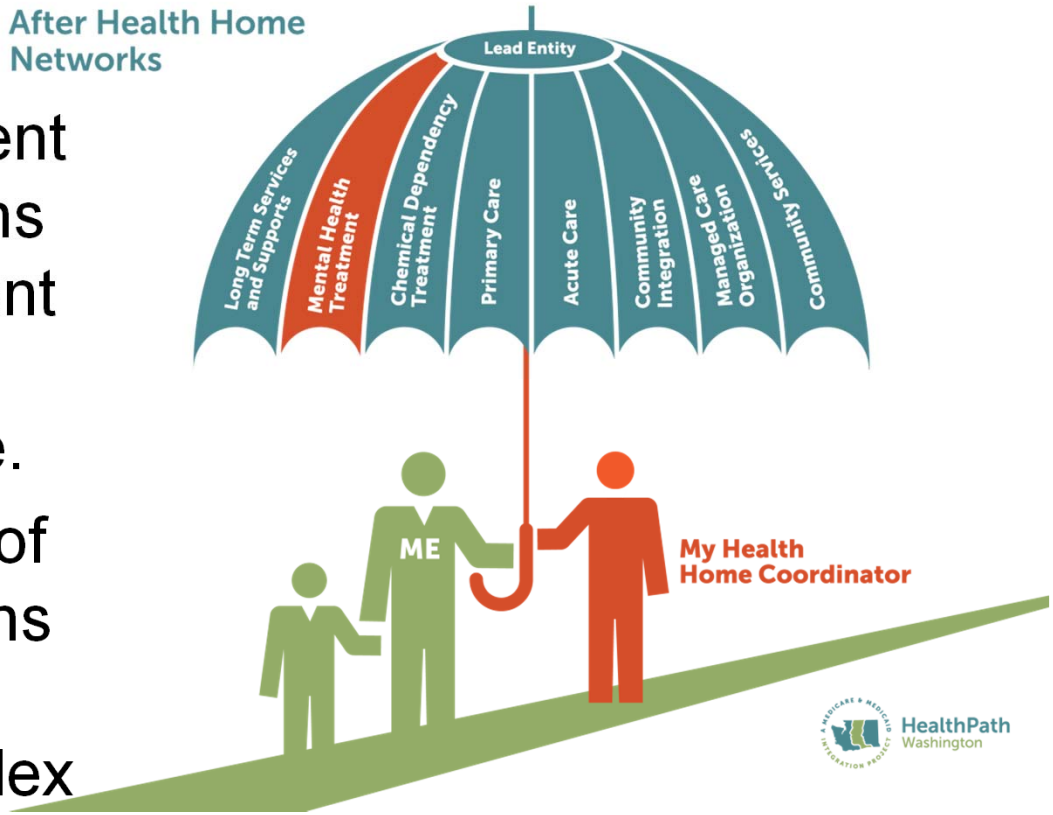
- Most at-risk for adverse health outcomes
- Greatest ability to achieve impacts on hospital and institutional utilization, and mortality
- Most likely to need/receive multiple Medicaid paid services
- Cost effective or achieve a return on investment
- Need to achieve funding sustainability for these interventions

Eligible Beneficiaries

- Identified chronic condition
- All ages, proportionally more dually eligible (Medicare/Medicaid) individuals have high risk scores
- High rates of Emergency Department use, hospitalization and re-hospitalization
- A risk score of 1.5 or greater; future costs predicted to be 50% higher than average population (disability-related eligible group)

Health Home “Umbrella”

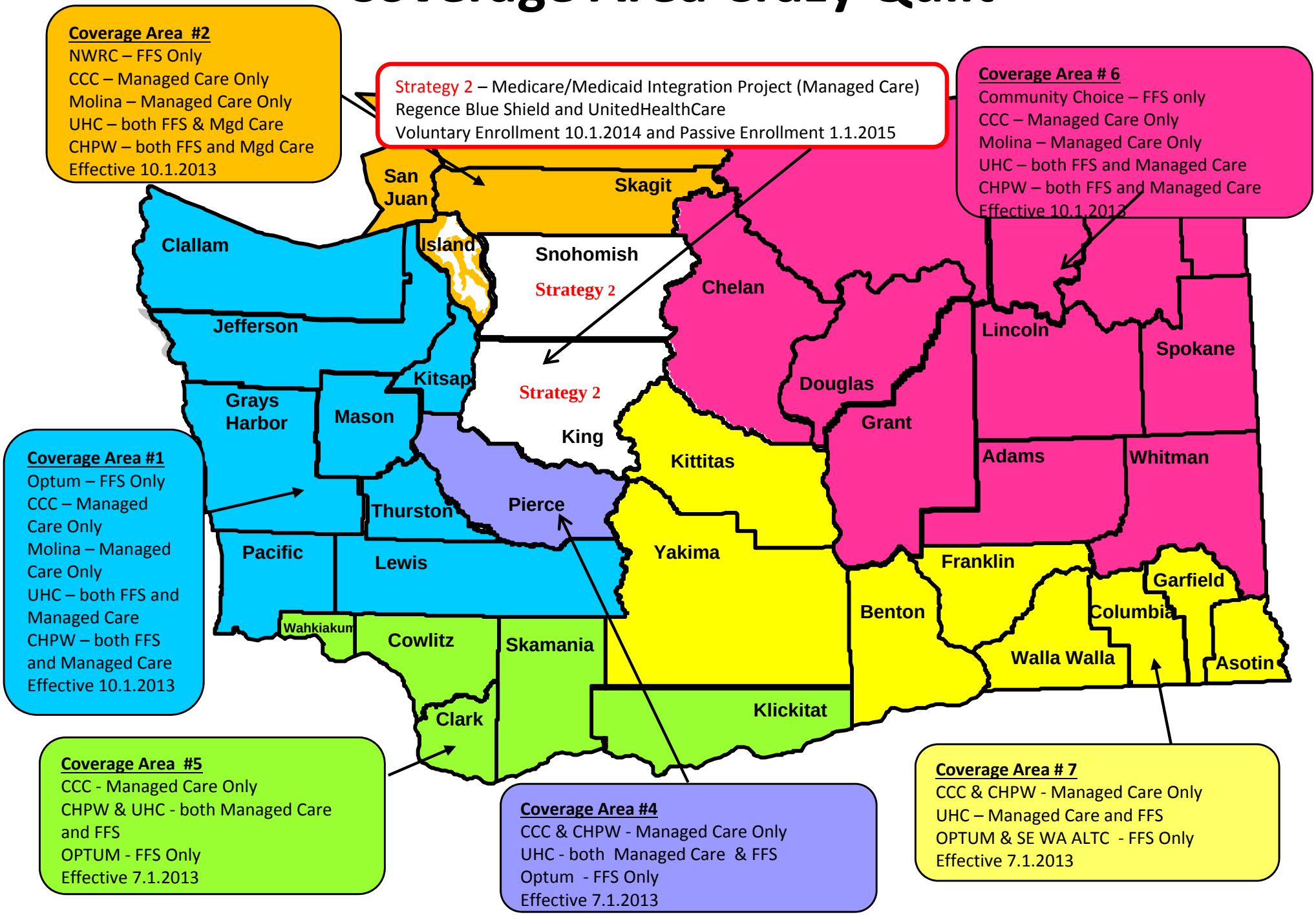
- Health Homes receive enrollment on a monthly basis: Health plans receive a “flag” on the enrollment file; other Health Home leads receive a unique enrollment file.
- Health Homes build a network of Care Coordination Organizations that serve mental health, long-term care, and medically complex clients.



Services

- Health Action Plans
  - Person-centered
  - Support self-management – Patient Activation Measure & Caregiver Activation Measure (PAM/CAM)
- Use of Health Information Technology
  - Local exchange of ED information
  - State systems: PRISM and OneHealthPort

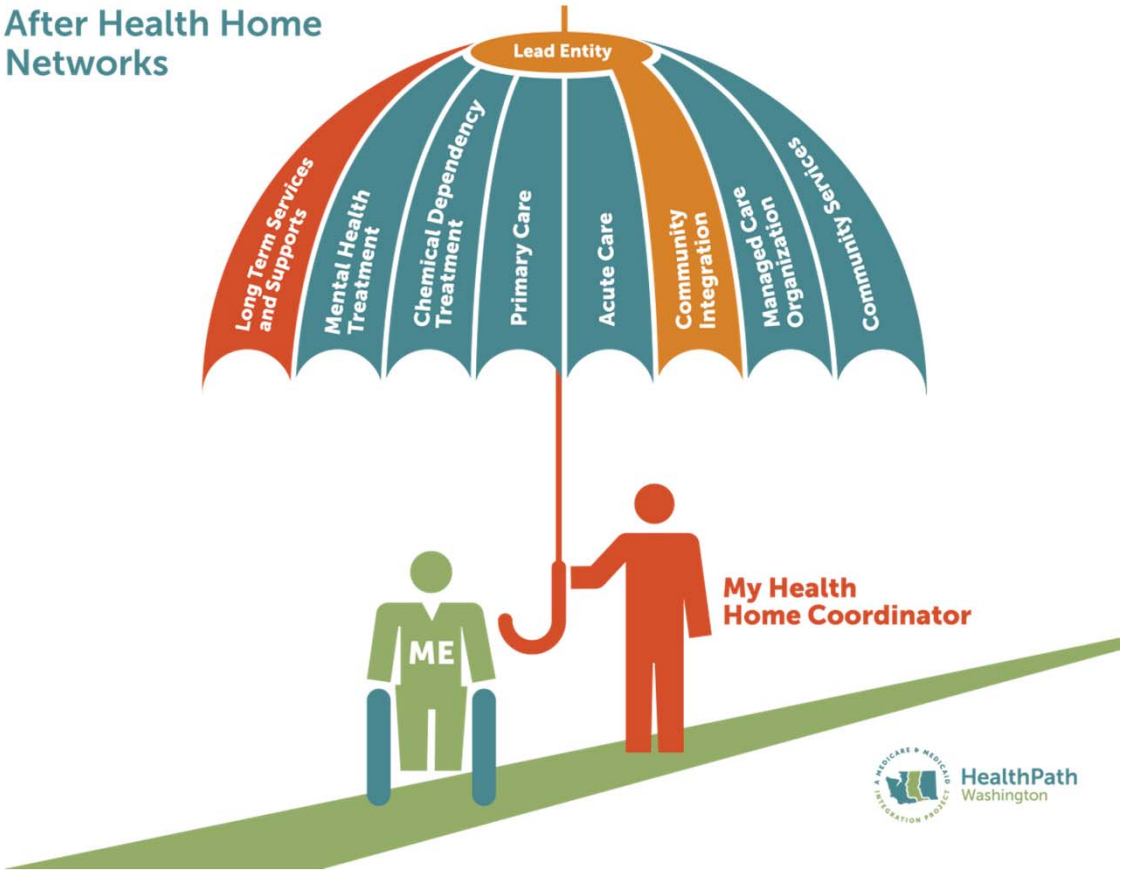
Coverage Area Crazy Quilt



6/25/2013 REV

Payment for Health Home Services

- $252 for outreach, engagement, and health action plan
- $172 for intensive care coordination services
- $67 for maintenance
- Health Home Leads establish a network; may also provide care coordination services directly



Health Homes

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The First Six Months: Successes and Lessons Learned

Washington State Health Care Authority

Washington State Department of Social & Health Services

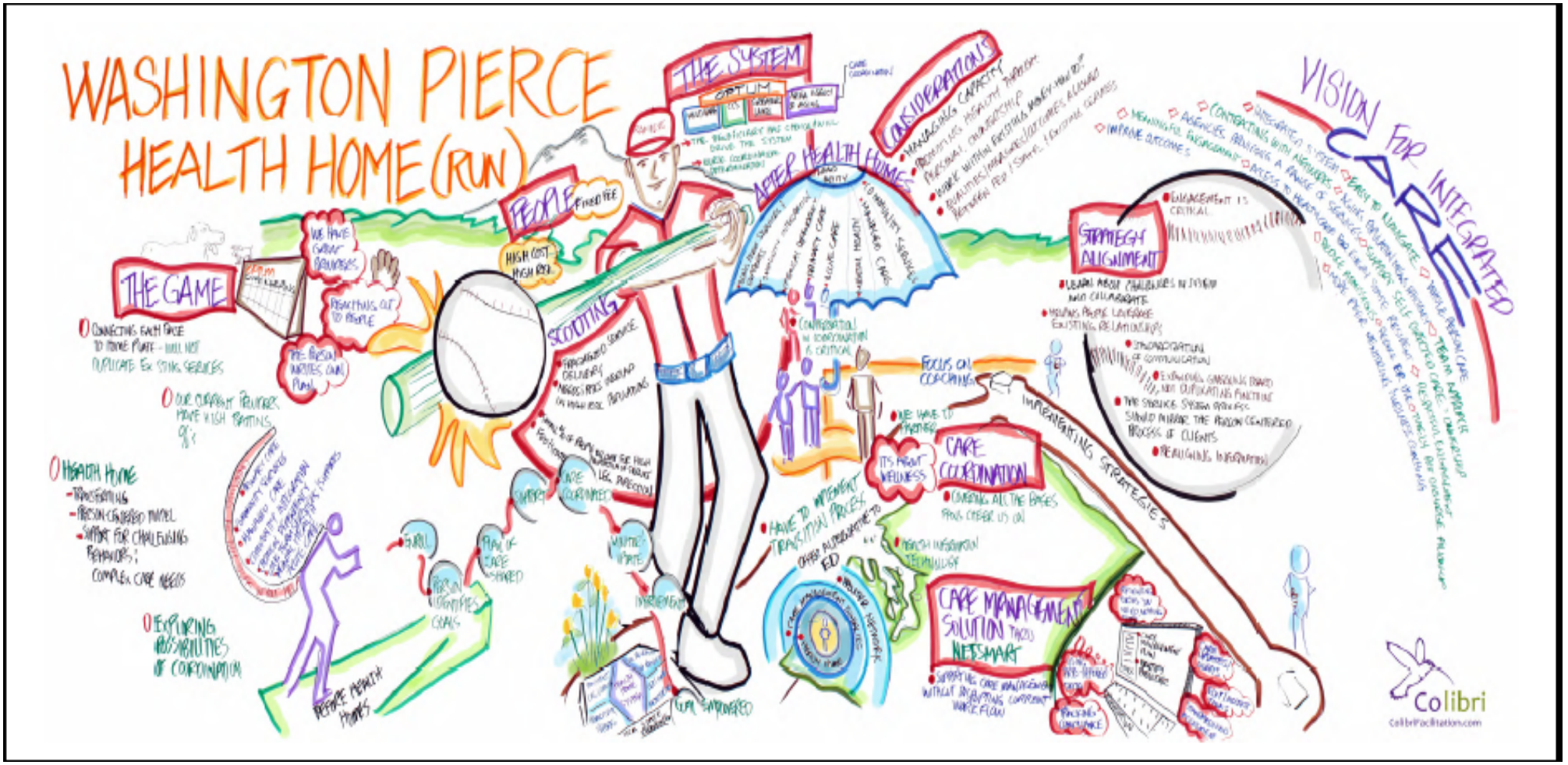
One Example of Qualified Lead Health Home: Optum

- Emphasis on creation of community partnerships, expert care coordination staff, outreach and high touch services delivered in community setting including a beneficiary's home
- Optum, a managed behavioral health organization, applied to serve as a Lead Health Home

HH Example: Optum

- Contracted with 10 Care Coordination Organizations throughout Washington
- Specializes in providing health home services to those with a mental illness
- Developed a network that includes Area Agencies on Aging, Chemical Dependency Treatment Centers, and large Federally Qualified Health Centers

Hitting It Out of the Park!



Health Homes: Implementation Challenges

- Health Home Leads challenges:
  - Locating and engaging clients
  - Planning for network capacity
  - Developing systems to receive and use information from new sources; transmit information to state
- Care Coordination Organization challenges:
  - Unique information exchanges with Health Home Leads
  - Unique caseload standards and contact requirements
  - Complex cases

Health Homes: Successes

- The demonstration required stakeholder outreach and participation. Stakeholder input resulted in a better design on the ground.
- Coordinated Care Organization model strengthens the role of community providers.
- Existing chronic care management model allowed knowledge transfer: We have trained over 300!
- New collaborative arrangements may lead to ACO relationships in the future.

Resources

Websites:

http://www.hca.wa.gov/health_homes.html

http://www.adsa.dshs.wa.gov/duals/

http://www.integratedcareresourcecenter.com/

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Thank you for joining our call today!

For more information about the California Improvement Network, go to www.chcf.org/cin

Today's webinar slides and recording will be available at that site within a week.

California Improvement Network Better Ideas for Care Delivery