Overview of Proposed Health Home Model for Indiana

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Background on Section 2703 of the ACA

- Under Section 2703, the ACA provides a state option to provide coordinated care through a Health Home for individuals with chronic health conditions.
- States through a an approved State Plan Amendment (SPA), may provide for medical assistance under this title to eligible individuals with chronic conditions who select a designated provider.
- The HHS Secretary shall establish standards for qualification as a designated provider.
- Section 2703 of the Act allows states, with approval of the HHS Secretary, to determine who is an eligible provider.
- The term 'designated provider' means a physician, clinical practice or clinical group practice, rural clinic, community health center, **community mental health center**, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians).

Background on Section 2703 of the ACA

- A State shall provide a designated provider with payments for the provision of health home services to each eligible individual with chronic conditions that selects such provider.
- Payments made to a designated provider, a team of health care professionals operating with such a provider, or a health team for such services shall be treated as medical assistance, except that, during the first 8 fiscal year quarters that the SPA is in effect, the Federal medical assistance percentage (FMAP) applicable to such payments shall be equal to 90 percent.
- Such an approach is used to incentivize states to pursue the Health home model as a way to improve health outcomes and reduce Medicaid costs.
- A participating state shall specify in the SPA the methodology the State will use for determining payment for the provision of health home services.
- In determining the state's payment methodology, the state must consider the following elements;

Background on Section 2703 of the ACA

- Payments may be tiered to reflect, with respect to each eligible individual with chronic conditions provided such services by a designated with respect to the severity or number of each such individual's chronic conditions or the specific capabilities of the provider.
- The methodology for determining payment for provision of health home services shall not be limited to a per-member per-month basis and may provide for alternate models of payment.
- A State shall include in the SPA a requirement to establish procedures for referring any eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.
- A State shall coordinate in addressing issues regarding **the prevention and treatment of mental illness and substance abuse** among eligible individuals with chronic conditions.

Background on Section 2703 of the ACA

- A State shall include in the SPA the following;

  (1) a methodology for tracking avoidable hospital readmissions and calculating savings that result from improved chronic care coordination and management under this section; and

  (2) a proposal for use of health information technology in providing health home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).
- As a condition for receiving payment for health home services a designated provider shall report to the State on all applicable measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the State with such information.
- States have been provided “voluntary” SMI HEDIS measures which may assist in determining health outcomes.

How to Define “Chronic Condition” and “Health Home”

- The term ‘chronic condition’ shall include, but is not limited to, the following;

  (A) A mental health condition.

  (B) Substance use disorder.

  (C) Asthma.

  (D) Diabetes.

  (E) Heart disease

- The term ‘eligible individual with chronic conditions’ means an individual who is eligible for medical assistance under the SPA and has at least 2 chronic conditions, or 1 chronic condition and is at risk of having a second chronic condition; or has a serious and persistent mental health condition.
- The term “health home services” is defined under the ACA as comprehensive and timely high-quality services described that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team.

Allowable Services Under a “Health Home”

- The services allowable under the health home model include;

(i) comprehensive care management;

(ii) care coordination and health promotion;

(iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;

(iv) patient and family support (including authorized representatives)

(v) referral to community and social support services; and

(vi) use of health information technology to link

services, as feasible and appropriate.

Outcome Measures and Program Assessment

- In determining outcome measures and program assessments, states shall report to HHS regarding the implementation of the Health home model particularly as it pertains to—

  (i) hospital admission rates;

  (ii) chronic disease management;

  (iii) coordination of care for individuals with chronic conditions;

  (iv) assessment of program implementation;

  (v) processes and lessons learned;

  (vi) assessment of quality improvements and clinical outcomes under such option; and

  (vii) estimates of cost savings.

ICCMHC Proposed Approach

The CMHCs met in November, 2011 to discuss the potential of establishing a Health home model in Indiana

Action teams were established to analyze the ability of the CMHC system to adopt to this model, including the business, staffing, and training required to implement.

Both DMHA and OMPP have expressed a willingness to receive a proposal from the ICCMHC with respect to implementing such a program.

The ICCMHC will be working with the membership, DMHA, OMPP, consumer groups and other interested parties over the next several months to pursue the health home model.

The Health Home Model – What it is not

To be clear, the health home model proposed by the ICCMHC is not fully integrated, bi-directional healthcare.

The health home model as proposed under the plan draft is a step towards full integration, however more work and training would be required.

While language currently exists in the proposed draft to authorize CMHCs to bill for basic primary health services as outlined under the “chronic conditions” section of the proposal, such an approach would require approval from OMPP and should be seen as a two step process towards integration.

The Health Home Model – What it is

The Health Home proposal is designed to provide statewide care coordination coverage for individuals with a chronic mental health conditions, and/or a corresponding chronic primary health conditions using a per member, per month payment methodology.

All populations are included in the draft to ensure preventative care for both SMI and SED populations.

Individuals at-risk are also included in the proposal.

The Health Home Model – What it is

Chronic conditions included in the proposal include;

- Mental health condition
- Substance use disorder
- Pulmonary Illness
- Diabetes
- Heart Disease
- Body Weight Index (BMI) over 25
- Hyper Tension
- HIV
- Other chronic health conditions that pose a threat to the individual

The Health Home Model – Population's Served

Description of Chronic conditions Covered:

- Individuals of any age, based on the following criteria between adults and children;
- Adults with a DSMIV (and any subsequent versions) diagnosis, other than alcohol or drug disorders alone, organic brain disorders, developmental disabilities, and anti-social conditions.
- A child or adolescent with a DSMIV (and any subsequent versions) diagnosis and corresponding conditions over an extended period of time and to a marked extent that adversely affects a child's educational performance.
- A serious mental illness or serious emotional disturbance and one other chronic health condition including asthma, cardiovascular disease, diabetes, substance abuse disorder, overweight with a BMI >25, hypertension, and/or HIV positive.
- A mental health condition and tobacco use or metabolic disorder, both of which constitute risk for developing a chronic health condition

The Health Home Model – Assignment

An outline of how individuals would be assigned to a health home:

- Auto assignment to the Health Home (certified CMHC) where the person has received previous services in a CMHC, to the Health Home where 51% or more of outpatient behavioral health services (per claims data).
- In locations where more than one CMHC provides services within the county, the individual will be provided a list of CMHCs identifying the options of services available within the CMHC and the individual may choose the Health home provider.
- Individuals who meet criteria and who have not been assigned to a Health Home and who are treated in an emergency room, inpatient hospital, FQHC of other health facilities will be referred to the Health Home(s) that operate in the geographic area of their residence, based on the established criteria.

The Health Home Model – Health Home Team

- At a minimum, the Health Team will be comprised of the following: Health Home Director, Primary Care Physician and/or Nurse Practitioner under the supervision of a physician, Registered Nurse, Care Coordinator (either a nurse or master level behavioral health professional).
- Other specialties that may be included on the Team are Licensed Behavioral Health Clinicians, Psychiatrists, Licensed Substance Abuse Clinicians, Nurse practitioners with specialty in psychiatry, Community Support Specialists, Registered Dieticians, Peer Recovery Specialists and Pharmacists.
- Other community based services and providers will be included in services as required to meet the needs of the individual. All Teams will be person centered, culturally competent and able to meet the linguistic needs of the persons enrolled.

The Health Home Model – Plan Elements

- The plan still needs extensive work in the area of how Health Information Technology (HIT) will link to the health home. Strong cooperation will be required with OMPP to develop an effective HIT linkage plan.
- CMHCs will be provided with training and supports that will enable them to make the transition to becoming an effective Health Home.
- Training needs will be assessed and training provided both prior to implementation of the SPA as well as during and after the initial implementation.

The Health Home Model – Service Definitions

- **Comprehensive Care Management**
  - Comprehensive care management will be provided by licensed Registered Nurses, by a licensed Master's level clinician, an HSPP or, by other licensed health professionals overseen by a licensed Registered Nurse. If a staff person other than a Registered Nurse is in this role the Health Team must include a Registered Nurse.
- **Care Coordination**
  - Undertake consumer engagement activities to ensure care coordination is implementation of the individualized treatment plan through appropriate linkages, referrals, non-traditional engagement, coordination and follow up to needed services and supports.

The Health Home Model – Service Definitions

- **Health Promotion**
  - Health promotion services include health education and active interventions specific to the enrollees' chronic condition(s), development of self-management plans and strategies, providing support for lifestyle changes to promote improved health including dietary management, as well as many other areas.
- **Comprehensive Transitional Care Including Appropriate Follow Up from Inpatient to Other Settings**
  - The goal of comprehensive transitional care is to decrease preventable or unnecessary medical and psychiatric hospital admissions and re-admissions emergency room use and ensure coordination of care across all types and levels of care including; long term care, primary health facilities, behavioral health facilities, State Operated Facilities (SOF), jail and residential group homes.

The Health Home Model – Service Definitions

- **Individual and Family Support Services**
  - Individual and family support services includes advocating and securing services needed for the individual and for involved families. This may include helping identify and access support networks, educational services regarding the chronic behavioral and medical conditions, peer supports, etc. with the objective of assisting them in obtaining the highest level of health and community functioning.
- **Referral to Community and Social Support Services**
  - Referral to community and support services provides enrollees with access to comprehensive community based support and services that are needed to maintain independence and optimal functioning in the community. These referrals also enable the enrollee to access services that are used by the general community population which results in fuller integration into the community. Services that enrollees may be referred to include: housing, health care services, Medicaid, food stamps, specialty health care, weight loss programs, fitness activities, smoking cessation, etc.

The Health Home Model – **Provider Standards**

- Ensure that the CMHC has the minimum levels and types of staff required for implementation of the Health Home. Ensure that should staffing vacancies occur that the CMHC secure the necessary staff by hire or by contract within time periods specified.
- Within a reasonable period of time an agreement with at least one area hospital(s) and other providers (e.g. residential providers for substance abuse) for transition planning and, in the case of hospitals, to provide for identification of individuals using the ER that potentially meet established Health Home eligibility criteria.
- Provide strong leadership for the Health Home including regular planning meetings to evaluate progress and make determinations of any operational changes that might be needed, including planning for goal implementation and practice transformation. Agree to communicate with the State of Indiana regarding any operational or training needs.

The Health Home Model – **Provider Standards**

- Providers must be a CMHC with appropriate licenses and have a state certification to operate as a CMHC with respect to the populations identified for the Health Home.
- Have the necessary contracts, staff and enrollment to participate fully in the Indiana Medicaid program including Care Select, MCOs, CHIP and HIP, as well as Medicare.
- Agree to provision of Health Home services as outlined in the SPA and as subsequently detailed in any administrative rules, OMPP bulletins, or program guidance correspondence produced by the State of Indiana for operation of Health Homes.
- Agree to participate in all pre and post implementation training programs provided for Health Homes including planning committees and learning collaborative as established for these programs.

The Health Home Model – **Provider Standards**

- Meet access requirements for medical home standards tied to accreditation/certification as a medical home.
- Provide 24/7 access for enrollees in mental health crisis stabilization or stabilization and other services that address whole-person needs, including telephone access.
- Conduct health wellness assessments as indicated based upon enrollee risk level.
- Participation in all data reporting and evaluation activities as required for Health Homes by both the State of Indiana and CMS.
- Develop an on-going quality improvement plan to address identified gaps in service that are identified by ensuring the currently assigned CMHC quality improvement coordinator is actively involved in this assessment process.

The Health Home Model – **Provider Standards**

- Demonstrate documented progress toward Health Home certification within 12, 24, and 36 months of becoming a Health Home.
- Following the establishment of accreditation standards by nationally recognized accreditation agencies, within 24 months of becoming a Health Home, the Health Home shall obtain accreditation as a Health Home from an approved list developed by the FSSA/DMHA.
- Maintain compliance with all of the terms and conditions as a CMHC Health Home provider.
- Successfully submit a complete proposal for Health Home status that presents a reasonable likelihood that the goals of the Health Home of improved health outcomes and a reduced cost trajectory.

The Health Home Model – **Provider Application Process**

All CMHCs that intend to participate as Health Home will be required to submit an application for this status. The application will include certification that the CMHC agrees to participate and meet all terms and conditions of the Health Home. A structured framework for application for Health Home status will be developed by the State of Indiana and include the following:

- Overview of the CMHCs philosophy of care as it relates to Health Home and integrated care;
- Description of the model of integration to be used;
- Description as to how the goals of lowered preventable readmissions and ER use will be met;
- Description of the Health Team including how primary care services are to be provided. If provided by agreement with another organization, identify that organization and secure written agreement to involvement (intent) as a part of the application;

The Health Home Model – **Provider Application Process**

- Established process for involving enrollees, families and others in the Health Home, describing how the Health Home will be person-centered and evidence based;
- Identification of the Leadership Team that will guide the development of the Health Home;
- Staffing plan and hiring schedule;
- A statement of commitment to the training program for the Health Home pre and post implementation phases;
- A statement of commitment and ability to provide the required reporting and data including data related to the goals as stated in this SPA; and
- Preliminary selection of the accreditation body for Health Home status. Please note that accreditation issues continue to be under development as a part of this proposal.

The Health Home Model – Monitoring

- As a part of the SPA, the State must extensively develop its monitoring approach to the health home. The following are initially proposed monitoring approaches;
  - OMPP will use claims data to measure readmissions per one thousand (1000) member months for any diagnosis among Health Home enrollees.
  - The State OMPP will pull claims data for Health Home enrollees for the year prior to Health Home enrollment and use these data elements for baseline comparison.
  - Use of HIT will be phased in. Initially providers will be supported in their delivery of health home services through provision of the data described in the subsequent bullets in this section. The State will work with CMS to secure comparable data for Medicare recipients. The objective is to secure utilization and cost data for the twelve (12) months preceding implementation of the Health Homes and for succeeding periods of time.
  - The State of Indiana will develop a system to be used to collect health data for aggregate data collection and analysis. Reports will be provided in total and by CMHC.
  - The OMPP has access to claims data by individual including adjudicated Medicare claims that have crossed over to Medicaid for payment after Medicare processing allowing collection of total medical claims payment information.

The Health Home Model – Monitoring

- The OMPP will provide by enrollee data on claims related to the following: inpatient medical, inpatient psychiatric, emergency room, pharmacy, laboratory, rehabilitation, long term care, outpatient primary care, outpatient specialty and outpatient psychiatry.

- Hospital emergency room use by Health Home enrollees will be determined for the period before implementation and subsequent months and provided to the Health Homes regularly for their assigned individuals. These data allow comparison of pre and post Health Home ER use and individual management of ER use

- Hospital admissions by Health Home enrollees will be provided pre and post Health Home implementation for Health Home enrollees and provided to Health Homes regularly for their assigned individuals. These data allow comparison of pre and post hospital use and individual enrollee management of hospital use. These data will be used to evaluate readmission rates and ER use.

The Health Home Model – Quality Measures

- **Goal 1: Improve Health Outcomes for Persons with Mental Illness**
- **Goal 2: Reduce Preventable Hospital Readmissions and Emergency Room Visits**
- **Goal 3: Increase Enrollee Use of Preventive Services**
- **Goal 4: Increase Enrollee Empowerment and Self-Management**
- **Goal 5: Improve Management of Chronic Conditions**

  - Clinical outcomes measures continue to need to be developed under this plan. HEDIS measures, including the potential for the recently developed voluntary SMI measures.
  - Quality of Care will consider areas such as improvement in BMI and diabetes.
  - Other factors examined under the proposal include experience of care, using customer satisfaction and survey tools.

The Health Home Model – Payment Methodology

- The proposal calls for a three part payment structure for CMHC Health Homes.
- All payments are contingent upon the Health Home meeting the requirements set forth in their Health Home applications, as determined by the State of Indiana.
- Failure to meet the requirements is grounds for revocation of Health Home status and termination of payments. The payment methodology is in addition to the fee for service payments for direct services.
- The State of Indiana will reimburse for initial start-up costs and lost productivity due to collaboration demands on staff not covered by other streams of payment. Indiana will also reimburse startup costs associated with hiring of new personnel required to appropriately staff the Health Home as well as costs associated with required accreditation/certification status as a Health Home.
- As proposed, payments will be paid at 1.5 times the Per Member Per Month (PMPM) rate for the two months prior and the three months after startup of the Health Home. Higher payments for the first five months (two prior to startup and three after) are based upon additional costs associated with developing the health home.

The Health Home Model – Payment Methodology

- After the startup period payment will be made at a PMPM that accommodates the additional responsibilities that Health Home Team members have, including clinical and administrative staff.
- The PMPM payment may be reduced according to a formula that reflects the anticipated time commitment to non- fee for service reimbursable services. The State will annually determine the extent of vacancy rates within Health Home teams and will determine any applicable reductions in rate as a result of a failure to achieve designed outcomes.
- All services, fee for service and Health Home codes, will be uploaded from the state Medicaid system for payment.
- The proposed PMPM reimbursement is to provide reimbursement for required Home Health services that are not reimbursed under the fee for service Medicaid or Medicare program. Many of these services are not traditional services in a fee-for - service environment or are provided to enrollees that are Medicare only or are not funded for any non-traditional services.

The Health Home Model – Payment Methodology

- PMPM payments are based upon a survey of CMHC of salaries of positions in the state CMHCs and include fringe, operating, and indirect costs.
- PMPM payments do not include in-patient treatment
- All CMHC Health Homes will receive the same PMPM payment regardless of location .
- The PMPM payment will be reviewed after the first 12 months to ensure that the payment is sufficient to support the Health Home goals and is consistent with quality of care.
- As fee for service billing declines, the PMPM rate may need to be reviewed to ensure sustainability of the Health Home operation.
- Staff whose time is fully funded by the PMPM will not bill for any other fee for service payments under other Medicaid programs. Staff whose time is partially supported by the PMPM will be allowed to bill fee for service for any time not covered by the PMPM.
- OMPP will modify current provider allowable billing standards based on service location to authorize CMHCs to bill for Medicaid services specific to the chronic primary health conditions identified in this Home health plan for basic screening and assessment services.

The Health Home Model – Payment Methodology

- **Performance Incentive Payments:**
  - Indiana intends to implement a performance incentive payment for demonstrated savings in combination with clinical quality. Incentive payments will not be paid if a CMHC Health Home falls below specified performance targets on selected quality measures. In Year one (1) baseline data will be collected. In year two (2), five (5) quality measures will be selected and in Year three (3), ten (10) quality measures will be selected.
  - Shared savings will be paid quarterly and remitted to CMHC Health Homes as a part of current distribution practices-based upon savings relative to baseline. Health Homes will be paid 50% of the saved cost associated with service. This amount reflects the decreased service levels under fee for service and incentivizes Health Homes for effectively managing costs and quality.
- The Draft payment methodology is being finalized pending the input of the Barry salary survey and will be provided once its finalized.

The Health Home Model – Q&A

- QUESTIONS?