The Hilltop Institute

analysis to advance the health of vulnerable populations

Evaluation of the Maryland Medicaid Chronic Health Homes Program

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Presentation Outline

- Health Home Overview
- Measures and Data Sources
- Lessons Learned

HEALTH HOME OVERVIEW

Health Home Overview

- Section 2703 of the Patient Protection and Affordable Care Act of 2010 created the option for state Medicaid programs to provide health homes to beneficiaries with chronic conditions
  - States submit a two-year state plan amendment (SPA) to CMS, during which time they receive an enhanced Federal Medical Assistance Percentage for health home services
- Health homes are designed for Medicaid beneficiaries with chronic illnesses, focusing on behavioral health and social supports rather than clinical services.
- States have the flexibility to define their health home services, but they must provide all six of the following:
  - Care management, care coordination, health promotion, comprehensive transitional care and follow-up, individual and family support, and referral to community and social support services

Maryland Health Home Program

- Implemented on October 1, 2013, and approved for 5 years
- The health home center is a behavioral health care setting, focusing on those with a serious mental illness or substance use disorder
- Providers receive $98.87 per month per participant, as well as upon intake
- As of March 2015, Maryland had 32 approved health home providers across 75 sites in 21 of the 23 counties in the state

Provider Types

1. Psychiatric rehabilitation programs (PRP)
   - Provide rehabilitation and case management to those with a serious mental illness to help them develop community living skills
2. Mobile treatment services (MTS)
   - Provide outpatient services for those with mental illnesses in the person's natural environment (home, shelter, or street)
3. Opioid treatment programs (OTP)
   - Provide medication-assisted treatment (e.g., methadone)

Provider Service Requirements

- Staff must include a health home director, physician or nurse practitioner, and care manager
- Required to provide at least two services per member per month
- A care manager monitors the participant's care and health status and coordinates with other staff to provide the appropriate health home services
- Health homes notify each of the participant's other providers and inform them of the participant's health home goals and services received

Eligible Populations

- Adults with a serious persistent mental illness
- Children with a serious emotional disorder
- Adults with an opioid substance use disorder **and** risk of additional chronic conditions due to current or prior tobacco, alcohol, or other non-opioid substance use
- Currently receiving care from a PRP, MTS, or OTP
- Excludes enrollees receiving Medicaid-funded 1915(i) waiver services, mental health case management, or other services that may duplicate those provided by health homes

Participation

- Participant's health and social service needs are assessed
- Assigned a care manager who monitors the participant's care and health status and coordinates with other staff to provide them with appropriate health home services
- A care plan, updated every 6 months, includes:
  - Participant's health home goals
  - Timeline for goal achievement
  - Intervention/services to be received
  - Community networks and supports

Monitoring Health Home Performance

- The Hilltop Institute is monitoring the health home program on behalf of Maryland Medicaid
- Hilltop reports quarterly on:
  - Participant characteristics
  - Health home services
  - Health care utilization and quality
- Measures selected based on the original Maryland SPA application and CMS quality measure recommendations

Data Sources

- *eMedicaid* data—an eligibility and payment data warehouse for all Medicaid practitioners
- Maryland Medicaid claims data

Measures

- eMedicaid-based measures
  - Demographics
  - Diagnoses
  - Clinical outcome measures
  - Health home services received
- Medicaid claims-based measures
  - Ambulatory care visits
  - Emergency department visits
  - Inpatient hospitalizations
  - All-cause 30-day readmissions
  - Avoidable emergency department visits
  - Ambulatory care sensitive hospitalizations

Enrollment

Quarter	Dates	Enrolled at Any Point in the Quarter	Enrolled For the Full Quarter	Percentage Enrolled for Full Quarter
Quarter 1	10/1/13 – 12/31/13	2,224	121	5.4%
Quarter 2	1/1/14 – 3/31/14	3,086	2,105	68.2%
Quarter 3	4/1/14 – 6/30/14	3,667	2,785	75.9%
Quarter 4	7/1/14 – 9/30/14	3,954	3,242	82.0%
Quarter 5	10/1/14 – 12/31/14	4,112	3,438	83.6%
Ever Enrolled		**4,809**		

Participant Characteristics

- More than 80% of participants are enrolled in the PRP program. The remaining participants are split evenly between the MTS and OTP programs.
- Approximately 60% of participants are aged 40-64 years, 25% are aged 21-39 years, and 10% are children under 21
- Primary mental health conditions
  - Approximately 30% are identified as schizophrenic
  - Major depressive disorder and bipolar disorder constitute approximately15% each
- Qualifying risk factors (OTP only)
  - The most frequent qualifying risk factor was tobacco usage at 50% of participants
  - Usage of another non-opioid substance closely followed at 40% of participants

Services

- Comprehensive care management and health promotion services are received at a significantly higher rate than others types of health home services – provided to 84% and 70%, respectively, of participants in the most recent quarter
- The majority of participants receive at least one care coordination service each quarter
- Participants are much less likely to use comprehensive transitional care or referral to community supports, at 7% and 12%, respectively, during the most recent quarter

LESSONS LEARNED

Data System Planning

- Obtain input from varied types of stakeholders
- Consider the efforts required to use the system, maintain the database, and evaluate the data
- Estimate the size of the participant population to inform the types of data to be collected
- Determine who will have access to what data, any necessary data sharing agreements that need to be put in place, HIPAA requirements, and data transfer logistics

Database Features that can Assist in Program Evaluation

- Develop a data dictionary, definitions, and other documentation
- Limit types of data that can be entered
- Consider a system requiring providers to enter key pieces of data
- Establish consistent data collection protocols
  - For example, require that certain information be collected at baseline and/or at certain regular intervals

Measure Selection

- Have clear goals for each measure
  - Regular reporting
  - Comparative provider assessments
  - Program-wide evaluation
- Claims data
  - Allow run-out time before finalizing claims measures
  - Anticipate linking data when using information from multiple programs or sources
- Where possible, use measures that have national benchmarks

About The Hilltop Institute

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a nationally recognized research center dedicated to improving the health and social outcomes of vulnerable populations. Hilltop conducts research, analysis, and evaluation on behalf of government agencies, foundations, and other non-profit organizations at the national, state, and local levels.

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