CENTERS FOR MEDICARE & MEDICAID SERVICES

Exploring Medicaid Health Homes:
Leveraging State Pilot Experience in Health Home Programs

August 2, 2012; 3:00 – 4:00PM (ET)

- For audio, dial: 1-800-273-7043; Passcode: 596413
- A video archive will be posted on http://www.medicaid.gov.

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

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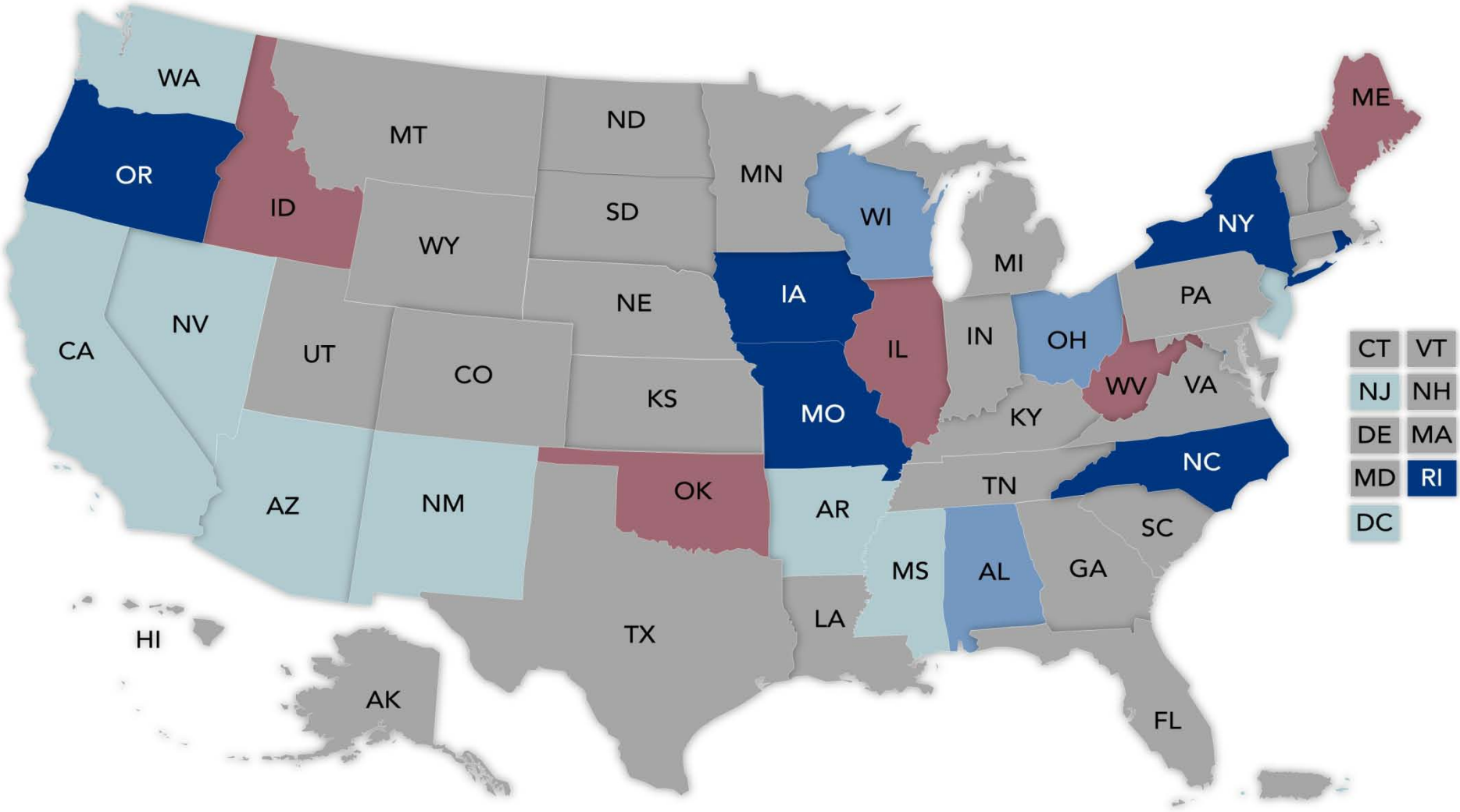
Types of Technical Assistance with Health Home Development

- One-on-one technical support to states
- Peer-learning collaboratives
- Webinars open to all states
- Online library of hands-on tools and resources, recently added tools include:
  - Implications of Health Homes for NCQA Health Plan Certification
  - Data Analysis Considerations to Inform Health Home Program Design
  - Updated Matrix of Approved Health Home SPAs
  - Map of State Health Home Activity

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
- Any state considering or pursuing health homes may participate in these webinars
- Goal of disseminating existing knowledge useful to health home planning

State Health Home Activity



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

National Landscape to Date:

- 8 approved State Plan Amendments across the following states: MO, RI, NY, OR, IA, NC
- Growing number of states in various stages of discussion with CMS
- Multiple other states exploring the opportunity
- Medicaid Adult Health Quality Grants - CDFA #93.609
  - Recently released funding opportunity announcement from CMS, designed to support states in developing their capacity to collect, analyze, and report quality data
  - Particular relevance to health home development as six of the required health home core quality measures align with the adult measures

Summary of Approved SPAs

SPA	Target Population	Target Providers	Payment Methodology
MO PCP focus	At least two of the following chronic conditions: asthma, heart disease, diabetes, developmental disability, overweight; or one of the previous chronic conditions and at risk of another	FQHCs, RHCs, or primary care clinics operated by hospitals	PMPM
MO CMHO focus	Diagnosis of SPMI only; MH or SA disorder plus a chronic condition; MH or SA disorder plus tobacco use	CMHCs meeting state requirements	PMPM
RI BH / CSHCN focus	Diagnosis of SMI or SED; At least two of the following chronic conditions: mental health condition, asthma, diabetes, developmental disability, Down's Syndrome, mental retardation, seizure disorder; or one of the previous conditions and at risk of developing another	CEDARR Family Centers	Case rate
RI CMHO focus	Individuals with SPMI who are eligible for state's community support program	CMHOs and providers of specialty mental health services	Case rate
NY Chronic medical & behavioral health focus	Diagnosis of SMI; At least two or more of the following chronic conditions: MH, SA disorder, asthma, diabetes, heart disease, overweight, HIV/AIDS, hypertension, (also other conditions identified in clinical risk group categories by data analysis)	Provider or group of providers meeting state requirements	PMPM adjusted by region, case mix, and (eventually) patient functional status
OR Chronic medical & behavioral health focus	Diagnosis of SMI; At least two of the following chronic conditions: MH, SA disorder, asthma, diabetes, heart disease, overweight, hepatitis C, HIV/AIDS, chronic kidney disease, chronic respiratory disease, cancer; or one of the previous chronic conditions and at risk of another	Patient Centered Primary Care Homes	PMPM Tiered by level of individual practice or provider group
NC Chronic illness focus	At least two of the following chronic conditions: asthma, diabetes, heart disease, overweight, blindness, chronic cardiovascular disease, chronic pulmonary disease, congenital anomalies, chronic disease of the alimentary system, chronic endocrine and metabolic disease, chronic infectious disease, chronic mental and cognitive conditions not including mental illness or developmental disabilities, chronic musculoskeletal conditions and chronic neurological disorders; or one of the previous chronic conditions and at risk of developing another	Medical Homes	PMPM Tiered by ABD or Non-ABD status
IA Chronic illness focus	At least two of the following chronic conditions: MH, SA disorder, asthma, diabetes, heart disease, overweight, or hypertension; or one of the previous chronic conditions and at risk for another	Primary care practices, CMHCs, FQHCs, RHCs meeting state requirements	PMPM Tiered by acuity

Ten Themes from Approved SPAs

1. Using existing building blocks as basis for health homes
2. Analyzing claims data to identify eligible population, considering varying diagnoses, associated costs and ideal “critical mass”
3. Using data to identify the greatest potential for savings and determine enrollment

Ten Themes from Approved SPAs

4. Employing a variety of strategies to maximize the enhanced 90/10 match and build sustainable programs
5. Using health homes as an opportunity to address system-level silos by engaging providers, stakeholders and other agencies in program development
6. Setting a high bar for provider eligibility

Ten Themes from Approved SPAs

7. Implementing various requirements to promote integrated and coordinated care
8. Focusing measures on appropriate management of both medical and behavioral health conditions
9. Re-examining the role of health plans in relation to health homes
10. Using reimbursement methodologies to move towards alignment of incentives with payment and delivery system reforms

Speakers

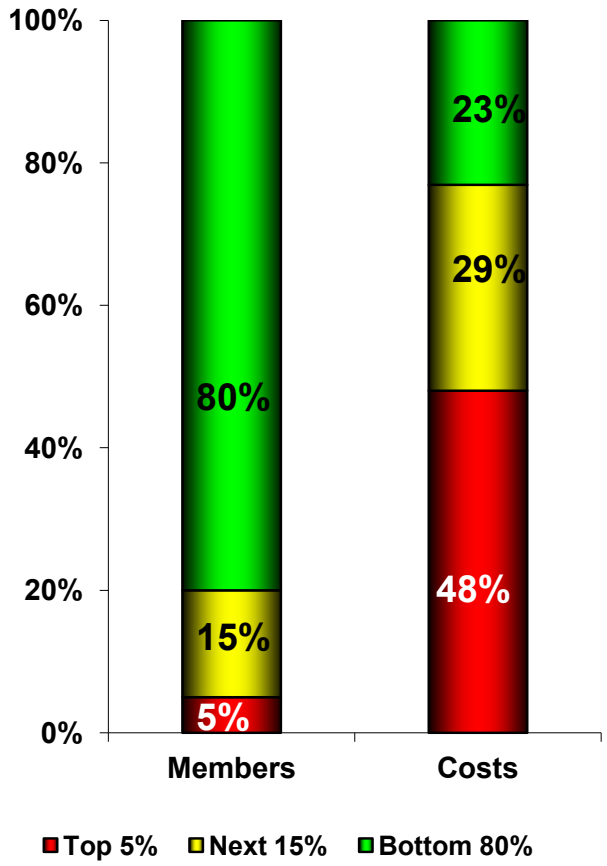
- Iowa
  - Jennifer Vermeer, State Medicaid Director
  - Marni Bussell, Health Home Project Manager
  - *Health Homes for Individuals with Chronic Illnesses* SPA approved 6/8/12

Iowa's Health Home for Medicaid Members with Chronic Conditions

Jennifer Vermeer, Medicaid Director

Marni Bussell, Project Manager

August 2, 2012



- Individuals with chronic disease drive a significant share of cost in the Medicaid Program
- 5% of members account for 48% of acute care costs*

*Excludes Long Term Care, IowaCare, Dual Eligibles, and maternity

Top 5% High Cost/High Risk Members* Accounted for:

- 90% of hospital readmissions within 30 days
- 75% of total inpatient cost
- Have an average of 4.2 conditions, 5 physicians, and 5.6 prescribers
- 50% of prescription drug cost
- 42% of the members in the top 5% in 2010, were also in the top 5% in 2009

*Excludes Long Term Care, IowaCare, Dual Eligibles, and maternity

Building Blocks

- IowaCare Medical Home Project
- Magellan's Community Reinvestment Project,
  - Integrated Health Homes for Adults with SPMI
- Statewide Mental Health Redesign Efforts

IowaCare Medical Home

- An 1115 waiver, provided limited benefits from only 2 providers for otherwise non-eligible adults:
  - Up to 200% FPL, Age19-64
- In 2010, legislation expanded the network of providers to include a few more FQHCs and implement a medical home model
- Increased access to care boosted enrollment
- Enormous challenges to serve a very sick population in a limited benefit package through a model that emphasizes comprehensiveness.

Integrated Health Home Pilot for Adults with SPMI

- Managed through Magellan Health Services of Iowa
- Promotes whole-health integrated coordination
  - Each CMHC has a partnership with local FQHC, to either provider physical care at CMHC or helps coordinate care at local FQHC
  - Financed through Community Reinvestment dollars
- June 2011 funded through December 2012

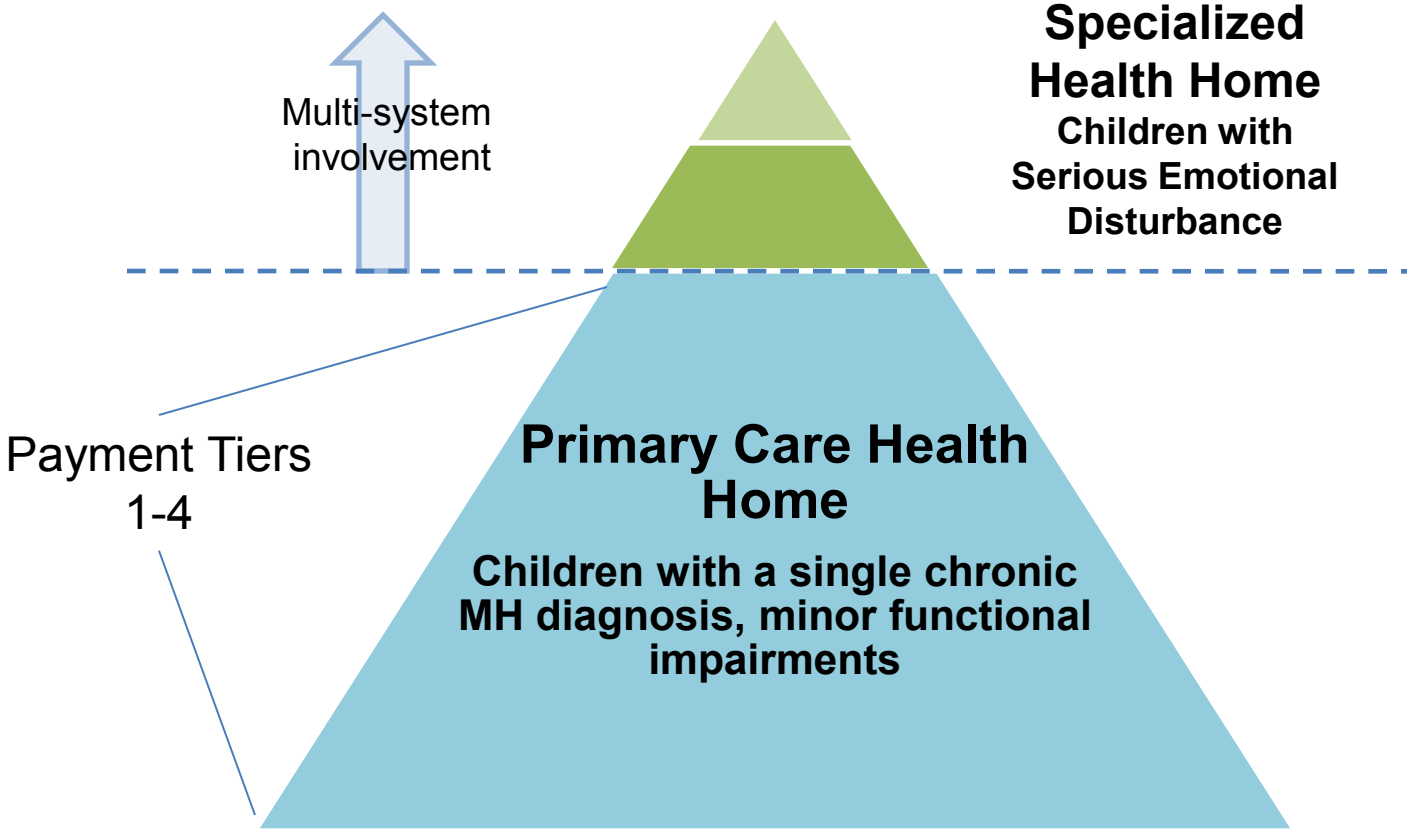
Iowa's Mental Health Redesign

- Reorganize the current county based MHDS system into a community based, person-centered system
  - Provides local service delivery, regional management, and statewide standards with performance outcomes
  - The legislature set a core list of services to be offered in every region with consistent eligibility requirements and standardized assessments
  - 5 year redesign plan that adds additional core services financed through system change, improvements, and efficiencies
- Began July 1, 2012. Significant target dates include:
  - Statewide core services effective July 1, 2013
  - Full regional implementation effective December 31, 2013.

Next SPA for Iowa "Specialized" Health Home

- Adults and children with serious and persistent mental illness
  - Pilots currently operating for adults
  - Children's concept developed by Children's Disability Workgroup to implement "Systems of Care model"
  - Developing separate State Plan Amendment – many details yet to be determined, but key details very likely to include:
    - Specialized provider requirements due to special population needs
    - Administered through the Iowa Plan
    - Additional payment tiers above the current 4 tiers due to high need of the population.
    - Patient/Family Centered, peer support, team approach

Primary Care and Specialized Health Home Model – example for children with mental health condition



Road to Approved Health Home SPA

March 2011
Initial (partial) Draft to CMS

June 2011
Consultation with SAMSHA

February 2012
Complete draft to CMS, Tribal Notice

March 2012
Official Submission of SPA to CMS

April/May 2012
CMS Questions /Responses,
Public Notice

June 8, 2012
SPA approved effective July 2012

Health Home Concept

The value added for comprehensive care coordination expects:

- Initial increases in office visits, and prescription drugs utilizations
- Savings in ER, Inpatient and avoidable hospital admissions

What can be achieved in a health home approach?

- For Members
  - Better coordination and management of their often complicated and complex care.
  - Help navigating multiple systems
  - More engagement in their own care
  - Access to a wider range of services
- For Providers
  - Practice more proactive, coordinated care that they want to provide, because of a new reimbursement structure.
  - More opportunities to track, coach and engage the patient's.
  - Improved communication and coordination for better patient outcomes
  - Improved utilization of health information technology

What is the benefit to the state?

- Improved health for a segment of Iowa Medicaid population with difficult health challenges
- Savings due to reductions in usage of health care services (expect reduced use of ER increased avoidance of hospital admissions)
- Projected savings between $7 million and $15 million in state dollars over three-year period ($4.9M built into Governor's budget)
- Access to enhanced funding (temporary 90% FMAP) under the Affordable Care Act to implement

Marketing to Providers:
What does a Health Home do differently?

- **Embeds population health management** into their workflow and demonstrates use of data to **drive quality improvements**.
- Use **evidenced-based guidelines** to improve quality and consistently among their providers.
- Focuses on **communication and coordination between referring providers** to ensure comprehensive patient-centered care.
- **Engages members** in their own care plans
- Has an **ongoing performance measurement system** in place that allows the practice to measure current performance to evidence based guidelines.
- **Identifies gaps in care** delivered compared to clinical guidelines and **deploy interventions designed to increase guideline compliance**

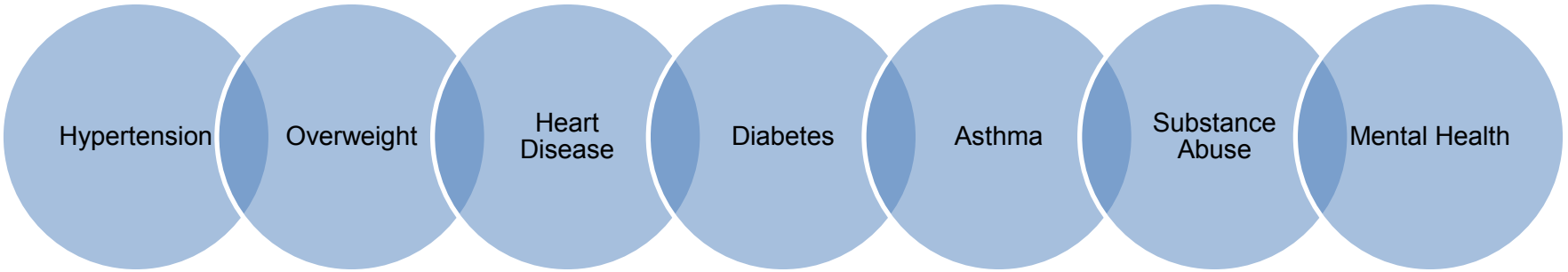
What are the Health Home Qualifications?

1. Medicaid enrolled practices including, but are not limited to:
   - Physician Clinic
   - Community Mental Health Centers,
   - Federally Qualified Health Centers
   - Rural Health Clinics
2. Adhere to the Health Home Provider Standards set by the State.

What are the Health Home Qualifications?

3. Fulfill, at a minimum, the following roles:
    - Designated Practitioner
    - Dedicated Care Coordinator
    - Health Coach
    - Clinic support staff
4. Seek NCQA Medical Home recognition or equivalent within 12 months
5. Effectively utilizes population management tools to improve patient outcomes.
6. Use an EHR and registry tool for quality improvements

Qualifying Members?



Adults and Children with
at least two chronic conditions, or
one chronic condition and at-risk of a second condition
from the above list.

IME's Proposed HH Model
Payment Methodology

In addition to the standard FFS reimbursement…

Patient Management Payment:

- Per Member Per Month (PMPM) targeted only for members with chronic disease
- Tiered payments increase (levels 1 to 4) depending on the number of chronic conditions
- Performance payment Starting in year 2(Providers must connect to the Statewide Health Information Network (IHIN)

Payment Rate

Member's Tier	PMPM Rate
Tier 1 (1-3 chronic conditions)	$12.80
Tier 2 (4-6 chronic conditions)	$25.60
Tier 3 (7-9 chronic conditions)	$51.21
Tier 4 (10 or more chronic conditions)	$76.81

- Practice uses Patient Tier Assessment Tool to identify correct tier
- Health Home submits monthly HCFA claim with diagnosis codes that support the tier.
- Payments are verified retrospectively through claims data, using the standard IME verification process.

IME's Proposed HH Model
Quality Measures

- Preventive (pneumococcal vaccines, flu shots and BMI)
- CC 1 Option: Diabetes or Asthma
- CC 2 Option: Hypertension or Systemic Antimicrobials
- Mental Health (discharge follow-up or depression screening)
- Total Cost of Care Measure

Provider Enrollment Process

- Provider enrolls with IME
- IME arranges two meetings with key staff members:
  - Kick-off and Follow-up
- Discuss readiness, NCQA timeline, Member Engagement, Processes, Implementation, and <u>All Questions Staff may have</u>
- Monthly Collaborative Learning Network:
  - Group discussions lead by Health Homes

Member Enrollment Process

- Provider Driven:
  - The provider engages the member, seeks member consent, tiers the member and requests enrollment through an online tool
  - IME exploring ways to assist:
    - Help prioritizing member enrollment,
    - Develop member engagement tools (brochures, letters, scripts, etc…)
    - Education to members and providers

Current Statistics

- 10 Health Home Entities
- 11 Iowa Counties
- 40 Different Locations
- 467 Individual Practitioners
- 671+ Members Enrolled for August
- 47% are Duals

For More Information

Contact

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