Thank you for joining today’s webinar. We will begin in a few minutes.

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Welcome and Introductions

Kathy Moses
Senior Program Officer
Center for Health Care Strategies

Questions?

To submit a question please click the question mark icon located in the toolbar at the top of your screen.

Your questions will be viewable only to CHCS staff.
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.

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**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

State Health Home Activity

As of April 2014

*Some states may be in the planning phase.*
The Ticking Clock...

When do states’ enhanced federal match periods end?

<table>
<thead>
<tr>
<th>DATE</th>
<th>STATE</th>
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<tbody>
<tr>
<td>10/2013</td>
<td>North Carolina, Oregon, Rhode Island (State Plan Amendment (SPA) #1 and SPA #2)</td>
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<tr>
<td>1/2014</td>
<td>Missouri (SPA #1 and SPA #2), New York (SPA #1)</td>
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<tr>
<td>4/2014</td>
<td>New York (SPA #2)</td>
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<td>1/2016</td>
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<tr>
<td>4/2016</td>
<td>Iowa (SPA #3)</td>
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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
**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
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:
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.
Questions?

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