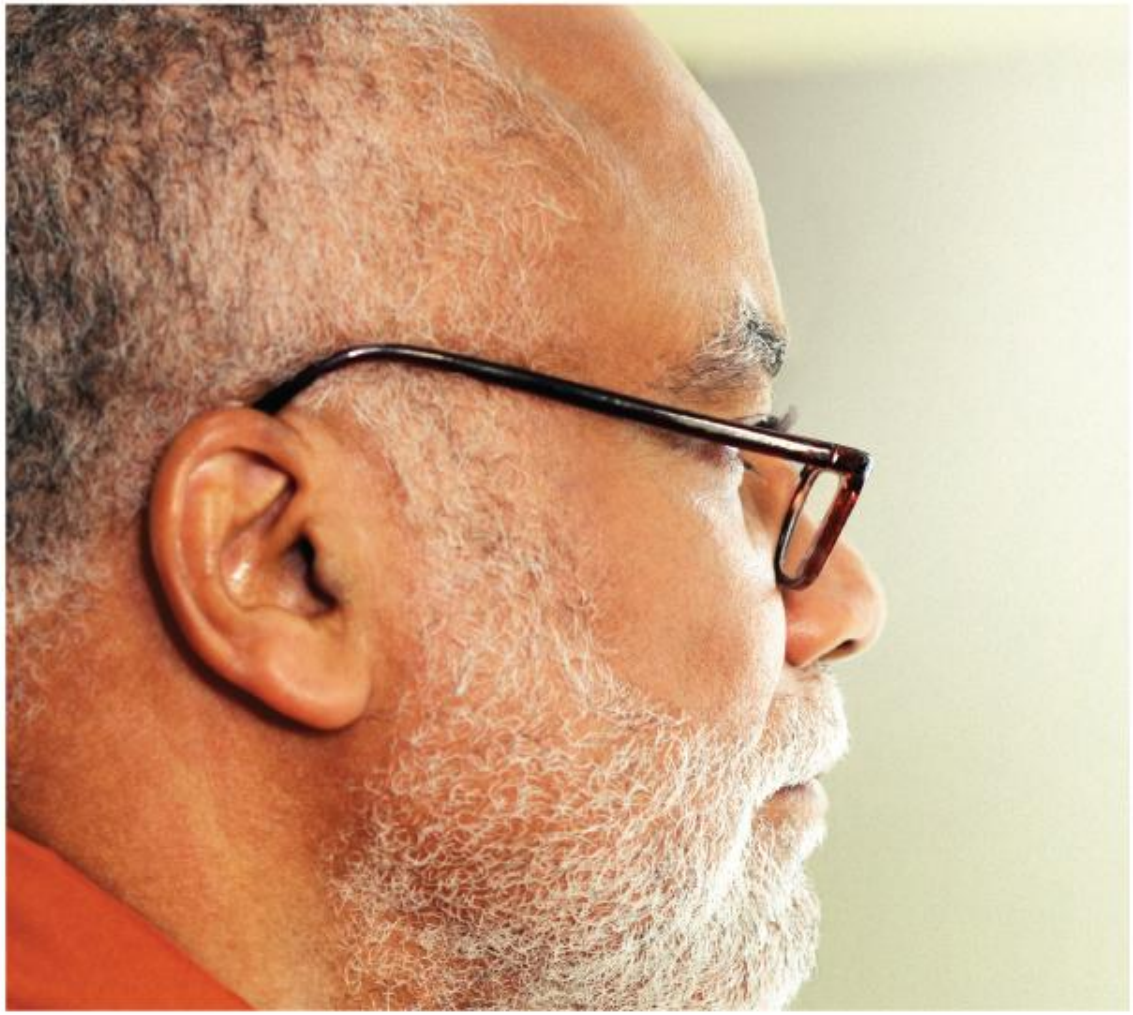


Medicaid Health Homes

HealthPath Washington

Public Informational Webinars

June 21, 2012

Washington State Health Care Authority

Washington State Department of Social & Health Services

Integrated Care

HealthPath Washington

The Need; The Vision

June 21, 2012

Washington State Health Care Authority

Washington State Department of Social & Health Services

The Need for Integrated Care in the 21st Century

- Fragmented service delivery and lack of overall accountability (medical and non-medical)
- Service needs and risk factors overlap in high-risk populations
- Incentives not aligned to achieve outcomes
- Sustainability concerns
- Small percent of people account for high proportion of costs
- Federal and state legislative direction

Integrated Care Vision

Integrated systems must:

- Be based in organizations that are accountable for costs and outcomes
- Be delivered by teams that coordinate medical, behavioral, and long-term services
- Be provided by networks capable of meeting the full range of needs
- Emphasize primary care and home and community based service approaches

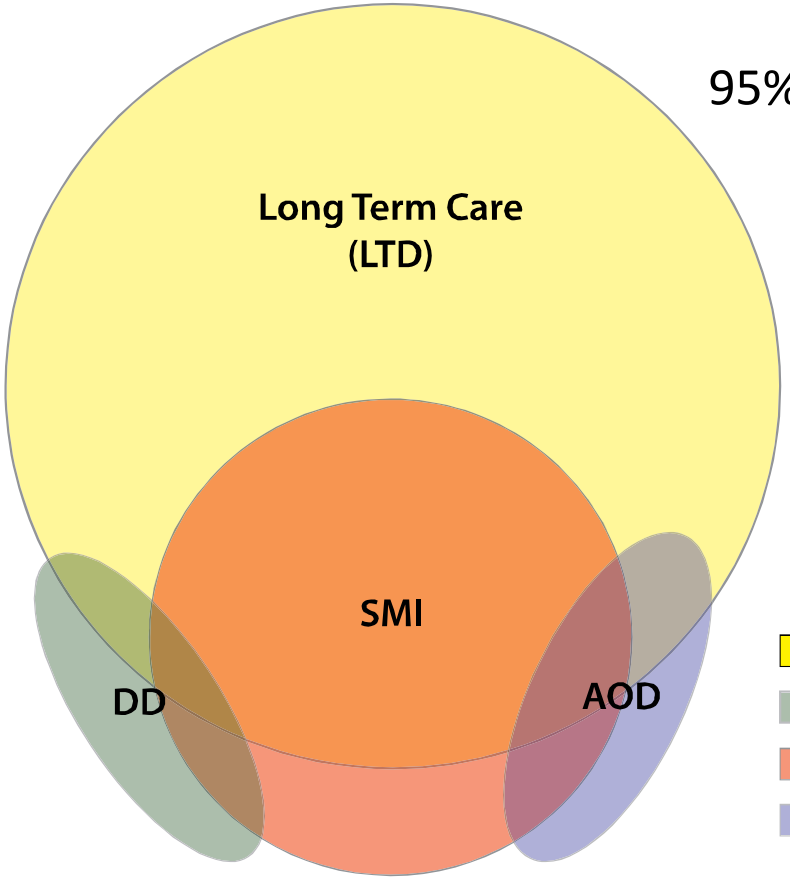
Integrated Care Vision *(cont.)*

Integrated systems must:

- Provide strong consumer protections that ensure access to qualified providers
- Respect consumer choices in the supports they receive
- Unite consumers and providers in eliminating use of unnecessary care
- Align financial incentives to impel integration of care

Service Needs Overlap for High Risk/High Cost Beneficiaries who are Eligible for Medicare & Medicaid

95% served by ADSA



LTD Long Term Care

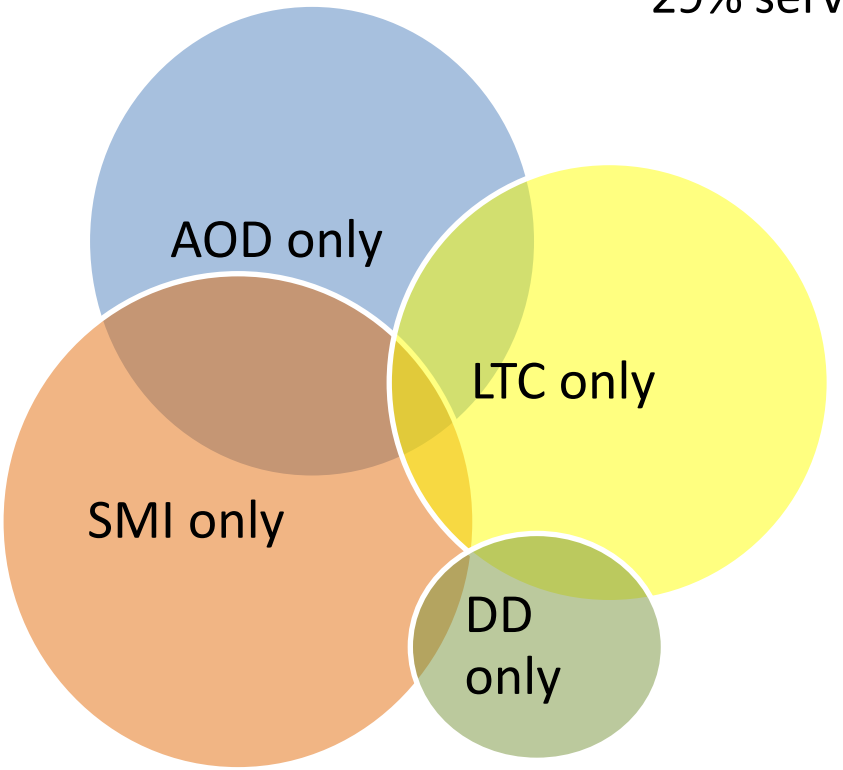
DD Developmental Disabilities

SMI Serious Mental Illness

AOD Alcohol and Drug Abuse

Service Needs for High Risk/High Cost Medicaid-Only Beneficiaries Overlap

29% served by ADSA



State Strategies for Integrating Care Include …

- Expanded service delivery, through capitated contracts with health plans
  - Part of state purchase strategy since 1994
  - July – September 2012 – Blind and Disabled (SSI) Medicaid enrollees who are not Medicare dual-eligible
  - January 1, 2014 –Dual-eligible (Medicaid-Medicare) enrollees, in counties where legislative authority approves and health plans demonstrate the required expertise and provider networks
- Embed robust delivery of Health Home services in all systems

Health Homes

HealthPath Washington

Description and Goals

June 21, 2012

Washington State Health Care Authority

Washington State Department of Social & Health Services

Sources that Inform Washington's Health Home Model

- Federal law – Section 2703, Affordable Care Act
- State law – SSB 5394 (passed in 2011)
- Stakeholder feedback during "Duals" planning
  - Integrate across medical and social services to improve coordination and align incentives
  - Create a single point of contact and intentional care coordination for beneficiaries
  - Build on what's working while improving, including flexibility to allow for local variances based on population need and provider networks

Overview

- Health Home entities must be state “qualified”
- Targeted to High Risk Individuals
- Required in the Medicaid/Basic Health contracts for the 5 managed care contractors
- HCA will contract for Health Home services under fee for service beginning January 2013
- Will be required under integrated managed care contracts for duals targeted for implementation January 2014

Services

- Comprehensive care management including
  - Intensive/Chronic Disease management
  - Transitions management/readmission reduction
  - Self-management support/patient education
  - Linkages to community/social support services
- Health assessment
- Coordinated Health Action Plans driven by the individual
- Use of Health Information Technology

Goals

- Establish person-centered health action goals designed to improve health, health-related outcomes and reduce avoidable costs
- Coordinate across the full continuum of services
- Organize and facilitate the delivery of evidence-based health care services
- Ensure coordination and care transitions
- Increase confidence and skills for self-management of health goals
- Single point of contact responsible to bridge systems of care

Health Homes

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Implementation Approach

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Health Home Differs From a "Patient Centered Medical Home"

- Health Home focuses on cross-system health care and social service delivery and coordination
- Medical Home focuses on medical care coordination and community referrals
- Health Homes provide care coordinators for high risk/high cost Medicaid population that work with multiple, cross system providers, including medical providers to facilitate care
- Health Home is focused on Medicaid, medical homes focus on all payers

Eligible Beneficiaries

- Identified chronic condition
- All ages, proportionally more individuals impacted among duals, than SSI Blind Disabled and traditional Healthy Options
- Statistically higher Emergency Department use, hospitalization and re-hospitalization
- A risk score of 1.5 or greater or recent evidence of high use patterns – Emergency Department and Hospitalization

Health Home Structure

- Network of organizations that provide health home services
- Each network has an identified “lead entity” that is responsible for administrative functions
- Bridges all service domains including medical, mental health, chemical dependency and long term services and supports
- May include health plans, community based organizations, clinics, etc.

Focus on High Risk Beneficiaries

- Most at-risk for adverse health outcomes
- Greatest ability to achieve impacts on hospital and institutional utilization, and mortality
- Most likely to need/receive multiple Medicaid paid services
- Cost effective / achieve a return on investment
- Need to achieve funding sustainability for these interventions

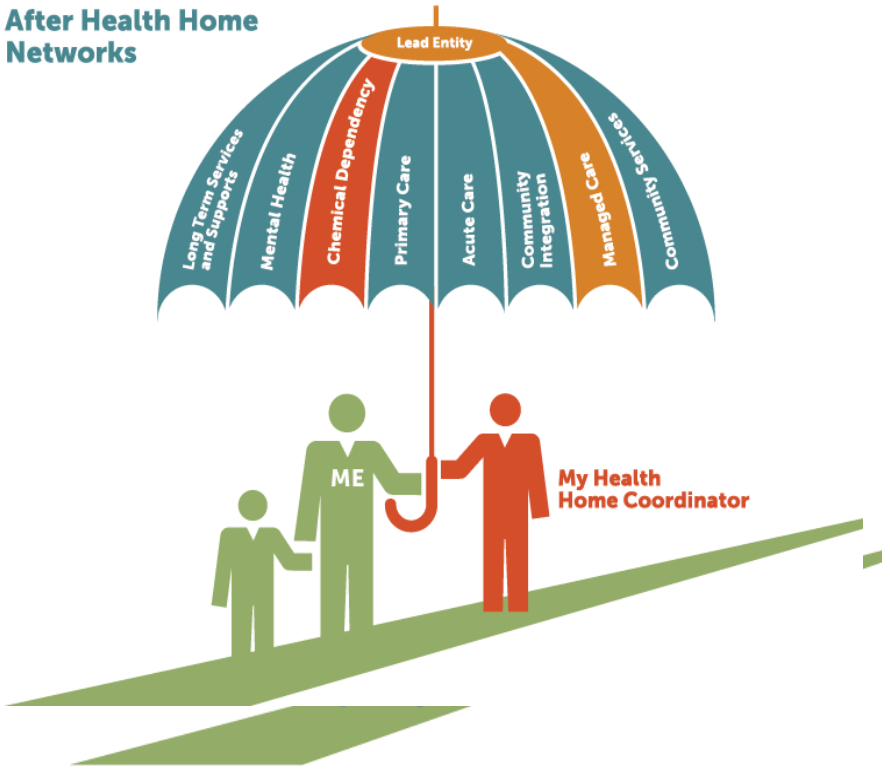
Payment for Health Home Services

- $150 - $180 per member/per month payment at highest level
- Potentially tiered based on level of intensity or time period
- Consideration of incentive payments
- Amounts the same for health plans or fee-for-service clients
- Health plans pass share of payment to network entities who provide care coordination services
- Fee-for-service: Payment to lead entity that passes share of payment to entities who provide care coordination services

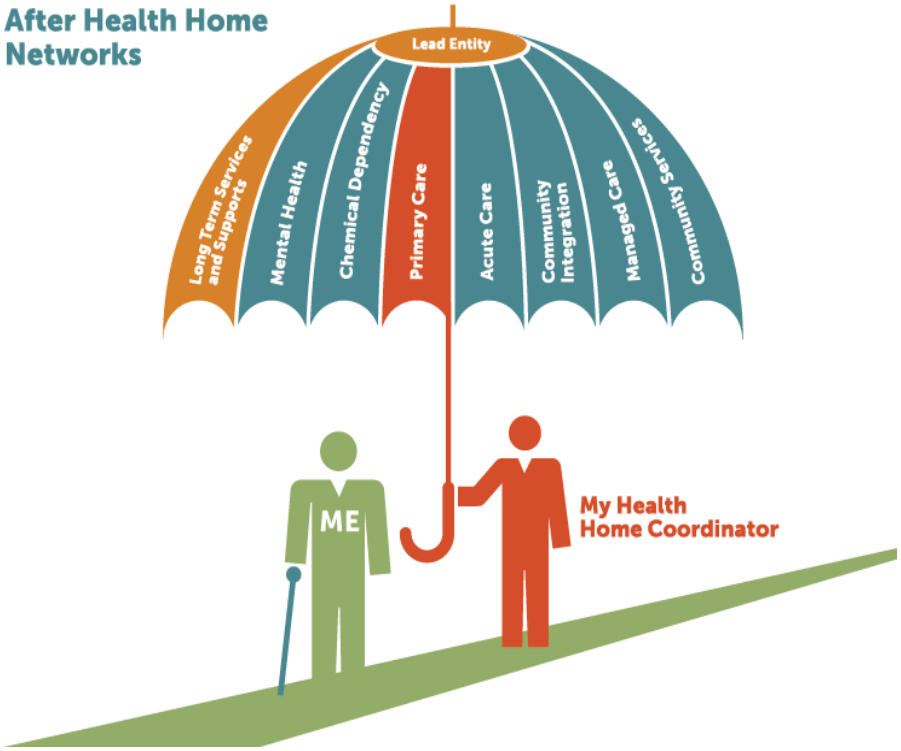
Health Homes

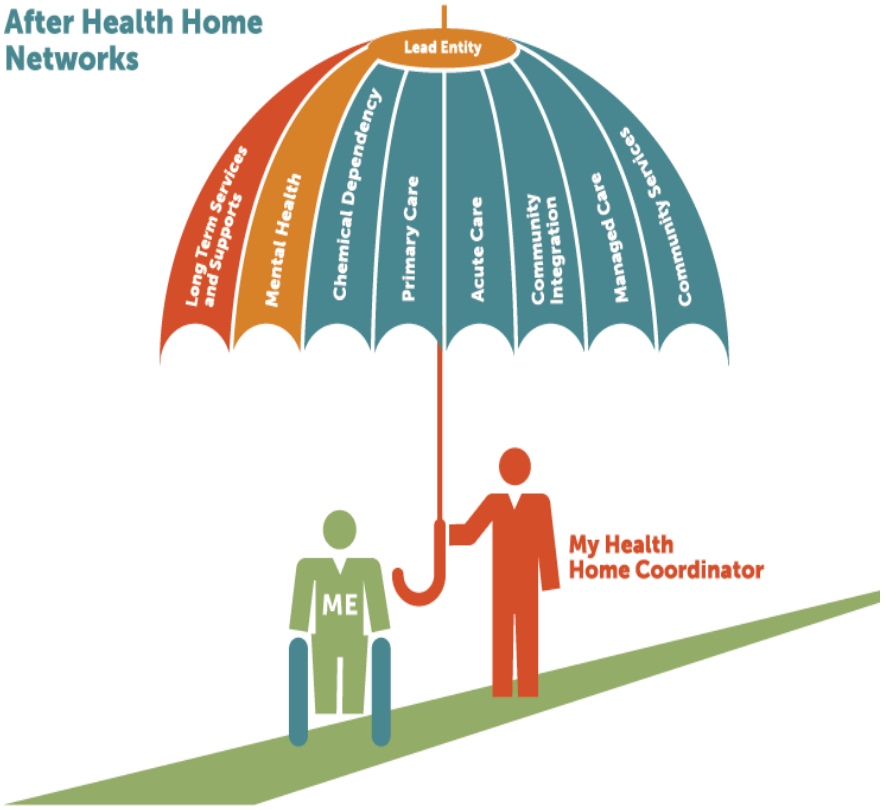
Before Health Home Networks

After Health Home Networks



Health Homes





Qualification Process

- An application and process for reviewing and qualifying health homes is being drafted
- Released in September, Scored in October
- Emphasis on creation of community partnerships, expert care coordination staff, outreach and high touch services delivered in community setting including a beneficiary's home

Community Input on Implementation

- Public comments on duals design plan and draft qualifications documents
- HealthPath Washington Advisory Team (HAT) Representation Includes:
  - Beneficiaries
  - Full range of service needs
  - Provider groups from medical and social services
  - Local governments
  - Public Health
  - Advocacy organizations

Next Steps

- Work with Healthy Options health plans to align with 2703 health home implementation
- Negotiations with CMS on implementing for duals
- Public Webinars on Health Homes last week of June (26th and 29th)
- State sponsored regional forums (Fall 2012)
- Qualifications and application process (Fall 2012)
- Contracting
- Training

Resources

Websites:

http://www.hca.wa.gov/health_homes.html

http://www.adsa.dshs.wa.gov/duals/

http://www.integratedcareresourcecenter.com/

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