Washington Duals Demonstration: The Health Home Model

NASHP October, 2015

Health Homes Implementation Approach
Goals

- Establish person-centered health action goals designed to improve health, health-related outcomes and reduce avoidable costs
- Coordinate across the full continuum of services
- Organize and facilitate the delivery of evidence-based health care services
- Ensure coordination and care transitions
- Increase confidence and skills for self-management of health goals
- Single point of contact responsible to bridge systems of care

Focus on High Risk Enrollees

- Most at-risk for adverse health outcomes
- Greatest ability to achieve impacts on hospital and institutional utilization, and mortality
- Most likely to need/receive multiple Medicaid paid services
- Cost effective / achieve a return on investment
- Need to achieve funding sustainability for these interventions
Eligible Beneficiaries

- Identified chronic condition
- All ages, proportionally more dually eligible (Medicare/Medicaid) individuals have high risk scores
- A risk score of 1.5 or greater; future costs predicted to be 50% higher than average population (disability-related eligible group)

Health Home “Umbrella”

- Health Homes receive enrollment on a monthly basis via a unique enrollment file.
- Health Homes build a network of Care Coordination Organizations.
Services

- Health Action Plans
  - person-centered
  - support self-management – Patient Activation Measure & Caregiver Activation Measure (PAM/CAM)

- Use of Health Information Technology
  - local exchange of ED information
  - state systems: PRISM and OneHealthPort

Payment for Health Home Services

- One time payment of $252 for outreach, engagement and health action plan
- Monthly allowable payment of:
  - $172 for intensive care coordination services;
  - $67 for maintenance
- Health Home Leads contract out through network and may also provide care coordination services directly
Health Homes

Preliminary Outcomes

Managed Fee-for-Service Duals are 1/3 of the Health Home Eligible Population

Health Home Eligible Clients – May 2015
TOTAL = 62,567

High Risk Medicaid-Medicare Dual Clients
33%
n = 20,887

High Risk Medicaid-Only Clients
67%
n = 41,680

NOTES: Includes all Health Home eligible clients
DATA SOURCE: Washington State Health Care Authority, ProviderOne (Medicaid) database
PREPARED BY: Department of Social and Health Services, Research and Data Analysis Division
Assignment of Eligible High-Risk Duals to a Health Home Lead has grown over time

Eligibility and Assignment

NOTES: Includes Full Dual Demonstration eligible clients not aligned with another Medicare shared saving program.
DATA SOURCE: Washington State Health Care Authority, ProviderOne (Medicaid) database
PREPARED BY: Department of Social and Health Services, Research and Data Analysis Division

97%

Once Assigned, Turnover is Low

Assignment Continuity

NOTES: Includes Full Dual Demonstration eligible clients not aligned with another Medicare shared saving program.
DATA SOURCE: Washington State Health Care Authority, ProviderOne (Medicaid) database
PREPARED BY: Department of Social and Health Services, Research and Data Analysis Division
Selected Preliminary Findings
Washington State Managed Fee-for-Service Duals Demonstration

Timeline

- Percent of high risk duals receiving home and community based long term services and supports increased (58% to 64%, p<.0002, N=408 clients)
- Avg. Patient activation (PAM® score) increased (54.6 to 59.2, p<.0001, N=285 clients)
- Number of emergency department visits deemed non-emergent or primary-care treatable (NYU algorithm) dropped 9.4% (339 to 307, p<.0316)
- Ambulatory care-sensitive hospital admissions per 100,000 client months dropped (1,225 to 817, p<.0001)

Results not yet compared to high-risk duals not receiving the intervention
Resources

Websites:
http://www.hca.wa.gov/health_homes.html
http://www.adsa.dshs.wa.gov/duals/

Alice Lind – Alice.Lind@hca.wa.gov