CENTERS FOR MEDICARE & MEDICAID SERVICES

Exploring Medicaid Health Homes:
Building upon Regional Care Networks for Medicaid Health Homes

May 29, 2013; 2:00 – 3:00PM (ET)

For more information or technical assistance in developing health homes, visit http://www.Medicaid.gov.

Exploring Medicaid Health Homes

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Health Home Information Resource Center

Technical Assistance for State Health Home Development

- Established by CMS to help states develop health home models for beneficiaries with complex needs
- Technical assistance led by Mathematica Policy Research and the Center for Health Care Strategies includes:
  - One-on-one technical support
  - Peer-learning collaboratives
  - Webinars open to all states
  - Online library of hands-on tools and resources, including:
    - Matrix of Approved Health Home SPAs
    - Map of State Health Home Activity
    - New draft SPA template

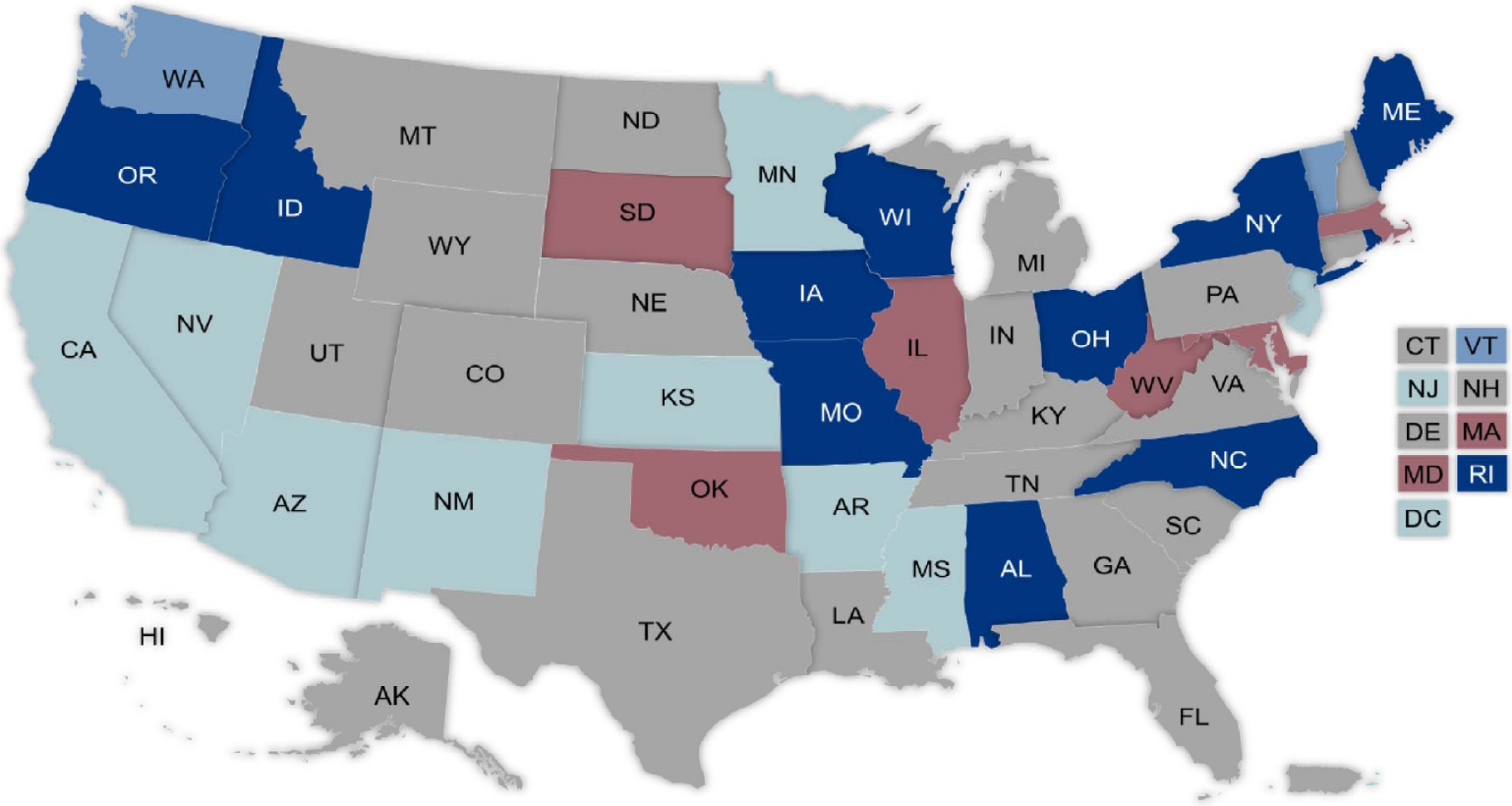
Exploring Medicaid Health Homes Webinar Series

- Provides a forum for states to share models, elements of their SPAs, and successes or challenges in their development process
- Creates an opportunity for CMS to engage in conversation with states considering and/or designing health home programs
- Disseminates existing knowledge useful to health home planning
- Open to any state considering or pursuing health homes

National Landscape to Date

- 15 approved State Plan Amendments in 11 states: AL, IA, ID, ME, MO, NC, NY, OH, OR, RI and WI
- Number of states in discussion with CMS
- Many other states exploring the opportunity to develop health homes

State Health Home Activity



	Approved Health Home State Plan Amendment (SPA)	Alabama, Idaho, Iowa, Maine, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island, Wisconsin
	Health Home SPA "On the Clock" (officially submitted to CMS)	Iowa (2nd SPA), Vermont, Washington
	Draft Health Home SPA Under CMS Review	Illinois, Maryland, Massachusetts, Oklahoma, Rhode Island (3rd SPA), South Dakota, West Virginia
	Approved Health Home Planning Request	Alabama, Arizona, Arkansas, California, District of Columbia, Idaho, Kansas, Maine, Minnesota, Mississippi, Nevada, New Jersey, New Mexico, North Carolina, West Virginia, Wisconsin
	No Activity	Alaska, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Indiana, Kentucky, Louisiana, Michigan, Montana, Nebraska, New Hampshire, North Dakota, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Wyoming

Context for Alabama

- Alabama Medicaid – saw an opportunity to leverage the existing building block of the state's regional Patient Care Networks
- North Alabama Community Care – one of Medicaid's health home providers

Today's Presenters

- Alabama Medicaid
  - Nancy Headley and Carolyn Miller
- North Alabama Community Care
  - Dana Garrard

PATIENT CARE NETWORKS OF ALABAMA

Nancy Headley, BSN,
Director Managed Care Division
Carolyn Miller, LCSW,
Patient Care Network Consultant

PATIENT CARE NETWORKS OF ALABAMA (PCNA'S)

- Health Home SPA approved – effective date July 1, 2012
- Features include:
  - Addressing physical and behavioral health of patient
  - Preventative care
  - Educational components
  - Transitional care from acute settings
  - Community involvement

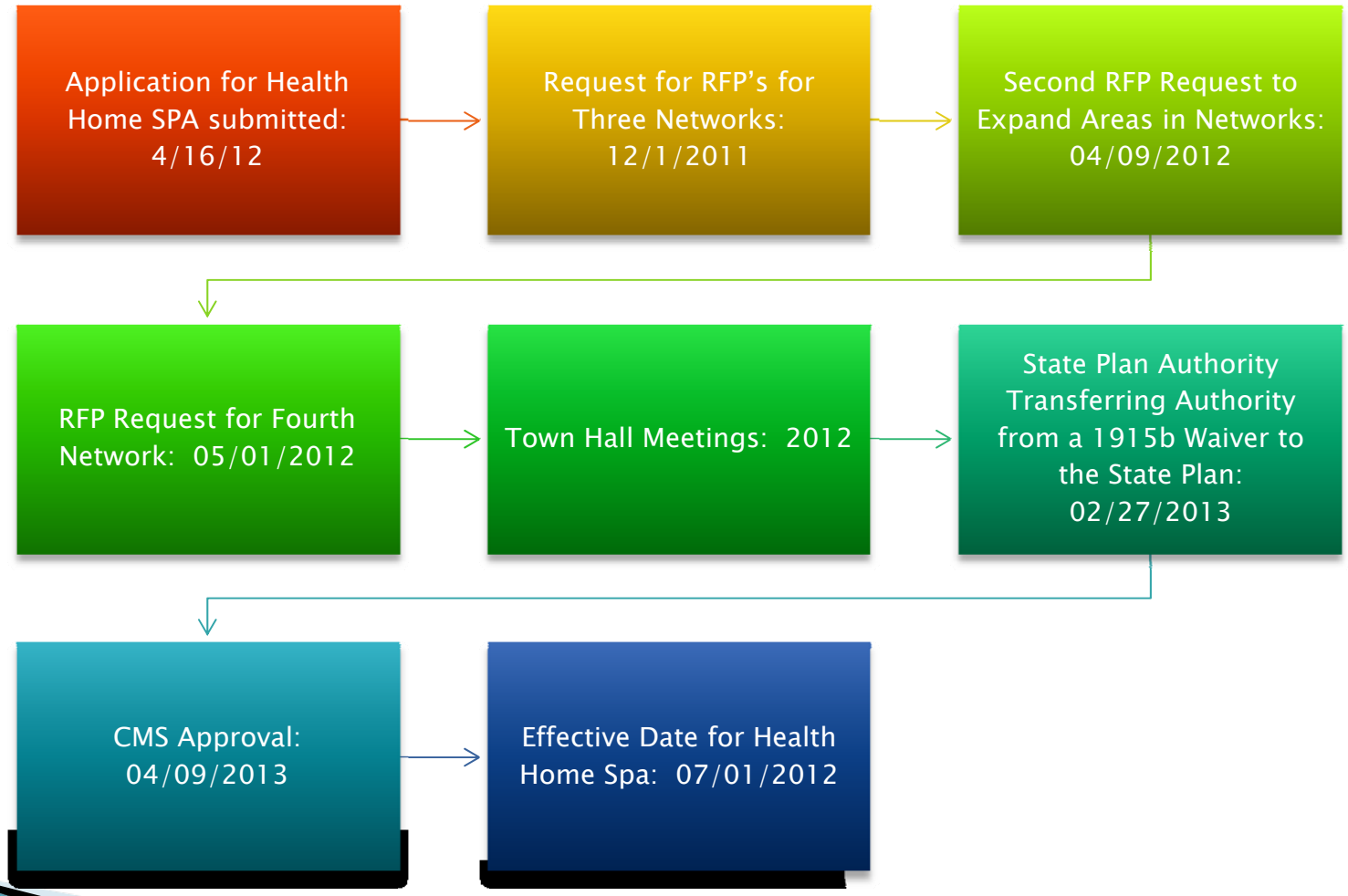
Current Issues in Alabama

- Alabama is ranked 45th in the nation on its health assessment.
- The state is the second highest for obesity.
- The diabetes rate is 50% higher than the national average.
- Alabama is ranked 7^{th} in heart disease.

BUILDING BLOCKS

- Community Agencies
- Alabama Department of Mental Health
- Medical Community
- Provider Associations
- Alabama Department of Public Health
- Alabama Medicaid

TIME FRAME FOR DEVELOPMENT



GEOGRAPHIC FOCUS

- **North Alabama**: Limestone, Madison, Morgan, Cullman Counties
- **West Alabama**: Lamar, Fayette, Pickens, Tuscaloosa, Green, Hale, Bibb, Sumter Counties
- **East Alabama**: Coosa, Tallapoosa, Chambers, Lee, Macon, Russell, and Bullock Counties
- **Gulf Coast**: Mobile and Washington Counties

QUALIFYING MEMBERS

- Recipient of Patient 1st Medicaid
- Adults and Children with at least two of the following chronic conditions:
  - Mental Health Condition
  - Substance Abuse
  - Asthma
  - Diabetes
  - Heart Disease
  - BMI over 25
  - Transplants in past five years
  - Cardiovascular Disease
  - Chronic Obstructive Pulmonary Disease
  - Cancer
  - HIV
  - Sickle Cell Anemia

QUALIFYING MEMBERS (Cont.)

- One chronic condition and the risk of developing another
- One serious mental illness

QUALITY MEASURES (Goal Based)

- Improved health outcomes for adults with diabetes.
- Improved health through the reduction of adult BMI.
- Improve coordination of care for individuals with asthma.
- Improve health outcomes of individuals with chronic illnesses through reduction in hospital re-admission rates and Ambulatory Care Sensitive Condition Admissions.

QUALITY MEASURES (Goal Based Cont.)

- Improved care coordination through timely transmission of transition records (inpatient discharges to home/self care or any other site of care).
- Improved preventive care for children.
- Improved treatment for patients identified as having clinical depression utilizing the PHQ-2 and PHQ-9 assessment tool.

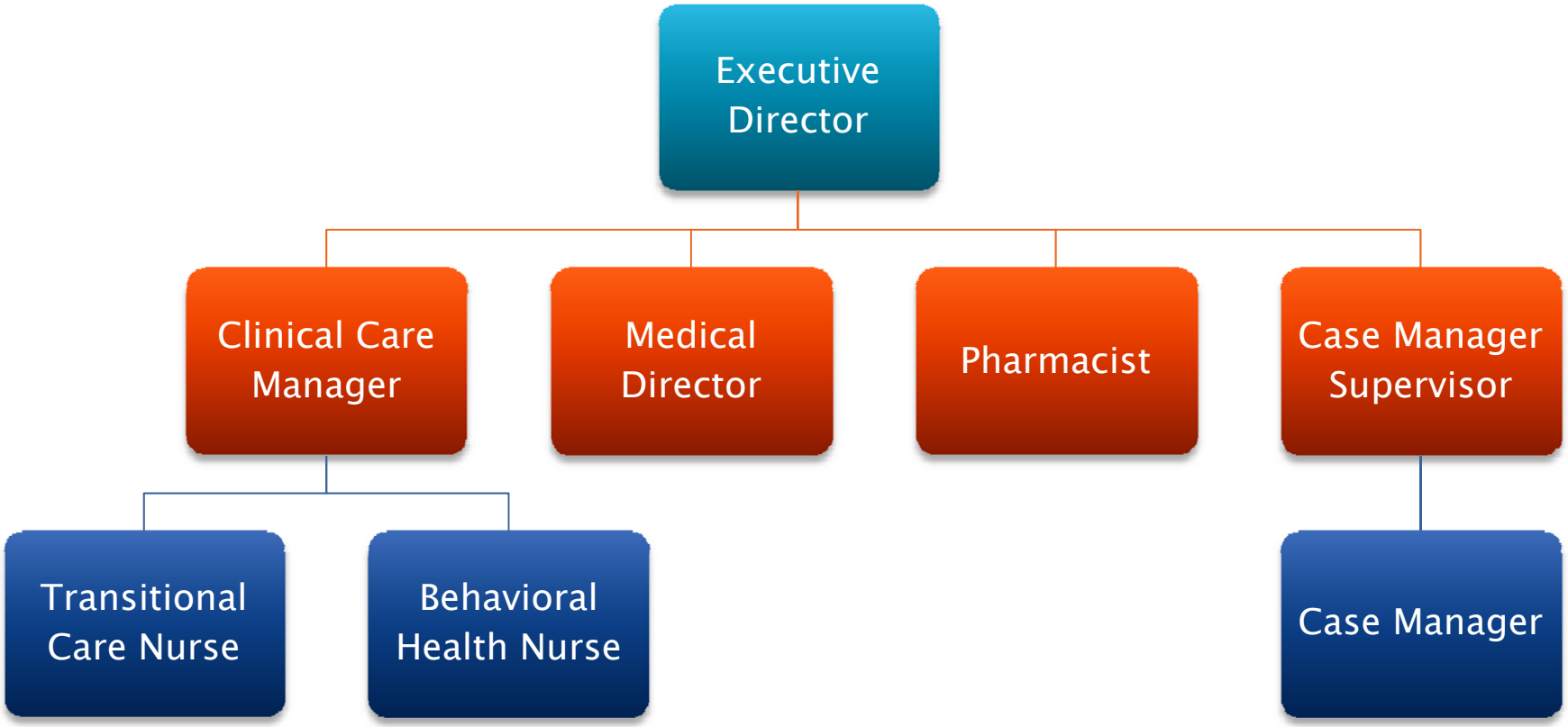
Quality Measures (Service Based Measures)

- Follow Up After Hospitalization for Mental Illness.
- Percentage of adolescents and adult members with a new episode of alcohol or other drug dependence who received initiation and engagement of AOD treatment.
- Transition record with specified elements received by discharged patients.

PROVIDER ENROLLEMENT

- Requirements for PMP participation:
  - The provider must have contracts with ASMA and the local PMA.
  - The provider must sign agreements that address core competencies.
- Each PMP contract addresses the integration and coordination of services for individuals with behavioral health or substance abuse issues.
- Encouraged attendance at quarterly medical management meetings.

PCNA STAFF


Executive Director
Clinical Care Manager
Medical Director
Pharmacist
Case Manager Supervisor
Transitional Care Nurse
Behavioral Health Nurse
Case Manager

CLINICAL CARE MANAGEMENT

- Each PCNA maintains a medical management committee composed of network providers who meet quarterly to share data analysis and selected program initiatives.
- The Medical Director and staff evaluate and compare performance with quality, access, cost and utilization benchmarks to develop strategies to achieve goals.
- The PCNA distributes reports to providers to assure comprehension and encourage collaboration of goal achievement.

PHARMACIST

- Coordinates pharmacy activities to assure safe, effective, appropriate and economical use of medications to improve continuity of care and outcomes.
- Supports local pharmacists and prescribers in management of drug costs and clinical initiatives.
- Serves as a resource to network physicians and care managers on general drug information and Medicaid pharmacy policy issues.

CARE COORDINATION

- Reduces psychosocial barriers impacting the health of the patient through Care Managers.
- Improves quality of care and quality of life.
- Promotes effective use of the healthcare system and community resources.
- Reduces inappropriate utilization and costs associated with emergency departments and hospital inpatient services.

TRANSITIONAL CARE PROGRAM

- Transitional Care Nurses collaborate with hospital discharge planners to develop plans and resources.
- Ensure appropriate home based support services.
- Implement medication reconciliation.
- Ensure appropriate follow-up appointments are made.
- Promote the ability and confidence in self management of chronic illnesses.

BEHAVIORAL HEALTH

- Behavioral health nurses develop relationships with behavioral health and substance abuse facilities.
- Assist patients in connecting with needed behavioral health and substance abuse services.
- Provide education to patients, staff, and providers regarding behavioral health issues.

PCNA BOARD

- Board membership includes at least one representative from each of the following:
  - A Federally Qualified Health Center
  - Hospital
  - The Health Department
  - Community Mental Health Center
  - A Community Pharmacist
  - A Substance Abuse Provider
- At least one-half of the board membership must be Patient 1st primary care physicians.

PAYMENT METHODOLOGY

Capitated Case Management rates in PCNA Networks:

$8.50 Physician PMPM – For Patients with identified Health Home chronic condition and participating in the network

$9.50 PMPM Network– For Patients with identified Health Home chronic condition and participating in the network

CURRENT INITIATIVES

- Dieticians hired in one PCNA to conduct nutrition classes.
- Care Managers accompany new mothers to their infant's first pediatric appointment.
- Contract established with local psychiatrist to see patients unable to schedule appointments following psychiatric hospitalization.
- Education to PMP's regarding Sickle Cell.

LESSONS LEARNED

- Engage stakeholders/partners early – educational material/ letters to the following would have been helpful:
  - PMP's
  - Hospital staff, including ER Directors and IT
- Establish smaller, informal meetings with providers.

CONTACT INFORMATION

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For More Information

- Download practical resources to improve the quality and cost-effectiveness of Medicaid services.
- Subscribe to e-mail updates to learn about new programs and resources.
- Learn about cutting-edge efforts to improve care for Medicaid's highest-need, highest-cost beneficiaries.

healthhomesTA@chcs.org

Additional TA Resource

- SAMHSA is funding technical assistance to states seeking to develop health homes for individuals with serious mental illness
- Goal: to assist states in thinking through their health homes strategies for children and youth with serious emotional disturbance
- Contact kmoses@chcs.org for further information