

## **AWHP Health Plan Comments on Draft Health Homes Documents**

**Presented to the HealthPathWashington Advisory Team**

**July 24<sup>th</sup>, 2012**

### **CHPW Health Homes Comments**

#### Health Home Designation for Individuals Served by Multiple Systems

Community Health Plan has serious concerns about how an individual served by multiple systems, including Regional Support Networks, long-term services and supports and a managed care plan, will receive health home services and how the agency will determine which entity will provide those services. The best model is one that is community-based, but there is also a need for consistency and strong oversight. Developing a health home program that involves so many players will require significant infrastructure, including training and oversight, from the state at a time when resources are limited. We think it would be more effective and efficient to rely on the infrastructure already providing the majority of health care services in the state to Medicaid enrollees: managed care plans.

#### Requirements to Become a Home Should Emphasize the Primary Care Setting

Our experience operating the Medical Care Services program demonstrates the importance of having the health home be driven from the primary care setting. We appreciate the role of an interdisciplinary team in meeting the needs of a complex population, however there should be a unifying structure to manage the team. It seems most realistic to utilize the structure that is already available through health plans via the Healthy Options contracts and by requiring that health plans support locally delivered health home services managed through the primary care setting.

#### Ratio Requirements for Comprehensive Care Management are Unrealistic and Should be Tiered According to Patient Risk

The 50:1 ratio requirement for care managers to beneficiaries seems unrealistic and should be adjusted according to patient risk and ongoing assessment of changing health conditions. Similarly, it is unrealistic to expect care managers to accompany all patients to all appointments. Not all enrollees will need as much assistance as others and it would be more realistic to allow flexibility in their requirements to accommodate different enrollees.

#### Qualifications for Health Homes Should Utilize Already-Existing Standards

Given the aggressive timeline and limited resources for implementation, it would be more appropriate to use tools and measurements already developed to qualify health homes, such as NCQA's Patient Centered Medical Home Standards.

#### More Information is Necessary on Payments and Payments Must Be Adequate to Support Health Home Services

While the proposal outlines the use of tiered payments that reflect severity of chronic condition, there is no information at all about the amount of payments, how the tiers will be established or the expectations for various levels of payments. It is difficult to plan for this potential option without more detail about how the financing will work.

## **Molina Healthcare Health Homes Comments**

Molina Healthcare recommends HCA encourage NCQA complex case management standards be followed on the application and essential requirements documents. We believe HCA should give preference to health homes who commit to following NCQA complex case management standards. For NCQA accredited plans, if complex case management is delegated to a health home, we need to monitor that NCQA complex case management standards are followed in order to maintain our accreditation status. If health homes are unwilling or unprepared to follow NCQA complex case management standards, we foresee it posing a barrier to the success of health homes. We understand this issue is being discussed at the national level and hope for a resolution.

At the 7/13/2012 All Plan meeting, HCA, ADSA and MCOs discussed modifying the below language from the essential requirements document. Please see suggestions in red font:

**Care Coordinator Functions:** Change 'care coordinator' to 'health home coordinator' to reduce confusion among the terms care coordination, case management, etc.

1. Use a clinical decision support tool (PRISM) to view cross-system health and social service utilization to identify care opportunities; Suggest not limiting the clinical decision support tool to PRISM only, allow for use of other tools. In addition, allow for use of other data sources (e.g. self-reported, prior authorization data, etc.)