

# Ohio Medicaid Health Homes Program



**BEHAVIORAL HEALTH LEADERSHIP GROUP  
HEALTH HOME OPERATIONAL LOGISTICS  
MEETING**

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VERN RIFFE STATE OFFICE TOWER,  
77 S. HIGH STREET, COLUMBUS, OHIO**

# A Health Home is ...



- A new service delivery model for Medicaid consumers with uncoordinated care
- Whole person care coordination / care management for consumers with complex conditions
- Person-centered planning approach to identify needed services and supports
- Consideration of the needs of the person without compartmentalizing aspects of the person, his/her health, or his/her well-being
- Providing care and linkages to care that address all of the clinical and non-clinical needs

# Affordable Care Act 2703

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**CMS is collaborating with**

- Substance Abuse and Mental health Services Administration (SAMHSA)
- HHS Assistant Secretary for Planning and Evaluation (ASPE)
- Health Resources and Services Administration (HRSA)
- Agency for Healthcare Research and Quality (AHRQ)

**to implement an evidence-based approach**

## Related to, but Not the Same as, the Patient-Centered Medical Home

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- Use Patient-Centered Medical Home (PCMH) as foundation for Medicaid Health Homes
- Medicaid Health Homes expand on PCMHs by:
  - Focusing on patients with multiple chronic and complex conditions;
  - Coordinating across medical, behavioral, and long-term care; and
  - Building linkages to community, social supports, & recovery services
- Focus on outcomes – reduced ED & hospital admissions & readmissions, reduced reliance on LTC facilities, improved experience of care and quality of care

# What are Medicaid Health Home services?

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ACA defines Medicaid health home services as:

- (1) comprehensive care management;
- (2) care coordination and health promotion;
- (3) comprehensive transitional care/follow-up;
- (4) patient and family support;
- (5) referral to community and social support services; and
- (6) use of HIT to link services

# Who Can Receive Medicaid Health Home services?

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- Medicaid consumers with:
  - *One Serious and persistent mental health condition; or*
  - Two or more of the following chronic conditions
    - mental health
    - substance abuse
    - asthma
    - diabetes
    - heart disease
    - being overweight (BMI >25)
  - One chronic condition and at risk for a second;
- Additional conditions considered by the HHS Secretary

# Who Can Receive Medicaid Health Home services?

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- Cannot exclude dual eligibles
- Cannot target specific ages
  - e.g., cannot target only children or only adults

# Who Can Provide Medicaid Health Home services?

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## **Team of Health Care Professionals Linked to a Designated Provider:**

Team of Health Care Professionals may include:

physicians and other professionals including a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State and;

Be free-standing, virtual or based at a hospital, community health center, community mental health center, rural clinic, clinical practice/group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary

## **Qualifications:**

Medicaid Health Homes must meet the State-defined Qualifying Core Conditions

# Ohio Medicaid Health Home Definition: Core Elements



- **Operate as a Patient Centered Medical Home**
  - Enhance Access and Continuity of Care
  - Plan and Manage Care
  - Monitor and Coordinate Care
  - Include patients and families
  - Integrate Community Resources
  - Quality Improvement
- **Integrate Physical/Behavioral Health Care**
- **Acquire Electronic Health Records**
- **Meet Additional Health Home Qualification**

# How and When Can States Participate?

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- State participation is optional
- States can start as soon as they get an approved State Plan Amendment (SPA)

# Funding & Roll-Out Options

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- Funding is a federal-state match for Medicaid Health Home Services
  - States contribute 10% - Feds contribute 90% of Health Home Services costs for 8 quarters; then regular match after 8 quarters
- Timing is flexible
  - Can roll-out program by geographic region &/or condition
    - ✦ Each geographic region & condition combination can have a separate 8 quarter 90/10 clock

# How are Services Reimbursed?

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- Flexibility in payment methods, including, but not limited to:
  - Tiered payment methods
  - Adjustments by patient severity
  - Adjustments by provider's skill set/capabilities
  - CMS open to alternatives to per member per month (PMPM) approaches, but must approve
- States with Medicaid Managed Care Programs, can deploy Health Homes through Medicaid Managed Care Plans
- No duplication of payment for health home services

# How will CMS and states measure success?

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CMS has significant evaluation expectations:

- States must track and report outcomes (e.g., avoidable readmissions, ER, SNF admissions) and calculate cost savings
- Designated providers must report quality measures as condition of reimbursement
- Independent evaluator will survey states on impact of Medicaid health home services on various cost, clinical and utilization measures

# Ohio Medicaid Stats

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- Source: Medicaid Claims/Encounter Data
- Seven Conditions: heart disease, substance abuse, asthma, diabetes, heart disease, overweight, serious & persistent mental health condition
- Medicaid Consumers with Qualifying Conditions
  - SPMI/SED: 177,000
  - Two conditions on list (non-SPMI/SED): 75,000
  - One condition and at-risk for a second: 360,000
  - Total: 612,000\*

\*Level of management not assessed

# Ohio Medicaid Stats

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- Rank Order of conditions - consumers with episodes including two or more of the seven conditions:
  - Diabetes
  - Heart Disease
  - Behavioral health
  - Asthma
  - Substance Abuse
  - Overweight \*\*\* Claims data likely under reports overweight consumers

# Ohio Medicaid Health Home Definition

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- MCPs administer Health Home Services
- Care Coordination: Based on Geisinger Medical Home Model
  - ✦ MCP-funded embedded Nurse Care Manager
    - Practice site treating primary condition to manage embedded Nurse Care Manager (inc., hire, pay, house)
  - ✦ Use Team of Health Care Professionals lead by a designated provider
    - Make-up of Team depends on needs of patient
    - Single point of accountability will be practitioner at practice site treating primary condition, e.g., Primary Care Practice, CMHC, FQHC
    - Embedded Nurse Care Manager part of Team
  - ✦ Due to the complexity of care management of SPMI/SED, innovative ideas within this model will be explored

# Ohio Medicaid Health Home Definition

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- Consumer Identification:

- ✦ Provider Referral
- ✦ MCP Informatics

to target most impactful consumers in geographic region

- Consumer Participation Process:

- ✦ Treat Health Home services like other health services: Providers offer/recommend service to qualifying patients: patients choose if they want the service
- ✦ Consumer Education: 'Health Home' sounds like a place, not an additional benefit

- Consumer Assessment: Provider complete:

- ✦ Comprehensive Health Assessment (for Care Treatment Plan) &
- ✦ Health Risk Assessment (for payment)

- Care Treatment Plan

- ✦ Data from MCP on patient utilization, hospital, ED use, drug use
- ✦ Team, patient, & family use comprehensive health assessment and MCP data to develop Care Treatment Plan, Goals, Priorities, follow-up plan

- HIT , MCP resources used to link services

# Ohio Medicaid Health Home Financing

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- **MCPs administer finances**
  - pmpm payment to practice site treating primary condition (designated provider meeting qualifying core elements)
  - Included in pmpm is payment for embedded Nurse Care Manager
  - May include shared savings and P4P
- **ROI calculated by Ohio Medicaid (or vendor)**



# OHIO MEDICAID HEALTH HOMES PROGRAM: ODMH UPDATE

# Health Homes Initiative Updates



- **Health Home Population Criteria**
  - Definition of SMI, SPMI & SED
- **Health Home Service Definitions**
  - CPST
- **Health Home Qualifying Core Elements**
  - NCQA PCMH Recognition
  - Embedded Nurse Care Manager (Geisinger Model)
  - Integrate Physical/Behavioral Health Care
- **Behavioral Health Site Visits**
  - What don't we know?
  - SAMHSA Integrated Care Grantees
  - Focused on core elements
  - Common Themes
  - Challenges
  - Opportunities

# Health Home Population Criteria: Serious and Persistent Mental Health Condition



- **Serious Mental Illness (SMI) :**
  - Must be 18 years of age or older
  - Must meet any of the DSM-IV TR diagnoses, except the exclusionary diagnoses (DD, AOD, V Codes & Dementia)
  - Treatment history criteria
  - Assessment of impaired functioning measured by the Global Assessment of Functioning scale (GAF) (score of 40 to 60)

# Health Home Population Criteria: Serious and Persistent Mental Health Condition



- **Serious and Persistent Mental Illness (SPMI):**
  - Must be 18 years of age or older
  - Must meet criteria for any of the DSM-IV TR diagnoses, except the exclusionary diagnoses (DD, AOD, V Codes & Dementia)
  - Treatment history criteria
  - GAF Score of 50 or below

# Health Home Population Criteria: Serious and Persistent Mental Health Condition



- **Serious Emotional Disturbance (SED):**
  - Must be 17 years of age or younger
  - Must meet criteria for any of the DSM-IV TR diagnoses, except the exclusionary diagnoses (Developmental disorders, Substance use disorders, and V Codes)
  - Duration of the mental health disorder has persisted or is expected to be present for 6 months or longer
  - Assessment of impaired functioning as measured by the Global Assessment of Functioning scale (GAF Score of below 60)

# Health Home Service Definitions: CPST Highlights



- Ongoing assessment of needs
- Assistance in achieving personal independence in managing basic needs
- Facilitation of further development of daily living skills
- Coordination of ISP
- Symptom monitoring
- Coordination and/or assistance in crisis management and stabilization
- Advocacy & outreach
- Family education and training
- Mental health interventions
- Activities that increase the individual's capacity to positively impact his/her environment

# Service Alignment Goals



- Truly integrate services
- Align health home services & CPST
- Avoid duplication and overlap
- Have a clear point of responsibility

# Site Visits - Purpose



- What do we know?
- What don't we know?
- Inform planning efforts
- Understand capacity & readiness using the core elements
- Identify challenges & opportunities

# Site Visits - Locations



- Eastway Behavioral Healthcare (Dayton)
- Shawnee Mental Health Center (Portsmouth)\*
- Greater Cincinnati Behavioral Health (Cincinnati)\*
- Center for Families and Children (Cleveland)\*
- Southeast, Inc. (Columbus)\*

\* SAMHSA Grantee

# Site Visits – Eastway Behavioral Healthcare



- ODMH & ODADAS Certified
- CARF Accreditation
- Provider of Comprehensive Behavioral Health Services
- Populations served include SMI adults and SED children
- Type of Integration:
  - Co-located with primary care provider
    - ✦ 400 patients receiving primary care services on site
  - Co-located with pharmacy services provider
  - Pending co-location with dental provider
  - Contracting with a private lab company for on-site lab services
  - Home-grown Electronic Health Record System
  - Baseline Data Collection

# Site Visits – Shawnee Mental Health Center



- ODMH Certified
- CARF Accreditation
- SAMHSA Grantee
- Type of Integration:
  - Primary Care Services delivered within Behavioral Health
  - Part-time DO treating high risk/high intensity cases
  - Two Nurse Practitioners with a collaborating DO
  - LPNs act as care managers and responsible for care coordination
  - Electronic Health Record and HIE contract with OHIP
  - SAMHSA Grant Data Collection
  - Program evaluation conducted by Center for Evidence-Based Practices at CASE

# Site Visits – Greater Cincinnati Behavioral Health



- ODMH and ODADAS Certified
- CARF Accreditation
- Comprehensive Behavioral Health Services
- Serve Adults, Transitional Youth and Children
- SAMHSA Grantee
- Type of Integration:
  - Co-located with an FQHC (The HealthCare Connection)
  - Nurse Practitioners with a collaborating physician
  - Three RNs care managers for patients with high risk and physical health needs
  - Co-located with a specialty pharmacy provider (QoL Med)
  - Contracting with a private lab company for on-site services
  - SAMHSA Grant Data Collection
  - Upgrading HIT to support integration and improve care coordination (The HealthBridge)

# Site Visits – Center for Families and Children



- ODMH Certified
- COA Accreditation (Switching to JCAHO)
- SAMHSA Grantee
- Type of Integration:
  - Co-located with the Cleveland Clinic
  - Nurse Practitioner with a collaborating physician
  - Only uninsured adults receiving primary care
  - In-house pharmacy owned by CFC
  - Small lab on-site and other lab services are contracted
  - SAMHSA Data Collection
  - Plans for HIT

# Site Visits – Southeast, Inc.



- ODMH and ODADAS Certified
- JCAHO Accreditation
- Comprehensive Behavioral Health Services
- Populations served include SMI adults, SED kids and outpatient adults
- Currently in 6 Counties
- Received FQHC grant for Homeless Population
- SAMHSA Grantee
- Type of Integration:
  - Primary care is provided within Behavioral Health
  - Two primary care physicians
  - In-house pharmacy (Apothecare)
  - Small lab on-site and other lab services are contracted
  - Implementing a new HIT (NextGen) with single integrated record for BH/PH and integrated billing system
  - Certified Billing/Coding staff for BH/PH
  - SAMHSA Data Collection
  - Variety of Health and Wellness Programs: Auricular Acupuncture Services, WMR
  - Seeking NCQA PCMH Recognition

# Site Visits – Challenges



- Blending of Primary Care & Behavioral Health “Cultures”
- Documentation Requirements
- Billing Requirements
- Covering Costs in a FFS environment
- Scheduling Flexibility
- Treatment plan integration
- Integrated electronic health record

# Site Visits - Opportunities



- CARF Accreditation
- Joint Commission Accreditation
- Enhanced community partnerships
- Exploring staffing arrangements to further support integration
- Alternative reimbursement arrangements that better support integration – Pay for Performance
- Health information technology

# Site Visits – Other Common Themes



- True integration & commitment to the patient
- Expansion of services to all consumers & meeting unmet need
- Health promotion, prevention & wellness
- Support from administration & clinicians
- Health information technology
- Dental services
- Variety of co-morbid conditions
- Prioritizing patient needs as a team
- Patient choice
- Family inclusion
- Physical plant changes that support integrated care

# Site Visits – Other Common Themes



- **Other Qualifying Chronic Conditions**
  - Hepatitis C
  - Dental Problems
  - GERD
  - Chronic Pain/Muscular/Skeletal problems
  - Podiatry
  - Cancers
  - Smoking and Respiratory diseases
  - High Blood Pressure
  - TBI
  - Seizures
  - HIV/AIDS
  - Obesity
  - High Cholesterol
  - Diabetes
  - Heart Disease

# Next Steps



- Continue Design Work
- Health Management Associates (HMA) contract to help with the SPA development
- Behavioral Health Leadership Group Health Home Operational Logistics Framework Ad Hoc Committees
- Block Grant Opportunities
  - Health Information Technology
  - Innovations in Integrated Care



Questions?