CHCS Center for Health Care Strategies, Inc.

Medicaid Health Home Program Design Strategies

Themes from Call #3: Implementing in a Managed Care Delivery System

The following insights were gathered during the third call in a series of health home program design calls hosted by the Center for Health Care Strategies (CHCS). The series is open to 15 states participating in various CHCS initiatives -- Arizona, California, Colorado, Illinois, Maine, Michigan, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Tennessee and Washington.

Key Themes

There are many issues for states to consider when implementing health homes in a risk-based managed care environment. The purpose of this call was to share potential models for incorporating managed care organizations (MCOs) into program design, and to discuss how to maximally leverage the core competencies of health plans for health home service delivery. As one might expect, states are considering a range of strategies for using MCOs for health home programs. The following are key themes that emerged during the call:

- **Accountability for services:** States recognize the need to develop clear lines of accountability for health home service delivery and are deliberating about how much health home responsibility to assign to MCOs versus directly to providers. Some states are considering using MCO contracts as the foundation for accountability and are building health home program requirements into their next MCO procurements. Along these lines, some states are focusing on developing standards and service requirements and leaving it to the MCOs to "figure out how to get there."

- **Leveraging core competencies and filling in the gaps:** Some states are thinking about how MCOs can use their core competencies to support the delivery of health home services by community-based providers. These competencies include population identification and stratification, data collection and reporting, quality improvement, and provider network development, among others. In addition, where community capacity is limited (e.g., workforce shortages in rural areas, small or otherwise under-resourced providers), MCOs could use their internal care management capacity to increase the availability of health home services.

- **Alignment with other initiatives and operating procedures:** States are considering how they can align health home activities with other existing MCO initiatives, such as medical homes, care management programs, and emerging duals integration projects. For example, states pursuing medical home initiatives through their MCOs could use such efforts as a foundation for evolution into health homes, and at a minimum must ensure that such efforts are complementary and not conflicting. In addition, states are thinking about how to implement health homes within the broader context of standard MCO operating procedures. For example, some may need to figure out how health home assignment will interplay with standard PCP assignment within the plans.

- **Creating coordination across carved-in and carved-out services:** Behavioral Health Organizations (BHOs) and Managed Long Term Care (MLTC) plans may have valuable

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roles to play with health homes for specific population subsets (e.g., the seriously mentally ill and beneficiaries receiving long term services and supports, respectively), but program design will need to address associated limitations in provider networks and benefit oversight. For example, to play a significant role in health home development, MLTC plans might need to contract with acute care providers to allow for care coordination across individuals' acute and long term care needs. Similarly, BHOs might need to contract with physical health providers or MCOs to enable coordination and integration of physical and behavioral health services.

- **Establishing appropriate rates:** Finally, states need to determine the rate implications associated with health homes implementation. For some, this may include estimating the investments required on the part of MCOs to develop health home infrastructure, as well as estimating expected medical cost savings that should result from improved care coordination. Some states have asked plans to weigh in on the rates discussion.

Related to rate-setting, CHCS also summarized recent information from CMS regarding MCO payment clarification on the call. It is as follows:

- **If health home services are <u>not</u> provided by a contracted Medicaid health plan**, the state must open the plan's capitation rate and extract dollars for care management/coordination services that would now be provided by a new health home provider outside of the plan. The state would need to be careful not to extract other care management-related functions that should stay in. For example, care coordination would be duplicative, so costs would be taken out; however, this is not the case for quality management that would still be included in the capitation rate. In other words, only portions of the capitation rate that account for services duplicative of health home services would need to be removed.

- **If health homes are provided by a plan (i.e., plan is the health home <u>in totality</u>),** the state would identify dollars in the capitation rate - relevant to care management for members eligible for and <u>enrolled in</u> the health home - in order to get a 90-10 match on those funds. A state, in partnership with its actuary and plans, should consider how to determine the number of eligible members and members actually enrolled -- for example, whether the number is an annual average, a point in time, or another approach.

- **If health homes are provided <u>in part</u> by the plan and in part by an external contractor** (e.g., plan staff participate as part of a health home team), the state would identify relevant dollars in the capitation rate and receive the 90-10 match. The plan would, in turn, pass through the appropriate reimbursement to health home team members outside of the plan. The state would need to confirm that the health plan does not retain a portion of the payment for the administrative purposes of issuing

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payment, because the money that CMS is matching is only associated with the health home services.

- Health home services will be reimbursed at the service rate, as opposed to the administrative rate, after the eight consecutive quarters of 90-10 match have ended.

Health Homes Program Design Call Series
Summaries of themes from each call will be available on CHCS' website at www.chcs.org. Future calls will focus on identifying health home providers, defining health home services, discussing reimbursement strategies, and other topics.

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