Health Homes

What is a Health Home?

- Created by Section 2703 of the ACA to help reduce the cost of services for some High Cost High Risk Medicaid populations.
- Health Homes are part of a person-centered system of care that achieves improved outcomes for recipients and better services and value for state Medicaid programs.
- The Medicaid Solutions Workgroup recommended that DSS implement a Health Homes initiative.
- Several States are currently approved to do Health Homes including, ID, ME, MO, IA, OH, NY, RI, OR, WI and NC.
- 57% of our costs in Medicaid come from 5% of our population.
- 83% of Health Home eligible individual are included in the individuals in the 5% who make up our Highest Cost Highest Risk Group.

What are Health Home Services?

- Six Core Services must be provided:
  - Comprehensive care management;
  - Care coordination;
  - Health promotion;
  - Comprehensive transitional care/follow-up;
  - Patient and family support; and
  - Referral to community and social support services.
- May or may not be provided within the walls of a primary care practice.
- Health Homes are NOT:
  - Home Health Services provided in the home
  - A place where recipients live and receive care.

Populations to be Served by Health Homes

- All Medicaid recipients will be considered when determining eligibility – regardless of aid category.
- Eligible recipients include those with two or more chronic conditions OR one chronic and one at risk condition.
  - **Chronic conditions include**: Mental Illness, Substance Abuse, Asthma, COPD, Diabetes, Heart Disease, Hypertension,Obesity,Muskoloskeletal and Neck and Back Disorders.
  - **At-risk conditions include**: Pre-Diabetes, tobacco use, Cancer Hypercholesterolemia, Depression, and use of multiple medications (6 or more classes of medications).
- Eligible recipients also include those with one Severe Mental Illness or Emotional Disturbance.

Health Home Infrastructure

- There are two types of Health Homes the Primary Care Provider and the Community Mental Health Center.
  - Designated providers for Health Homes include licensed providers who practice as a primary care physician, (e.g., family practice, internal medicine, pediatrician or OB/GYN), physicians assistant, an advanced practice nurse practitioner working in a Federally Qualified Health Center, Rural Health Clinic, Indian Health Service Unit, or clinic group practice; or a mental health professional working in a Community Mental Health Center.
  - Each designated provider attests that they meet the provider standards.
  - The designated provider leads a team of health professionals needed to support each recipient. The team may include a primary care physician, physician assistant, advance practice nurse, behavioral health provider, a health coach/care coordinator/care manager, chiropractor, pharmacist, support staff, and other services as appropriate and available.

Proposed Payment Methodology

- Medicaid will continue to pay for Medical Services on a Fee for Service Basis.
- PMPM will be developed to cover core services not traditionally covered by Medicaid. Enhanced 90/10 funding provided by CMS for the PMPM during the pilot.
- Workgroup recommended 4 Payment Tiers based on the Chronic Illness and Disability Payment System (CDPS).
- Recipients stratified in to 1 of 4 Tiers using CDPS.

Using CDPS to Attribute Those Eligible

- Publicly available tool validated for use in Medicaid populations, developed by the University of California San Diego.
- Used by States who use Medicaid Managed Care Companies to manage their populations including Washington, Utah, Delaware and Michigan.
- Accounts for broad spectrum of diseases (not just those included in HH definition) and historical costs in order to predict risk for future high costs that are amendable to change.
- CDPS stratifies each diagnostic category into hierarchical levels of severity that demonstrate the level of healthcare needs of a recipient with a diagnosis within a given category.
- Analytics/tier assignment will be performed by an external vendor.
- Claims data analyzed for newly eligible recipients every month, new tier applied at six month intervals.

Attribution Process

- Those eligible for Tier 1 have option to opt-in.
- Claims for those eligible for Tiers 2-4 are reviewed to determine if the recipient has a history with a provider who is a Health Home. If they do, they are assigned to that provider with the ability to change or opt out.
- If the recipient does not have a history with a provider, they are sent a letter and asked to choose. They also have the option to opt out.
- Health Homes are voluntary.

Review Flowchart

- Health Home Attribution Process

Next Steps for Health Homes

- State Plan amendment has been submitted. Awaiting approval.
- Educating eligible recipients about the functions and benefits of a Health Home.
- Educating stakeholders about Health Homes.
- Approving New Health Home Applications.

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Questions?

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