



Chronic Health Homes Workgroup

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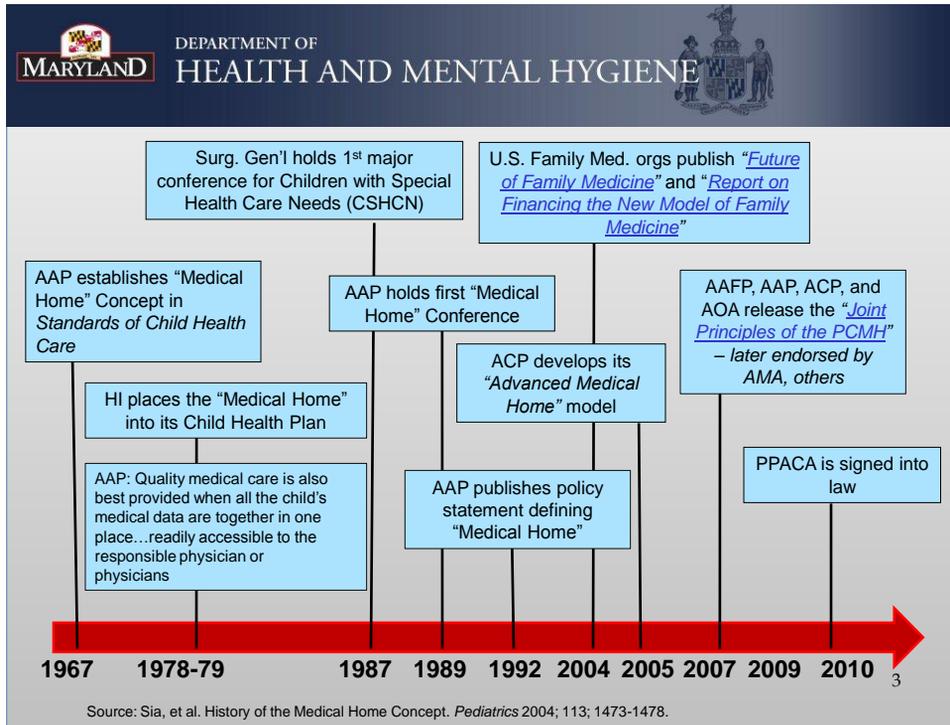
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Workgroup Agenda

- Historical Overview
- Health Reform and Health Homes
- Policy Considerations
- Questions/Discussion

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Pre-Reform Homes

- [Group Health Cooperative, WA](#)
 - 580k member network with PCMH; emphasis on EHR
- [Vermont Chronic Care Initiative](#)
 - Pilot program w/tiered approach for MA enrollees w/some chronic conditions
- [Community Care of North Carolina](#)
 - MA beneficiaries receive care via a multidisciplinary network; PCP serves as medical home

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Medical Home v. Health Home

Patient Centered Medical Home	Health Home
Serves all populations	Serves those with chronic disease, SMI, and/or SA
Typically physician-led, primary somatic care practices	May include PCP practices, but also community mental health centers, FQHCs, home health agencies, etc.
Reimbursement from many payers (commercial insurance, health plans, etc.)	Medicaid-only

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Medical Home v. Health Home

Patient Centered Medical Home	Health Home
Focused on the delivery of “traditional” health care services, tends to be somatic-focused	Strong focus on BH, SA, social supports, linkages to whole-person benefits
Health IT for prescribing, labs, record-keeping	Health IT for care coordination AND EHR (provider-to-provider communication, telemedicine)

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Patient-Centered Health Home



Source: National Center for Primary Care, Morehouse School of Medicine



Health Reform and Health Homes

- Created under Section 2703 of ACA
- As of Jan. 2011, states can submit a State Plan Amendment (SPA) for eligible beneficiaries
- Federal funding is 90, 10% State for coordination services *only*
 - Time limited: 8 quarters, then regular match₈



Eligible Populations

Medicaid beneficiaries with:

- Two+ chronic conditions (mental health, substance abuse, asthma, diabetes, heart disease, overweight, or others as approved by CMS);
- One chronic condition and at risk for a second; or
- Serious and persistent mental health condition.

✓ **CAN** target by condition or geography

✗ **Cannot** exclude dual eligibles

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Six Mandated Core Services

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care, including appropriate follow-up from inpatient to other settings
- Patient and Family Support
- Referral to community and social services, if relevant
- Use of HIT to link services, as feasible and appropriate

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Provider Requirements

Can be a physician, clinical group practice, rural clinic, community health center, community mental health center, teams of providers, other entity

- Provide quality-driven, cost-effective, culturally appropriate, person-/family-centered services;
- Coordinate/provide access to: high-quality, evidence-based preventive services;
- Develop a person-centered care plan that coordinates/integrates clinical/non-clinical health care needs/services;
- Link services with HIT, communicate across team, individual and family caregivers, and provide feedback to practices; and
- Establish a continuous QI program.

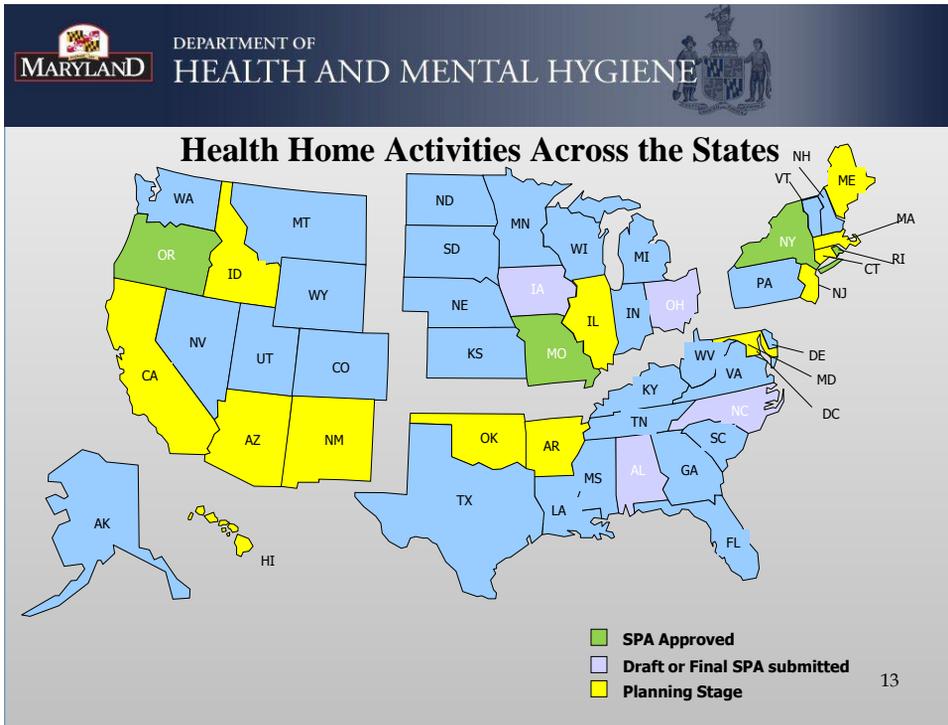
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Measurement and Reporting

- States must track and report outcomes (e.g., avoidable readmissions) and calculate cost savings
- Designated providers must report quality measures as condition of reimbursement
- SPA requires substantial description of evaluation and monitoring plans
- Independent evaluator will survey states on impact of health home services on various cost, clinical and utilization measures

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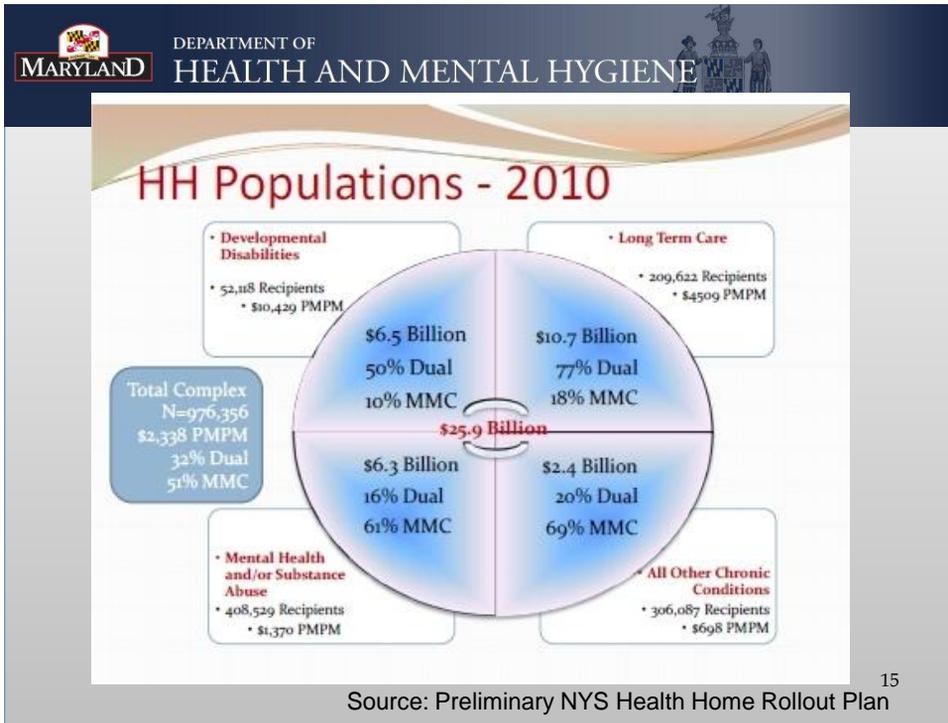



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New York Health Home

- Targets adults MH, SA, and/or other chronic health conditions
- 1st wave roll Jan. 2012; LTC, Spring 2012; DD, Fall 2012
- Eligible members assigned to HH based on predictive risk for hospitalization; low connectivity to ambulatory care; provider loyalty; geographic factors

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New York Health Home

- HH providers can be any entity that meets State/ Federal requirements.
- Teams of medical, MH, SA providers, LCSWs, RNs, etc. led by a dedicated care manager
 - Optional: nutritionists/dieticians, pharmacy, peer specialists, housing representatives, entitlement and employment specialists, etc.
- Single electronic care record for care manager, team

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New York Health Home

Services:

- Comprehensive care mgmt
- Care Coordination
- Health Promotion
- Comp. Transitional Care
- Ind. & Family Support Services
- Referral to Community/
Social Supports

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Missouri Health Home

- Targets adults MH, SA, and/or other chronic health conditions
- Eligible members assigned to HH based on geography
- Eligible providers limited to community mental health centers (CMHCs)

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Missouri Health Home

- CMHC HH team is physician-led with PCP Consultant, a Nurse Care Manager(s), and a HH admin support staff
 - Optional: treating psychiatrist, MH case manager, pharmacy, peer specialists, housing representatives, employment or educational specialists, etc.
- Single EHR portal from MO HealthNet for all Medicaid Providers

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Missouri Health Home

Services:

- Comprehensive care mgmt
- Care Coordination
- Health Promotion
- Comp. Transitional Care
- Ind. & Family Support Services
- Referral to Community/
Social Supports

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Policy Considerations

- Target Population Criteria
- Provider Capacity and Qualifications
- Service Description
 - What coordination services are already being provided by MHA, ADAA, MCOs?
 - Payment for coordination and linkage; not treatment
- Coordination with Data Workgroup
 - Monitoring (e.g., cost savings, avoidable hospitalizations)
 - Quality measures (e.g., clinical outcomes, consumer satisfaction)

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Questions/Discussion

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