

Health Homes (1945 of SSA/ Section 2703 of ACA)

Frequently Asked Questions

Series II

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I. Chronic Condition Definition

1. Question: What is the definition for chronic condition?

Answer: The term “chronic condition” means any physical or behavioral health condition that is persistent or recurring, typically affecting a person for twelve months or longer and requiring long term monitoring and/or management to control symptoms and to monitor the course of the disease. This definition is consistent with the framework developed by the Department of Health and Human Service’s Multiple Chronic Condition Taskforce (http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf).

2. Question: What chronic conditions have been targeted by States?

Answer: Please refer the following link for the summary chart of targeted chronic conditions by approved Health Home programs. (http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/Targeted-conditions-matrix_12_10_15.pdf)

II. Health Home Service Definitions

1. Question: What are the recommended definitions and related activities for each of the six Health Home services: 1) Comprehensive Care Management; 2) Care Coordination; 3) Health Promotion; 4) Comprehensive Transitional Care; 5) Individual and Family Supports; and 6) Referral to Community/Social Supports.

(1) 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.

(2) 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 home 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.

(3) 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 home 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.

(4) Comprehensive Transitional Care

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 Home 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 Home 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.

(5) Individual and Family Supports

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.

(6) Referral to Community/Social Supports

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.

III. Enrollment Standards

1. Question: How do eligible individuals become enrolled in a Health Home?

Answer: The State, health care providers and hospitals may refer individuals to the Health Home providers. Individuals may choose among the qualified Health Home providers, and may change or disenroll at any time. However, individuals may only receive Health Home 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 Home program and has consented to receive the health home services noting the effective date of their enrollment.

2. Question: What information about the Health Home benefit should be given to potential enrollees? How can this information be disseminated?

Answer: Potential enrollees should be given information in writing, and orally as appropriate, describing:

- (1) Purpose of the benefit;
- (2) Health Home services generally;
- (3) Individual's right to choose, change or disenroll from a Health Home provider at any time.

Information shall be provided in plain language and in a manner that is accessible to individuals who have limited English proficiency and to individuals with disabilities (through auxiliary aids and services at no cost to the individual if necessary).

3. Question: Does participating in the Health Home benefit restrict or adversely affect an enrolled individual's ability to receive other Medicaid covered services?

Answer: No, Health Home enrollees cannot be restricted from receiving other medically necessary covered Medicaid services.

IV. Provider Certification Standards

1. Question: What are the key functional requirements for Health Home providers?

Answer: As described in the November 16, 2010 State Medicaid Directors letter, CMS identified the key functional components of health home services and asked States to address in any home health state plan amendment (SPA) how they will support providers of Health Homes services in furnishing these components:

- (1) Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Home services;
- (2) Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
- (3) Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
- (4) Coordinate and provide access to mental health and substance abuse services;
- (5) 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;
- (6) Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
- (7) Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
- (8) Coordinate and provide access to long-term care supports and services;

- (9) 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;
- (10) 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;
- (11) 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.

2. Question: What are the certification requirements for Health Home providers?

Answer: Section 1945(b) of the Act directed the Secretary to establish standards for qualification as a designated provider of Health Home services. 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 State Plan Amendments (SPAs), many states require designated Health Home 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 requirements, CMS recommends that Health Home providers use one of the following options:

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

V. Provider Delivery System

1. Question: At a minimum, who should make up the Health Home interdisciplinary team?

Answer: At a minimum, a designated provider and team of health care professionals should include, employ, contract with, or otherwise have 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.

2. Question: What are the Health Home provider delivery system requirements?

Answer: Health Home providers should meet the key health home service delivery requirements listed below:

- (1) Demonstrate clinical competency for serving the complex needs of health home enrollees using evidence based protocols;
- (2) 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;
- (3) 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;
- (4) Have conflict of interest safeguards in place to assure enrollee rights and protections are not violated.
- (5) 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.
- (6) 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.);
- (7) Have protocols for ensuring safe care transitions, including established agreements and relationships with hospitals and other community based settings;
- (8) 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;
- (9) Use data for population health management, tracking tests, referrals and follow-up, and medication management;
- (10) 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.

VI. Quality Measurement and Evaluation

1. Question: What are the Health Home Core quality measures?

Answer:

NQF #	Measure Title	Measure Description	Measure Steward
N/A	1. Adult Body Mass Index (BMI) Assessment	Percentage of members 18-74 years of age who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to the measurement year	NCQA
N/A	2. Prevention Quality Indicator (PQI) 92: Chronic Condition Composite	The total number of hospital admissions for chronic conditions per 100,000 Health Home enrollees age 18 and older	AHRQ http://www.qualityindicators.ahrq.gov/
648	3. Care Transition – Transition Record Transmitted to Health care Professional	Care transitions: percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.	AMA-PCPI
0576	4. Follow-Up After Hospitalization for Mental Illness	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.	NCQA
1768	5. Plan- All Cause Readmission	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	NCQA

0418	6. Screening for Clinical Depression and Follow-up Plan	Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented	CMS
0004	7. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received the following: <ul style="list-style-type: none"> • Initiation of AOD treatment. • Engagement of AOD treatment. 	NCQA
0018	8. Controlling High Blood Pressure	The percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.	NCQA

2. Question: Is there a guide with information on each measure?

Answer: CMS issues a “Technical Specifications and Resource Manual” for health homes annually and posts it on Medicaid.gov. <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/health-home-core-set-manual.pdf>

3. Question: Does CMS offer technical assistance to states regarding the quality measures?

Answer: To help states collect, report, and use the Health Home Core Measures, CMS does offer technical assistance. States can submit technical assistance requests to: MACQualityTA@cms.hhs.gov.

4. Question: Is CMS evaluating the Health Home program?

Answer: The Assistant Secretary for Planning and Evaluation (ASPE) has been tasked with independently evaluating the Health Homes provision and will provide a report to Congress in 2017, as required by Section 2703 of the ACA.

5. Question: What state’s Health Home programs are being evaluated?

Answer: Rhode Island, Oregon, North Carolina, Missouri, New York, Iowa, Alabama, Ohio, Wisconsin, Idaho, and Maine.

VII. Payment Questions for Health Home SPAs

1. What information is necessary for States to consider when developing their health home payment methodology?

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.

In reviewing health home 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.

Health homes rates must be based on health home 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 home health services rendered, may not be made for such costs. The health home 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 addition, CMS reminds states of the requirement to provide public notice to affected stakeholders of changes in state plan methods and standards prior to the effective date of a SPA, consistent with the public notice requirements at §447.205. The State must issue public notice prior to the effective date of the SPA, conduct tribal consultation in accordance with requirements specified in the State plan and adhere to the SPA submission procedures.

CMS 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 home 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.

2. Can there be more than one payment to health home providers within a payment period?

No. Section 1945(c)(1) of the Act authorizes states to make medical assistance payments for health home services delivered by a designated provider, a team of health care professionals operating with the designated provider, or a health team. The “whole-person” philosophy requires the health home to have the systems and infrastructure in place for coordinating and integrating all care for the health home enrollees, therefore, there can only be one health home billing entity in any given time period, to prevent fragmentation and duplication of services. The health home would then be accountable for meeting all the health home delivery system requirements and responsible for distributing payments to the other health home team members and partners as appropriate. Moreover, health homes may develop methodologies to pay participating providers for health home services. Additionally, separate payments would be made for covered services other than health home services that are furnished to health home enrollees.

3. Can health home payment rates include costs related to start up and infrastructure costs?

Health home payment rates are for furnishing covered health home services, and separate payment is not available for start-up and infrastructure costs. In developing payment rates, states may consider market factors and provider costs that may take into account service overhead expenditures. But these costs are not separately payable and would need to be amortized and recouped as services are provided. For instance, there may not be a PMPM specific to provider information systems or staff hiring, but costs of those functions could be considered in setting the overall PMPM for home health services. Additionally, states may not claim under the health home benefit distinct payments to administrative entities that are not part of a health home team. CMS also reminds states that costs related to the proper and efficient administration of the State plan (administrative costs) cannot be claimed under the home health or any other service benefit.

Can payments to health homes be based on the severity of the chronic condition?

Yes. Section 1945(c)(2)(A) of the Act expressly permits states to structure a tiered payment methodology that accounts for the severity of each individual's chronic conditions and the "capabilities" of the designated provider or the team of health care professionals. In addition, section 1945(c)(2)(B) of the Act permits states to propose alternative models of payment for CMS approval that are not limited to per member per month payments.