



SIM Care Delivery Work Group

10/15/15

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 

Care Coordination

- **Organizing patient care activities**
- **Sharing information among all care participants**
- **Achieving safer, more effective care**
- **Improving health outcomes**

Goal

To meet patient (client) needs and preferences in delivery of high quality, high value healthcare

- **Assess individual's needs and preferences**
- **Communicate needs and preferences at right time to right people**
- **Use information to guide delivery of safe, appropriate effective care**
 - **Scope and intensity of care coordination guided by patient needs and preferences**

Components of Care Coordination

- **A Health Care Home**
 - Establishes accountability and responsibility
 - Aligns resources with patient and population needs
- **Interdisciplinary teamwork**
- **Comprehensive care management**
 - Individual assessment
 - Needs and goals
 - Proactive care plan
 - Monitoring and responsive follow up
 - Support for self-management goals
 - Management of care transitions
 - Linkage to community resources
 - Medication management
 - Health promotion and wellness
- **Health Information Technology and Exchange**



Chronic Condition Management Initiatives

Medicaid Health Home

- Program Summary: Pays providers to integrate and coordinate primary, acute, behavioral health, and long-term services and supports to treat the whole person
- Patient Eligibility:
 - Have 2 or more chronic conditions
 - Have 1 chronic condition and are at-risk for a 2nd
 - Have 1 serious & persistent mental health condition
- Mandatory Services:
 - Comprehensive care management
 - Care coordination
 - Comprehensive transitional care/follow-up
 - Health promotion
 - Patient & family support
 - Referral to community & social support services
- Eligible Providers:
 - Designated provider (e.g. physician, group practice, clinic)
 - Team of health professionals (e.g. physicians, nurse care coordinators, nutritionists, social workers)
 - Health team (e.g. specialists, nurses, pharmacists, nutritionists, dieticians, social workers)

Medicare Chronic Care Management (CCM)

- Program Summary: Pays physicians ~\$40 PMPM for care management (outside of face-to-face visits) that includes at least 20 minutes of clinical staff time
- Patient Eligibility:
 - Patients with 2 or more chronic conditions lasting at least a year
- Mandatory Services:
 - 24/7 care management services
 - Continuity of care via a designated practitioner
 - Care transition management
 - Creation of an electronic patient-centered care plan
 - Enhanced chances to communicate with provider
 - Home and community-based services coordination
 - EHR utilization for structured recording of clinical data
- Eligible Providers:
 - Physicians and non-physician practitioners (Certified Nurse Midwives; Clinical Nurse Specialists; NPs; and PAs) may bill the CCM code
 - Clinical staff can provide the CCM service incident to the services of the billing physician under general supervision of a physician

HH2: Target Population and Payment Tiers

- **Target Population**

- FFS & MCO individuals with 2 – 4 chronic conditions, or 1-3 chronic conditions and at risk of another (based on 37 conditions outlined in slide 9).
- Two risk factors: Chronically homeless; Smoking

- **Payment Approach**

Payment Tier	Target Population Cohort
Highest/Homeless	Chronically homeless + 1 (or more) chronic condition
High	5 or more chronic conditions
Low	2-4 chronic conditions; <u>or</u> 1 chronic condition + smoking

Medicaid Chronic Conditions by Prevalence and Cost

	Most Prevalent Chronic Conditions	Most Prevalent Chronic Conditions Associated with Top 1% of Spenders
#1	Hypertension	Hypertension
#2	Hyperlipidemia	Behavior Problems
#3	Asthma/COPD	Diabetes
#4	Diabetes	Dementia
#5	Depression	Paralysis

Chronic Conditions: Prevalence & Amenability to Care Coordination

<u>Health Home-Eligible Chronic Condition</u>	<u>Top 20 Chronic Conditions, Prevalence</u>	<u>Top 24 Chronic Conditions, Cost</u> (Associated with Top 1% of Spenders)
Anemia	N	N
Aneurysm	N	N
Asthma/COPD	Y (#3)	Y (#16)
Cerebrovascular Disease	Y (#15)	Y (#6)
CHF	N	Y (#8)
Chronic Liver Disease	N	N
Chronic Renal Failure	N	Y (#7)
Conduction Disorders/Cardiac Dysrhythmias	Y (#17)	Y (#18)
Coronary Atherosclerosis	Y (#18)	N
Cystic Fibrosis	N	N
Diabetes	Y (#4)	Y (#3)
Epilepsy	N	Y (#19)
Heart Valve Disorders	N	N
Hepatitis	N	N
HIV	N	Y (#13)
Hyperlipidemia	Y (#2)	Y (#10)
Hypertension	Y (#1)	Y (#1)
Lupus	N	N
Major Intestinal Disorder	N	N

<u>Health Home-Eligible Chronic Condition</u>	<u>Top 20 Chronic Conditions, Prevalence</u>	<u>Top 24 Chronic Conditions, Cost</u> (Associated with Top 1% of Spenders)
Malignancies	N	Y (#24)
MI	N	N
Multiple Sclerosis	N	N
Obesity	Y (#6)	N
Other Central Nervous System Diseases	N	Y (#21)
Paralysis	N	Y (#5)
Parkinson's Disease	N	N
Peripheral Atherosclerosis	Y (#13)	Y (#12)
Pulmonary Heart Disease	N	Y (#22)
Sickle Cell Anemia	N	Y (#23)
Thyroid/ Parathyroid/ Pituitary Disorders	Y (#20)	Y (#17)
Anxiety Disorders	Y (#11)	N
Behavior Problems	Y (#16)	Y (#2)
Dementia	N	Y (#4)
Depression	Y (#5)	Y (#11)
Other Mental Disorders	N	N
Personality Disorders	Y (#8)	Y (#14)
Substance-Related Disorders	Y (#14)	N

Discussion