Center for Health Care Strategies
Seizing the Opportunity: Early Medicaid Health Home Lessons

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

Seizing the Opportunity: Early Medicaid Health Home Lessons

April 24, 2014

Kathy Moses, Senior Program Officer
Center for Health Care Strategies

Made possible by the Missouri Foundation for Health and the New York State Health Foundation

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Welcome and Introductions

Kathy Moses
Senior Program Officer
Center for Health Care Strategies

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Questions?

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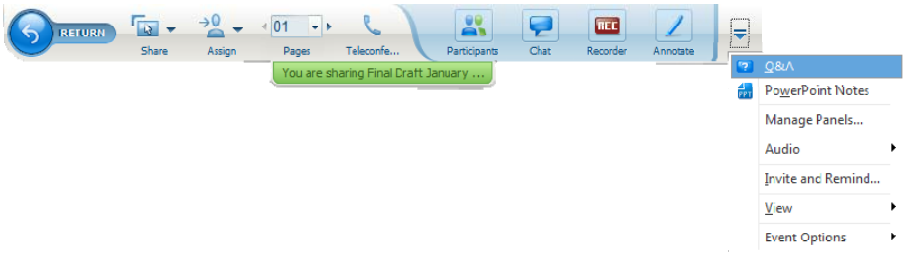

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A non-profit health policy resource center dedicated to improving the quality and cost-effectiveness of publicly financed care

- **Priorities**: (1) enhancing access to coverage and services; (2) advancing quality and delivery system reform; (3) integrating care for people with complex needs; and (4) building Medicaid leadership and capacity.
- **Provides:** technical assistance for stakeholders of publicly financed care, including states, health plans, providers, and consumer groups; and informs federal and state policymakers regarding payment and delivery system improvement.
- **Funding:** philanthropy and the U.S. Department of Health and Human Services.

Agenda

I. Introduction to Foundations' Role
II. Overview of Lessons from Early Adopters
III. Frontline Perspectives on Health Homes
IV. Moderated Q&A/Discussion

New York State Health Foundation

- **David Sandman**
  Senior Vice President
  New York State Health Foundation

Missouri Foundation for Health

- **Web Brown**
  Program Director
  Missouri Foundation for Health

Health Home Basics

- New state plan option created under Affordable Care Act 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

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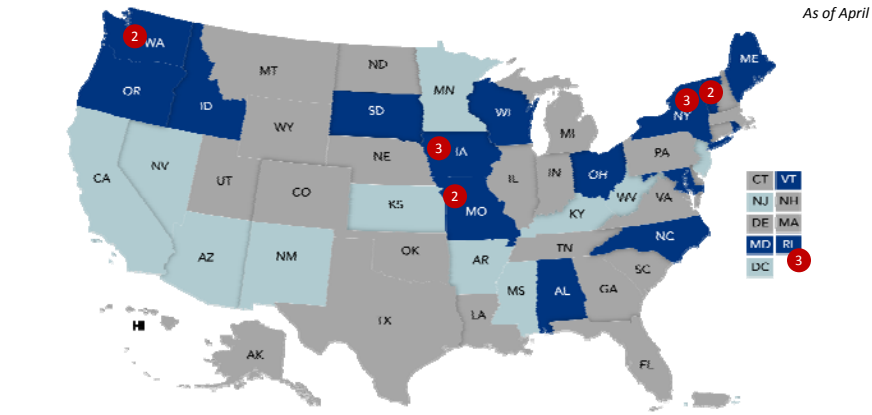
State Health Home Activity

As of April 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, Vermont, Washington, Wisconsin
Health Home SPA "On the Clock" (officially submitted to CMS)	Maine (2nd SPA), Ohio (2nd SPA), 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, Illinois, Indiana, Louisiana, Massachusetts, Michigan, Montana, Nebraska, New Hampshire, North Dakota, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Wyoming

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*Some states may be in the planning phase.

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The Ticking Clock…

When do states' enhanced federal match periods end?

DATE	STATE
10/2013	North Carolina, Oregon, Rhode Island (State Plan Amendment (SPA) #1 and SPA #2)
1/2014	Missouri (SPA #1 and SPA #2), New York (SPA #1)
4/2014	New York (SPA #2)
7/2014	Alabama, Iowa (SPA #1), New York (SPA #3)
10/2014	Ohio, Wisconsin
1/2015	Idaho, Maine
7/2015	Iowa (SPA #2), Rhode Island (SPA #3), South Dakota, Vermont, Washington (SPA #1)
10/2015	Maryland, Washington (SPA #2)
1/2016	Vermont (SPA #2)
4/2016	Iowa (SPA #3)

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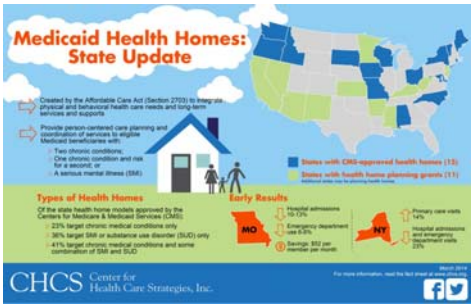
Early Adopters: Seizing the Opportunity

- CHCS convened early adopting health home states in Fall 2013 to reflect on key lessons in effectiveness and sustainability of models
- States included: IA, MO, NY, OR, RI
- Additional resources:
  - Brief
  - Fact Sheet
  - Infographic



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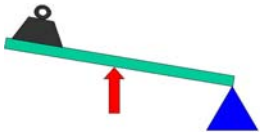
Lesson 1: Use flexibility of the health home option to advance policy goals

- Leverage to advance policy goals at a time of tight budgets and limited opportunity to invest in delivery system and establish new services
- Examples include:
  - Target individuals at higher risk or with significantly complex needs
  - Invest in primary care capacity and infrastructure
  - Improve coordination and transitions of care
  - Remove programmatic silos and strategically improve integration



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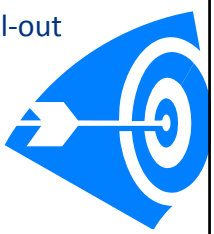
Lesson 2: Define health home target populations and models for the greatest impact on outcomes

- Health home provision specifically focuses on populations with chronic conditions
- Provides foundation for other design decisions related to return on investment, outcomes, and sustainability
- Examples include:
  - Opportunity to define population narrowly (single condition) or broadly (population-based)
  - Limit to specific geographic areas, or regional roll-out
  - Prioritize enrollment by patient severity



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Lesson 3: Align payment models with policy goals to drive payment modernization

- Align incentives and accountabilities for delivering the right care at the right time
- Examples include:
  - Range of health home reimbursement rates
  - Tier payments based on acuity
  - Develop a outreach/engagement fee
  - Use quality withholds to drive practice transformation
  - Link additional payments to achieving provider enrollment targets

Lesson 4: Use experience with complex populations to drive service definition

- Extend the reach of care beyond the walls of the office visit and to promote strong patient-provider relationships
- Examples include:
  - Care coordinator accompanies clients to primary care visits or conducts in-person assessment and care planning
  - Build team-based models of care
  - Integrate services that address individuals' most pressing needs (housing, employment)
- Link activities that meet population's needs to health home service definitions

Lesson 5: Support health home providers to achieve culture change

- Invest in building the capacity of health home providers to increase potential for success
- Examples include:
  - Support growth and development of provider practices through learning collaboratives and/or practice coaches
  - Provide workforce training, particularly in new skills
  - Support providers in working more effectively within the construct of global payments
- May require investment of state-only funds

Lesson 6: Invest in access to real-time data to support effective care coordination

- Importance of making actionable, real-time data and information available to providers (e.g., to better manage transitions of care)
- Many data systems still lack connectivity, particularly with emergency departments and hospitals
- Health plans and hospitals can partner to help bridge this gap in connectivity
- Identified as an area for more growth and development as health homes continue to evolve

Early Findings

- New York
  - ↑ Primary care visits increased by 14%
  - ↓ Inpatient admissions and emergency department visits decreased by 23%
- Missouri
  - ↓ Emergency department visits decreased 8% (community mental health center - CMHC) and 6% (primary care health home - PCHH)
  - ↓ Ambulatory-sensitive hospitalizations decreased 13% (CMHC) and 10% (PCHH)
  - ↑ Combined savings of approximately $52 PMPM

Support for States Pursuing Health Homes

- Health home planning funds from the Centers for Medicare & Medicaid Services (CMS)
- Health Home Information Resource Center: http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html

Frontline Perspectives on Health Homes

Discussion with:

- **Joe Parks, MD**
  Director, MO HealthNet Division
  Missouri Department of Social Services
- **Deirdre Astin**
  Program Manager, Health Home Program
  New York State Department of Health

Question 1

- What key policy goals were your states focused on when developing their health home models?

Question 2

- Given the relationship between member engagement and overall outcomes, do you have any suggestions for what states can do to enhance the member engagement potential of their programs?

Question 3

- What is the role of managed care plans in your health homes and what perspectives can you share from "on the ground" implementation experience?

Question 4

- Discuss the necessary culture change for providers and the role that the state and the health homes play in supporting this change.

Question 5

- How did you develop your reimbursement strategy to align with policy goals?

Question 6

- MO – Please share your insights on implementing multiple health home models in your state.
- NY – Please describe your experience implementing one health home model with a geographically-based roll out.

Question 7

- Please share any final reflections on your experience with the first 18-24 months of health home implementation.

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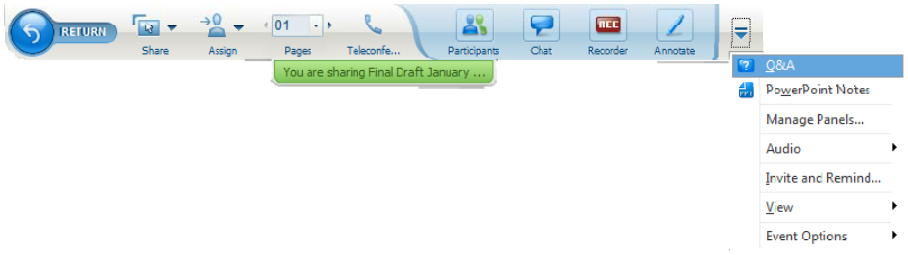

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