About the Center

In partnership with Health & Human Services (HHS)/Substance Abuse and Mental Health Services Administration (SAMHSA), Health Resources and Services Administration (HRSA).

Goal:

To promote the planning, and development and of integration of primary and behavioral health care for those with serious mental illness and/or substance use disorders and physical health conditions, whether seen in specialty mental health or primary care safety net provider settings across the country.

Purpose:

- To serve as a national training and technical assistance center on the bidirectional integration of primary and behavioral health care and related workforce development
- To provide technical assistance to PBHCI grantees and entities funded through HRSA to address the health care needs of individuals with mental illnesses, substance use and co-occurring disorders

For information, resources and technical assistance contact the CIHS team at:

Online: integration.samhsa.gov
Phone: 202-684-7457
Email: Integration@thenationalcouncil.org

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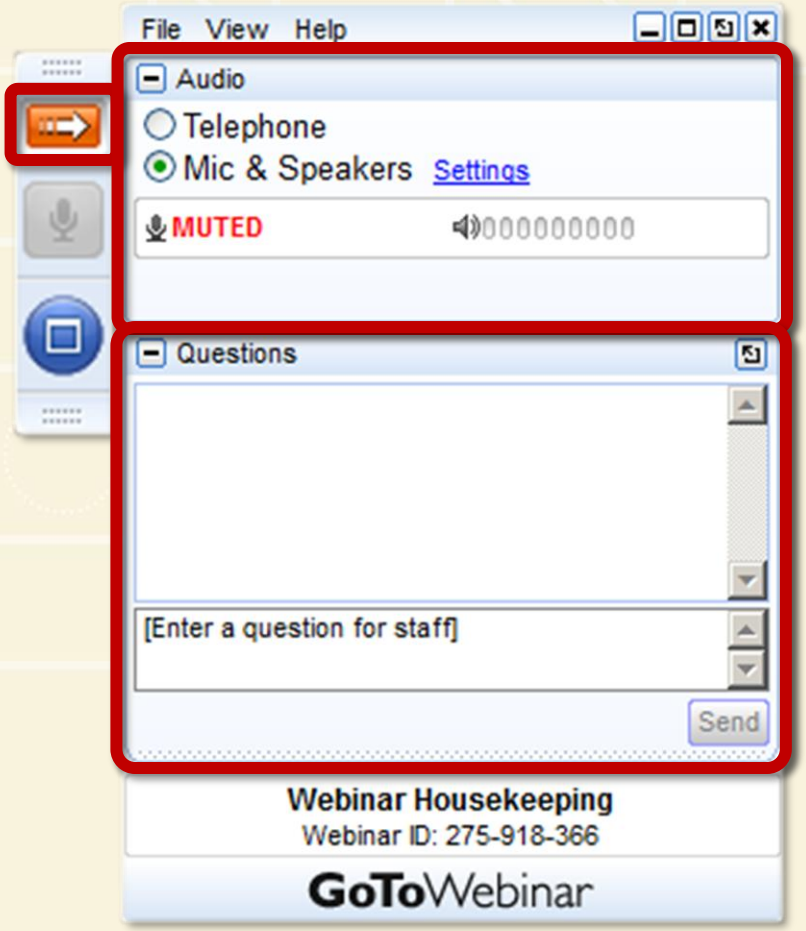
Financing and Policy Considerations for Medicaid Health Homes for Individuals with Behavioral Health Conditions

Monday, April 15th



Join audio:

- Choose “Mic & Speakers” to use VoIP
- Choose “Telephone” and dial using the information provided

Submit questions and comments via the Questions panel.

Today’s webinar is being recorded and will be available within 48 hours.

Welcome and Introductions

- **Robert Glover**, Executive Director, National Association of State Mental Health Program Directors
- **Alicia D. Smith**, Principal, Health Management Associates
- **Eliot Fishman**, Principal, Health Management Associates

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Medicaid Health Homes for Individuals with Behavioral Health Conditions: Financing and Policy Considerations

Presented By Health Management Associates:
Eliot Fishman, PhD - Principal
Alicia D. Smith - Principal

Agenda

- Overview of Health Homes paper
- Key discussion areas:
  - Target populations
  - Team composition
  - Provider standards
  - Rate setting
- Action Steps / Take-aways
- Q and A session
- Wrap-up

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Our Presentation Today

- Meant to supplement White Paper: “Financing and Policy Considerations for Medicaid Health Homes for Individuals with Behavioral Health Conditions”
  - SAMHSA-HRSA Center for Integrated Health Solutions.
- White Paper is a comprehensive guide
- Today’s presentation is a deep dive on some key design issues

Objectives of White Paper

- Discuss financing considerations for states and potential providers
- Highlight the roles of quality measurement, health information exchange (HIE) and health information technology (HIT)
- Discuss considerations reimbursement methodologies and payment rates

Poll Question

What best describes your agency affiliation?

- State Medicaid office
- Primary care provider agency
- Behavioral health provider agency
- State behavioral health agency

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Overview of Health Home Services

Overview of Health Home Services

- Enumerated in Title XIX , Section 1945 of the Social Security Act
- Provides states the option to cover care coordination for individuals with chronic conditions through health homes
- Requires submission and approval of a Medicaid State Plan Amendment (SPA)
- Eligible Medicaid beneficiaries have:
  - Two or more chronic conditions,
  - One condition and the risk of developing another, or
  - At least one serious and persistent mental health condition

Overview of Health Home Services

Provides 90% FMAP for eight quarters for:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care
- Individual and family support
- Referral to community and support services

Payment is for 6 components of "health home" care coordination services and **NOT** direct treatment

Health Homes and Medical Homes

- Health Home expands on the Medical Home model
  - Enhanced Care Management and Coordination
  - Integration of Medical and Behavioral health care
- The Health Home and patient centered medical home retain the goal of the Three-Part Aim
  - Improve the population's health
  - Improve the quality of health care
  - Improve the patient's experience

Health Homes and Medical Homes

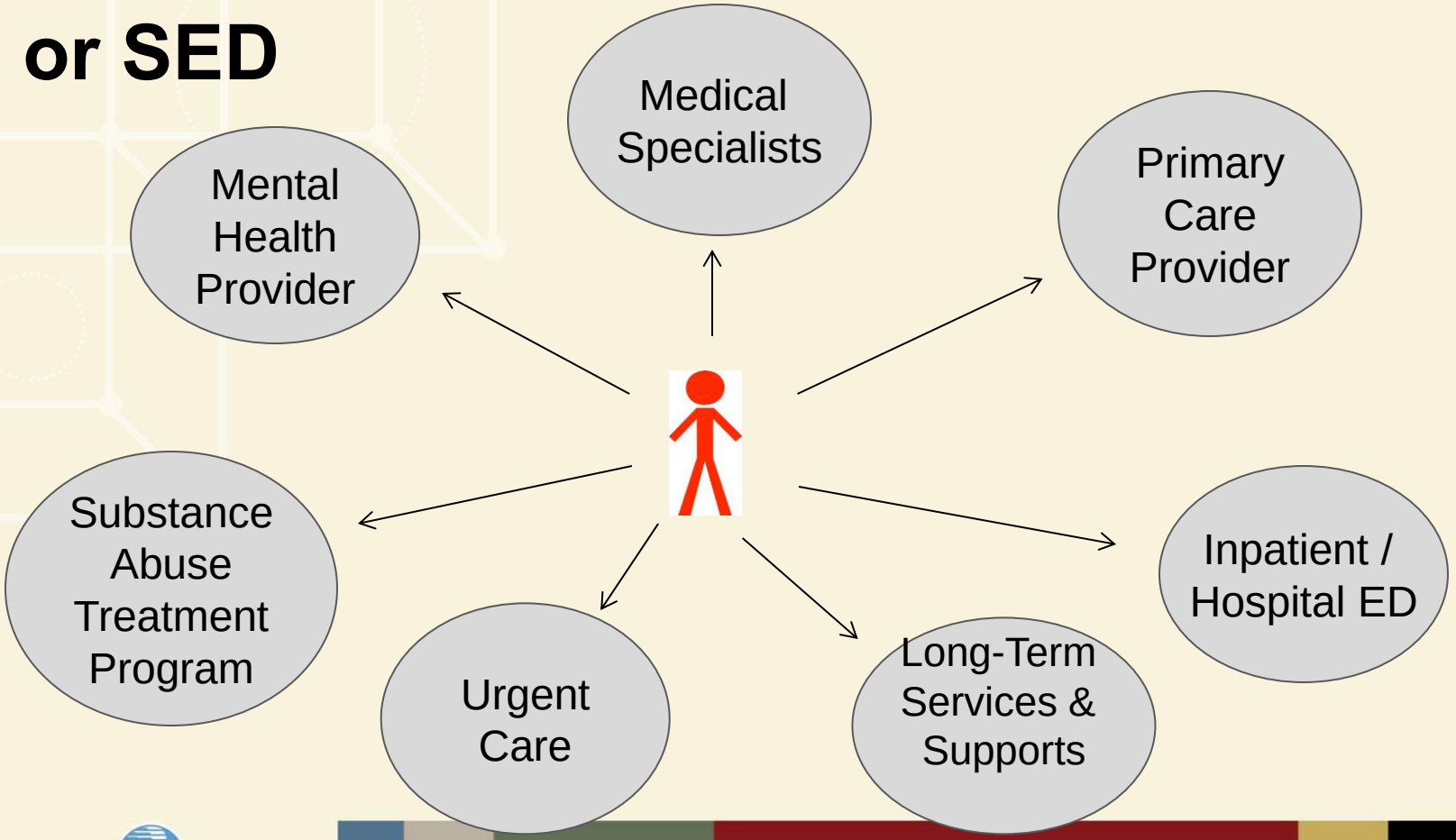
Health Homes	Medical Homes
Temporary enhanced Medicaid reimbursement to States for services to individuals with approved chronic conditions	Serve all populations
May include primary care practices, community mental health organizations, addiction treatment providers, Federally Qualified Health Centers, health home agencies, etc.	Typically defined as physician-led primary care practices, but may include some mid-level practitioners such as nurse practitioners
Currently a Medicaid-only construct	Exist for multiple payers (e.g., Medicaid, commercial insurance)

Poll Question

Where does your state stand on the establishment of Medicaid Health Homes?

- Not talking about it / don't know
- Engaged in preliminary discussions
- Working on submitting a SPA
- Have submitted a SPA, waiting on CMS approval
- Have received CMS approval, in implementation phase

Clinical needs for individuals with SMI or SED



What does the Health Home require?

- Creating new or expanded roles, such as:
  - Team Leader
  - Nurse Care Manager
  - Primary Care Liaison/Consultant
  - Behavioral Health Liaison/Consultant
  - Care Coordinator
- Thinking about the mission of provider services in a new way
  - "Whole Person" orientation
  - Accountability for a population
- Transforming the delivery of care
  - Establish the competency of staff to recognize and deal with new clinical issues
  - Redesign the model of care

Accountability and Planned Care

- The Health Home is accountable for all the health needs of its members
  - By assuring and coordinating that care is received even if the Health Home does not directly provide it
  - By assuring all of the health home population is addressed even those who rarely “show”
- Planned care is the only effective manner to meet all the needs of eligible members
- Certain members provide most of the decrease in health status and most of the costs

Accountability and Planned Care

Ultimately, the Health Home is responsible for coordinating and providing access to :

- high-quality health care services for all conditions informed by evidence-based clinical practice guidelines;
  - preventive and health promotion services
  - mental health and substance abuse services
  - comprehensive care management, care coordination, and transitional care across settings (transitional care)
- appropriate follow-up from inpatient to other settings
- chronic disease management, including self-management support to individuals and their families;
- individual and family supports, including referral to community, social support, and recovery services;
- long-term services and supports

Accountability and Planned Care

To be effective, health homes must:

- develop a care plan for each individual that coordinates and integrates all clinical and non-clinical services and supports required to address the person's health-related needs
- use HIT to link services, facilitate communication between and among providers, the individual, caregivers, and provide feedback to practices
- establish a continuous quality improvement program, and
- collect and report data that support the evaluation of health homes

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Determining Target Populations

Who is target population?

1. **Serious Mental Illness**

Focused on adding primary care to SMI providers (sometimes converting existing case management benefit):

- Missouri SMI
- Ohio
- Rhode Island SMI
- Iowa SMI

2. **Broad Chronic Illness**

Focused on driving PCMH practice transformation:

- Idaho
- Iowa PCMH
- Missouri PCMH
  North Carolina
  Oregon

3. Broad Chronic Illness and SMI

Focused on building accountable networks with specialty providers:

- New York
- Washington State

Other possible populations of interest

- More specialized populations:
  - Medication-Assisted Treatment
  - Homelessness
  - More specific condition or utilization profiles
- There is flexibility in defining target population(s)
  - Can't be defined formally by age or eligibility category
  - CMS will likely support any other definition based on logical policy goals
- One way to target the population is to target specific providers (e.g., Rhode Island CEDARR program)

Example: The Ohio Medicaid Business Case for Coordinated Care

Ohio's adult Medicaid beneficiaries with serious mental illness (SMI):

- Represent about 10% of total Medicaid beneficiaries and account for 26% of total Medicaid expenditures;
- Have higher rates of co-occurring chronic physical health conditions (heart disease, hypertension, diabetes, chronic respiratory conditions, dental disease);
- Have more than twice as many hospitalizations for certain ambulatory care sensitive conditions (asthma and diabetes); and
- Have two times higher rates of emergency department visits for asthma than non-SMI adults.

Example: The Ohio Medicaid Business Case for Coordinated Care

As a subset of the SMI population, Ohio's adult Medicaid beneficiaries with schizophrenia:

- Have three times more hospitalizations for uncontrolled diabetes and twice the number of hospitalizations for pneumonia and chest pains compared with non-SMI adults;
- Have twice the number of hospital emergency department visits for hypertension and uncontrolled diabetes as non-SMI adults; and
- Have three times higher costs for skilled nursing facility, prescription drug and home health services than non-SMI adults.

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Providers and Standards

Identifying Providers and Provider Standards

- What are your goals?
  - Drive practice change in the mental health system
  - Maximize the enhanced federal match over the available two years by converting some community behavioral health care management
  - Develop fully integrated primary/behavioral healthcare delivery
- Each potential goal implies a different approach to provider standards
- Considerations:
  - Timing of the SPA effective date
  - Provider capacity to meet new health homes standards and requirements.
  - Existing enrollee relationships with primary care providers

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Patient Enrollment and Provider Assignment

Assigning Clients and the Challenge of Engagement

Each enrollment step below involves key design decision

1. How to stratify
2. Will the state assign members to health homes?
3. How to locate assigned members?
4. How will providers engage members?

These issues are particularly difficult for individuals with SMI.

Engaging "High Fliers"

1. Highest utilizers are often not appropriately engaged in community mental health system
2. Assignment using claims can be challenging for providers
3. It is possible to pay providers for a short-term period of finding and engaging assigned members before enrollment
4. Alternative is to enhance delivery of integrated care to already-engaged populations

Engagement Example: New York

- New York is the first state to pay providers for program outreach and enrollment activities as part of their health homes reimbursement,
  - For SPA purposed NY defined engagement as “health promotion”.
- New York expects that health home providers will conduct outreach and enrollment activities to individuals who have mental illnesses and no medical home.
- New York received CMS approval to pay health homes 80% of their PMPM for all Medicaid eligible enrollees for up to two periods of 3 months each while they find and engage them.
- CMS has clarified that it is allowing payment for a non-enrolled individual only for a time-limited period when the health home provider is making efforts to enroll them.

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Considerations for State Plan Implementation

Phasing

- Rolling 8 quarters for geographic expansions or new populations
- States can phase-in health homes geographically by submitting multiple SPAs for different regions. Each SPA would have its own eight quarters of enhanced federal match.
  - The state cannot receive the enhanced match for a particular beneficiary for more than eight quarters.
  - May involve tracking by Medicaid ID.
  - Need to think carefully about relocation, administrative complexity.
- States can also phase in multiple health homes programs with different start dates. These programs could involve different chronic illnesses, different geographic regions, or an alternative phase-in structure.

Program and Phasing Choices for SMI and non-SMI programs

- Missouri and Rhode Island: Separate SMI and chronic illness programs, Chose to make both programs with aligned start dates.
  1. Administrative simplicity for claiming, minimizes federal concern re: double-dipping
  2. Still allowed states to submit SPAs at different times.

Program and Phasing Choices for SMI and non-SMI programs

- Iowa: Single SPA covering both SMI and PCMH
  1. Offers consumers with mental illness flexibility with regard to medical home
  2. Potential forgone FMAP as SMI component is phased in.

Program and Phasing Choices for SMI and non-SMI programs

- Ohio: Geographical phasing of SMI-focused SPA
  1. Maximizes match given program decision to pilot geographically
  2. Allows for testing and refining of model

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Quality Outcomes Measures

CMS quality are divided into three categories:

- **Clinical outcome**: Measures that assess beneficiaries' health status and related healthcare utilization (e.g., reduced hospital admissions and readmissions, reduced hospital emergency department visits, improved adherence to psychotropic medications, controlled blood pressure).
- **Experience of care**: Measures that assess beneficiaries' perceptions of care received.
- **Quality of care**: Measures that evaluate the processes used in the delivery of care such as completed needs assessment, a developed care plan, and regular receipt of services that maintain or improve health.

CMS Core Quality Measures

1. Adult Body Mass Index (BMI) Assessment
2. Ambulatory Care-Sensitive Condition Admission
3. Care Transition: Transition Record Transmitted to Health care Professional
4. Follow-Up After Hospitalization for Mental Illness
5. Plan- All Cause Readmission
6. Screening for Clinical Depression and Follow-up Plan
7. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
8. Controlling High Blood Pressure

State Measurement Challenges

- Most clinical information is only found in the medical record, not in data submitted on the claim form
- Not all services generate a claim
- Not all claims will be in the same data system because of multiple healthcare payers (e.g., Medicare)
- Unless a provider has an electronic health record it can be a laborious process to review charts to extract clinical information such as, for example, BMI
- Electronic health records may not necessarily include the CMS performance measures

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Use of Health Information Technology in Health Homes

Use of Health Information

- Electronic health records
- Patient registries
  - Contains patient information most relevant to chronic illness or preventive care, provides decision support
  - Is effective in avoiding patients “falling through the cracks”
- Shared care plans
  - Contain all the care a patient needs and is dynamic
  - Have limitations when only a paper document
- Notifications from hospitals to facilitate care transitions
  - Real time notification of inpatient or ED admission and that an intervention has occurred by the Health Home

Poll Question

To what extent is your agency using patient registries?

- Not at all
- Currently discussing implementation
- At beginning stages of implementation
- Have been using for a while
- N/A

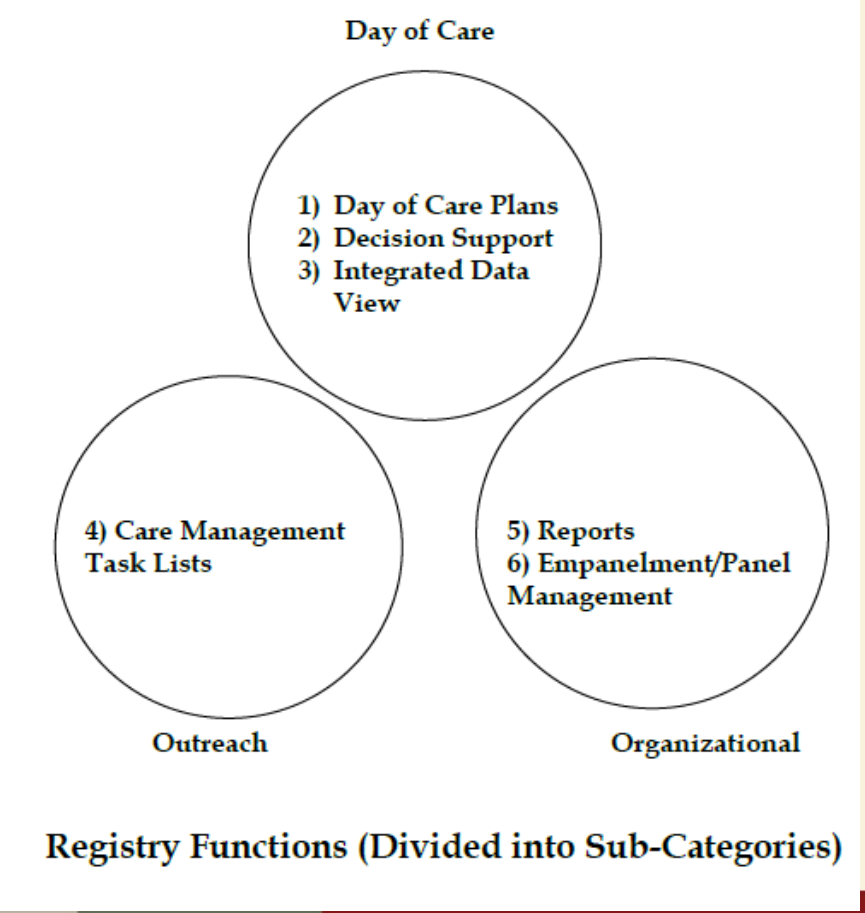
Core Patient Registry Functions

A patient registry is a set of functions within an electronic tool that facilitates the delivery of deliver planned care. Registries are most effective when they:

- Aggregate data (from EHR, hospital admit/discharge, vaccine registry, shared info from other partner health organizations). Business rules are developed.
- Result in development of a care plan.
- Summarize tasks to be completed and alerts team members (e.g., telephone outreach).
- Stratify populations by risk (e.g., demographic, clinical) .
- Generate reports to show whether quality is improving over time.
- Facilitate provider empanelment is a key piece of the patient centered medical home. The registry is a key place where empanelment resides.
- Allow for customization (e.g., creation of disease management protocols)

Functions of Registries

During a Visit, Between Visits, Unrelated to a Specific Visit



Patient Visit Summary (Diabetic)

									Last Visit	This Visit
Patient ID:	2996	MR:		Age:	54 Yrs	DOB:	4/20/1957	Sex: F	Date:	9/7/2010	
Name:	Richardson, Anna			Race:	HISPANIC				Blood Pressure:	120/88	
Address 1:	822 East Valley			Language:	English				BMI:	43.49	
Address 2:				Phone:	707-385-2371				Pain Score:	1	
City:	Santa Rosa			PCP:	Robert Wright, MD				Weight (lbs):	245	
State:	CA	ZIP:	95403	Insurance:	None						

PROBLEMS: Depression (i2i); Diabetes (MU); Diabetes Type II; DVT History; Family History of Breast Cancer; Leg Ulcers; Vascular: HTN (i2i)

MEDICATIONS: Anti-Depressant, Unspecified (i2i) (100 mg once every day); ARB, Unspecified (i2i); Coumadin (i2i) (1 mg 3 times every week); Diuretic, Unspecified (i2i); Lipid Lowerer

Alerts:

Due: Procedure / Referral: Mammogram (i2i)	Due: Procedure / Referral: Pap (i2i)
Due: Procedure / Referral: Depression Screening (i2i)	Due: Procedure / Referral: Colonoscopy (i2i)
Due: Procedure / Referral: Mammogram	Abnormal EyePACS Case (8/27/2008)

Procedures / Referrals	C	Date	N
Due: Depression Screening (i2	Received	12/16/2009	
Ophthalmology Visit (i2i)	Received	11/25/2010	
Podiatry Visit (i2i)	Received	3/12/2010	
EKG (i2i)	Not Applicable		

Other Profile Items	C	Date	N
Smoker (i2i)	Present - No coun	12/4/2006	
Homeless Status	Transitional	9/8/2007	
Drug Asst Program	Approved	9/8/2007	

Educations	C	Date	N
Diabetes (i2i)	Received	6/2/2011	
Exercise (i2i)			
Med Management	Received	9/7/2010	

Immunizations	C	Date	N
Flu (i2i)	Received	9/7/2010	
Pneumovax (i2i)	Received	12/3/2009	
Tetanus (i2i)	Received	5/7/2009	

Goals	C	Date	N
Exercise (i2i)	3 or more times/w	2/22/2008	
HbA1c (i2i)	less than 8	9/8/2007	

Blood Pressure	
Date	Val
9/7/10	120/88
3/18/10	140/95
12/3/09	118/77
10/18/09	122/68
5/7/09	114/80

BMI	
Date	Val
9/7/10	43.49
3/18/10	34.61
12/3/09	42.96
10/18/09	42.6
5/7/09	41.36

HbA1c	
Date	Val
9/29/10	8.7
9/17/10	7.1
10/29/09	8.2
5/20/09	9
10/14/08	13

LDL	
Date	Val
10/29/09	114
5/20/09	142
2/20/09	150
10/14/08	185

INR	
Date	Val
9/17/10	3.3
8/15/09	1.7
5/20/09	1.7
8/15/08	3

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Health Home Payments

Health Home Payment

- Reimbursement to Providers:
  - Case rate
  - PMPM
    - Base rate
    - Tiered by severity
    - Performance incentive
    - Other
- Need to avoid duplicative care management payments (e.g., health homes and separate TCM for same individual)

PMPM Payment Issues

- CMS has offered states considerable flexibility in designing payment.
- Flexibility includes documentation of receipt of Health Homes service:
  - Can be monitoring of patient without face to face encounter.
- States should carefully consider implications of paying providers on a PMPM basis:
  - Pro: Gives providers flexibility to target service delivery based on need, not billing.
  - Con: Danger of provider abuse and enrollment of non-active individuals into program.

Health Home Payment in Missouri

- Missouri built the CMHC health home PMPM rate around the costs of the state's required team of healthcare professionals.
- The PMPM rate is based on the state's analysis of the sum of team member and other costs necessary for administration of the benefit.

Health Home Payment in New York

- The state began with an analysis of projected staff member ratios in setting base rates.
- These rates are risk adjusted based on region and the CRG Grouper, using Medicaid claims.
- Providers are not bound to any specific staffing model: the state wants providers to maintain flexibility initially and over time, with ultimate accountability for outcomes.
- New York structured its health home program around networks. Networks selected have included hospitals, community mental health treatment, and intensive case management capacity.
  - The state has undertaken a competitive procurement and contracting approach to provider selection in order to assure the caliber of health homes networks.

Payment and Conversion of Existing Benefits

- New York is converting Medicaid enrolled targeted case management programs to designated health homes since the current programs provide similar comprehensive case management and community supports to help meet the extensive and complex needs of their clients. Rates are initially the same as under the previous TCM program, administered through the new Health Home network structure.
- Rhode Island converted community psychiatric supportive treatment, a care coordination and support service, to a health home program and imposing additional requirements to ensure that the service meets federal coverage requirements. Rhode Island developed its monthly case rate based on personnel costs of individual team members, the team composition, and the overall estimated caseload to yield a single statewide average case rate. The rate also reflects operating and support costs.

Tiering PMPM Payment by Enrollee Acuity

- Using claims, provider assessment, or both
  - New York using grouper software.
- Pros:
  - Makes it easier to accomplish conversion of existing care management programs into Health Homes.
  - Encourages providers to target intensive interventions
  - Reduces incentive to avoid high-need enrollees
- Cons:
  - Because Health Homes must be voluntary, need to think through interaction with other forms of community mental health payment
  - Incentive effects can be complicated.

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Health Homes and Managed Care Organizations

Health Homes and MCOs

- Enhanced federal share could support plan-level activities
- Examples:
  - North Carolina (Plan not at-risk)
  - New York (Plans paid for administrative activities as of now)

Managed Care Model Options

1. Health home operated outside the managed care organization (MCO);
2. Health home operated in partnership between MCO and health home provider, and MCO is already providing care management services;
3. Health home operated in partnership between MCO and health home provider, and MCO does not already provide care management services;
4. Health home operated solely by the MCO and MCO is already providing care management services;
5. Health home operated solely by the MCO, and MCO does not already provide care management services; and
6. MCO is health home provider not only for its enrolled members but also for Medicaid beneficiaries remaining in fee-for-service (FFS).

For more information see http://www.integratedcareresourcecenter.com/ under Health Homes and Managed Care

Contact Information

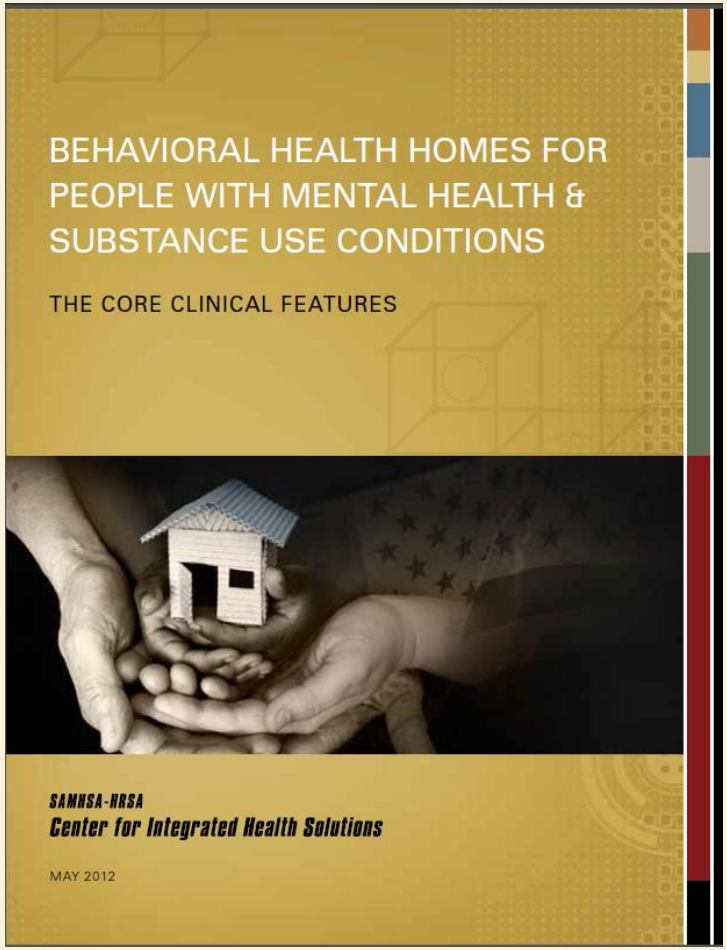
- Alicia D. Smith – asmith@healthmanagement.com
- Eliot Fishman – efishman@healthmanagement.com

For more information on health homes…

- Download CIHS' core clinical features paper at: www.integration.samhsa.gov

→ Integrated Care Models

- Stay tuned for the financing and policy considerations and children's health homes papers…



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