CHCS Center for Health Care Strategies, Inc.

Medicaid Health Home Program Design Strategies

Themes from Call #7: Designing Reimbursement Methodologies

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

Section 2703 of the Affordable Care Act (ACA) describes three types of health home provider arrangements for the delivery of health home services, with one being Community Health Teams (CHTs). Vermont has included the use of CHTs as part of their "Blueprint for Health" and today's call provided states with the opportunity to learn about Vermont's CHT reimbursement strategy, as well as the opportunity to share their own emerging reimbursement methodologies. Key payment components from Vermont's CHT model are as follows:

- Vermont has chosen a multi-payer approach for investing in primary care infrastructure, including support for patient-centered medical homes and community health teams. Medicaid, Medicare, and three commercial insurers in the state contribute to the payments.
- Each payer contributes a per member per month (PMPM) payment to the practices based on the number of their beneficiaries served by the practice; all payers pay the same PMPM rate based on the practices' NCQA recognition level.
- CHTs provide extra support to practices at no cost to the providers or beneficiaries. They are paid a fixed salary per year (not based on services provided), which is split between the payers with each paying a fixed percentage. The salary is dependent on how many patients a team serves, with the maximum salary set at $350,000 per team per year (for up to 20,000 patients).
- Although payment is not based on services, the state is beginning to collect and analyze utilization data. CHTs do not have to meet set standards, but the state is beginning to collect data on quality measures as well. Early trends can be found on the state's website at: http://hcr.vermont.gov/sites/hcr/files/final_annual_report_01_26_11.pdf

The broader health home reimbursement discussion revealed many key issues for states to consider. Highlights of those considerations are as follows:

- Some states are considering tiered payments to providers based on acuity of patient condition; however, there could be a lot of guess work with respect to defining what services would make up a payment for patients with "low" need vs. "medium" need conditions. In addition, the boundaries between "low" and "medium" could easily be blurred. As an alternative approach, states could consider risk adjusting an average payment rate, which would allow them to avoid defining each condition category and service mix.

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- Some states will be implementing health homes in a managed care setting and will need to make decisions regarding whether to pay for services:
    - Through the plans or directly to providers -- Going through the plans allows states to leverage managed care infrastructure for ensuring accountability and supporting health home capacity. If payments go through the plans, states also need to decide whether/how to mandate how much money the plans pass downstream to providers.
    - Within or outside of the capitation rate -- Given the novelty of health home services and the limited experience in rate-setting for these services, a number of states are inclined to keep health homes payment outside of the capitation rate during initial implementation. As their ability to develop accurate rates increases, these payments could be folded into the cap rate over time. Another consideration for keeping health home payments outside the cap rate is ease of identifying and claiming payments eligible for 90/10 match.

- Some states are considering shared savings and risk as part of their reimbursement strategies. Shared savings will likely be tied to performance on quality measures to give providers "skin in the game" for improving outcomes and reducing costs. With shared risk, states are mindful not to set the initial risk level too high and thus deter participation.

In addition to states sharing their initial reimbursement strategies, CHCS shared the following summary of recent guidance from the Centers for Medicare & Medicaid Services (CMS) related to health home payment:

- States must give prior notice to the effective date of the state plan amendment (SPA) letting providers know they will be paying for health home services.
- States need to set the SPA start date very carefully – they need to be ready to hit the ground running, e.g., would be good to have beneficiaries already enrolled in health home before clock starts; in other words, don't waste the 90/10.
- Payment for infrastructure: states can include in the health home reimbursement $$ for the ongoing cost of doing business (e.g., admin costs) but may not be able to include start up costs (pending further guidance). Providers have to meet all health home criteria to get paid. Furthermore, planning funding can't be used to ramp up providers.
- HIT is not defined in the statute and is not a requirement – it is certainly helpful and valuable, but the law states "if feasible".
- If states want to institute an opt-out (passive enrollment), they have to provide appropriate educational information and sufficient time to opt out. Otherwise need a waiver.
- Reimbursement rates must be set so that eligible beneficiaries can access services; there must be sufficient providers/providers who are interested in participating

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- States can set rates based on bands of patients or the unique qualifications of the providers.
- On the backend, states need to think about how to monitor the payments annually to confirm that people are getting the services included in the PMPM.
- If plans want to participate as health homes and states want to use incentive payments, states should consider two separate contracts: one for "regular" managed care services, and one for health home services which would allow the state to get around the 105% ceiling on payments to health plans.