Changing the Model for Health Care Delivery

Chronic Health Homes

Managed Care

Accountable Care Organizations

Ryan White
NEED FOR COORDINATED WHOLE PERSON CARE

- Current fee-for-service system leads to fragmentation across many providers
- Tendency not to pay for care coordination, case management and other vital support services
- Incentive to see many patients = not enough time with each patient individually
- Often insufficient cultural competence and health navigation

*Existing system not ideal for chronic disease management, particularly for high-need individuals*
The Medicaid Health Home Option

• This model builds on the PCMH models already implemented in many states to focus specifically on people living with chronic conditions

• Development of health homes can help states:
  - Improve care for people with chronic conditions
  - Restrain growth in Medicaid costs
Who is eligible for a Health Home?

Medicaid Beneficiaries who:

- Have 2 or more chronic conditions
- Have one chronic condition and are at risk for a second
- Have one serious and persistent mental health condition

Chronic conditions listed in the ACA: mental health, substance abuse, asthma, diabetes, heart disease, and being overweight.
What services are included in the ACA Health Home Option?

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care/follow-up
- Patient & family support
- Referral to community & social support services
States Have Considerable Flexibility to Design Their Own Health Homes

States can determine their own

- Population
- Providers
- Payment
Selection of Health Home Population

- States determine which chronic conditions to cover
  - Most have adopted the chronic conditions listed in the ACA -
  - States can also target individuals with chronic conditions outside the ACA list with CMS’ approval
    - Example: Oregon, Alabama, Washington, Wisconsin and New York include HIV
- Can be limited to certain acuity levels/ those with more severe conditions
- Can be limited to specific geographic areas
Selection of Health Home Providers

- **Designated provider**
  - May be a physician, clinical/group practice, rural health clinic, community health center, community mental health center, home health agency, pediatrician, OB/GYN, or other provider

- **A team of health professionals operating w/ desig. provider**
  - May include physicians, nurse care coordinators, nutritionists, social workers, behavioral health professionals, or others
  - Can be free-standing, virtual, hospital-based, or a community mental health center or another appropriate setting

- **Health team**
  - Must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractic, licensed complementary and alternative practitioners
What are the Financial Benefits to States?

- 90% federal matching funding for health home services for the first two years
  - After 2 yrs, reverts to the state’s normal Medicaid rate
  - Enhanced match does not apply to the underlying Medicaid services provided to individuals enrolled in a health home, only to the specific health home services (e.g. care coordination) listed in the statute

- States are also eligible for up to $500,000 in planning funds to explore the feasibility of creating health homes
Payment methodologies:

- Monthly management care fee (most states)
  - Can vary based on the severity of a person’s condition or the capabilities of health home provider
- Fee-for-service
- State may propose alternative approach
Medical Homes vs. Health Homes

Similar goals but a few important differences:

• Unlike PCMHs, Health Homes must coordinate with behavioral health providers

• Health Homes are required to help enrollees obtain non-medical supports and services (e.g. public benefits, housing, transportation)

• Health Homes can move coordination beyond primary care

*Health Homes offer flexibility to address the specific needs of the chronically ill*
Accountable Care Organizations

An entity made up of health care providers across the continuum of care that agrees to be held accountable for improving the health of its patients. If patients’ health care costs end up being less than would otherwise be expected while quality is maintained or improved, providers keep a share of that savings.

Source: Families USA
ACOs in the ACA

- Medicare Shared Savings Program and Pioneer ACOs: Began in 2012.

- CMS has shown willingness to explore innovative partnerships (e.g. Walgreens partnering with physician groups in Texas, Florida and New Jersey)

- ACA is silent on ACOs in private market, but insurers are developing partnerships with hospital and provider networks
PSH Opportunities in ACOs

- Provider organizations have incentives to reduce costs. PSH providers would make excellent members of care teams and can be employed by provider groups.

- Quantitative + Qualitative Data Collection: identify criteria around health outcomes and track them for all patients.

- Use the data to argue for cost-effectiveness and inclusion in Marketplace, Medicaid, Medicare plans.
Managed Care Organizations

- 70% of all Medicaid beneficiaries nationally are enrolled in MCOs
- 28% of Medicaid enrollees with disabilities are in managed care
- Provides opportunity for innovative models that can reimburse for more services and providers

Source: National Health Care for the Homeless Council; Center for Health Care Strategies, Inc.
ACA/Ryan White Program Intersection

- Ryan White Program not going anywhere – yet

- Payer of last resort requirement: cannot use RW funds when “payment has been made or can reasonably be expected to be made” by another source (eg, Medicaid)

- HRSA expects grantees to assess clients for eligibility for other insurance coverage and facilitate enrollment

- RW/ADAP $ can be used to pay premiums, deductibles & cost sharing in both Medicaid and Marketplace
RW providers = “essential community providers” for qualified health plans in state-based Marketplace

Ongoing need for Ryan White:
- To cover **services** not required by ACA (eg, dental, legal services, treatment adherence counseling)
- To cover **populations** not included in the ACA (people without documented immigration status, people under 100% FPL in non-expansion states)
Contact info:

- Maggie Morgan, mmorgan@law.harvard.edu
- Amy Rosenberg, arosenbe@law.harvard.edu