The Affordable Care Act: Section 2703. Health Homes Overview and Considerations For Your State/Region

December 16, 2010, 12:00 to 1:30 p.m. EST (9:00 to 10:30 a.m., PST)

To join, visit: https://chcs.webex.com/chcs/onstage/g.php?d=712082980&t=a.

Event number: 712 082 980

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Agenda

- Health homes versus medical homes
- Health home requirements
- Questions and considerations
- Review planning grant process and the State Plan Amendment (SPA) template

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CHCS Mission

To improve health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care.

CHCS Priorities

- Enhancing access to coverage and services;
- Improving quality and reducing racial and ethnic disparities;
- Integrating care for people with complex and special needs; and
- Building Medicaid leadership and capacity.



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Related to, but Not the Same as, the Medical Home

- Health homes expand on traditional medical home models by:
 - Focusing on patients with multiple chronic and complex conditions;
 - Coordinating across medical and behavioral health care; and
 - Building linkages to community and social supports.
- Services are specific to Medicaid beneficiaries.
- Focus on outcomes reduced ED, hospitalizations/ readmissions, and reliance on
 LTC facilities.

Framework in Development

"...CMS encourages states with existing or planned medical home initiatives to compare those programs to the definition of health home..." State Medicaid Director Letter, November 16, 2010

Program Design Feature	Medical Home Initiative	Health Home Program
Intent		
Population Focus		
Delivery Models		
Provider Network		
Services		
Provider Standards		
Quality Measure Reporting		
State Oversight		

General Information

- Program: State participation is optional
- Timing: Flexible
 - Could submit letter of request to access Title XIX funds for planning 1.1.11
 - Could submit SPA via web-based tool and start services 1.1.11
 - Would provide services only after SPA approval
- Funding: Federal-State match
 - Planning: Regular, pre-Recovery Act, medical assistance service match
 - Services: After SPA approval, 90-10 for 8 quarters

Pre-Recovery FMAP for HCR Teams*

State	Pre-Recovery Act FMAP	Current Enhanced FMAP
New Mexico	71%	80%
Maine	65%	75%
Ohio	63%	74%
Oregon	63%	74%
Washington	50%	65%

^{*}Source: Department of Health and Human Services; Office of the Secretary; Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the State Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2009, through September 30, 2010. http://aspe.hhs.gov/health/fmap10.htm.

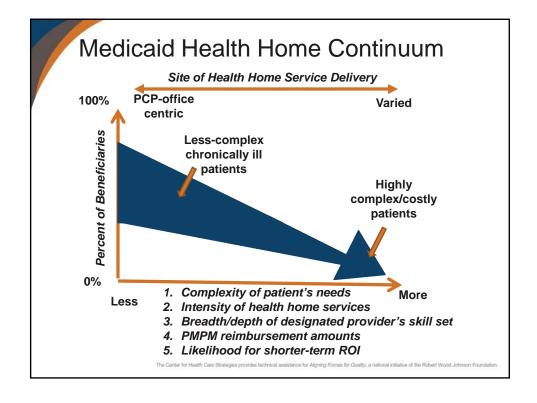
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Who can receive health home services?

- Medicaid beneficiaries with:
 - Two or more chronic conditions (mental health, substance abuse, asthma, diabetes, heart disease, being overweight);
 - One chronic condition and at risk for a second; or
 - Serious and persistent mental health condition.
- Cannot exclude dual eligibles
- Can serve individuals within a subset of specific chronic conditions (i.e., CMS waiving comparability requirements)

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How are health homes defined?

- Health homes comprise six services:
 - (1) Comprehensive care management; (2) care coordination and health promotion; (3) comprehensive transitional care/follow-up; (4) patient and family support; (5) referral to community and social support services; and (6) use of HIT to link services.
 - May or may not be provided within the walls of a primary care practice.
 - May or may not be incorporated into a medical home initiative.

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Designing Health Homes to Address Needs of Subpopulations

Subpopulation	Potential Considerations
"Generally" chronically ill	Primary care as "home"
Dual eligibles	LTC, Medicare provider networks
SPMI	Mental health system as "home"
HIV/AIDS	Relationship to TCM
Developmental disabilities	Provider networks, residential care
Other?	

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How are services reimbursed?

- Flexibility in payment methods, including, but not limited to:
 - Tiered payment methods
 - Adjustments by patient severity
 - Adjustments by health home "capabilities"
 - Alternatives to per member per month (PMPM) approaches
- Consulting CMS is encouraged, particularly if deploying via managed care delivery system

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Who provides health home services?

- <u>Designated provider</u>: Physician, clinical/group practice, rural health clinic, CHC, CMHC, home health agency, pediatrician, OB/GYN, other
- <u>Team of health professionals</u>: Physician, nurse care coordinator, nutritionist, social worker, BH professional
 - Free-standing, virtual, hospital-based, CMHC, etc.
- Health team: Community health team (CHT) –
 interdisciplinary, must include: medical specialists,
 nurses, pharmacists, nutritionists, dieticians, social
 workers, BH providers, chiropractics, licensed
 complementary and alternative medical practitioners,
 and physician assistants

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Health homes must:

- Provide quality-driven, cost-effective, culturally appropriate, person-/family-centered services;
- Coordinate/provide access to: high-quality, evidence-based services; preventive/health promotion services; MH/SA services; comprehensive care management/ coordination/ transitional care across settings; DM; individual/family supports; LTC supports and services
- Develop a person-centered care plan that coordinates/ integrates clinical/non-clinical healthcare needs/services;
- Use of HIT to link services, communicate across team members, health team, individual and family caregivers, and provide feedback to practices; and
- Establish a continuous QI program.

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How will CMS and states measure success?

- States must track and report outcomes (e.g., avoidable readmissions, ER, skilled nursing facility admissions) and calculate cost savings.
- Designated providers must report quality measures as condition of reimbursement.
- Health teams (Section 3502 of ACA) must also report patient outcomes and experience.
- Independent evaluator will survey states on impact of health home services on various cost, clinical and utilization measures.

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Questions and Considerations:

- How can health homes build off of/complement other state initiatives (e.g., medical home, care management, targeted care management, etc.)?
- How much overlap would occur with existing initiatives?
 - Patients
 - Practices
 - Services

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Questions and Considerations

- How could a state synchronize or optimize timing with other events (e.g., contracting, procurements, etc.)?
- How will the state define health home services?
- How "high" does state want to set the bar for health home services?
- Would the state request to use Title XIX funding for planning or jump right to SPA?

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Questions and Considerations

- How would state identify eligible population?
 How broad or narrow does the state want its health home approach to be?
- Would state phase in eligible populations? If so, how?
- How would the state provide services for complex subpopulations like dual eligibles? individuals with developmental disabilities? with serious and persistent mental illness? with HIV/AIDS?

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Questions and Considerations

- How will state reimburse for services? in feefor-service delivery system? in managed care delivery system?
- What tiers might a state use in developing rates?
- When should a state hope to see a return on investment?
- How will states fund their share of costs?
- How can the state align performance measures with regional or national measures?

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Questions and Considerations

- Is there an existing provider infrastructure to deliver health home services?
- How would the state identify eligible providers?
- Would skill sets and team structures vary? If so, how would payment reflect variations?
- How could state and/or plans support providers in reporting activities?

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Key Issues Raised by States

- Statewideness versus regional implementation
- Defining serious and persistent mental illness (SPMI)
- Operationalizing in a managed care delivery system
- Access to data and gain-sharing for duals
- Other

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Planning Support: Letter of Request

- Letter requesting up to \$500K in Title XIX funds
- Budget may include:
 - Personnel to determine feasibility and develop the program
 - Outreach to consumers and providers
 - Training and consultation for designing components required in the SPA
 - Development of reporting systems and other infrastructure building
 - Required travel

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Submitting a SPA

- Formally consult with SAMHSA when developing program
 - Must ensure access to a wide range of physical health, mental health and substance abuse prevention, treatment, and recovery services
- Comprehensively describe payment methods and rate-setting policies
- Delineate designated provider types, health care teams
- Articulate goals and measurement approaches for efficiency, economy, and quality of care

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Look for Future CMS Guidance

- Expanded service definitions
- Additional chronic conditions
- Integration of dual eligible benefits
- Quality measure reporting requirements

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For More Information:

- www.healthcare.gov
- health.home@samhsa.gov
- healthhomes@cms.hhs.gov
 - Barbara Edwards, Director of the Disabled and Elderly Health Programs Group, at 410.786.0325
- CHCS Resources:
 - Dianne Hasselman at dhasselman@chcs.org
 - Allison Hamblin at ahamblin@chcs.org
 - Alice Lind at alind@chcs.org

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