Care Delivery Work Group:
Discussion of Initial DHCF Considerations for Health Home 2

November 23, 2015

High Level Care Coordination Timeline

	SPA Submitted	Implementation Target
SMI Health Home (HH1)	July, 2015	January 1, 2016
Chronic Conditions Health Home (HH2)	*Target SPA Submission Date: June, 2016*	*October 1, 2016*

General Design Considerations

MODEL:

- Providers integrate and coordinate all primary, acute, behavioral health, and long-term services and supports
- Integrated into primary care
- Must include FFS and MCO

ELIGIBILITY:

- Have 2 or more chronic conditions
- Have 1 chronic condition and are at risk for a 2nd (e.g. chronic homelessness)
- Have one SMI

REQUIRED SERVICES:

- Comprehensive care mgmt.
- Care coordination
- Health promotion
- Comprehensive transitional care/follow-up
- Patient & family support
- Referral to community & social support services

OTHER POTENTIAL SERVICES:

- 24/7 Provider Access
- Telephone/Email access
- EHR/Electronic Care Plan

POPULATION SIZE:

- Target Size = ~25,000 – 30,000
- Majority are Medicaid fee-for-service beneficiaries

FINANCING:

- 90/10 for 8 quarters
- P4P in years 2-4

Proposed Principles for Eligibility Criteria

Chronic condition amenable to health improvement and/or cost savings

Chronic condition associated with high costs and/or high utilization

Chronic condition predominant in the Medicaid population (as opposed to Medicare)

Others?

Chronic Conditions in Other HH Programs

State	Conditions
Alabama	Mental illness, Substance use disorder, Asthma, Diabetes, Transplant recipients (within last 5 years), Cardiovascular disease, COPD, Cancer, HIV/AIDS, Sickle cell anemia
Idaho	SMI or SED, asthma, diabetes
Iowa	Mental health condition, Substance use disorder, Asthma, Diabetes, Heart disease, BMI over 25, Hypertension, BMI over 85th percentile for pediatrics
Maine	Mental health condition, Substance use disorder, Asthma, Diabetes, Heart disease, BMI over 25, Tobacco use, COPD, Hypertension, Hyperlipidemia, Developmental disabilities or autism, Seizure disorder, Congenital cardiovascular abnormalities, Other conditions as identified by providers
Missouri	Asthma, Cardiovascular disease, Developmental disability, BMI over 25, Diabetes, Tobacco use
New York	Substance use disorder, Respiratory disease, Cardiovascular disease, Metabolic disease, Body mass index over 25, HIV/AIDS
North Carolina	Blindness, Congenital anomalies, Alimentary system disease, Mental/cognitive conditions, Musculoskeletal conditions, Cardiovascular disease, Pulmonary disease, Endocrine/metabolic disease, Infectious disease, Neurological disorders
Oregon	Asthma, Overweight, Cancer, Chronic kidney disease, Chronic respiratory disease, Diabetes, Heart disease, Hepatitis C, HIV/AIDS, Substance use disorder
Rhode Island	Asthma, Overweight, Cancer, Chronic kidney disease, Chronic respiratory disease, Diabetes, Heart disease, Hepatitis C, HIV/AIDS, Substance use disorder
Wisconsin	HIV/AIDS

Potential Chronic Conditions for DC's HH2

Chronic conditions listed in the statute (ACA) include mental health, substance abuse, asthma, diabetes, heart disease and being overweight. Additional chronic conditions, such as HIV/AIDS, may be considered by CMS for approval

Chronic Condition	Chronic Condition
Asthma/COPD	Multiple Sclerosis
Cerebrovascular Disease	Morbid Obesity
CHF	Paralysis
Chronic Renal Failure (On Dialysis)	Peripheral Atherosclerosis
Conduction Disorders/Cardiac Dysrhythmias	Pulmonary Heart Disease
Diabetes	Sickle Cell Anemia
Hepatitis	Behavior Problems
HIV	Dementia
Hyperlipidemia	Depression
Hypertension	Other Mental Disorders
Malignancies	Personality Disorders
Myocardial Infarction	Substance-Related Disorders

Possible Tiering Criteria

Past costs	Past utilization	Risk prediction tool
Housing status	Combination of criteria	Other?

Opt-In vs. Opt-Out

	Opt-In	Opt-Out
Pros	• Incents providers to recruit participants (e.g. providers are bought in) • Stronger buy-in from patients	• Lessens the stigma of case management • Boosts participation levels • Easier to build into provider's workflow
Cons	• Smaller enrollment numbers • Self selection bias • Lower provider participation due to heightened outreach (on the front end)	• Patients might not know they are in program • Providers might not know how to reach patients in their panel • DHCF must cross-reference with HH1 beneficiaries (to avoid double enrollment)
Design Considerations	• Provide HH2 providers with list of potential eligible participants • A hybrid model, in which the low tier was opt-out and the high/highest tier opt-in	• Auto-assign providers – attribution method must be determined • Could establish a health home "first visit" payment rate to trigger initiation of PMPM
State Examples	IA (P4P), NY	ID, ME, MO, OR, RI

Initial Thinking: Hybrid Opt-Out Policy

- Opt-out with a utilization/activity trigger

- Two Step Process:
  - <u>Step 1</u>: Patient must meet eligibility criteria to be enrolled in HH2
  - <u>Step 2</u>: Initial payment to HH2 provider "triggered" once HH2 services are initiated

- May include an inactivity clause
  - HH2 provider will not be reimbursed if HH2 services are not delivered within a certain time frame