FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

January 2011

Medicaid's New "Health Home" Option

Many Medicaid beneficiaries suffer from multiple or severe chronic conditions and could potentially benefit from better coordination and management of the health and long-term services they receive, often in a disjointed or fragmented way. An increasing number of states have been adopting strategies to achieve such improvements, such as medical homes and enhanced primary care case management. The Patient Protection and Affordable Care Act (ACA), the health reform law enacted on March 23, 2010, provided states with a new Medicaid option along these lines – to provide "health home" services for enrollees with chronic conditions. Further, to encourage states to take up the new option, ACA authorized a temporary 90% federal match rate (FMAP) for health home services specified in the law. The health home option, established by 2703 of ACA, became available to states on January 1, 2011.

Health homes are designed to be person-centered systems of care that facilitate access to and coordination of the full array of primary and acute physical health services, behavioral health care, and long-term community-based services and supports. The health home model of service delivery expands on the traditional medical home models that many states have developed in their Medicaid programs, by building additional linkages and enhancing coordination and integration of medical and behavioral health care to better meet the needs of people with multiple chronic illnesses. The model aims to improve health care quality and clinical outcomes as well as the patient care experience, while also reducing per capita costs through more cost-effective care.

On November 16, 2010, CMS issued guidance to the states, outlining the requirements, choices, funding opportunities, and expectations that states interested in adopting the health home option through a state plan amendment (SPA) will wish to consider. CMS encourages states with existing or planned medical home initiatives to compare those programs to the definition of health homes under ACA and to design their health homes to complement those initiatives. Key information about the new health home option and highlights of the CMS guidance are summarized below.

Who can qualify for Medicaid health home services?

To be eligible for health home services, Medicaid beneficiaries must have at least two chronic conditions, including asthma, diabetes, heart disease, obesity, mental condition, and substance abuse disorder; one chronic condition and be at risk for another; or one serious and persistent mental health condition. Both children and adults who meet these criteria are eligible for health home services; individuals who are dually eligible for Medicaid and Medicare cannot be excluded. States can target health home services to those with particular chronic conditions or those with higher numbers or severity of chronic or mental health conditions. In addition, because the Medicaid "comparability" requirement is waived, states can offer health home services in a different amount, duration, and scope than services provided to individuals not in the health home population.

What are health home services?

Health home services that are eligible for the 90% FMAP include: comprehensive care management; care coordination and health promotion, comprehensive transitional care from inpatient to other settings, including appropriate follow-up; individual and family support; referral to community and social support services, if relevant; and the use of health information technology (HIT) to link services. These services must be provided by a "health home provider arrangement," as described next.

What is a health home provider arrangement?

Medicaid beneficiaries may receive health home services from three distinct types of health home provider arrangements: 1) a designated provider; 2) a team of health care professionals that links to a designated provider; or 3) a health team. Designated providers include physicians or physician practices, group practices, rural health clinics, community health centers, and community mental health centers, home health agencies, and any other entity or provider determined appropriate by the state and approved by the HHS Secretary. A "team of health care professionals" may comprise a physician and other professionals including a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any other professionals deemed appropriate by the state. The ACA requires the HHS Secretary to define "health team," but specifies that the team should be interdisciplinary and inter-professional and must include medical specialists, nurses, pharmacists, dieticians, social workers, behavioral health providers, chiropractors, licensed complementary and alternative medicine practitioners, and physician assistants. Under the CMS guidance, states can choose which health home provider arrangement(s) to offer, and if more than one option is offered, beneficiaries may choose among them.

What capabilities must a health home have?

The CMS guidance establishes standards for health homes to ensure that they have the capacity for a "whole-person" approach to care that identifies needed clinical and non-clinical services and supports, and provides or makes linkages to all such care. CMS expects health homes to perform a wide array of functions. They must provide quality-driven, cost-effective, and culturally appropriate person- and family-centered health home services. They are responsible for coordinating and providing access to preventive and health promotion services; mental health and substance abuse services; comprehensive care management, care coordination and transitional care across settings; chronic disease management; individual and family supports, including referrals to community and social supports; and long-term supports and services. As prescribed by the ACA, the CMS guidance requires states to consult and coordinate with the Substance Abuse and Mental Health Services Administration (SAMHSA) in designing their approaches to health homes.

Health homes must develop a care plan for each individual that coordinates and integrates all clinical and non-clinical services and supports required to address the person's health-related needs. They must use HIT to link services, facilitate communication between and among providers, the individual, and caregivers, and provide feedback to practices. In addition, they must establish a continuous quality improvement program, and collect and report data that support the evaluation of health homes.

What are the payment rules for health home services?

The federal match rate for health home services is 90% for the first eight fiscal quarters that a state's health home SPA is in effect. States have considerable flexibility in designing their payment methodology for health home services. The ACA expressly permits states to adopt a tiered payment structure that takes into account the severity of each person's conditions and the capabilities of the health home provider arrangement. States may pay for health home services on a fee-for-service or capitated basis or may propose an alternate payment model for CMS's approval. States must include a comprehensive description of their rate-setting policies in their SPA. Also, consistent with Medicaid law, states must provide public notice of changes to affected stakeholders prior to the SPA's effective date.

What funding is available to help support state planning activities?

CMS will authorize state applicants to spend up to $500,000 of Medicaid funding for planning activities related to the development of a health home SPA; state spending for this purpose will be matched at the state's regular FMAP rate for Medicaid services. The funds can be spent for activities such as hiring personnel to determine feasibility and develop a health home program, outreach to obtain consumer and provider feedback, training and consultation, systems development and other infrastructure-building tasks, and associated travel. To receive funding, available beginning January 1, 2011, a state must submit a Letter of Request to CMS, outlining its planning activities.

What state monitoring and reporting requirements apply?

States are expected to collect and report information required for the comprehensive evaluation of the health home model; CMS recommends that states collect individual-level data to permit comparative analyses of the effect of the health home model across Medicaid sub-populations, as well as comparisons between those who do and do not receive health home services. States must track avoidable hospital readmissions, calculate savings due to improved care coordination and disease management, and monitor the use of HIT; they are also required to track emergency department visits and skilled nursing facility admissions. CMS plans to specify a uniform methodology for tracking avoidable hospital readmissions and calculating savings.

States must also report on quality measures. CMS will provide further guidance on these requirements and plans to develop a core set of quality measures for assessing health homes, in consultation with the states and others. Until then, states are expected to define the measures they will use, which should capture information on clinical outcomes, experience of care outcomes, and quality of care outcomes.

How will health homes be evaluated?

HHS must survey all states that elect the home health option by January 1, 2014 to prepare an interim report to Congress. The HHS Secretary must contract for an independent evaluation of the health home model and report to Congress by January 1, 2017, and states must cooperate with the entity conducting the evaluation. CMS will provide further guidance on the evaluation design to the states implementing the health home option. The evaluation must address the effect of the model on reducing hospital readmissions, emergency room visits and admissions to skilled nursing facilities. Findings from the evaluation will be used to drive system-wide improvement in the delivery of health home services.

Looking ahead

As states continue to move forward to improve the coordination and management of care for Medicaid enrollees – especially those with the most complex and expensive needs – the health home option offers them a new strategy, along with significant federal support in the form of a 90% match for these services for two years. At a time when interest in creating a high-performing health care system has never been greater, but the recessionary demands on state resources remain difficult, the health home option offers states a programmatic and funding opportunity that addresses both these important realities.

This publication (#8136) is available on the Kaiser Family Foundation's website at www.kff.org

THE HENRY J. KAISER FAMILY FOUNDATION www.kff.org

Headquarters: 2400 Sand Hill Road Menlo Park, CA 94025 650.854.9400 Fax: 650.854.4800
Washington Offices and Barbara Jordan Conference Center: 1330 G Street, NW Washington, DC 20005 202.347.5270 Fax: 202.347.5274