NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

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Implementing Medicaid Health Homes for Enrollees with Chronic Conditions

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On Nov. 16, 2010, the Centers for Medicare and Medicaid Services (CMS) issued a State Medicaid Directors Letter providing guidance on how states may take advantage of the new Medicaid Health Home state option enacted as part of the Affordable Care Act. This provision of the law creates a new option for states to enroll beneficiaries with two or more chronic conditions, including serious mental illness or substance use disorders, into health care homes for the coordinated treatment of their conditions. Following is a synopsis of the Nov. 16 guidance, which outlines CMS' expectations for initial applications to the Health Homes program.

Effective Date, Submission Details, and Review Process

The state option to provide health homes to Medicaid beneficiaries with chronic conditions becomes effective on Jan. 1, 2011. To take advantage of this option, states must submit a State Plan Amendment (SPA). CMS has developed a template Health Home SPA for states to use in this process. CMS strongly encourages states to use the draft template to prepare for SPA submission and to submit their SPAs online using a special web-based tool, to be available in December 2010.

CMS will use the guidance in the Nov. 16 letter to review and approve health home SPAs. States are expected to describe in their SPAs how their programs adhere to the guidance reflected in this letter. Final regulations will be issued at a future date, at which time states may need to further amend their state plans to be in compliance with the federal regulations. CMS has established an inbox for inquiries or comments about the Medicaid Health Home state option: healthhomes@cms.hhs.gov.

Eligibility Criteria

The Nov. 16 CMS letter reiterates the eligibility criteria outlined in the Affordable Care Act (ACA). Individuals are eligible for participation in the Health Home program if they meet at least one of the following criteria: a) have at least two chronic conditions; b) have one chronic condition and are at risk for another; or c) have one serious and persistent mental health condition. The ACA specifies that "chronic condition" includes a mental health condition, substance use disorder, asthma, diabetes, heart disease, or being overweight. The ACA also gives the Secretary of the Department of Health and Human Services the authority to select additional chronic conditions that may be included in the Health Homes program.

The ACA allows states to provide health home services to individuals based on all of the listed chronic conditions, or to target specific populations experiencing selected chronic conditions. The CMS guidance notes that **even if a state does not elect to target individuals with mental illness or substance use disorders, the state must specify in its application how it plans to meet enrollees' behavioral health needs.**

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Required Health Home Services

The ACA requires health homes to provide at least the following services: comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings; individual and family support; referral to community and social support services (if relevant); and the use of health information technology to link services. In its recent letter, CMS further clarified the required services that health homes must provide. The full list of service components is included under the heading "Provider Standards;" **these services must include prevention and treatment of mental illness and substance use disorders,** along with chronic disease management. Further guidance on how CMS will define these services will be forthcoming in future rulemaking.

CMS stated that it recognizes the importance of health IT in furthering the aims of the health home model of service delivery. Although under the statute, states do have flexibility in their use of health IT, CMS strongly encourages states to "consider utilizing technologies to provide health home services and improve care coordination across the care continuum." Future rulemaking will provide additional guidance on the health IT component of the health homes state option.

States will receive a 90% match rate (FMAP) from the federal government **for these specified health homes services** for the first 8 quarters that the health homes SPA is in effect. This enhanced match dates from the effective date of the SPA, not from the first day on which health homes begin submitting claims.

Coordination with SAMHSA

Because individuals with untreated mental illness or substance use disorders experience higher rates of co-morbid conditions requiring increased medical treatment, states participating in the health homes program must develop a plan for addressing enrollees' behavioral health needs. The CMS guidance states that health home SPAs must address how the proposed approach will assure access to mental health and substance use prevention, treatment, and recovery services. Approaches may include: "screening for alcohol and certain illegal drugs, identifying available mental health and substance abuse services, discharge planning, care planning that integrates physical and behavioral health services, person/family-centered treatment planning, referral and linkage to other specialty health and behavioral health treatment, and supports that promote recovery and resiliency."

CMS is also requiring states to consult with the Substance Abuse and Mental Health Services Administration (SAMHSA) **prior to submitting their state plan amendments.** States should send an email to health.homes@SAMHSA.hhs.gov and include the following information:

- A brief overview of the proposed design of the health home;
- The specific areas for SAMHSA consultation;
- The state contact person; and
- State timeframes and availability for obtaining the consultation.

SAMHSA has created a Health Homes section of its website, with information about the consultation process, screening tools, health home models, outcomes and quality measures, additional research, and other helpful documents.

Provider Arrangements

The ACA describes three types of provider arrangements that may be used in the health homes program: designated providers, a team of health care professionals, or a "health team." CMS is interpreting the statute to allow states to choose which of the three arrangements to offer, or, if more than one arrangement is selected, to ensure that beneficiaries have a choice among the options.

- **Designated Providers:** As specified in the ACA, designated providers include physicians and clinical practices, along with community mental health centers and other types of health organizations. The ACA also allows states to include additional providers in this category, including "other agencies that offer behavioral health services." States should describe all designated providers in their SPAs.
- **A Team of Health Professionals:** This provider arrangement comprises multiple types of providers working together in a variety of ways that link to designated providers – for example, operating out of a community mental health center. The ACA lists examples of providers that may be included on the team; these include social workers, behavioral health professionals, or any other professionals deemed appropriate by the state and approved by CMS. The SPA should include a description of the composition of these teams.
- **"Health Teams":** Defined as part of a separate program in the ACA, community health teams are interdisciplinary, inter-professional groups of providers that must include social workers and behavioral health providers (including mental health providers as well as substance use prevention and treatment providers). States should describe the composition of the health teams in their SPAs.

Regardless of the provider arrangement(s) selected, states must describe in their SPAs how they will ensure a whole-health approach to providing care and how they will address the required functions of a health home.

Payment Methodologies

The ACA permits states a considerable amount of flexibility in designing payment methodologies for their health home programs. Consistent with this approach, CMS notes that although it is envisioning a model of service delivery with either a fee-for-service or capitated payment structure, it is willing to consider alternative methods of payment. CMS will allow tiered payment methodologies that account for the severity of the individual's chronic conditions as well as the "capabilities" of the designated provider. Payment methodologies and rate-setting policies must be described in detail in the SPA. As part of the SPA review process, CMS will examine any proposed payment methodology to ensure that it meets the goals of efficiency, economy, and quality of care.

Planning Support

States may receive up to $500,000 of matching funds (at the regular, pre-Recovery Act match rate) for planning activities related to the program. Planning funds are expected to be used for development of the SPA

and are therefore only available prior to a state's SPA submission. A full list of acceptable planning activities can be found in the Nov. 16 letter. Planning funds will be available beginning Jan. 1, 2011. States must submit a letter of request to healthhomes@cms.hhs.gov outlining their health home planning activities and providing an estimated budget.

Monitoring, Reporting, and Evaluation

CMS is required to monitor, evaluate, and report to Congress on the health homes program. To fulfill this reporting requirement, CMS is requiring states to collect and report certain information, including avoidable hospital readmissions, costs savings that resulted from improved coordination of care and chronic disease management, emergency room visits, skilled nursing facility admissions, and more. Reporting must be conducted for health home enrollees and benchmarked against a comparison subgroup of Medicaid enrollees. The Nov. 16 letter provides information for states to consider as they design the monitoring and quality reporting portions of their SPAs; additional information will be forthcoming in future guidance.

For more information, please contact Chuck Ingoglia, Vice President, Public Policy, National Council for Community Behavioral Healthcare, at ChuckI@thenationalcouncil.org or 202.684.7457 ext. 249.