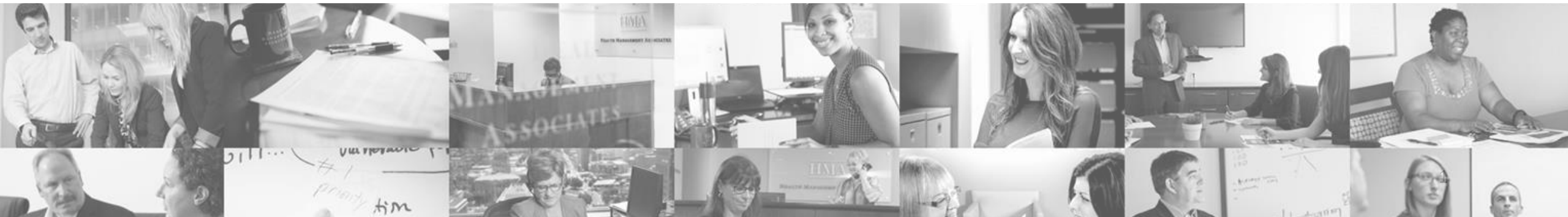
HEALTH MANAGEMENT ASSOCIATES

Medicaid Health Homes: Lessons from the Field

By Margaret Kirkegaard, Meggan Schilkie, Jean Glossa



OUTLINE OF TODAY'S DISCUSSION

+ Overview of Health Home policy, beneficiaries, services, and providers
+ Discussion of Health Home clinical and financial outcomes
+ Lessons learned in New York's Health Home program after seven years
+ Early lessons learned in DC's program in second year of implementation
+ Question and answers

HEALTH HOME POLICY BACKGROUND

- "Health Homes" (HHs) were authorized as a Medicaid State Plan Option under the Affordable Care Act, Section 2703.
- States must file a State Plan Amendment (SPA) outlining how they plan to implement HHs and, when approved by CMS, states receive eight quarters of 90/10 federal match for implementation.
- States must consult with SAMHSA prior to submitting the SPA to CMS regardless of targeted conditions.
- As of September 2018, 22 states and DC have implemented 35 HH models.

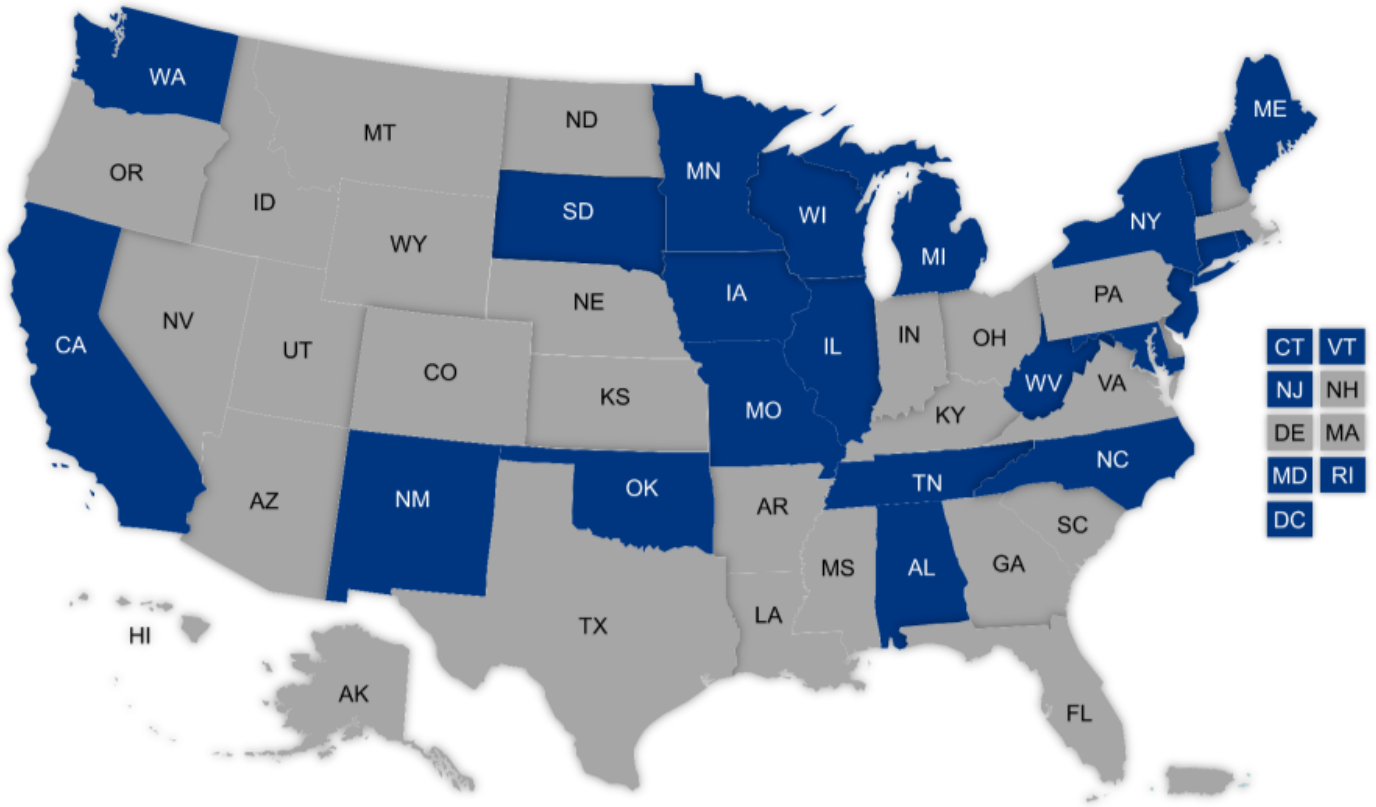
Report To Congress on the Medicaid Health Home State Plan Option; Prepared by: The U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation; May, 2018.

Health Home Information Resource Center, Medicaid.gov

NATIONAL SNAPSHOT OF HEALTH HOMES

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Approved Medicaid Health Home State Plan Amendments *(September 2018)*



As of September 2018, 22 states and the District of Columbia have a total of 35 approved Medicaid health home models.

States with Approved Health Home SPAs (number of approved health home models)	**Alabama, California, Connecticut, District of Columbia (2), Illinois, Iowa (2), Maine (3), Maryland, Michigan (2), Minnesota, Missouri (2), New Jersey (2), New Mexico, New York (2), North Carolina, Oklahoma (2), Rhode Island (3), South Dakota, Tennessee, Vermont, Washington, West Virginia (2), Wisconsin**

Note that Idaho, Kansas, Ohio, and Oregon have terminated their Medicaid health home state plan amendments and are no longer providing services under a 2703 SPA.

HEALTH HOME BENEFICIARIES

- To qualify for Health Home services, Medicaid beneficiaries must: (1) have two or more chronic conditions; (2) have one chronic condition and be at risk of developing another; or (3) have a serious and persistent mental health condition.
- Some states identify eligible beneficiaries and assign them to HHs. In other states, enrollment is entirely through provider referral subject to state verification of eligibility.

The Health Home option allows states the flexibility to identify a target population of persons with chronic health or behavioral conditions and offer them six required Health Home services:

+ Comprehensive care management.
+ Care coordination and health promotion.
+ Comprehensive transitional care from inpatient to other settings, including appropriate follow-up.
+ Patient and family support, which includes authorized representatives.
+ Referral to community and social support services, if relevant.
+ The use of HIT to link services, as feasible and appropriate.

The states can designate eligible providers to provide HH services. These include:

- FQHCs/RHCs
- CMHCs
- Local MH authorities
- Clinical practices
- Specified teams (constellation of providers)
- Community Care Teams
- Psych Rehab programs
- Tribal Health Centers
- Managed Care Plans
- Hospitals
- Medical Centers
- Mental and Chemical Dependency Treatment Teams
- Primary Care Practitioners
- Home Health Agencies
- Case Management Agencies

Health Homes have created pathways and systems for integration by:

- Shared electronic medical records between behavioral and physical health providers;
- Embedded mental health professionals in primary care and primary care consultants in mental health clinics;
- Depression and substance use screenings in primary care; and
- Co-location of behavioral and physical care within a building or clinic.

May 2018: Report to Congress on Health Home State Plan Option

- The evaluation covers the first 13 programs in the first 11 states to launch Health Homes: Alabama, Idaho, Iowa, Maine, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island, and Wisconsin.

1) Health Homes created pathways to target high-cost, high-need patients, and initial results suggest potential for improvements in care utilization patterns, costs (five states), and quality (four states).
2) The use of multidisciplinary care teams was broadly recognized as the most important change to emerge from Health Homes.
3) Initial and continuing assistance with practice transformation and team-based care is important, particularly to address the behavioral health needs and social determinants of health that impact patients.

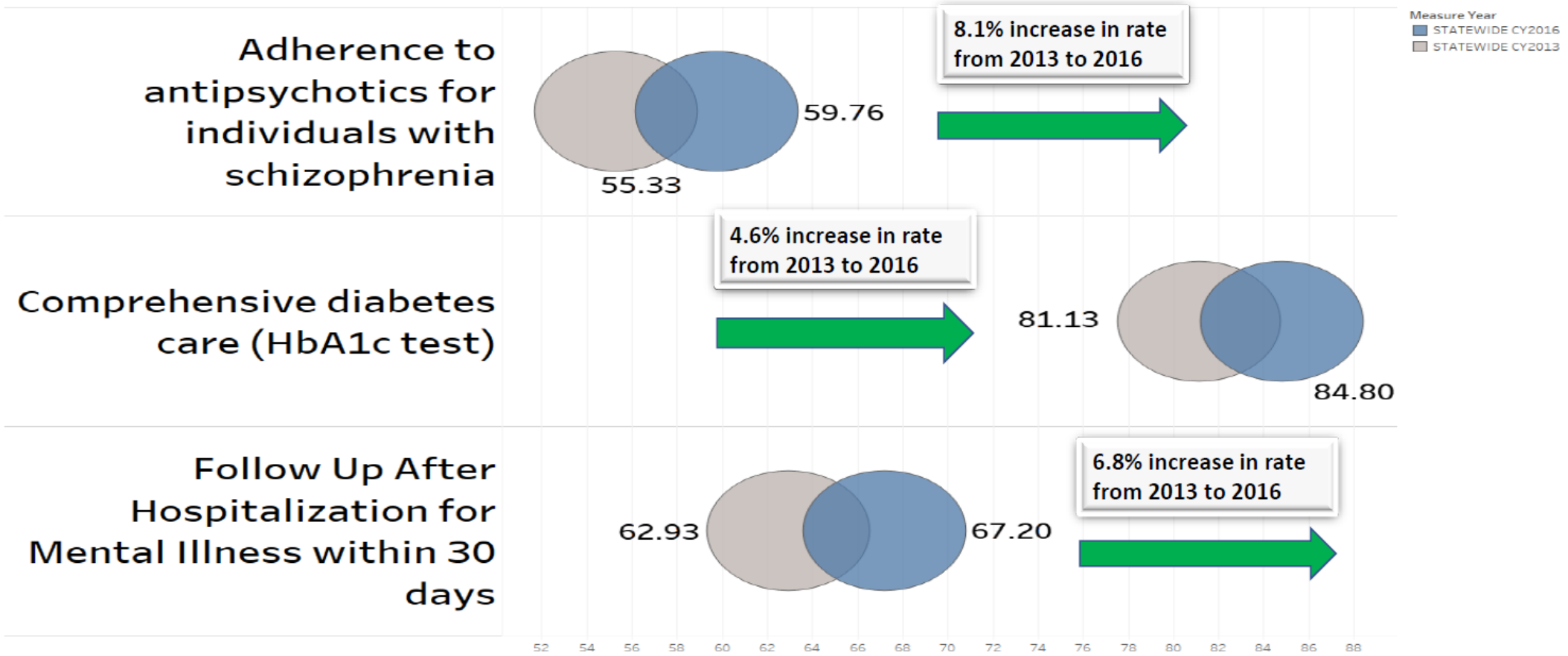
4) Well-developed HIT and other infrastructure is needed for care coordination and quality improvement.
5) HH programs show promise in effectively addressing needs of individuals with complex chronic physical and mental health conditions and substance use disorder, particularly those who also have high social needs.
6) Most of the early HH states continue to offer the HH program beyond their initial enhanced match period, which suggests that states have found value in HH models.

Lessons From the Field: New York

NEW YORK STATE LESSONS LEARNED: ENGAGEMENT

- Outreach and engagement is critical to enrolling people and difficult
  - Analytic algorithms can only play a minor role in identifying these people
  - Face to face community-based, feet on the street outreach is needed
  - Stationing skilled outreach workers in high volume areas like local Medicaid offices and homeless shelters is another
  - Requires constant system education
  - It must be reimbursed in a rational way
  - Real time data (ADT feeds, Managed Care alerts) are critical
  - Education and empowerment of the value added of the service for individuals and families is necessary

Health Homes Improving Quality of Care for Enrolled Members



Measure Includes Adult Members 21 and Older

Measure Rate → Higher rate is better

NEW YORK STATE OF OPPORTUNITY. Department of Health

NEW YORK STATE LESSONS LEARNED: QUALITY OVERSIGHT AND DATA EXCHANGE

- State standards and early guidance are critical to consistent implementation and setting up systems for long term program evaluation and demonstrating ROI
  - This includes a statewide platform to collect, aggregate and disseminate information for the purposes of evaluation and improvement of care management
  - Making changes later is far more difficult than instituting clear policies and procedures up front
  - Once you implement, give folks time to do so before making changes
  - Establish clear up front metrics and stick to them to establish a baseline and measure progress against them. (Limit the number of metrics to avoid pushing Health Homes to try to "boil the ocean.")
  - Access to claims data is critical
  - Standardized data exchange with MCOs, hospitals and other partners is needed
  - Connectivity to Health Information Exchanges

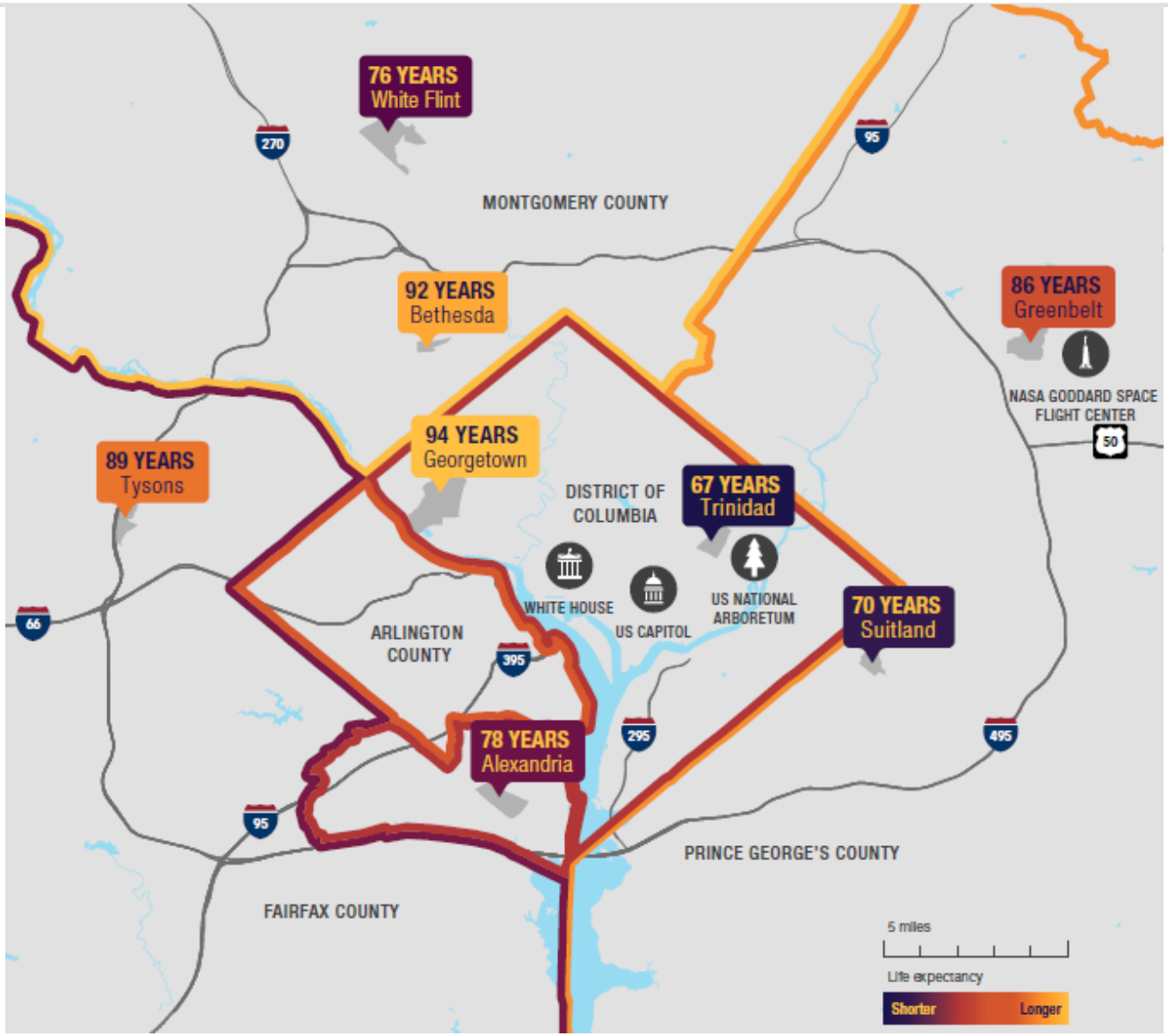
NEW YORK STATE LESSONS LEARNED: PARTNERING WITH PAYERS

- The most critical relationship for Health Home success is between Health Homes and the payers (MCOs, State Medicaid or other)
- Clarity of roles, responsibilities, points of coordination and communication are necessary.
- Health Homes can play a critical role in value-based payments arrangements.
- Health Homes working with MCOs can establish meaningful metrics and processes for evaluating cost savings.
- Data exchange, collaboration and real time coordination between MCOs and Health Homes is necessary for success and can result in mutual benefit for both but can be very messy (control/turf issues, accountability)

Lessons From the Field: Washington DC

LIFE EXPECTANCY AT BIRTH IN THE METROPOLITAN WASHINGTON REGION

Life expectancy, how long a newborn can expect to live, varies 27 years across the census tracts of the metropolitan Washington region.

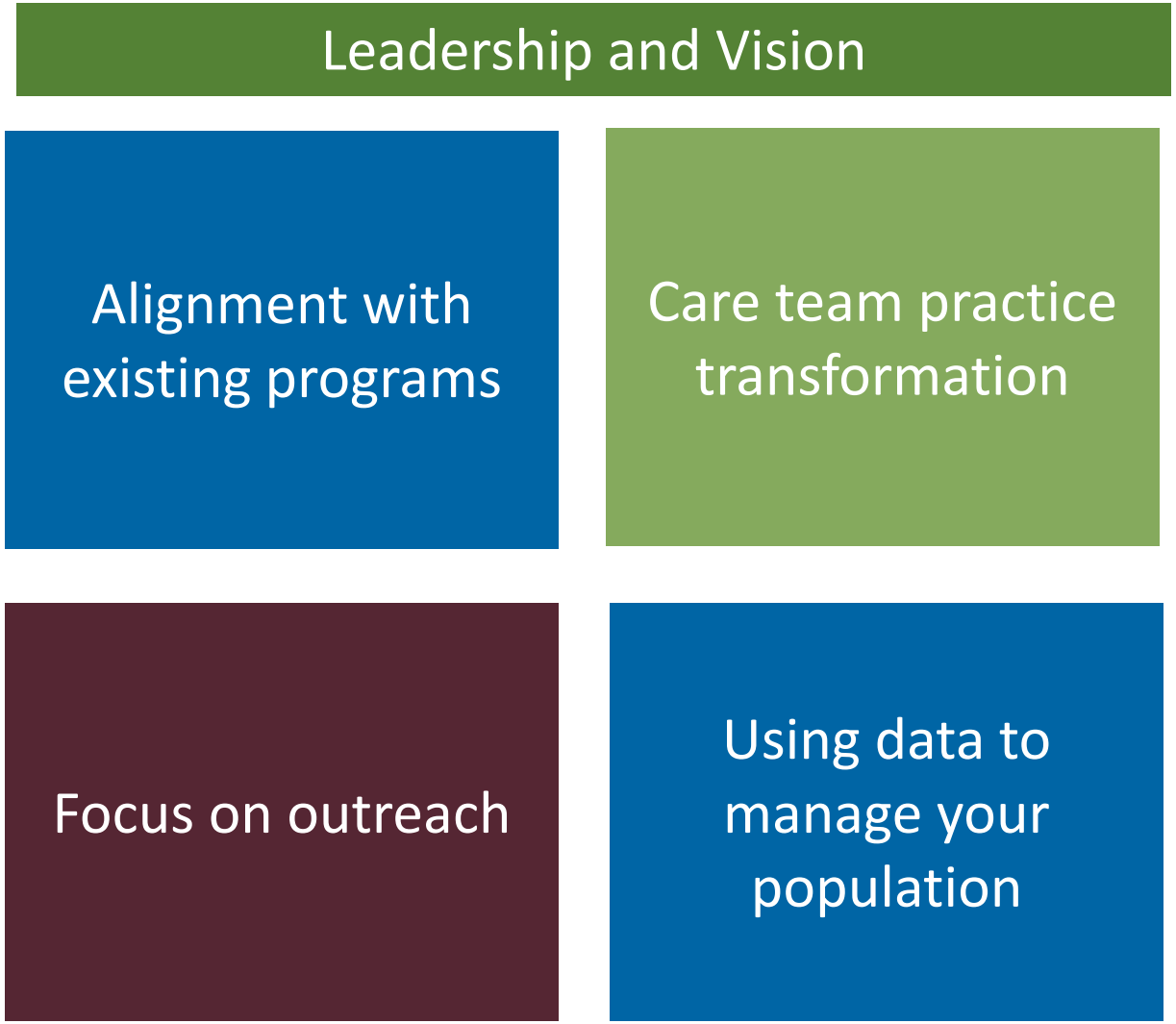


HEALTH MANAGEMENT ASSOCIATES

Source: Uneven Opportunities: How Conditions for Wellness Vary Across the Metropolitan Washington Region; VCU Center for Society and Health, October 2018

DC HEALTH HOME COMPARISON

	My DC Health Home Program	DC HH 2 My Health GPS
District Agency	Dept of Behavioral Health (DBH)	Dept of Health Care Finance (DHCF)
Providers	Core Service Agencies	FQHCs, individual providers or primary care practices
Launch/status	January 2016	July 2017
Enrollment Process	Consent, assessment and care plan	Consent, assessment and care plan
Criteria for Eligibility	SMI/adults	Chronic conditions/adults and children
Reimbursement	PMPM/bill per service	PMPM/bill per service
Acuity	2 tiers- blended	2 tiers based on medical acuity
Incentives	None	Incentive to complete the enrollment in the 1st qtr
Quality	CMS	CMS and P4P
IT tools/support	iCAM: DBH internal EHR	CRISP ENS and MHGPS specific tools
MCO: Delegation of HH services	No NCQA recognized PCMH practices	Practices need to be PCMH level 2 or in the application process for levels 2 or 3.


Leadership and Vision
Alignment with existing programs
Care team practice transformation
Focus on outreach
Using data to manage your population

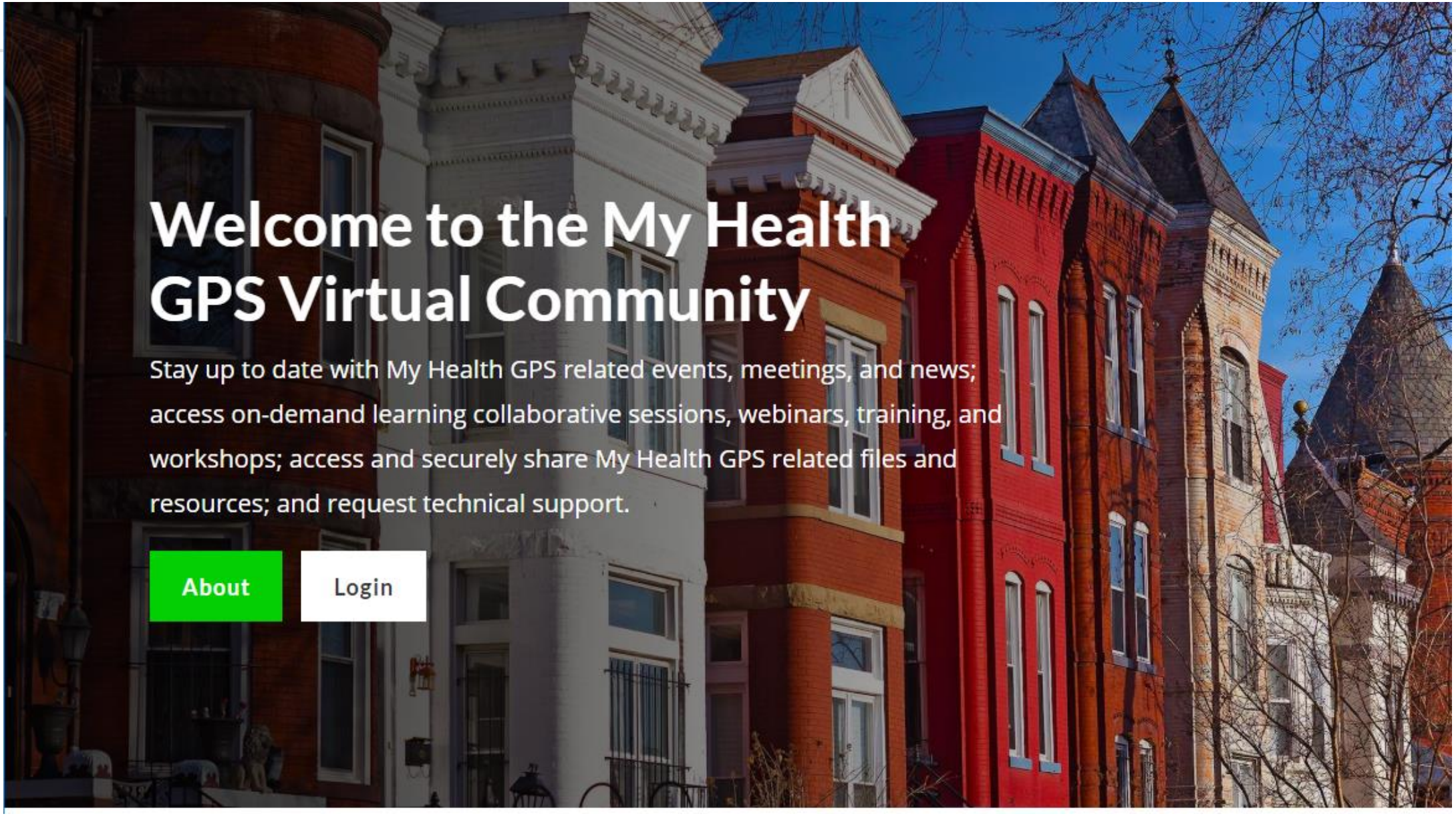
DC MY HEALTH GPS – TECHNOLOGY SUPPORTS

- MyhealthGPS.org – use of customized, newly developed website for MHGPS practices

- Practice Management tools with CRISP:
  - CRISP- Regional HIE
  - DC investment for TA to increase data collection/contributors
  - DC investment for TA to end users
  - Development of additional tools- (review in next slides)

MyHealthGPS
Healthy Starts Here

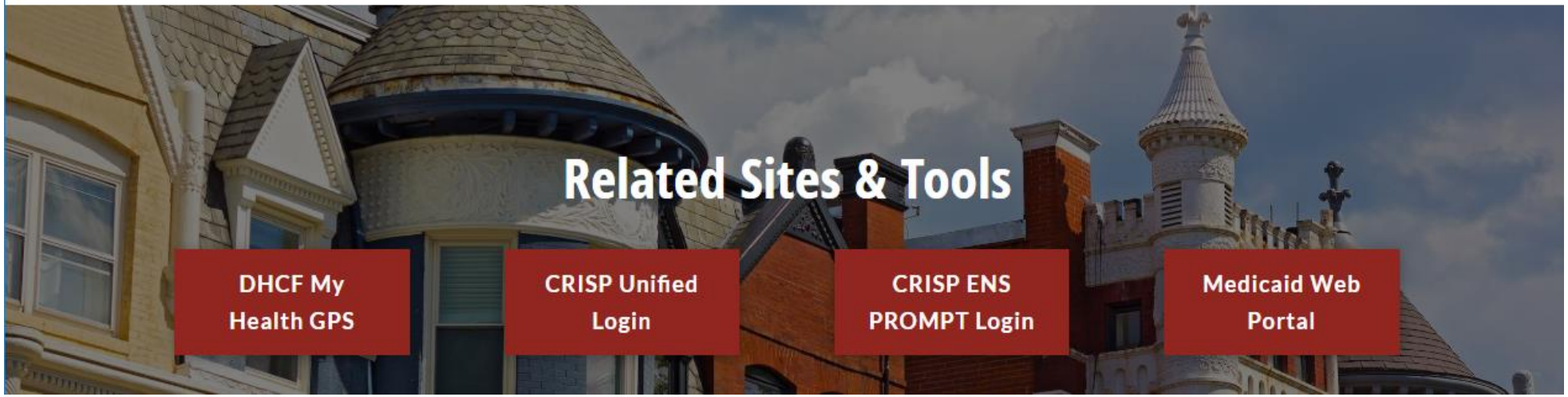
A free program for Washington, DC residents with Medicaid

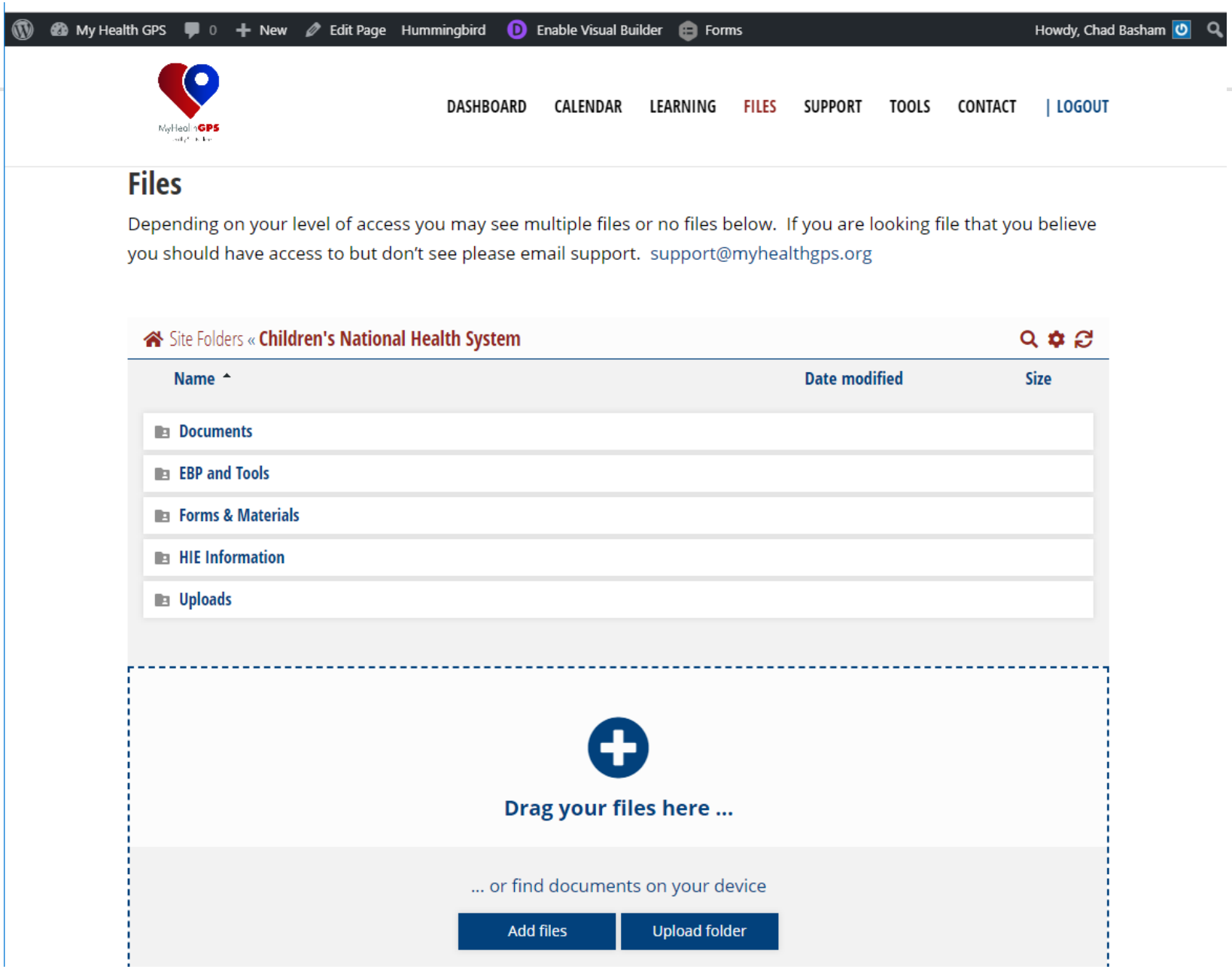

Welcome to the My Health GPS Virtual Community
Stay up to date with My Health GPS related events, meetings, and news; access on-demand learning collaborative sessions, webinars, training, and workshops; access and securely share My Health GPS related files and resources; and request technical support.
About
Login

HOME CALENDAR LEARNING SUPPORT TOOLS CONTACT | LOGIN

MyHealthGPS
Healthy Starts Here

As part of the District's My Health GPS program, interdisciplinary teams embedded in the primary care setting will serve as the central point for integrating and coordinating the full array of eligible beneficiaries' primary, acute, behavioral health, and long-term services and supports to improve health outcomes and reduce avoidable and preventable hospital admissions and ER visits. The My Health GPS program will deliver care coordination services to beneficiaries with multiple chronic conditions, enrolled in either Fee-For-Service or Managed Care. The District's My Health GPS program was launched in July 2017.



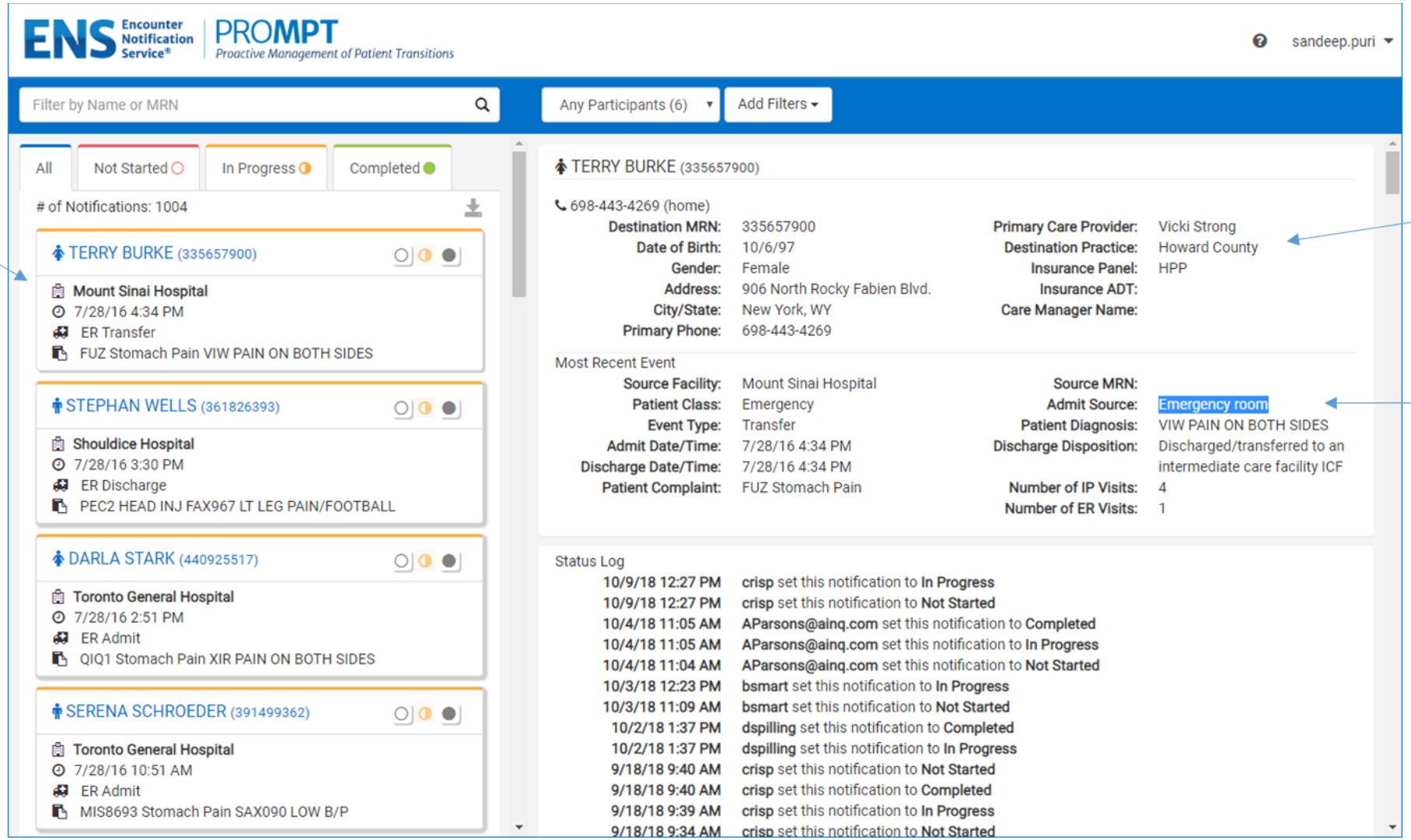

My Health GPS
0
New
Edit Page
Hummingbird
Enable Visual Builder
Forms
Howdy, Chad Basham
DASHBOARD
CALENDAR
LEARNING
FILES
SUPPORT
TOOLS
CONTACT
| LOGOUT
Files
Depending on your level of access you may see multiple files or no files below. If you are looking file that you believe you should have access to but don't see please email support. support@myhealthgps.org
Site Folders « Children's National Health System
Name
Date modified
Size
Documents
EBP and Tools
Forms & Materials
HIE Information
Uploads
Drag your files here ...
... or find documents on your device
Add files
Upload folder

CRISP ENCOUNTER NOTIFICATION SERVICE PROMPT TOOL

Feed of event alerts for panel

Patient Information

Event Information



CRISP PATIENT CARE SNAPSHOT

Patient Care Snapshot

Patient Name: GILBERT GRAPE Gender: Date of Birth: 01-01-1984

Profile Sections | Collapse/Expand All

Patient Demographics

GILBERT GRAPE		4145 EARL C ADKINS DR. RIVER, WV 26000	
Gender		D.O.B.	01-01-1984

Medications From Claims

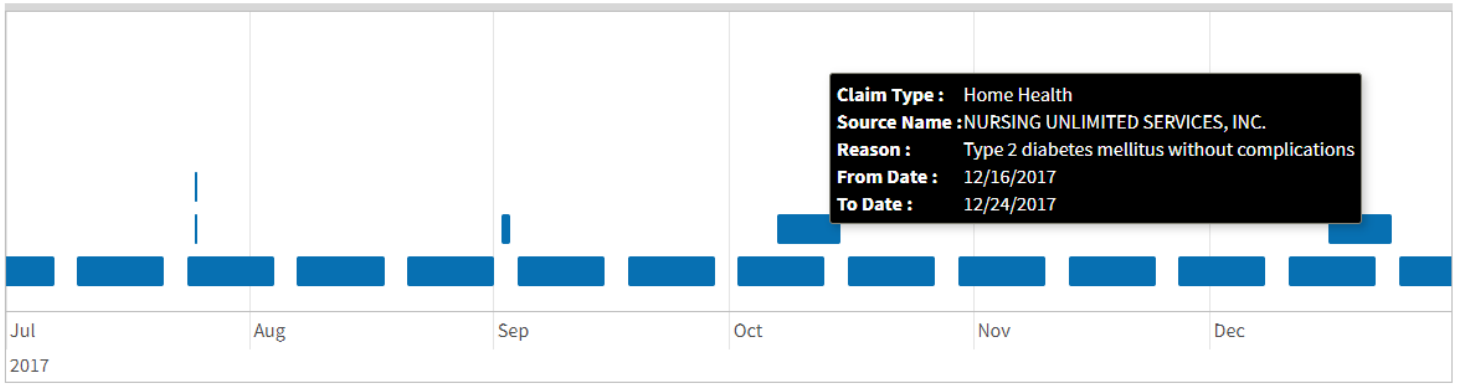
Fill Date	Medications	Quantity	Days Supply	Prescriber Name
09/26/2017	Lisinopril 40 mg/1	30	30	Prescriber1
09/26/2017	Aspir Low 81 mg/1	30	30	Prescriber1
09/26/2017	AMLODIPINE BESYLATE 5 mg/1	30	30	Prescriber1
09/20/2017	Ergocalciferol 1.25 mg/1	1	30	Prescriber1
09/20/2017	Fluticasone Propionate 50 ug/1	60	30	Prescriber1

Diagnoses From Claims

Condition	Date Recorded
Abnormality of gait	
Late effects of cerebrovascular disease, hemiplegia affecting dominant side	
Pain in left shoulder	
Unspecified schizophrenia	

Encounters From Claims

Event



1y | 6m | 3m | 1m | 7d | 7/1/2017 | to | 01/01/2018 | Apply | Clear

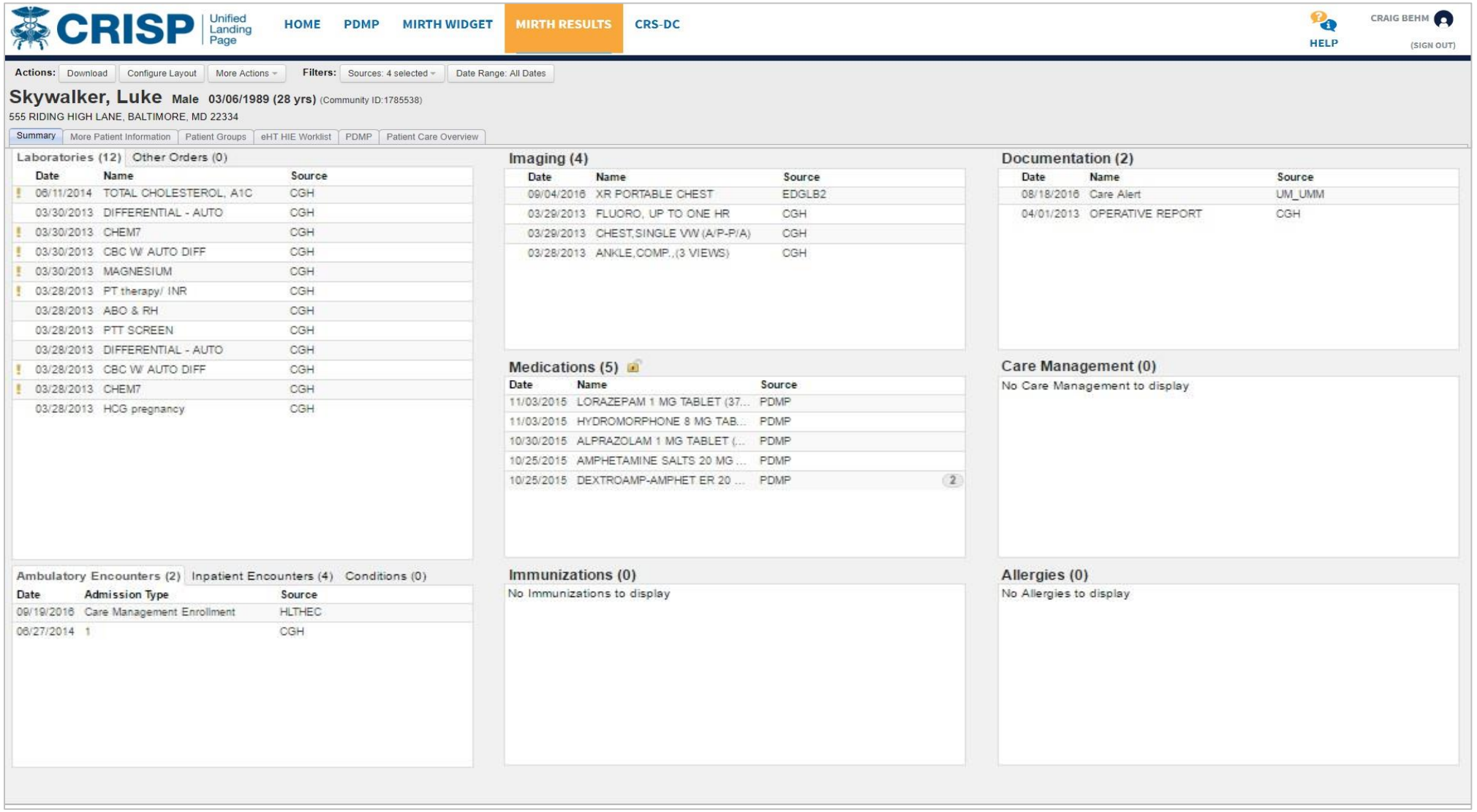
From Date	To Date	Source Name	Claim Type	Reason
01/05/2018	01/05/2018	MEDICAL TRANSPORTATION MANAGEMENT	Services	
12/25/2017	01/05/2018	NURSING UNLIMITED SERVICES, INC.	Home Health	Type 2 diabetes mellitus without complications
12/16/2017	12/24/2017	NURSING UNLIMITED SERVICES, INC.	Home Health	Type 2 diabetes mellitus without complications
12/11/2017	12/22/2017	NURSING UNLIMITED SERVICES, INC.	Home Health	Type 2 diabetes mellitus without complications
11/27/2017	12/08/2017	NURSING UNLIMITED SERVICES, INC.	Home Health	Type 2 diabetes mellitus without complications
11/13/2017	11/24/2017	NURSING UNLIMITED SERVICES, INC.	Home Health	Type 2 diabetes mellitus without

Encounters From ADT

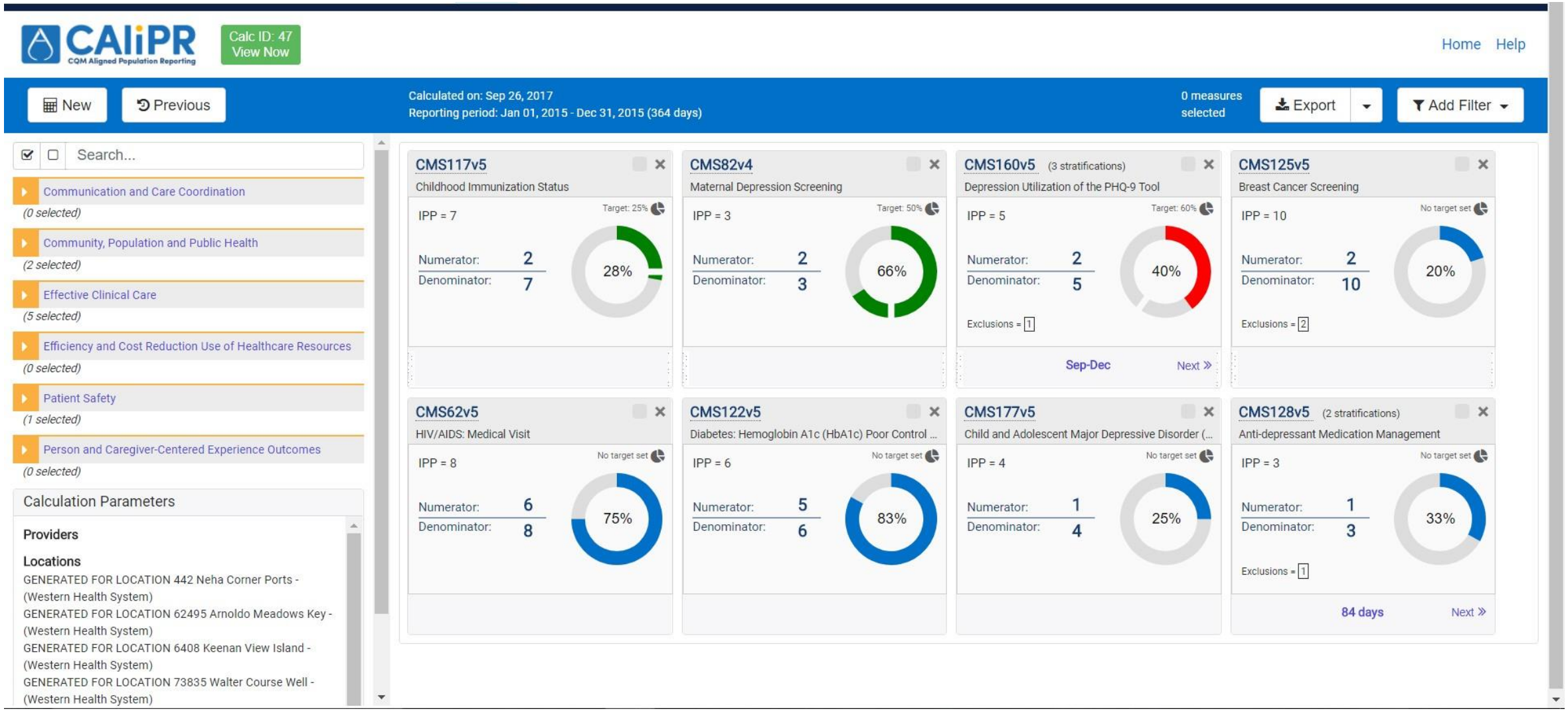
Emergency | Inpatient | Outpatient

CLINICAL QUERY PORTAL

- + Lab results
- + Radiology reports
- + Discharge summaries
- + Consultations
- + Operative notes
- + Images
- + Immunizations



CALIPR


CAliPR
CQM Aligned Population Reporting
Calc ID: 47
View Now
Home
Help
New
Previous
Calculated on: Sep 26, 2017
Reporting period: Jan 01, 2015 - Dec 31, 2015 (364 days)
0 measures selected
Export
Add Filter
Search...
Communication and Care Coordination
(0 selected)
Community, Population and Public Health
(2 selected)
Effective Clinical Care
(5 selected)
Efficiency and Cost Reduction Use of Healthcare Resources
(0 selected)
Patient Safety
(1 selected)
Person and Caregiver-Centered Experience Outcomes
(0 selected)
Calculation Parameters
Providers
Locations
GENERATED FOR LOCATION 442 Neha Corner Ports - (Western Health System)
GENERATED FOR LOCATION 62495 Arnoldo Meadows Key - (Western Health System)
GENERATED FOR LOCATION 6408 Keenan View Island - (Western Health System)
GENERATED FOR LOCATION 73835 Walter Course Well - (Western Health System)
CMS117v5
Childhood Immunization Status
IPP = 7
Target: 25%
Numerator: 2
Denominator: 7
28%
CMS82v4
Maternal Depression Screening
IPP = 3
Target: 50%
Numerator: 2
Denominator: 3
66%
CMS160v5 (3 stratifications)
Depression Utilization of the PHQ-9 Tool
IPP = 5
Target: 60%
Numerator: 2
Denominator: 5
40%
Exclusions = 1
Sep-Dec
Next »
CMS125v5
Breast Cancer Screening
IPP = 10
No target set
Numerator: 2
Denominator: 10
20%
Exclusions = 2
CMS62v5
HIV/AIDS: Medical Visit
IPP = 8
No target set
Numerator: 6
Denominator: 8
75%
CMS122v5
Diabetes: Hemoglobin A1c (HbA1c) Poor Control ...
IPP = 6
No target set
Numerator: 5
Denominator: 6
83%
CMS177v5
Child and Adolescent Major Depressive Disorder (...
IPP = 4
No target set
Numerator: 1
Denominator: 4
25%
CMS128v5 (2 stratifications)
Anti-depressant Medication Management
IPP = 3
No target set
Numerator: 1
Denominator: 3
33%
Exclusions = 1
84 days
Next »

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ANY
QUESTIONS?