Consolidated Implementation Guide: Medicaid State Plan – Health Homes

Health Homes Intro

POLICY CITATION

Statute: 1945 of the Social Security Act

Formal Guidance: SMDL #10-024 dated November 16, 2010; Health Homes FAQs dated May 5, 2012 and December 20, 2015

BACKGROUND

The purpose of this screen is for the state to provide an executive summary of their Health Homes program including the goals and objectives of the program, the population served, provider requirements, services provided, and the service delivery model used in the program.

This section also covers general assurances related to Health Homes regulatory requirements including a mandatory consult with SAMHSA, regardless of the targeted chronic conditions; agreement to reporting on quality measures as a condition for payment; understanding that dual-eligible beneficiaries cannot be excluded from a Health Home program; guaranteeing that beneficiaries will be given a free choice of providers; assuring the active participation of local hospitals; and ensuring non-duplication of services.

The Affordable Care Act of 2010, Section 2703, created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions by adding Section 1945 of the Social Security Act. In 2010, a State Medicaid Director Letter was released to expand upon the purpose of the benefit and the requirements for implementation. The benefit is intended to enhance the integration of services and coordination of care for beneficiaries with chronic illnesses across their lifespan. Health Homes must operate under a "whole-person" philosophy and be responsible for coordinating primary and acute care, behavioral health (mental health and substance use) and long term services and supports; providing wellness support and transitional services; as well as linkages to community and social support services.

Health Homes provide an opportunity for: improved access to primary care services; improved prevention; early identification and intervention to reduce the incidence of serious physical illnesses, including chronic disease; and increased availability of integrated, holistic care for physical and behavioral disorders, as well as better overall health status for individuals. Health Homes are expected to operate within a culture of continuous quality improvement to enhance health outcomes and quality of life for individuals with chronic conditions by working with all of the individual's care providers, establishing prevention strategies, and having ways to support the individual by educating and developing the knowledge and activities that support wellness.

States which elect to implement the Health Homes benefit will be able to define, within certain parameters, the population of Medicaid beneficiaries with chronic conditions that they wish to

target for Health Home services. States may also decide whether to provide their Health Homes benefit statewide or only in certain geographic areas of the state. States electing the Health Homes benefit will be required to cover a comprehensive package of Health Homes care coordination services delivered by certain types of providers who meet specified qualifications and standards. The Health Homes services are intended to be comprehensive and to enhance and be integrated into the care otherwise needed and received by the beneficiary. States electing this optional benefit are given considerable flexibility in designing and developing the delivery system for Health Home services as well as in developing a payment methodology/s for those services.

Health Home providers are required to report on health home quality measures to the state as a condition of receiving payment. States electing the optional Health Homes benefit will be required to collect, track/monitor and report information and data for the evaluation of the program. States are also required to report utilization, expenditure and quality data for an interim survey and an independent evaluation. States will have to work in concert with their Health Homes providers to obtain the necessary information and data. Health Home quality measures are an integral part of a larger payment and care delivery reform effort that focuses on quality outcomes for enrollees. This data is reported in the Quality Measures section of the system.

States which elect to implement the Health Homes benefit will be able to define, within certain parameters, the population of Medicaid beneficiaries with chronic conditions that they wish to target for Health Home services. To be eligible for Health Homes services, a beneficiary must have either: two or more chronic conditions; one chronic condition and are at risk for a second; or a serious and persistent mental health condition. Chronic conditions identified in statute include mental health, substance use disorder, asthma, diabetes, heart disease, and being overweight (as evidenced by a BMI of >25). States may request that CMS approve other chronic conditions for purposes of eligibility.

States electing the Health Homes benefit will be required to cover a comprehensive package of Health Homes care coordination services including: comprehensive care management; care coordination; health promotion; comprehensive transitional care/follow-up; patient and family support; and referral to community and social support services. The Health Homes services are intended to be comprehensive and to enhance and be integrated into the care otherwise needed and received by the beneficiary.

Section 1945 of the Social Security Act permits states to waive the comparability provision under the state plan at 1902(a)(10)(B) of the Act, which allows for Health Homes services to be provided in a different amount, duration, and scope than services provided to individuals who are not in the targeted Health Home population. States electing the Health Homes benefit must cover, at a minimum, **all** Categorically Needy eligible individuals who have the chronic conditions the state specified/selected in their SPA. Section 1945 does not mandate beneficiary enrollment in the Health Homes program, so beneficiary enrollment in the program is voluntary.

The target population cannot be based on the age of the beneficiary and dual-eligibles cannot be specifically excluded from the target population. Although the statute does not permit states to target their Health Homes programs by age, we recognize that states have faced challenges

developing Health Homes that serve both children and adults, and to address this challenge, states may tailor their standards or specifications for Health Homes to meet the unique needs of children and adult populations. For example, a state may adopt standards for designating providers or for teams of health care professionals that require specialized provider qualifications or team members when serving children, or that require systems and infrastructure that coordinate with different types of community-based service providers. States may also identify different providers for different age groups, for example: identifying providers who serve adults and separately identifying providers who serve children. This could be done as two separate Health Homes programs or within one program.

Health Homes services will be delivered by certain types of providers who meet specified qualifications and standards. States have flexibility to determine eligible Health Homes providers. Health Homes providers can be a designated provider; a team of health professionals; or a health team, as described in section 3502 of the Affordable Care Act. States also have considerable flexibility in designing and developing the delivery system for Health Homes services as well as in developing a payment methodology/s for those services. States may also decide whether to provide their Health Homes benefit statewide or only in certain geographic areas of the state.

States will receive a 90 percent enhanced FMAP for the specific Health Home services in Section 2703. The enhanced match does not apply to the underlying Medicaid services also provided to individuals enrolled in a Health Home. The 90 percent enhanced match is in effect for the first 8 quarters in which the program is operational, after which rates return to the regular service match rate. A state may receive more than one period of enhanced match by expanding the Health Home program geographically or by adding a new chronic condition, understanding that they will only be allowed to claim the enhanced match for a total of 8 quarters for one beneficiary.

States with one or more existing care management program must assure that there will be no duplication of services and no duplicate payment for the same services as those provided through the Health Home. Potential sources of duplication may include care management and/or care coordination services provided under managed care, home and community-based services waiver programs, and targeted case management programs. States must account for care management services that are provided to Medicaid individuals through other program authorities, such as CMMI demonstrations, and design their Health Home program to complement these services by ensuring that Health Home services are distinct and are not duplicating existing care management services.

When designing a Health Home program, states will need to consider strategies to avoid duplication when an individual is eligible to receive care management/care coordination services under separate program authorities. For example, under Health Homes, states may integrate the existing care management services into Health Homes by allowing providers of the duplicative services to be integrated within the Health Home structure. Some states have incorporated their targeted case management providers into their Health Home program. Another strategy is to allow an eligible individual to choose between the duplicative services/programs to avoid duplication. However, if the state can clearly differentiate the care management and care

coordination services provided by another provider (that is, a waiver case manager or a health plan from the services provided by a Health Home), the beneficiary can receive services from both providers without duplication.

General Assurances

States must assure that:

- Eligible individuals will be given a free choice of Health Homes providers;
- Individuals who are dually-eligible for Medicare and Medicaid will not be prevented from receiving Health Homes services;
- There will be no age restrictions and that Health Homes services will be made available to all individuals who meet the eligibility criteria;
- Participating hospitals will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers. We expect that states will need to communicate with hospitals and other stakeholders on the expectations for referring eligible individuals to a Health Home. We interpret this section to mean that hospitals will work with Health Homes to make referrals and to provide timely medical information on potential or current Health Homes enrollees who have received medical treatment at the hospital, whether through emergency room or inpatient admissions. Health Homes providers must develop a working relationship with hospitals to assure that information is shared and communicated efficiently to all community providers.
- FMAP for Health Homes services shall be at 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate;
- The state will have systems in place so that only one 8-quarter period of enhanced FMAP for each Health Homes enrollee will be claimed;
- There will be no duplication of services and payment for similar services provided under other Medicaid authorities. States with one or more existing care management program must assure that there will be no duplication of services and no duplicate payment for the same services as those provided through the Health Homes program.

INSTRUCTIONS

Program Authority

This section displays the following:

- The statutory authority citation under which the Health Homes program may be implemented (1945 of the Social Security Act).
- A statement as to the state's election to implement Health Homes.
- The name of the Health Homes program either entered or selected in the Submission Summary screen will display opposite "Name of Health Homes Program."

Executive Summary

You must provide a summary of the Health Homes program including the goals and objectives of the program; the population, providers, services and service delivery model. This summary is limited to 4000 characters.

General Assurances

In the last section, read and check the general assurances.

REVIEW CRITERIA

The state's executive summary (description/explanation) of this Health Home program must include the goals and objectives, population, providers, services and service delivery model used for this Health Homes program.

Health Homes Population and Enrollment Criteria

POLICY CITATION

Statute: 1945 of the Social Security Act

Formal Guidance: SMDL #10-024 dated November 16, 2010; Health Homes FAQs dated May 5, 2012 and December 20, 2015

BACKGROUND

The purpose of this screen is for the state to identify the population and chronic conditions it plans to target and the method for enrolling beneficiaries into the Health Homes program being described. (The Health Homes program name was either entered or selected previously in the Submission Summary screen.)

Eligible Population

Section 1945 of the SSA permits states to waive the comparability provision under the state plan at 1902(a)(10)(B) of the Act, which allows for Health Homes services to be provided in a different amount, duration, and scope than services provided to individuals who are not in the targeted Health Homes population. States electing the Health Homes benefit must cover, at a minimum, all Categorically Needy eligible individuals who have the chronic conditions specified/selected in their SPA.

The target population cannot be based on the age of the beneficiary and dual eligibles cannot be specifically excluded from the target population. Although the statute does not permit states to target their Health Homes programs by age, we recognize that states have faced challenges developing Health homes that serve both children and adults, and to address this challenge, states may tailor their standards or specifications for Health Homes to meet the unique needs of children and adult populations. For example, a state may adopt standards for designating providers or for teams of health care professionals that require specialized provider qualifications or team members when serving children, or that require systems and infrastructure that coordinate with different types of community-based service providers. States may also identify different providers for different age groups, for example: identifying providers who serve adults and separately identifying providers who serve children. This could be done as two separate Health Homes programs or within one program.

Section 1945(h) of the Act sets forth the minimum criteria that an "eligible individual with chronic conditions" must meet. The state must identify who is an "eligible individual with chronic conditions." The Statute defines the minimum criteria as follows: an individual who is eligible for assistance under the state plan or under a waiver of such plan and has at least 2 chronic conditions; 1 chronic condition and is at risk of having a second chronic condition; or 1 serious and persistent mental health condition, per the state's defined chronic condition eligibility criteria.

Health Home services can be provided to individuals who have chronic conditions, or categories of conditions, specified under section 1945(h)(2) of the Act, but states may choose to include other chronic conditions, as well. Specific chronic conditions, and categories of chronic conditions, authorized under section 1945(h)(2) of the Act include the following: mental health condition; substance use disorder; asthma; diabetes; heart disease; and being overweight, as evidenced by having a body mass index (BMI) over 25.

While all individuals served must meet the minimum statutory criteria, in accordance with section 1945(h)(1)(B) of the Act, states may elect to have a medical necessity test that makes Health Homes services available only to individuals with higher severity of chronic or mental health conditions.

Enrollment of Participants

The state, health care providers and hospitals may refer individuals to the Health Homes providers. Individuals may choose among the qualified Health Homes providers, and may change or disenroll at any time. However, individuals may only receive Health Homes services from one provider in a given period of time. Enrollment must be documented by the provider, and that documentation should at a minimum indicate that the individual has received required information explaining the Health Homes program and has consented to receive the Health Homes services noting the effective date of their enrollment.

Section 1945 does not mandate beneficiary enrollment in the Health Homes program, so beneficiary enrollment in the program is voluntary. Consistent with Medicaid state plan requirements, eligible individuals must be allowed the choice of a qualified Health Homes provider. While states may refer eligible individuals to a qualified Health Homes provider, enrollment of the individual would occur only if the individual consents and is accepted by the Health Homes provider. The state must allow an individual to change Health Homes providers or to opt out of receiving the Health Homes services at any time.

Eligible individuals may receive Health Homes services from any qualified and willing Health Homes provider, however, an eligible individual may only be enrolled with one Health Homes provider at a time. To assist individuals in obtaining services, the state may refer eligible individuals to particular Health Homes providers based on geographic area, established relationship with a provider, or other criteria, but must inform individuals of the option to receive such services from other qualified providers (if there are any). Eligible individuals may also be referred to a Health Homes program by a hospital or other health care provider. The eligible individual must provide active consent to enroll in that Health Homes program and must be allowed to change Health Homes providers or opt out of the service at any time.

The state will need to make sure that the Health Homes providers maintain documentation indicating that the individual has, in fact, enrolled and given consent to participate in the Health Homes program. This documentation should, at a minimum, indicate that the individual has received required information explaining the Health Homes program and the date that the individual enrolled in the program. Documentation of the individual's enrollment, and of any subsequent disenrollment, must be maintained in the enrollee's health record by the Health

Homes provider. The Health Homes provider should notify the state of the disenrollment and cease Health Homes billing for the disenrolled person.

INSTRUCTIONS

Categories of Individuals and Populations Provided Health Homes Services

Identify and select the categories or groups of individuals for whom the Health Homes program will be available:

- The state must cover all Categorically Needy (mandatory and options for coverage) eligibility groups (i.e., CN individuals who have the chronic conditions specified by the state) in their Health Homes program. The system, therefore, will automatically indicate that Health Homes services will be available to all the Categorically Needy eligibility groups. (Note that the state cannot elect to cover Categorically Needy groups or individuals based on their age. Also, dual-eligibles cannot be excluded from the target population.)
- If the state has a Medically Needy program, and it will also be covering Medically Needy eligibility groups in its Health Homes program, you must select the Medically Needy Eligibility Groups option.
- If Medically Needy Eligibility Groups is selected:
    - The following groups will display as pre-selected:
        - Medically Needy Pregnant Women
        - Medically Needy Children under Age 18
    - Additional groups (Optional Medically Needy) will display as options for selection. Select any of these groups as included in the population of this Health Homes program.

Population Criteria

In this section, select the target population of individuals with chronic conditions that will be served by this Health Homes program.

- Select one or more of the following three options:
    - Individuals with two or more chronic conditions,
    - Individuals with one chronic condition with the risk of developing another chronic condition,
    - Individuals with one serious and persistent mental health condition.

- If "Two or more chronic conditions" was selected as a target population:
    - A list of chronic conditions will display.
        - Select one or more of these options to indicate which chronic conditions are included in the population for this Health Homes program.
        - Select "Other" if there is a chronic condition included in the program that is not listed.

        - Enter the name of the chronic condition and briefly describe why it is considered chronic and how Health Homes services will help improve overall care and reduce costs for these individuals. You may add more than one "Other" chronic condition.

- If "One chronic condition and the risk of developing another" was selected as a target population:
    - A list of chronic conditions will display.
        - Select one or more of these options
        - Select "Other" if there is a chronic condition included for this criterion that is not listed.
            - Enter the name of the chronic condition and briefly describe why it is considered chronic and how Health Homes services will help improve overall care and reduce costs for these individuals. You may add more than one "Other" chronic condition.
        - Briefly describe the criteria for determining that the individual is at risk of developing another chronic condition and how Health Homes services will help improve overall care and reduce costs for these individuals.
- If "One serious and persistent mental health condition" was selected as a target population:
    - Specify the criteria for identifying the serious and persistent mental health condition and briefly describe why it is considered serious and persistent and how Health Homes services will help improve overall care and reduce costs for these individuals.

Enrollment of Participants

In this section, indicate which one of the following methods will be used to enroll eligible individuals into the Health Homes program. Only one selection may be made.

- Opt-in to Health Homes provider
    - If this is selected, describe the process used in the text box provided.
- Referral and assignment to Health Homes provider with opt-out
    - If this is selected, describe the process used in the text box provided.
    - Check the assurance that the state will clearly communicate the individual's right to opt out or to change providers.
    - Upload a copy of any letters or other communications used to information individuals of their rights. At least one document must be uploaded, and more than one may be uploaded.
- Other
    - If this is selected, describe the process used in the text box provided.

REVIEW CRITERIA

Review Criteria for Population Section: The state's description/explanation for considering a condition chronic, determining an individual at risk for developing a chronic condition, or considering a mental health condition serious and persistent plus its explanation for how Health Homes services will improve care and reduce costs for such individuals, should be

sufficiently clear, detailed and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements. One thing to note is that while states are not permitted to select a target population based on the age of the individual, there are a number of chronic conditions and serious and persistent mental health conditions that involve or impact individuals generally within a certain age range (e.g., juvenile diabetes, juvenile rheumatoid arthritis, adult-onset diabetes, Alzheimer's disease, etc.). If a state selects a chronic disease or condition that is a well-recognized and established condition by the medical profession, then the condition should be acceptable for population targeting under the Health Homes benefit. If the state specifically selects an age range or a chronic condition based on age that is not a recognized or established chronic condition (e.g., individuals 65 and older with congestive heart failure or adult onset congestive heart failure), then this would be unacceptable.

<u>Review Criteria for Enrollment Section:</u> During the SPA review process, states will need to explain their enrollment process including how they determine eligible enrollees and how they inform and educate eligible enrollees. For example, individuals eligible for Health Homes services may be identified through claims or encounter data, referrals from providers, or any other system the state has developed to identify those who would benefit from Health Homes services.

The information should clarify that selection of a Health Homes provider is optional, that the individual may have other choices of Health Homes providers and explain that the individual may disenroll from a Health Homes provider at any time. This information should also explain that the Health Homes program will not restrict access to providers or limit access to other Medicaid benefits.

Regardless of which option is selected, the enrollment is considered voluntary and the eligible individual must agree to receive Health Homes services and provide consent that would be maintained in the enrollee's health record.

Health Homes Geographic Limitations

POLICY CITATION

Statute: 1945 of the Social Security Act

Formal Guidance: SMDL #10-024 dated November 16, 2010; Health Homes FAQs dated May 5, 2012 and December 20, 2015

BACKGROUND

The purpose of this screen is for the state to identify the geographic limitations, if any, to be imposed by the state on the population included in the Health Homes program.

States are able to target their Health Homes program geographically. The statewide provision at 1902(a)(1) is waived by section 1945, so states may elect to have their Health Homes program operate statewide or only in specific geographic regions of the state. Unlike traditional state plan benefits, Health Homes do not have to be provided on a statewide basis. If the state provides Health Homes less than statewide, the state must specify the geographic areas in which the services will be offered in the state plan. States may also choose to phase-in their Health Homes programs geographically by adding one phase at a time. States may start with the first phase when they create the Health Homes programs and then amend their state plan to add new geographic areas over time. As new geographic areas are added to the state plan, the state receives a new period of enhanced match for the beneficiaries receiving Health Home services in the new coverage area.

INSTRUCTIONS

Geographic Limitations

In this section, indicate if the services for this Health Homes programs will be provided statewide from the beginning, permanently limited to certain geographic areas, or phased-in by geographic area to eventually be statewide. Select one of the following three options:

- Health Homes services will be available statewide.
- Health Homes services will be limited to the following geographic areas.
- Health Homes services will be provided in a geographic phased-in approach.

If Health Homes services will be limited to the following geographic areas is selected, select the option which best describes the limited geographic area.

- If county is selected, indicate in which counties the services will be available by entering the county names, one by one. As you start typing, a pop-up list will display county names for you to choose from.

- If region or other geographic area is selected, describe the region(s) or other geographic area(s).
- If city/municipality is selected, enter the name(s) of the city(ies) and/or municipality(ies).

If Health Homes services will be provided in a geographic phased-in approach is selected, enter a description of each phase, one at a time, by clicking on the Add Phase button. The first phase should be entered when the program starts. Enter subsequent phases by amending the program – one additional phase per Submission Package.

- For each phase:
    - Enter the date the phase will be implemented.
    - Select the option which best describes the geographic area designated for that phase, following the instructions described above. Indicate whether, with this phase, Health Homes services become available state-wide.
        - For the phase where the answer to this question is ***Yes***, enter the effective date of the state-wide implementation.
    - Enter any additional information you believe would clarify how the phase will be accomplished. This field is optional.
- When you are ready to enter another phase (under a new Submission Package), click the Add Phase button and follow the steps above.

REVIEW CRITERIA

States will need to identify whether the Health Homes benefit will be made available statewide or be limited to certain geographic areas in the state. In this section the state will need to be strategic about how they plan to phase-in their Health Homes benefit statewide, if they intend to do so. Ensure that only one new phase is added with each Submission Package.

Health Homes Services

POLICY CITATION

Statute: 1945 of the Social Security Act

Formal Guidance: SMDL #10-024 dated November 16, 2010; Health Homes FAQs dated May 5, 2012 and December 20, 2015

BACKGROUND

The purpose of this screen is for the state to define the six types of Health Homes services that are statutorily required to be provided by each Health Homes provider arrangement and covered under the Health Homes benefit. The state also will describe how health information technology will be used to link each Health Homes service in a comprehensive approach across the care continuum, including a flow chart illustrating how Health Homes services will be integrated into the overall care received by the beneficiary.

Section 1945(h)(4) of the Act defines Health Homes services as "comprehensive and timely high quality services," and includes the following list of services to be provided by Health Homes providers. Health Homes must provide all six of the required Health Homes services, based on the individual's needs as appropriate:

- Comprehensive Care Management
  Comprehensive Care Management means the initial and ongoing assessment and care management services aimed at the integration of primary, behavioral and specialty health care and community support services, using a comprehensive person-centered care plan which addresses all clinical and non-clinical needs and promotes wellness and management of chronic conditions in pursuit of optimal health outcomes.

  Comprehensive care management services include, but are not limited to the following activities:
  - Conducting outreach and engagement activities to gather information from the enrollee, the enrollee's support member(s), and other primary and specialty care providers.
  - Completing a comprehensive needs assessment.
  - Developing a comprehensive person-centered care plan.

  The comprehensive assessment includes current and historical information provided by the enrollee, as well as information received from available health care records, input received through consultation with other health care providers and the enrollee's support member, and assessments performed by telemedicine or other information technology medium as appropriate.

The comprehensive assessment includes a physical examination, behavioral assessment, medication reconciliation, functional limitations, screenings as deemed appropriate, assessment of clinical and social support needs, and any "at risk" concerns. Information received from the comprehensive assessment then serves as the basis for the person-centered care plan.

The comprehensive needs assessment should be conducted at least every 12 months (or more frequently as needed), when the individual's needs or circumstances change significantly, or at the request of the enrollee or the enrollee's support member.

- Care Coordination

  Care Coordination means facilitating access to, and the monitoring of, services identified in a person-centered care plan to manage chronic conditions for optimal health outcomes and to promote wellness. Care coordination includes the facilitation of the interdisciplinary teams to perform a regular review of person-centered care plans and monitoring service delivery and progress toward goals. This is accomplished through face-to-face and collateral contacts with the Health Homes enrollee, family, informal and formal caregivers, and with primary and specialty care providers. It also includes facilitation and sharing of centralized information to coordinate integrated care by multiple providers through use of electronic health records (EHRs) that can be shared among all providers.

  Care coordination services include, but are not limited to, the following activities:
  - Implementing the person-centered care plan.
  - Continuous monitoring of progress towards goals identified in the person-centered care plan through face-to-face and collateral contacts with enrollee, enrollee's support member(s) and primary and specialty care providers.
  - Supporting the enrollee's adherence to prescribed treatment regimens and wellness activities.
  - Participating in hospital discharge processes to support the enrollee's transition to a non-hospital setting.
  - Communicating and consulting with other providers and the enrollee and enrollee's support member, as appropriate.
  - Facilitating regularly scheduled interdisciplinary team meetings to review care plans and assess progress.

  The person-centered care plan serves as the basis for the coordination of care among Health Homes providers. The Health Homes interdisciplinary team develops a person-centered care plan jointly with each Health Homes enrollee consistent with §441.725. The care plan is to be developed by a licensed health care professional for the Health Homes program, in collaboration with the Health Homes enrollee, and individuals chosen by the enrollee to serve as contributors to the planning process. In addition, it must include input from an interdisciplinary team and other key providers (the individual's primary care physician, nurse care manager, behavioral health providers, social work professionals and other providers as appropriate) to assess and evaluate the health, behavioral health, and long term services and supports, as well as the social needs of the

participant. The proposed requirements for the person-centered care plan are consistent with those required in the January 16, 2014 HCBS final rule. We expect that the person-centered care plan reflects what is important to the individual and important for his or her health and welfare and is developed at a time and location of convenience to the Health Homes enrollee. The plan reflects the Health Homes enrollee's values and preferences, and current and long term needs and goals for care and specifies the types and frequency of all planned health, rehabilitation, behavioral health treatments, medications, home care services and supports and other services as needed. The plan also identifies who is responsible for providing each service and any areas that may require further follow up or revisions to the plan. The plan must be accessible to the Health Homes enrollee and the Health Homes team.

- Health Promotion

  Health Promotion means the education and engagement of an individual in making decisions that promote his/her maximum independent living skills and lifestyle choices that achieve the following goals: good health, pro-active management of chronic conditions, early identification of risk factors, and appropriate screening for emerging health problems.

  Health promotion services include, but are not limited to, the following activities:
  - Promoting enrollee's education of their chronic condition.
  - Teaching self-management skills.
  - Conducting medication reviews and regimen compliance.
  - Promoting wellness and prevention programs by assisting Health Homes enrollees with resources that address exercise, nutrition, stress management, substance use reduction/cessation, smoking cessation, self-help recovery resources, and other wellness services based on enrollee needs and preferences.

- Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

  Comprehensive Transitional Care means the facilitation of services for the individual and family/caregiver when the individual is transitioning between levels of care (including, but not limited to hospital, nursing facility, rehabilitation facility, community based group home, family or self-care) or when an individual is electing to transition to a new Health Homes provider. This involves developing relationships with hospitals and other institutions and community providers to ensure and to foster the efficient and effective care transitions. Health Homes should establish a written protocol on the care transition process with hospitals (and other community-based facilities) to set up real time sharing of information and care transition records for Health Homes enrollees.

  Comprehensive transitional care services include, but are not limited to, the following activities:
  - Establishing relationships with hospitals, residential settings, rehabilitation settings, other treatment settings, and long term services and supports providers to

promote a smooth transition if the enrollee is moving between levels of care and back into the community.

- This includes prompt notification and ongoing communication of enrollee's admission and/or discharge to and from an emergency room, inpatient residential, rehabilitative or other treatment settings.
- If applicable, this relationship should also include active participation in discharge planning with the hospital or other treatment settings to ensure consistency in meeting the goals of the enrollee's person-centered care plan;
- Communicating and providing education to the enrollee, the enrollee's support member and the providers that are located at the setting from which the person is transitioning, and at the setting to which the individual is transitioning.
- Developing a systemic protocol to assure timely access to follow-up care post discharge that includes at a minimum all of the following:
  - Receipt of a summary of care record from the discharging entity.
  - Medication reconciliation.
  - Reevaluation of the care plan to include and provide access to needed community support services.
  - A plan to ensure timely scheduled appointments.

- <u>Individual and Family Support (which includes authorized representatives)</u>
  Individual and family supports mean the coordinating of information and services to support enrollees and the enrollee's support members to maintain and promote the quality of life, with particular focus on community living options.

  Individual and family support services include, but are not limited to, the following activities:
  - Providing education and guidance in support of self-advocacy.
  - Providing caregiver counseling or training to include, skills to provide specific treatment regimens to help the individual improve function, obtain information about the individual's disability or conditions, and navigation of the service system.
  - Identifying resources to assist individuals and family support members in acquiring, retaining, and improving self-help, socialization and adaptive skills.
  - Providing information and assistance in accessing services such as: self-help services, peer support services; and respite services.

- <u>Referral to Community and Social Support Services</u>
  Referral to community/social supports means the provision of information and assistance for the purpose of referring enrollees and enrollee support members to community based resources, regardless of funding source, that can meet the needs identified on the enrollee's person-centered care plan.

Referrals to community/social support services include, but are not limited to, the following activities:

- Providing referral and information assistance to individuals in obtaining community based resources and social support services;
- Identifying resources to reduce barriers to help individuals in achieving their highest level of function and independence.
- Monitoring and follow up with referral sources, enrollee, and enrollee's support member, to ensure appointments and other activities, including employment and other social community integration activities, were established and enrollees were engaged in services.

Based on the statute and the 2010 State Medicaid Director's (SMD) letter, each type of Health Homes provider arrangement (Designated Provider, Team of Health Care Professionals and Health Team) in a state's Health Homes program must be able to provide the six core Health Homes services identified in section 1945(h)(4) in order to assure that beneficiaries receive comprehensive, coordinated, and high quality care throughout their lifespan, using a person-centered care process. Both section 1945 and the SMD letter mention the importance of using health information technology in delivering coordinated care and meeting the purpose of the Health Homes benefit.

The Health Homes service delivery model effectively transforms the way care has traditionally been provided by coordinating care and focusing on the goals of maintaining and protecting wellness. Health Homes provide an opportunity to transition away from the traditional model of chronic illness care. Under the traditional model, separate providers treat symptoms on an individual and episodic basis as they occur, without necessarily coordinating care for multiple symptoms and considering the overall causes and implications of the chronic condition. The Health Homes program is focused on activities that maintain wellness and improve overall health quality through coordinated care for all the individual's needs. It is important to note that even if a state has not elected to target individuals with mental illness or substance use disorders, the state must specify how it plans to meet the enrollee's behavioral health needs.

Health Homes services do not replace treatment of chronic conditions which is otherwise covered under Medicaid; instead, Health Homes services coordinate and support such treatment to ensure that the result is better health and quality of life. The Health Homes providers must work with all of the individual's care providers, establish prevention strategies, and have ways to support individuals by educating and developing the knowledge and activities that support lifestyle changes. Health Homes are the support system that encourages the Health Homes enrollee to be educated about their chronic condition and to take control of their own wellbeing by partnering with their providers, health coaches, and others to get the outcomes they want for themselves.

Key to the success of care coordination is the ability to engage the individual and build trust and support on an ongoing basis. We want to emphasize the importance of engaging the Health Homes enrollee to achieve successful health outcomes. Health Homes team members may need to meet with the Health Homes enrollee multiple times in person in their home or in a community setting to build trust and establish a relationship.

INSTRUCTIONS

Service Definitions

Indicate whether or not the common Health Homes services definition, as noted in the background section, is used. If not, provide a detailed definition of the service, including the specific activities to be performed under the service. Regardless of which definition is used:

- Clearly explain how it will operate under a whole-person approach to care.
- Describe how the approach to care will be person-centered, taking into account each person's unique needs, culture, values and preferences, with the person involved in the care plan.
- Describe the comprehensive team-based approach to care provided by a cohesive team, including:
    - The roles and responsibilities of team members;
    - How primary and behavioral health will be integrated;
    - Describe how the team will coordinate care across all elements of the health care system and provide the linkages to medical and social resources in the community.

Describe how health information technology will be used to link each service in a comprehensive approach across the continuum of care.

Describe the scope of services, by provider types.

- Select one or more provider types that can provide the Health Homes service and enter a description of each provider type selected.
- If "Other" is selected, enter the provider type in addition to a description.
- More than one "Other" provider type may be entered

Health Homes Patient Flow

Describe a typical patient's flow through the Health Homes system, including how Health Homes services are integrated into the overall care received by the beneficiary. Upload via the "Saved Documents" feature one or more flow-charts which describe this process. At least one flow-chart is required.

REVIEW CRITERIA

The description for each of the Health Homes services should clearly explain how it will operate under a whole-person approach to care. The descriptions should include how the approach to care will be person-centered, taking into account each person's unique needs, culture, values and preferences, with the person involved in the care plan. There needs to be a comprehensive, team-based approach to care provided by a cohesive team that includes a description of how the team will operate, the roles and responsibilities of each team member, and how primary and behavioral health will be integrated. The description needs to include how the team will coordinate care across all elements of the health care system and provide the linkages to medical and social resources in the community.

CMS will review state service definitions and compare them to the defined Health Homes services identified above in the Background section, which were developed based upon the

experience from approved Health Homes programs. The activities identified under each service definition should be incorporated into the state's definitions to achieve a common approach to the delivery of Health Homes services.

The state's description of how health information technology will be used to link each Health Homes service should be sufficiently clear, detailed, and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements.

Health Homes Providers

POLICY CITATION

Statute: 1945 of the Social Security Act

Formal Guidance: SMDL #10-024 dated November 16, 2010; Health Homes FAQs dated May 5, 2012 and December 20, 2015

BACKGROUND

The purpose of this screen is for the state to select/identify the types of providers of Health Homes services to be included in its Health Homes program and for the state to describe the standards and qualifications that these Health Homes providers must meet in order to participate in the program. The state will also describe how its Health Homes providers will be able to provide timely, comprehensive, and high-quality Health Homes services and how the state will support providers in this effort.

Section 1945(a) of the Act describes three distinct types of Health Homes provider arrangements from which a beneficiary may receive Health Homes services: designated providers, as defined in section 1945(h)(5) of the Act; a team of health care professionals, which links to a designated provider, as defined in section 1945(h)(6) of the Act; and a health team, as defined in section 1945(h)(7) of the Act. Note that section 1945(h)(7) defines *Health Team* to have the same meaning given *health teams* in section 3502 of the ACA.

Section 1945(h)(5) of the Act includes examples of providers that may qualify as a "designated provider," such as physicians, clinical practices or clinical group practices, rural health clinics, community health centers, community mental health centers, home health agencies, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined appropriate by the state and approved by the Secretary. The statutory list, therefore, is not an exhaustive list. States may include additional providers in this category, meeting the criteria of section 1945(h)(5) of the Act. States will need to identify all designated providers in its SPA. As discussed in more detail below, each designated provider must have the systems and infrastructure in place to provide Health Home services and to be able to satisfy the core Health Homes functions and service delivery principles.

States will be expected to develop a Health Home model of service delivery that has designated providers operating under a *whole-person* approach to care within a culture of continuous quality improvement. A whole-person approach to care looks at all the needs of the person. Providers of Health Homes services are expected to 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. Health Home providers must agree to report on the health home quality measures as a condition of receiving payment for health home services. In addition, Health Homes must have mechanisms in place to share health information, link services, facilitate communication among the interdisciplinary team members and other

providers to coordinate care and improve service delivery across the care continuum. States will need to describe the provider infrastructure and how their providers will meet the Health Homes core functions and service delivery requirements, and incorporate them into the state's provider standards.

States will need at a minimum, to include a designated provider or team of health care professionals that includes, employs, contracts with, or otherwise has access to interdisciplinary teams that consist of the following:

(1) Primary care physician/nurse practitioner;
(2) Nurse;
(3) Behavioral health care provider;
(4) Social work professional; and
(5) Other providers appropriate for the condition of the enrollees.

For each kind of provider/practitioner the state includes in it Health Homes program, the state will need to describe the qualifications and standards that each must meet in order to participate in its program.

States are expected to describe the infrastructure in place to provide timely, comprehensive, high-quality Health Homes services. The state also will need to describe the methods by which the state will support providers of these services in addressing the following core functional components.

Health Home Core Functional Components:

- Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
- Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
- Coordinate and provide access to mental health and substance abuse services;
- Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
- Coordinate and provide access to long-term care supports and services;
- Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;

- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
- Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Section 1945(b) of the Act directed the Secretary to establish standards for qualification as a designated provider of Health Home services. CMS is sharing Health Home service delivery principles to assist States who are submitting Health Home SPAs. CMS has worked collaboratively with States implementing Health Homes to assure that the benefit aligns with the requirements in 1945 of the Act. In reviewing best practices and lessons learned from states with approved Health Home SPAs, several states require designated Health Homes providers to obtain certification from a national accrediting organization as a patient-centered medical home/Health Home or meet state specific certification standards similar to those of a national accrediting organization.

To support the key Health Home service delivery system principles, CMS recommends that Health Home providers use one of the following options:

- Meet state specific standards for a patient-centered medical home/Health Home which, at a minimum, encompass the health home delivery system requirements (listed below), or
- At state option, be accredited by a national accreditation organization that has standards equal to or more stringent than applicable state-specific standards.

Health Homes Service Delivery System Principles:

- Demonstrate clinical competency for serving the complex needs of health home enrollees using evidence based protocols.
- Demonstrate the ability for effectively coordinating the full range of medical, behavioral health, long-term services and supports, and social services for medically complex individuals with chronic conditions.
- Provide health home services that operate under a “whole-person” approach to care using a comprehensive needs assessment and an integrated person-centered care planning process to coordinate care.
- Have conflict of interest safeguards in place to assure enrollee rights and protections are not violated, and that services are coordinated in accordance with enrollee needs expressed in the person-centered care plan, rather than based on financial interests or arrangements of the health home provider.
- Provide access to timely health care 24 hours a day, 7 days a week to address any immediate care needs of their health home enrollees.
- Have in place operational protocol, as well as communication procedures to assure care coordination across all elements of the health care system (hospitals, specialty providers, social service providers, other community based settings, etc.).

- Have protocols for ensuring safe care transitions, including established agreements and relationships with hospitals and other community based settings.
- Establish a continuous quality improvement program that includes a process for collection and reporting of health home data for quality monitoring and program performance; permits evaluation of increased coordination and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.
- Use data for population health management, tracking tests, referrals and follow-up, and medication management.
- Use health information technology to link services and facilitate communication among interdisciplinary team members and other providers to coordinate care and improve service delivery across the care continuum.

Finally, if the state is involved in other types of care coordination or medical home projects or initiatives, which impose additional or other requirements on the Medicaid Health Homes program, the state will be asked to identify and specify these additional requirements. States are expected to describe how these standards align with the Health Homes delivery system principles, and/or have been modified to address the specific Health Homes services States will also be asked to describe how their model will avoid duplication with other care coordination programs.

It is important to note that each Health Homes/provider type arrangement must have the capability of providing all six of the Health Homes services identified in the Health Homes Services screen, and that all payments for Health Homes services will be paid to the single entity that is qualified by the state as the Health Homes provider or the entity that is permitted to receive payments on behalf of the Health Homes provider. This will be described in more detail in the Health Homes Payment Methodologies and Health Homes Services screens.

INSTRUCTIONS

Types of Health Homes Providers

Select one or more of the following three types of Health Homes provider arrangements that can participate in the Health Homes program:

- Designated Providers
- Teams of Health Care Professionals
- Health Teams.

For each type of Health Homes provider arrangement selected, select from the list provided the specific kinds of professionals/practitioners or providers who are qualified to participate in the program.

For each specific kind of professional/provider selected, describe the qualifications and standards that must be met in order for that kind of professional/provider to participate in the Health Homes program, including professional degrees, certifications and licenses to practice in the state and the capability to provide all of the following required Health Homes services:

- Comprehensive care management
- Care coordination
- 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 the list of professionals/providers under Designated Providers or Teams of Health Care Professionals does not include a kind that is used in the program, select "Other" and enter the provider type in addition to a description of the provider qualifications and standards. You may add more than one "Other."

If Health Teams is selected, in addition to selecting one or more of the kinds of professional/provider listed, also check the assurance, "The state provides assurance that it will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945 of the Social Security Act."

Provider Infrastructure

Describe how the infrastructure of the selected Health Homes provider arrangements will meet the eleven core functional components of a Health Homes program identified by CMS in its SMD letter as being critical in assuring timely, comprehensive, and high-quality Health Homes services. (The eleven core functional components of a Health Homes program are listed above in the Background section.) In addition, states will need to address how their providers will adhere to the Health Homes service delivery system principles, also listed above in the Background section.

Supports for Health Homes Providers

Describe the methods by which the state will support the Health Homes providers in addressing each of the eleven components of a Health Homes program identified by CMS as being critical in assuring timely, comprehensive and high-quality Health Homes services.

Other Health Homes Provider Standards

Describe the state's requirements and expectations for Health Homes providers. Indicate how these requirements align with the key Health Homes expectations, and how they address specific Health Homes services.

Upload Documents

At the state's option, upload any provider standards documents which support the descriptions provided of provider standards and qualifications. More than one document may be uploaded.

REVIEW CRITERIA

Provider Qualifications: ***The descriptions of the providers' qualifications and standards must include appropriate professional degrees, certifications and licenses to practice in the state, and the capability to provide all six Health Homes services, as well as to meet expectation of***

high quality care. The descriptions of the providers' qualifications should also include an explanation of how they are consistent with the Health Homes Service Delivery System Principles, described in the Background section.

<u>Infrastructure:</u> The description of the infrastructure of provider arrangements must include how they will meet the eleven core functional components identified as being critical in assuring timely, comprehensive and high-quality Health Homes services. In addition, states will need to address how their providers will adhere to the Health Home Service Delivery System Principles. Include in the description providers who may not be employed by the Health Homes program but to whom enrollees may be referred for needed services.

<u>Supports for Health Homes Providers:</u> The description of the methods by which the state will support the Health Homes providers must include how the state will support the providers in addressing each of the eleven core functional components of a Health Homes program identified by CMS as being critical in assuring timely, comprehensive and high-quality Health Home services.

<u>Other Health Homes Provider Standards:</u> The description of other requirements and expectations should include how the requirements align with the key Health Homes expectations, and how they address specific Health Home services.

Health Homes Service Delivery Systems

POLICY CITATION

Statute: 1945 of the SSA

Formal Guidance: SMDL #10-024 dated November 16, 2010; Health Homes FAQs dated May 5, 2012 and December 20, 2015

BACKGROUND

The purpose of this screen is for the state to identify the type(s) of service delivery system(s) that will be used for individuals receiving Health Homes services. Depending on the type of service delivery system to be used, in this screen states may also be asked to specify the payment methodology, as well as to provide assurances and descriptions of the service delivery system(s).

Health Homes providers must have an infrastructure in place to provide timely, comprehensive, and high-quality Health Home services. Neither the statute nor the SMD letter requires a specific system for delivering Health Homes services under section 1945. Therefore, states are given the flexibility to determine which service delivery system or combination of systems will be used in its Health Homes program. The state may use a fee-for-service, primary care case management (PCCM), risk-based managed care delivery system and/or some other model of service delivery. Regardless of the service delivery system, Health Homes providers will need to meet the core Health Homes functional requirements and Health Homes service delivery principles as described under Provider Standards.

The Health Homes statute provides states considerable flexibility to design a Health Homes service delivery model appropriate to the needs of the population and each State's existing delivery system. States may utilize managed care, including prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs); primary care case management (PCCM); fee-for-service; or a combination of these delivery system arrangements to provide Health Homes services. We recognize that as states enroll more clinically complex individuals into a managed care delivery system, Health Homes models may provide an effective strategy and tool for managed care organizations that are responsible for providing the medical, behavioral, and/or long term care services and supports for Medicaid beneficiaries with chronic conditions.

CMS can work with states to assist in developing models that incorporate Health Home services into capitated managed care arrangements. In addition, some states have chosen to carve Health Homes services out of the managed care contracts and capitation and pay for Health Homes services directly, often using a per member per month payment to Health Homes providers for the Health Homes services. Because health plans typically have systems for data analytics, quality improvement, and reporting capabilities, approved Health Homes states are generally requiring a partnership between their contracted health plans and the community-based Health Homes providers, even if Health Homes services are carved out.

All states with an existing Medicaid managed care delivery system that are implementing a Health Homes program must compare the care coordination activities provided by the health plan to the care coordination activities required for Health Homes in order to avoid duplicative payment for the same service. If the state determines that there is some duplication of activity, the state must take measures to account for that duplication and avoid duplicate payment. The most frequently observed examples seen from approved Health Homes state plans include adjusting the health plan's capitation payment downward to address the duplicative care management activities or imposing additional contract requirements so that the managed care plans perform additional non-duplicative services. If a Health Homes program is provided under an MCO, a PIHP, PAHP or a PCCM, the arrangements must comply with both the Health Homes requirements as well as with the requirements of 42 CFR part 438 regarding Medicaid managed care.

To support Health Homes providers, CMS encourages states to obtain and utilize Medicare claims data to support delivery and oversight of Health Homes services for beneficiaries who are dually eligible for Medicare and Medicaid. For more information on accessing Medicare claims, please see the following link: State Data Resource Center.

INSTRUCTIONS

Select the service delivery system(s) that will be used for individuals in the Health Homes program from the following list. One service delivery system must be selected and more than one may be selected.

- Fee-For-Service
- Primary Care Case Management (PCCM)
- Risk-Based Managed Care
- Other Service Delivery System

If Fee-for-Service is selected, no other information about this service delivery system is requested in this screen. The payment methodology will be described in the Health Homes Payment Methodologies screen.

If PCCM is selected, indicate *Yes* or *No* if the PCCM will be a Designated Provider or part of a Team of Health Care Professionals.

- If *Yes* is selected (PCCM will be a Designated Provider or part of a Team of Health Care Professionals):
    - Select the option(s) which best describe on what basis the PCCM/Health Homes providers will be paid:
        - Fee-for-Service methodology that is described in the Payment Methodologies screen
        - Alternative Model of Payment that is described in the Payment Methodologies screen
        - Other payment methodology. If Other is selected, describe the payment methodology.

- Select *Yes* or *No* whether the requirements for the Health Homes PCCM will be different from those of a regular PCCM.
    - If *Yes* is selected (the requirements for the Health Home PCCM will be different than those for non-Health Home PCCMs):
        - Describe how the requirements will be different.
        - Check the assurance, "The state provides assurance that these requirements will be incorporated into the next PCCM contract submitted to CMS."
    - If *No* is selected, this option is complete.
- At your option, upload any documents which support the information/descriptions provided of the proposed PCCM system. More than one document may be uploaded.

- If *No* is selected (PCCM will NOT be a Designated Provider or part of a Team of Health Care Professionals), check the assurance, "The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments."

If Risk Based Managed Care is selected, indicate *Yes* or *No* if the Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.

- If *Yes* is selected (Health Plans will be a Designated Provider or part of a Team of Health Care Professionals):
    - Provide a summary of the contract language imposed on the Health Plans in order to deliver Health Homes services
    - Check the assurance, "The state provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review."
    - At your option, upload a copy of the Health Plan contract.
    - Select *Yes* or *No* whether Health Homes payments will be included in the Health Plan capitation rate.
        - If *Yes* is selected, check the three assurances displayed.
        - If *No* is selected, select one or more of the options to indicate which payment methodology(ies) will be used to pay the Health Plans:
            - Fee-for-Service methodology that is described in the Payment Methodologies screen
            - Alternative Model of Payment that is described in the Payment Methodologies screen
            - Other payment methodology. If Other is selected, describe the payment methodology.

- If *No* is selected (Health Plans will NOT be a Designated Provider or part of a Team of Health Care Professionals), select one or more of the options to indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be avoided:
    - The current capitation rate will be reduced

- The state will impose additional contract requirements on the plans for Health Homes enrollees.
    - If this option is selected, provide a summary of the contract language containing these additional requirements.
- Other
    - If this option is selected, provide a description of the other method used to avoid duplication of payment.

If Other Service Delivery System is selected:

- Describe whether or not the providers in this other delivery system will be a Designated Provider or part of the Team of Health Care Professionals and how payment will be delivered to these providers.
- Check the assurance, "The state provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review."
- At your option, upload a copy of pertinent contract requirements.

REVIEW CRITERIA

PCCM Other Payment Methodology: The description of a different payment methodology should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements.

PCCM Requirements Different from Regular PCCM: The description of the requirements for Health Homes PCCM that are different than those for regular PCCM should include how the PCCM requirements add value or enhance the level of service activity beyond the care coordination that a regular PCCM provides. Health Homes services must go above and beyond the services otherwise provided through PCCM.

Summary of Health Plan Contract Language: Under Risk Based Managed Care, if the health plans will be a Designated Provider or part of a Team of Health Care Professionals, the state must provide a summary of the additional contract language explaining how the health plans will work with the Health Homes program. This summary should include an explanation of the roles and responsibilities of health plans versus those of the Health Homes providers. Specifically, it should explain what additional activities the health plans may be providing instead of adjusting the capitation rate. It should also summarize the contract language with respect to the responsibilities of the health plans providing and/or coordinating services with the Health Homes providers. It is preferable that the contract have a separate addendum for Health Homes.

Health Homes Payments Not Included in Health Plan Capitation Rate: Under Risk Based Managed Care, if Health Homes payments will not be included in the Health Plan capitation rate, and the state indicates that it will use a payment methodology other than Fee-for-Service or Alternative Model of Payment, the description of the different payment methodology should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements.

Health Plans Will NOT Be a Designated Provider or Part of a Team of Health Care Professionals: *Under Risk Based Managed Care, if the Health Plans will* **not** *be a Designated Provider or part of a Team of Health Care Professionals, and the state has indicated that it will avoid duplication of payment for care coordination by imposing additional contract requirements on the plans for Health Homes enrollees who are also enrolled in a health plan, the state must provide a summary of the Health Plan contract language related to these additional requirements. This summary should include an explanation of the roles and responsibilities of health plans versus those of the Health Homes providers which demonstrates how the state will avoid duplication of payment. Specifically, it should explain what additional activities the health plans may be providing instead of adjusting the capitation rate. It should also summarize the contract language with respect to the responsibilities of the health plans providing and/or coordinating services with the Health Homes providers. It is preferable that the contract have a separate addendum for Health Homes.*

Other Method of Avoiding Duplication of Payment: *Under Risk Based Managed Care, if the Health Plans will* **not** *be a Designated Provider or part of a Team of Health Care Professionals, and the state has indicated that it will avoid duplication of payment for care coordination by some method other than reducing the capitation rate or adding requirements to the Health Plan contract, the state must provide a description of the other method it will use. This description of the other method to avoid duplication of payment should be sufficiently clear, detailed and complete to permit the reviewer to determine that the method meets applicable federal statutory, regulatory and policy requirements.*

Other Service Delivery System: *If a service delivery system other than Fee-for-Service, PCCM or At Risk Managed Care is selected, the state must completely describe the other service delivery system. This description should include whether the providers will be a Designated Provider or part of a Team of Health Care Professionals and how payment will be delivered to these providers. It should distinguish between Health Homes services and other similar programs and authorities and explain how the state will avoid duplication of activities, such as care coordination, between Health Homes and other Medicaid services.*

Health Homes Payment Methodologies

POLICY CITATION

Statute: 1945 of the SSA; 1902(a)(30)(A)

Regulations: 42 CFR 430.10; 42 CFR 447.10; 42 CFR 447.205

Formal Guidance: SMDL #10-024 dated November 16, 2010; Health Homes FAQs dated May 5, 2012 and December 20, 2015

BACKGROUND

The purpose of this screen is for the state to select/identify the type of payment methodology(s) it will use to reimburse for Health Homes services. The state may use fee-for-service, PCCM (Primary Care Case Management), risk-based managed care, and/or an alternative methodology for reimbursing Health Homes services.

Under section 1945, states are given considerable flexibility in developing payment methodologies to reimburse for Heath Homes services. The statute requires that the payment methodology used be specified in the state plan. The statute states that Health Homes payments may be tiered to reflect the severity or number of chronic conditions which a beneficiary has and/or to reflect the capabilities of the Health Homes provider. States could, for example, include medical necessity criteria to target individuals with a specific chronic condition who have a level of severity that required an inpatient stay in the past 12 months, repeated emergency room visits, or equivalent measures of severity. The statute requires that the payment methodology promote the principles of economy, efficiency and quality care consistent with section 1902(a)(30(A). The statute also permits states to propose an "alternative" model for paying for Health Homes services.

States seeking to establish a new Health Homes program or to change a payment methodology for an existing Health Homes program must publish notification consistent with the public notice requirements at 42 CFR 447.205.

Section 1945(c)(1) of the Act authorizes states to make payments for Health Homes services delivered by a designated provider, a team of health care professionals, or a Health Team. Consistent with the "whole-person" philosophy that requires the Health Homes to have the systems and infrastructure in place for coordinating and integrating all primary, acute, behavioral health (mental health and substance use), long term services and community and social supports for the Health Homes enrollees, only one Health Homes entity can bill for an enrollee's services in any time period, to prevent duplication of services. The Health Homes is accountable for meeting all the Health Homes delivery system requirements and responsible for distributing payments to the other Health Homes team members as appropriate.

Section 1902(a)(30)(A) of the Act requires that state plan rates be economic and efficient and provide for quality care. Regulations at 42 CFR 430.10 require that the State plan include a comprehensive description of the methods and standards used to set payment rates and provide a basis for Federal financial participation. These requirements are applied in reviewing all SPAs, including those for Health Homes.

Health Homes rates must be based on Health Homes units of service, whether on a fee-for-service basis, a per member per month (PMPM) basis, or another approved methodology. These rates may reflect any service overhead costs. Separate payments, apart from payment for Health Homes services rendered, may not be made for such costs. The Health Homes payment methodology should include a description of how the state will review the rates and rebase, if necessary. This should include an explanation of the factors that will be reviewed (such as staff salaries and other cost data) and the state's procedures and timetable (at least annually) for reviewing the rates to ensure that they remain economic and efficient and ensure the provision of quality care.

States are required to provide for the non-federal share of the payment through an allowable source (i.e., appropriations from state or local funds, intergovernmental transfers (IGTs) derived from state or local taxes, certified public expenditures by a governmental entity (CPEs) for costs payable under the approved state plan, or permissible provider taxes or donations). CMS cannot approve the SPA until we understand and document that the state is using permissible sources for the non-federal share of payments.

In reviewing Health Homes rates, CMS will ask for the amount of the rate and an explanation of how the state developed the rate based on cost or other considerations and how it determined that the rate was appropriate for the particular covered services. Any variations in payment or any tiered structure (based on beneficiary need or qualifications or composition of the health home team) must be described. The state plan should identify the unit of service that will be billed, that payment will be triggered by the provision of at least one billable unit of service, and identify where auditable documentation of the provision of service will be located, such as in a patient's chart. CMS will also ask the state to explain in the SPA how the State will track billable services if claims are not submitted through the MMIS and include assurances and a description of the manner in which the state will identify Health Homes services to ensure that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

State officials clearly have much to consider in constructing state plan payment methodologies for Health Home services that improve service delivery, provide for quality health outcomes for Medicaid participants and help to document the evaluative measures at section 2703(b) of the Affordable Care Act. We encourage states to work closely with their stakeholder and provider communities, and to draw upon national experience in developing payment methodologies for these services. We also invite states to work with CMS before formally submitting a SPA to ensure that proposed payment methodologies meet these objectives and all applicable federal and statutory requirements. While we envision a Health Homes model of service delivery with either a fee-for-service or capitated payment structure, we would consider other methods or strategies utilizing additional payment models.

INSTRUCTIONS

Any state plan amendment submitted to establish a new Health Homes program or to change payment methodologies for an existing program must also include the public notice and tribal input screens indicating how and when the public was notified of the change.

Health Homes Payment Methodologies

Select one or more of the following payment methodologies it will use to reimburse for Health Homes services:

- Fee-for-Service
- PCCM
- Risk-Based Managed Care
- Alternative models of payment

If Fee-for-Service is selected:

- Select one or more of the following options to describe how the payments are structured:
    - Individual rates per service
    - Per member, per month rates
    - Comprehensive methodology included in the plan
    - Incentive payment reimbursement
- For each of the options above selected:
    - First select "Fee for Service Rates based on"
    - Next select one or more of the following options to describe the basis of the rates:
        - Severity of each individual's chronic conditions
        - Capabilities of the team of health care professionals, designated provider, or health team
        - Other
            - If "Other" is selected, provide a description.
- After the Fee-for-Service selection(s) have been made, describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided. This includes a description of tiered rates, if appropriate. If not posted on a website (described below), include the amount of the rates in this section.

If PCCM is selected, no further description of the PCCM payment methodology is needed here because it was described in the Service Delivery Systems screen.

If Risk Based Managed Care is selected, no further description of the PCCM payment methodology is needed here because it was described in the Service Delivery Systems screen.

If Alternative models of payment other than Fee for Service or PMPM payments is selected:

- Indicate if the alternative model of payment includes tiered rates by checking that box.
    - If Tiered Rates is selected:
        - Select one or more of the following options to describe the basis of the rates:
            - Severity of each individual's chronic conditions
            - Capabilities of the team of health care professionals, designated provider, or health team

        - Other
            - If "Other" is selected, provide a description.
        - Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided.
- Regardless of whether or not you checked "Tiered Rates based on", provide a comprehensive description of the policies the state will use to establish Health Homes alternative models of payment, which must include:
    - How the methodology is consistent with the goals of efficiency, economy and quality of care
    - Nature of the payment, the activities and associated costs or other factors used to determine the amount
    - Any limiting criteria used to determine if a provider is eligible to receive payment
    - Frequency and timing of distribution of payments to providers.

Agency Rates

If Fee for Service was selected as a payment methodology, the Agency Rates section must be completed. Select one option which best describes the rates used from the following:

- FFS rates included in the plan
- Comprehensive methodology included in the plan
- The agency rates are set as of the following date and are effective for services provided on or after that date.
    - If this is selected:
        - Enter the effective date
        - Enter the website where the rates are displayed

    Note: If the fee-for-service rates are not displayed on a website, they should be entered above in the text box for the description of variation of fee-for-service rates.

Rate Development

If Fee for Service was selected as a payment methodology, the Rate Development section must be completed. Provide a comprehensive description of the manner in which rates were set, which must include:

- Cost data and assumptions used to develop each of the rates
- Reimbursable units of service
- Minimum level of activities required for providers to receive payment per the defined unit
- Standards and process required for service documentation
- Procedures for reviewing and rebasing the rates, including:
    - Frequency of review
    - Factors that will be reviewed in order to understand if the rates are economic, efficient and sufficient to ensure quality services.

Assurances

Check the four assurances at the bottom of the screen and describe how the state will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

REVIEW CRITERIA

Fee for Service

Other Basis for Fee-for-Service Rates: ***Under Individual Rates Per Service, Per Member, Per Month Rates, Comprehensive Methodology Included in the Plan, and Incentive Payment Reimbursement, the state selects the basis of the rates. If a basis other than severity of each individual's chronic conditions and the capabilities of the team of health care professionals, designated provider or health team is selected, the description of the other basis for the rates should be sufficiently clear, detailed and complete to permit the reviewer to determine if the basis of the rate meets applicable federal statutory, regulatory and policy requirements.***

Variation in Payments: The description of variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided should be sufficiently clear, detailed and complete to permit the reviewer to determine that it meets applicable federal statutory, regulatory and policy requirements. If the rates will not be displayed on a website, the rate amounts must be included in this section.

Fee-for-Service Rate Development

The description of the rate setting (development) policies should be sufficiently clear, detailed and complete to permit the reviewer to determine that they meet applicable federal statutory, regulatory and policy requirements. Generally, the rate narrative should include all of the factors included in the formulation of the payments, the basis or unit through which the providers are reimbursed and (as appropriate) the expected level of service within the unit. Any variation in payments based on geography, higher levels of provider qualification or other factors should also be explained in this section. The description must include:

- ***Cost data and assumptions that were used to develop each of the rates;***
- ***Payable unit(s) of service - identify the unit of service that will be billed, that payment will be triggered by the provision of at least one billable unit of service, and identify where auditable documentation of the provision of service will be located, such as in a patient's chart;***
- ***Variations in payment - Any variation in payments based on geography, higher levels of provider qualification or other factors should be explained in this section.***
- ***The minimum level of activities that the state agency requires for providers to receive payment per the defined unit;***
- ***How the state determined that the rate was appropriate for the particular covered services;***
- ***The state's standards and process required for service documentation;***
- ***Procedures for reviewing and rebasing the rates, including the frequency with which the state will review the rate and the factors that will be reviewed by the state in order to***

understand if the rates are economic and efficient and sufficient to ensure quality services; and

- ***Payment adjustments - for example, if a state adjusts rates based on a nationally recognized inflation factor, the state should name the factor and/or the percentage adjustment that will be applied in accordance with the factor for the applicable rate year. Similarly, if the state is making an adjustment that is not based on inflation, such as a percentage increase to the rates based on a state specific index, the state should note so and include the percentage increase applicable to the rate year.***

Alternative Models of Payment

Other Basis for Tiered Rates: ***Under Tiered Rates, the state selects the basis of the rates. If a basis other than severity of each individual's chronic conditions and the capabilities of the team of health care professionals, designated provider or health team is selected, the description of the other basis for the rates should be sufficiently clear, detailed and complete to permit the reviewer to determine if the basis of the rate meets applicable federal statutory, regulatory and policy requirements.***

Variation in Payments: The description of variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided should be sufficiently clear, detailed and complete to permit the reviewer to determine that it meets applicable federal statutory, regulatory and policy requirements. The rate amounts may be included in this section, or may be included in the comprehensive description, below.

Comprehensive Description for Alternative Models of Payment: The description of the policies used in establishing alternative models of payment should be sufficiently clear, detailed and complete to permit the reviewer to determine that they meet applicable federal statutory, regulatory and policy requirements.
The description must include:

- ***The amount of the rates, if not included in the Variations in Payments section;***
- ***How the methodology is consistent with the goals of efficiency, economy and quality of care;***
- ***The nature of the payment;***
- ***How the state determined that the rate was appropriate for the particular covered services;***
- ***The activities and associated costs or other relevant factors used to determine the payment amount;***
- ***Any limiting criteria used to determine if a provider is eligible to receive the payment; and***
- ***The frequency and timing through which the Medicaid agency will distribute the payments to providers.***

Assurances – Non-Duplication of Payment

The description of how the state will not be duplicating payment in its Health Homes program for the same or similar services offered/covered in a different program or under another

statutory authority should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state's approach meets applicable federal statutory, regulatory and policy requirements and should include:

- ***The manner in which the state will identify health homes services to ensure that there will be no duplication of services and payment for similar services provided under other Medicaid authorities, including whether billing and payment is handled through MMIS and how the State will track billable services if claims are not submitted through the MMIS.***

Health Homes Monitoring, Quality Measurement and Evaluation

POLICY CITATION

Statute: 1945 of the Social Security Act

Formal Guidance: SMDL #10-024 dated November 16, 2010; Health Homes FAQs dated May 5, 2012 and December 20, 2015

BACKGROUND

The purpose of this screen is for the state to describe its methodology for calculating cost-savings; describe how it will use health information technology to improve service delivery and coordination of care; and to provide assurances related to quality measurement and evaluation reporting.

States should collect, track/monitor and report specific types of information and data for evaluation purposes that are statutorily required for the Health Homes benefit. This information and data also will be used to inform stakeholders including the state, CMS and Congress about the success of the Medicaid Health Homes program in improving the coordination and quality of health care for the beneficiary with chronic conditions while reducing costs. The information and data collected and reported also will be used to inform and assist in the continuous improvement of the state's Health Homes program/model.

The statute at 1945(f) requires that states include in their Health Homes SPAs a methodology for tracking avoidable hospital readmissions and calculating savings that result from improved chronic care coordination and management. Section 1945(f) also requires states to describe in their state plan how health information technology will be used to improve service delivery and coordination across the continuum of care, including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their providers. In its November 16, 2010 Health Homes State Medicaid Director (SMD) letter, CMS makes several suggestions for how states can measure and track avoidable hospital readmissions and calculate cost savings, including what baselines/controls/comparison groups could be used in demonstrating the effect of the Health Homes program on these two measures.

The statute at 1945(g) indicates that as a condition for receiving payment for Health Homes services that providers report to the state in accordance with the requirements specified by the Secretary on all applicable measures for determining the quality of such services. The SMD letter discusses in some detail the quality measurement reporting requirements for states and providers of Health Homes services. In a separate component of MACPro, Health Homes Quality Measures, states should submit their Quality Measure reporting for each Health Homes program, for each federal fiscal year, starting with 2013. The Quality Measures reporting includes core measures, utilization measures and state-specific measures. States should enter the

specific goals and related measures for each Health Homes program in the state-specific section of the report.

INSTRUCTIONS

Monitoring

Describe the state's methodology for calculating cost saving. The description should include:

- Savings resulting from improved coordination of care and chronic disease management, including data sources and measurement specifications;
- Savings associated with serving dual-eligibles, including if Medicare data was available to the state and used in calculating the estimate.

Quality Measurement and Evaluation

Check the four assurances related to:

- Requiring providers to report to the state all applicable quality measures as a condition of receiving payment;
- Identifying measureable goals and quality measures for each goal;
- Reporting information to CMS; and
- Tracking avoidable hospital readmissions and reporting annually in the Quality Measures report.

Go to Quality Measure Reports

States may click on this link to either view and/or update Health Homes Quality Measures reporting.

REVIEW CRITERIA

Cost Savings Methodology: The state's description for calculating cost savings should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements. It should include the methodology used to calculate savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates.

Use of Health Information Technology: The state's description for using health information technology in providing Health Homes services should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements. It should include the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider.

Health Homes Program Termination – Phase-out Plan

POLICY CITATION

Statute: 1945 of the Social Security Act

Formal Guidance: SMDL #10-024 dated November 16, 2010; Health Homes FAQs dated May 5, 2012 and December 20, 2015

BACKGROUND

The purpose of this screen is to provide detailed information about the state's plans to terminate a specific Health Homes Program. It may be necessary to terminate a Health Homes Program due to state legislative action, reduction of funding or some other reason making the continuation of the program not possible. When this happens, the state may choose to terminate the program statewide as of a certain date, or may phase-out the program over time. Notifications of the program termination should be sent to all participants and providers, giving information about the program termination and how it will affect them. CMS must approve the state's plans to terminate the program, as described in this screen.

INSTRUCTIONS

This screen can be accessed in either of the following two ways:

- There is an existing approved Health Homes program and the state creates a submission package to end the program by selecting the option, "Terminate existing Health Homes program" in the Medicaid State Plan reviewable unit.
- A Termination – Phase-Out Plan reviewable unit has already been completed and the submission package has been approved, and now the state has to change the information previously provided in this reviewable unit. This is done by selecting "Amend existing Health Homes program" in the Medicaid State Plan reviewable unit, and selecting the Health Homes Program – Termination – Phase-Out Plan reviewable unit.

Under "Provide a description of the phase-out or transition plan for the Health Homes Program that is being terminated, complete the following:

- Enter a reason the program is being terminated.
- Describe the overall approach to be used in terminating the program
- Under "Indicate the method of termination," choose whether the state will terminate all participants on the same date or phase-out the termination.
    - If you select "The state will terminate all participants from the Health Homes Program on the same date, you must enter the effective date of the termination.
    - If you select "The state will phase-out the termination of participation in the Health Homes Program:"
        - You must enter a date in two fields, to indicate the period of the phase-out:
            - Begin phase-out date

        - Complete phase-out date
    - You must also upload the state's phase-out plan. This plan must include a description of the phase-out, as well as the strategy for communicating the phase-out to participants and providers, including the dates of communication.
- Regardless of whether the program will be terminated for all participants at the same time or the termination is phased-out, you must describe the process that will be used to transition all of the participants and how referrals will be made to other health care providers.

Note: When terminating a Health Homes Program, the state must continue to submit Health Homes Quality Measures reports covering the entire period the program was active, through to the end of the program.

REVIEW CRITERIA

Reason for termination: ***The state's description of the reason for termination should be clear and provide enough detail for the reviewer to understand the underlying causes of the decision to terminate, for example: lack of funding; provider capacity; change in administration or legislation; new service delivery systems.***

Overall approach the state will use to terminate the program: The state's description of the overall approach used to terminate the program should summarize the termination plan in a way that is sufficiently clear, detailed and complete to permit the reviewer to determine that it meets applicable federal statutory, regulatory and policy requirements.

Description of the process used to transition all participants: ***The state's description of the process used to transition all beneficiaries should include how the beneficiaries may continue to access services, how referrals will be made to other services and the methods of communication that will take place to the beneficiaries, providers and other stakeholders so that the affected beneficiaries will continue to be able to access medical care and other social and supportive services.***