Spotlight on the States

NATIONAL ASSOCIATION OF Community Health Centers

Key State Policy Issues for Health Care Reform Implementation
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Issue Brief #3:

SUMMARY OF INITIAL CMS GUIDANCE ON THE STATE OPTION TO PROVIDE HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS

Background

Section 2703 of the Affordable Care Act[1] added a new section 1945 to the Social Security Act providing states with a Medicaid State plan option to receive enhanced federal support for the provision of health home services to eligible children and adults with chronic conditions. This provision became effective on January 1, 2011. On November 16, 2010, CMS issued initial guidance[2] to states including the opportunity for states to seek federal funding to support their health home planning efforts prior to submitting a State Plan Amendment (SPA). This initial guidance will be used by CMS to review and act on SPAs pending issuance of final regulations; states will be required to modify their SPA if necessary to comply with final regulations. CMS has developed guidance to assist states with the SPA submission process.[3]

The health home provision is designed to further efforts by CMS and states to improve health care access, quality and efficiency through a health home service delivery model providing comprehensive and coordinated medical, behavioral health and social supports and services.

What populations can be included?

Eligible individuals include those with chronic conditions as defined in 1945(a) of the Act as a mental health condition, a substance use disorder, asthma, diabetes, heart disease or being overweight (BMI over 25) and who select a designated health home provider. The HHS Secretary has the authority to expand this definition. Individuals must have at least two of these chronic conditions OR one chronic condition and be at risk of another OR one serious and persistent mental health condition.

States can further define the population to be covered by selecting particular chronic conditions or by targeting those individuals with higher numbers or severity of chronic conditions. Once defined, states must include all categorically eligible individuals including those served through 1915(c) home and community based services waivers and may include medically needy groups and those served through 1115 demonstrations. States have no current option to exclude dually eligible individuals.

[1] Public Law 111-148 revised by Public Law 111-152
[2] State Medicaid Director Letter #10-024, ACA# 12
[3] CMCS Information Bulletin – December 22, 2010

Who are eligible providers of health home services?

Three types of eligible providers are specified in 1945(a):

- Designated provider – physician, clinical practice or clinical group practice, rural health clinic, community health center, community mental health center, home health agency, or others designated in the State SPA and approved by the Secretary.
- Team of health care professionals – physicians and other professionals (nurse care coordinator, nutritionist, social worker, behavioral health professional, others designated by State and approved by Secretary) that operate either free standing, virtually, or based at a hospital, community health center, community mental health center, rural health clinic, clinical practice or clinical group practice, academic health center or other entity designated in the State SPA and approved by the Secretary.
- Health team – as defined in Section 3502 of ACA which requires the Secretary to define community health teams for the purpose of supporting patient-centered medical homes.

CMS states its expectation that providers "use a person-centered planning approach to identifying needed services and supports, providing care and linkages to care that address all of the clinical and non-clinical care needs of an individual."

What services are eligible for enhanced federal support and to what extent?

States that secure approval of a SPA under 1945(a) are eligible for FMAP of 90% for health home services provided within a health home model of service delivery. Covered services are:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support, which includes authorized representatives;
- Referral to community and social support services, if relevant; and
- The use of health information technology to link services, as feasible and appropriate.

States are eligible for the 90% enhanced match for the first 8 quarters after their SPA has been approved. States will receive their regular FMAP for other eligible services provided in a health home.

What payment methodologies can States use for health home services?

States have a great deal of flexibility in designing how they will pay for health home services. The methodology must be detailed in the SPA and States are encouraged to work with stakeholders and providers and draw upon their own and national experience in designing their methodology. Specific statutory allowance is provided for a tiered payment methodology which takes into consideration the severity of a person's chronic conditions and the capabilities of the provider. CMS states that while they "envision" a fee for service or capitated model, they will "consider other methods or strategies utilizing additional payment models."

What State planning activities will be supported and to what extent?

To support States in their efforts to plan and design their health home model prior to submittal of their SPA, CMS is making federal support up to $500,000 per state available. States must match this federal support at their pre-Recovery Act, medical assistance service match rate. Planning activities eligible for reimbursement include:

- Personnel and contractors to determine feasibility and develop the health home program;
- Outreach initiatives to obtain consumer and provider feedback;

- Training and consultation related to designing components of any provision of the SPA;
- Development of systems for reporting and other infrastructure building tasks; and
- Travel related to the above activities.

States may request more than $500,000 by submitting additional justification to CMS for their review and approval.

Whether or not a State seeks federal planning support, CMS is requiring States to consult with the Substance Abuse and Mental Health Services Administration (SAMHSA) prior to submitting their SPA as required in Section 1945(e) of the Act. States must specify in their SPA how their health home approach will provide access to a wide range of physical health, mental health and substance use prevention, treatment, and recovery services.

What data will States collect and report?

States will be required to collect and report data to CMS for purposes of evaluating the health home delivery model; they will be encouraged to collect data at the individual level. States will be required to:

- Track avoidable hospital admissions
- Calculate cost savings
- Monitor use of health information technology to improve service delivery and coordination
- Track emergency room use and skilled nursing admissions

CMS intends to provide standardized methodologies for tracking hospital readmissions and calculate cost savings as well as a core set of quality measures to be reported by designated providers to the State as a condition of receiving payment.

What PCAs and Health Centers Can Do

- Encourage your State Medicaid agency to participate in this program. Since many states have new Medicaid Directors, educate them about the importance of health care homes Work with your state to develop the provider standards that must be met by providers and show how health centers already meet those standards and are therefore well positioned to participate.
- Work with your State Medicaid agency to determine a fair reimbursement methodology for health home services.
- Health centers should continue to work to achieve Medical Home accreditation including the adoption and meaningful use of health information technology.
- Explore partnerships between health centers and other parts of the health care system (i.e. community mental health centers).

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