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Phase-Out of Health Care Guidance Program & Next Steps

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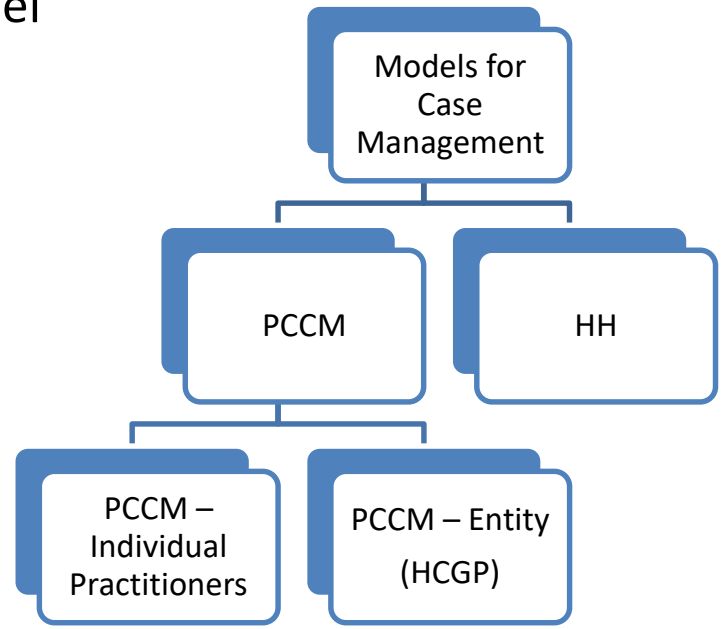
Introduction

- Review of the Health Care Guidance Program (HCGP)
  - Operates as a Primary Care Case Management (PCCM) – Entity model
- Review of Health Home (HH) model
- Review of Primary Care Case Management (PCCM) – Individual Practitioners model



Health Care Guidance Program (HCGP)
PCCM - Entity

- Approved by CMS as a 1115(a) demonstration waiver for 7/1/13 – 6/30/18
- Technically the HCGP is a model under the Primary Care Case Management (PCCM) – Entity
- Vendor is a Care Management Organization (CMO)
  - 3rd party vendor that provides care management services, not medical services
- Payment Model – Per Member Per Month (PMPM)
- Serves Fee-for-Service (FFS) Medicaid recipients who have:
  - At least one qualified health condition, or
    - Heart disease, diabetes, end stage renal, obesity, musculoskeletal system conditions, mental health conditions, substance use disorder, HIV/AIDS, pregnancy, etc.
  - Complex condition/high utilizer with treatment costs exceeding $100,000 in claims

HCGP Top 10 Conditions

% of HCGP members with specific conditions in January 2018

* Some members may have more than 1 condition

Condition	% of Members
Mood Disorder	27.6%
Anxiety Disorder	26.5%
Substance Abuse Disorder	22.2%
Asthma	18.2%
Bipolar	14.2%
Obesity	13.7%
Diabetes	10.8%
Osteoarthritis	10.2%
Schizophrenia	8.3%
Pregnancy	7.5%

HCGP - continued

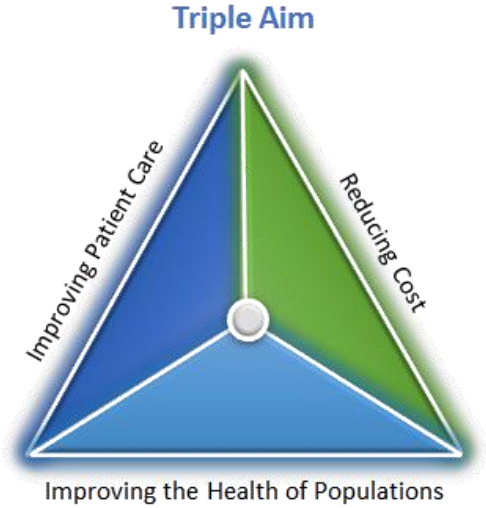
- Mission – Improve the quality of health and wellness of the enrolled program members by providing care in a more cost-efficient manner.
- Goals
  - Coordinate care for highest risk, chronically ill recipients that qualify for the program
  - Help improve the quality of health care that certain Nevada Medicaid FFS recipients receive through the program
  - Promoting increased self-management skills through one-on-one assistance.
- Service Examples
  - Help in locating and scheduling appointments with a doctor
  - Help with scheduling transportation assistance to medical appointments
  - Help with finding other resources such as food, housing, and utility assistance
  - Reminder for yearly flu shots and other preventive health care.

Phase-Out

- Demonstration Waiver ends 6/30/2018
- Per Special Terms and Conditions, DHCFP must submit a Phase-Out Plan that includes:
  - Public Notice (posted 1/29/18)
  - Public Comment (1/29/18 – 2/27/18)
  - Tribal Consultation (Letter 1/29/18 & consultation on 4/10/18)
- Command Center
- Phase-Out Plan submitted to CMS on 3/1/18 with all required documents above
- Public workshops will be conducted to discuss phase-out plan and options for Care Management Services

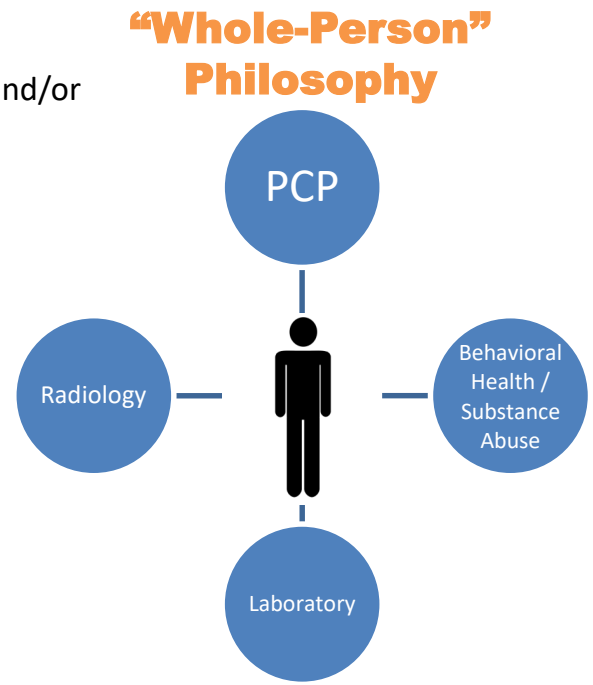
Next Steps

- What are the next steps for the DHCFP in regards to this population?
- Options:
  - Health Home
  - Primary Care Case Management
    - Individual Practitioners



Health Homes (HH)

- Whole Person Philosophy
- Providers of a HH
  - State can choose which type of providers
  - Providers can be a designated provider, team of health professionals, and/or a health team.
- 6 Core Services:
  1) Comprehensive care management
  2) Care coordination
  3) Health promotion
  4) Comprehensive transitional care
  5) Individual and family support
  6) Referral to community & social support services
- Recipients:
  - All recipients - FFS, MCO, Dual eligible's
- Eligibility Criteria
  - 2 or more chronic conditions, or
  - 1 chronic condition and at risk for a 2nd, or
  - 1 Serious and Persistent Mental Health condition (SPMH)
  - States have the flexibility to choose which chronic conditions and/or (SPMH) to target



HH- continued

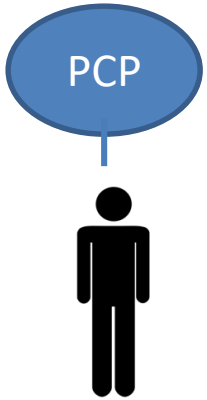
- State Plan Amendment
- $500,000 for planning
- 90/10% FMAP for 1st eight quarters
- Payment Models:
  - PMPM for 6 core services
    - Alternatives = 1) Tiered payments, 2) Bundled payments
- Does not require:
  - Cost-effectiveness or budget neutrality
  - Statewideness, comparability, freedom of choice

HH - Benefits, Limitations, Challenges

- Benefits
  - Whole person philosophy
  - Highest level of quality care
  - Includes behavioral health & substance abuse
  - Can target geographically and/or by condition
  - Does not require cost-effectiveness or budget neutrality
  - Does not require statewideness, comparability, freedom of choice (scalable to NVs needs)
  - State Plan Amendment
  - Improves program quality/implementation by utilizing HEDIS measures
- Limitations
  - Depends on states ability to locate and enroll providers willing to offer the service to Medicaid recipients. Provider may need to hire additional staff and/or provide additional hours
  - Only available to Medicaid recipients with the targeted conditions
  - Opt-In Programs = lower enrollment rate, but higher participation rate, may miss some Medicaid recipients that need services
  - Opt-Out Programs = higher enrollment rates, lower participation rate, unable to locate, pay for all enrolled
- Challenges
  - Lack of providers in Nevada, especially Rural Nevada
  - Rural providers – insufficient financial resources, shortage of trained staff, delays in adopting technology
  - Transforming a practice into a HH is lengthy and complex process especially for solo or small group providers
  - All recipients (FFS, MCO, dual eligible's) who meet the criteria of the chronic conditions and geographic location = Could be very large population

Primary Care Case Management (PCCM) – Individual Practitioners

- Serves as a medical home for **primary & preventative care**
- Providers of PCCM
  - Primary care providers (physician, physician group practice, or an entity having other arrangements with physicians to provide services – APRN, certified nurse midwife, PA)
  - State sets the requirements for participating providers – min. hrs open, referrals to specialist, etc.
- Core Services
  - Not restricted or defined like those listed in HH
- Recipients
  - All, if not operated under a waiver
  - 1932(a) waiver targets all FFS recipients, with MCO and dual eligible's optional
  - Target only specific conditions and/or only certain geographic regions of the state
- Eligibility Criteria
  - Less defined than with the HH
  - No mental health requirement
  - Based on physical health
  - State designates what population, conditions to serve



PCCM – continued

- 1932(a) waiver
- No funding for planning
- 65.75/34.25% FMAP
- Payment Models:
  - PMPM for care management services
- Does not require:
  - Cost-effectiveness or budget neutrality
  - Statewideness, comparability, freedom of choice

PCCM - Benefits, Limitations, Challenges

- Benefits
  - Does not require cost-effectiveness or budget neutrality
  - Does not require statewideness, comparability, or freedom of choice (scalable to NVs needs)
  - State Plan Authority
  - Lower reporting burden than 1115(a) waiver
- Limitations
  - No special emphasis on mental health
  - No enhanced FMAP
  - Opt-In or Opt-Out enrollment
- Challenges
  - Lack of providers in Nevada, especially Rural Nevada
  - Rural providers – insufficient financial resources, shortage of trained staff, delays in adopting technology
  - PMPM + FFS Rates. Similar to the current 1115(a) waiver

HH vs. PCCM

	HCGP PCCM - Entity (current model)	HH	PCCM – Individual Practitioners
Authority	1115(a)	SPA	1932(a)
Authority Length	5 year demonstration	Indefinite	Indefinite
Funding	62/38% FMAP	$500,000 planning 90/10% FMAP for 1st eight quarters	65.75/34.25% FMAP
Provider	3rd party vendor (medical services not provided by vendor)	Physician, team of health professionals, or health team	Primary Care Provider(s)
Contract	Vendor level	Provider level	Provider level
Eligibility	-1 or more qualified health condition, or - Complex condition/high utilizer with treatment costs exceeding $100,000 in claims	- 2 chronic conditions, or - 1 chronic condition with risk of developing a 2nd, or - SPMH	Can target specific conditions. Generally based on physical health
Population	All FFS	All recipients (FFS, MCO, dual eligible's)	FFS (MCO and dual eligible's optional)
Payment Methodology	PMPM for care management	PMPM for care management	PMPM for care management
Statewideness	Yes	Not required	Not required

MCAC

- DHCFP seeking input from the MCAC on models to serve Medicaid recipients who have chronic health conditions or are high utilizers.

Contact Info

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