CENTERS FOR MEDICARE & MEDICAID SERVICES

Exploring Medicaid Health Homes:
Building on Existing Infrastructure

February 7, 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.

Exploring Medicaid Health Homes: Building on Existing Infrastructure

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Center for Health Care Strategies

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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

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 a forum 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

National Landscape to Date:

- 5 approved State Plan Amendments
- Small number of states in various stages of discussion with CMS – 6 of these have SPAs in draft form for CMS
- Multiple other states exploring the opportunity

National Landscape to Date:

- Early health home models focus heavily on targeting behavioral health
- Several states interested in leveraging PCMH building blocks
- States with managed care delivery systems plan to leverage MCO infrastructure but still figuring out how/to what extent;
- Strong partnership between states, CMS, and SAMHSA
- Similar challenges within states - how to track and assess health home services, how to meet HIT “bar”, how to provide the infrastructure supports needed by providers

Trends in Population Selection Criteria:

- States are analyzing claims data to identify eligible population, considering:
  - Varying diagnoses
  - Associated costs
  - Best way to serve the population (behavioral health vs primary care health home)
- Some adding diagnoses to expand eligibility
- Data analysis – though time consuming – can help states identify if they have sufficient “critical mass” or whether they need to expand their criteria

Opportunities to Build Upon Existing Infrastructure Include:

- Existing initiatives
- Current partnerships
- State requirements
- Priority Medicaid chronic conditions
- Existing roll-out approaches

Speakers

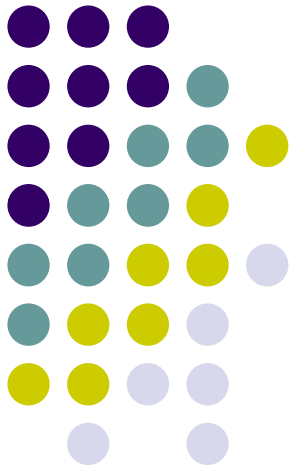
- Rhode Island
  - Alison Croke and Paul Choquette
  - CEDARR SPA and CMHO SPAs approved 11/23/11, with a 10/1/11 start date

- CMS
  - Mary Pat Farkas, Health Insurance Specialist, Disabled and Elderly Health Programs, Center for Medicaid, CHIP and Survey & Certification
  - Technical Director for Health Homes Team

Rhode Island Health Home Initiative

February 7, 2012

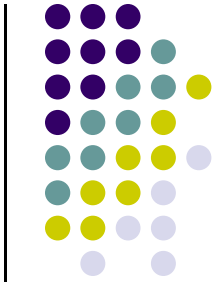
Paul Choquette and Alison L. Croke
Medicaid Division
Rhode Island Executive Office of Health and Human Services



Why These Populations?

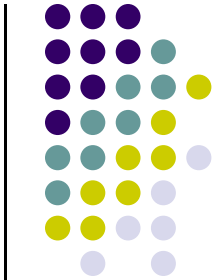
- Both populations (CYSHCN and SPMI) have complex medical, behavioral health and psychosocial needs
- Both are at greater risk of developing secondary conditions than the general Medicaid population
- Both have higher utilization of Emergency Department and Inpatient Care
- 7,000+ adults with SPMI and 12,000+ CYSHCN

Why These Populations (cont'd)



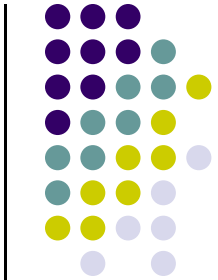
- **Some Infrastructure already in place**
  - Community Mental Health Centers (CMHOs) (Adults with SPMI)
  - CEDARR Family Centers (CFCs) (CYSHCNs)
- **Opportunity for further innovation**
- **Promote natural transitions between child and adult systems of care**

Other Opportunities



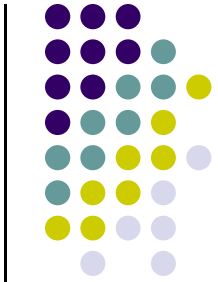
- Harness unique capabilities of CMHOs and CFCs “boots on the ground”
- Enhance connections between Health Homes and PCPs and specialists
- Take advantage of data collected by Medicaid Managed Care Organizations (MCOs) and Medicare claims to inform delivery of care

CEDARR Family Centers for Children and Youth with Special Health Care Needs



- ***C***omprehensive, ***E***valuation, ***D***iagnosis, ***A***ssessment, ***R***eferral and ***R***e-evaluation
  - Started in 2000
  - Teams led by Licensed Clinicians (LICSW, RN, Psychologist)
  - Family Centered Practice *Approach*
  - Statewide Coverage
  - 95% of work done in Child's home or in a community setting

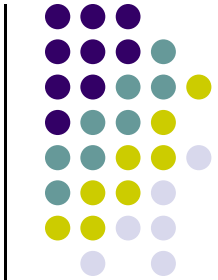
History of CEDARR



- Launched as part of a broader initiative to address the needs of CSYHCN and their families

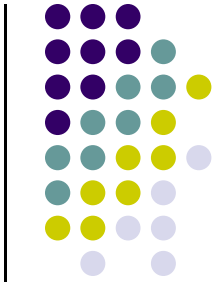
- Broad based stakeholder involvement in entire development and implementation process (advocates, family members, providers, state agencies)

Goals of the CEDARR Initiative



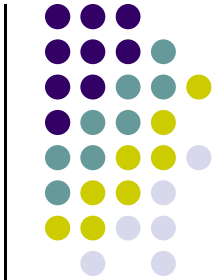
- Decrease fragmentation within and between the systems serving children with special health care needs and their families through care management including the coordination and integration of services
- Assure that services are provided through a strength-based and person-oriented system of care
- Support families to their fullest potential and provide direct services, where necessary
- Assure a flexible and responsive delivery system with adequate staffing, equipment and educational resources

CEDARR Today



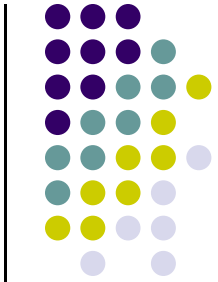
- Approximately 2,700 children and youth enrolled at any point in time
- Birth to 21 Years of age
- 30% Developmental Disabilities, 50% Behavioral Health, 20% Physical Health conditions

CEDARR Responsibilities



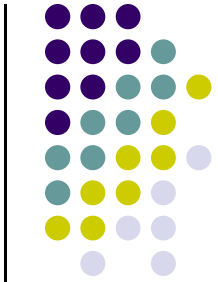
- Assessment of Need
- Identification of, and referral to resources
- Integration of services provided through different systems (LEA, Medicaid Fee-for Service, Medicaid Managed Care, Child Welfare)
- Oversight of Medicaid Fee-for-Service specialized Home and Community based services
- Re-Assessment and adjustment of Treatment Plans on an annual basis

Why CEDARR as a Health Home?



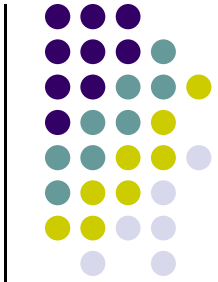
- Required Home Health Services is the core foundation of CEDARR
  - Comprehensive Care Management
  - Care Coordination and Health Promotion
  - Transitional Services
  - Individual and Family support
  - Referral to Community and Social Support Services
- 95% of current population meets HH diagnostic criteria

Enhancements to CEDARR practice as a result of Health Homes



- Enhanced screening for secondary conditions (yearly BMI and Depression screening)
- Additional re-imbursement to PCP's to engage in Care Planning and dashboard report developed to share CEDARR information with PCPs
- Enhanced Information sharing between CEDARR and Medicaid Managed Care Plans

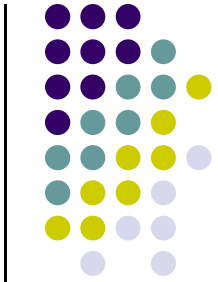
How will we measure success?



Traditional Methods

- Decrease in ED utilization for ACS Conditions
- Reduction in Re-Admissions
- Provision of services within required time frames
- Medical follow-up after ED visit
- HH Services provided within required time-frames
- Collaboration between PCP and/or MCO in development of Care Plan

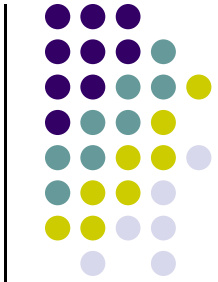
How will we measure success? Cont'd



Outcomes Based measurements

- Child/Youth/Family Satisfaction with service delivery, content of services, appropriateness of interventions
- Child and Family Outcomes
  - Knowledge of Condition and available services and resources
  - Child's participation in age appropriate, peer group activities
  - Ability of family to engage in "normal family activities"

Community Mental Health Organizations – the 2nd Health Home

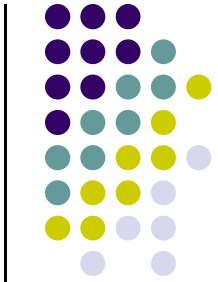


- 9 CMHOs operating statewide
- Serve clients with Severe and Persistent Mental Illness
  - Approximately 5000 Medicaid clients who are SPMI
  - About 2/3 of them have both Medicare and Medicaid
- Like CEDARR, CMHOs perform all the Health Home services.

Health Home Services at CMHOs

Health Home Service	CMHO Service
Care Management	Community Psychiatric Supportive Treatment (CPST) Assertive Community Treatment
Care Coordination	CPST Nursing Care Management – RN service
Health Promotion	CPST Supported Employment Services Assertive Community Treatment
Transitional Care	CPST Hospital Liaison
Individual and Family Supports	Family Psycho-education CPST Assertive Community Treatment (ACT)
Referral to Community and Social Support Services	CPST Community Integration Services

CMHO Health Home – Measuring Success – a few examples



- Percentage of hospital-discharged patients with a follow-up visit to a CMHO clinician (a physician, nurse or prescribing nurse) or a PCP within 14 days of hospital discharge.
- Percentage of drug users counseled and referred to drug treatment, and percentage of drug users who got treated following referral.
- Percentage of patients readmitted for non-psychiatric and psychiatric conditions within 30 days of hospital discharge –

Core Quality Measures

Adult BMI Assessment	Percentage of members 18-74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year
Ambulatory Care Sensitive Condition Admission	Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population under age 75 years. http://www.guideline.gov/content.aspx?id=15067
Care Transition – Transition Record Transmitted to Health care Professional	Care transitions: percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge. http://qualitymeasures.ahrq.gov/content.aspx?id=15178
Follow-Up After Hospitalization for Mental Illness	Mental health: percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge. http://qualitymeasures.ahrq.gov/content.aspx?id=14965
Plan- All Cause Readmission	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.
Screening for Clinical Depression and Follow-up Plan	Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received the following: . Initiation of AOD treatment. Engagement of AOD treatment.

Engagement with Federal Partners

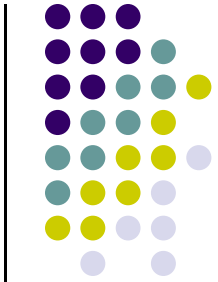
Process followed

- SMD Letter issued November 2010
- Internal Discussion and Identification of service models December and January
- Draft SPA submitted April 2011
- Final SPA submitted August 26
- SPAs approved November 23, 2011

Federal partnership throughout the process

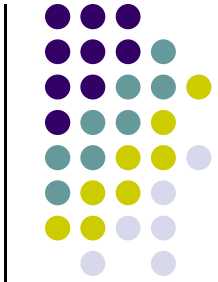
- Multiple conference calls with CMS HH Team on:
  - Services
  - Program Design
  - Rate Methodology
  - Quality and Measurement
- Conference Call with SAMHSA

Coordination with MCOs



- 2 participating Medicaid Health Plans
- Both paid capitation, inclusive of an administrative rate that includes care management
- CMS concern/requirement that no duplication of functions occur between Health Home and MCO
- Created contract amendment – protocols for collaboration/coordination

Coordination with MCOs, cont.



- Development and Implementation of a common communication protocol
- Joint Planning and Implementation Meetings convened by the State
- Enhanced Data Sharing between MCOs and HHs
  - Health Utilization Profile (MCO to HH)
  - Monthly Enrollment Report (HH to MCO)

Thank you

Questions

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Questions?

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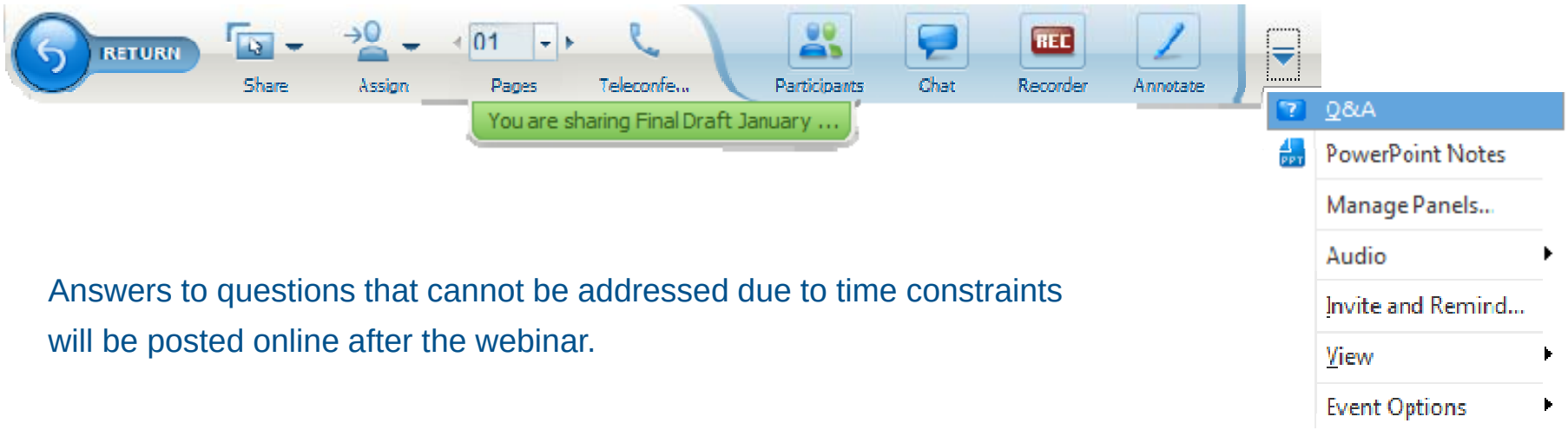
Your questions will be viewable only to CHCS staff and the panelists.



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Population Selection Criteria

Mary Pat Farkas
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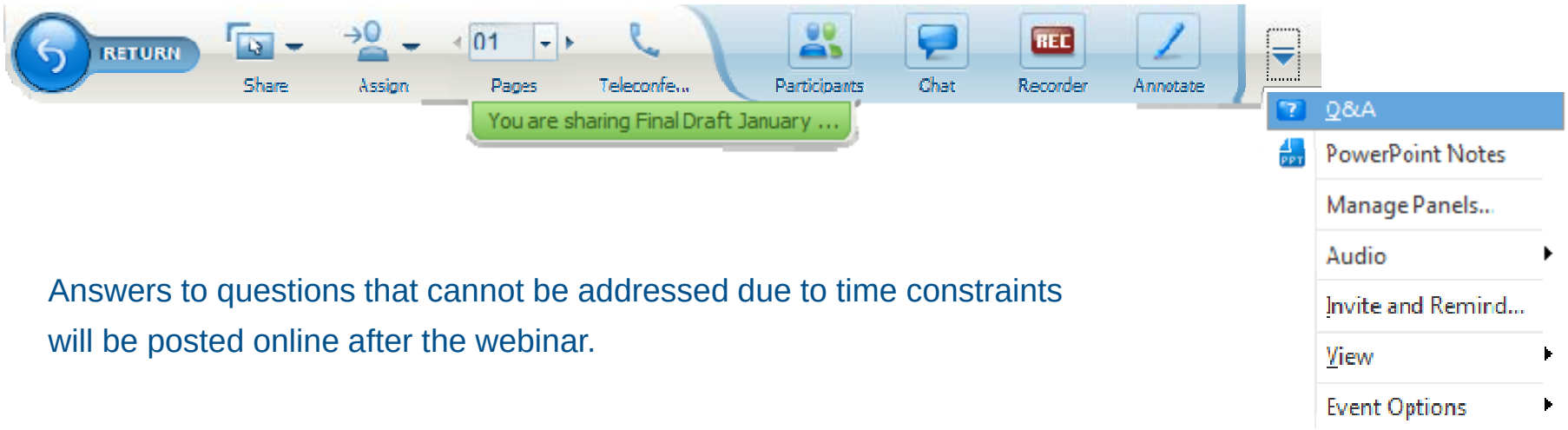

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