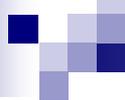


Complex Care Committee Update on Health Home Option

September 28, 2012





Question presented:

Should Connecticut elect Affordable Care Act (ACA) health home funding within the “health neighborhood” model that will be implemented under the Demonstration to Integrate Care for Dually Eligible Individuals?

Background:

- ACA built upon existing efforts to **integrate medical, behavioral and social services and supports for individuals with behavioral health and chronic conditions** by permitting states to seek approval of state plan amendments to implement such coverage
- ACA “health home” amendments qualify states to receive eight quarters of **enhanced Federal Medical Assistance Payment (FMAP)** in support of this work
- By contrast to the typical Connecticut FMAP of 50% FMAP for health homes is at **90%**

Background:

- To be eligible for the health home option, beneficiaries must have:
 - two or more chronic conditions
 - one chronic condition and risk of developing a second or
 - a serious and persistent mental health condition

- Chronic conditions are defined as including behavioral health conditions, substance use disorders, asthma, diabetes and heart disease

Background:

- States have the option to elect health home funding for all beneficiaries with these conditions, or to limit the set of conditions that are included
- States may define the level of severity that is required to qualify

Background:

- CMS has stated that electing health home funding in support of one population tolls the eight quarters only for that group, and does not foreclose electing successive 90% FMAP periods for other populations

Background (cont.):

- DMHAS has been partnering with a work group of the CT Behavioral Health Partnership (BHP) since enactment of the ACA health home option to assess how this model could be implemented in support of the needs of individuals with Serious and Persistent Mental Illness (SPMI)

DSS/DMHAS Working Agreement:

- Connecticut should not elect health home funding within the health neighborhood model that will be implemented under the duals demonstration
- Connecticut should elect health home funding outside the context of the duals demonstration and implement a number of condition-specific health homes for both dually-eligible and single-eligible individuals with Serious and Persistent Mental Illness (SPMI)
- Health neighborhoods should include a behavioral health co-Lead Agency.

Rationales:

- Incorporating health home funding under the health neighborhood would introduce a level of complexity to the funding model that is undesirable:
 - creates challenges with attribution
 - potentially confusing for beneficiaries
 - potentially burdensome for providers (tracking of data, reporting)
 - difficult to partialize APM II payments and to isolate outcomes for purposes of performance payments

Rationales (cont.):

- Individuals with SPMI should be prioritized for participation in the health home model because they face serious access barriers in receiving integrated medical and behavioral health care
 - no identified source of regular and consistent primary care
 - high utilization of hospital emergency departments
 - inadequate attention to co-morbid conditions
 - lack of trust basis with providers
 - stigma

Rationales (cont.):

- Implementing health homes in this way supports best practices demonstrated in other states that have already done so:
 - smaller scale of participation and number of providers
 - leadership by behavioral health entities
 - an orientation that regards the behavioral health condition as the driver for purposes of care coordination

Rationales (cont.):

- This also permits Connecticut to build on lessons learned from both health home and health neighborhood models in developing additional types of health homes without having “run the clock” on the enhanced federal match by broadly incorporating health home funding for all types of chronic conditions within the health neighborhoods
 - individuals with other qualifying chronic conditions
 - individuals in other geographic areas, should the state elect to pilot this model only in certain geographic areas

Comparison of models:

Feature	Health Neighborhood (3-5 to be procured)	Health Home (number to be determined)
Provider composition	Broad range of medical, behavioral health, and long-term services and supports.	Care team selected from among three options identified in State Medicaid Director letter.

Comparison of models:

Feature	Health Neighborhood (3-5 to be procured)	Health Home (number to be determined)
Population served	All Connecticut individuals who 1) are dually eligible for Medicare and Medicaid except those served by a Medicare Advantage plan; and 2) have received their primary care from a HN participating provider in the twelve months preceding implementation. Each HN is anticipated to serve a minimum of 5,000 individuals.	Individuals with an identified SPMI who are either eligible for Medicaid only, or eligible for Medicare and Medicaid. The population may further be limited by the severity of the chronic condition and potentially by geography.

Comparison of models:

Feature	Health Neighborhood (3-5 to be procured)	Health Home (number to be determined)
Method of attribution	Individuals who have received their primary care from an HN participating provider within the twelve months preceding implementation of the Demonstration will be passively enrolled with that HN and will have the opportunity to opt out.	To be determined, but a typical means is to attribute participants based on their source of behavioral health care.

Comparison of models:

Feature	Health Neighborhood (3-5 to be procured)	Health Home (number to be determined)
Care coordination model	Proposes to permit participants to select a Lead Care Manager (LCM) from among a list of qualified participating members of the HN. This LCM will be the single point of contact for a multi-disciplinary team of providers, whose goal it is to integrate the beneficiary's services and supports through a person-centered care plan.	Care team composition is determined by the option that is selected. The health home care team's goal is to integrate the beneficiary's behavioral health, medical and community services and supports through a person-centered care plan.

Comparison of models:

Feature	Health Neighborhood (3-5 to be procured)	Health Home (number to be determined)
Means of paying for care coordination	Connecticut proposes to make a PMPM payment that will incorporate the costs of care coordination as well as supplemental services including medication therapy management, nutrition counseling, falls prevention, recovery assistant and peer support.	States that have implemented health homes have typically made a PMPM payment to the behavioral health entity in support of the costs of care coordination.