CONCLUSION

The CMS Medicaid health home option presents an opportunity for behavioral health agencies to optimize consumers' overall health and wellness, build on the experience they have developed in integrated healthcare, and carve out an important niche in the evolving healthcare system. Becoming a behavioral health home will require a major shift in the roles, processes, and care agencies provide. It will mean embracing, or strengthening, a new culture of care based on the four principles addressed in this paper: person-centered care, population-based care, data-driven care, and evidence-based care.

Unfortunately, this opportunity comes at a time when many behavioral health organizations are struggling with the difficult economic environment and change fatigue. Agencies committed to taking on this challenge will need to give careful consideration to how to support their organization and its staff and bolster the internal resources necessary to survive and thrive during an extended period of disruptive change.

Behavioral health agencies already positioned to take on the challenge likely have a track record of being an innovative, high-achieving organization. Such agencies are nimble and able to lead and sustain major organizational change. They have embraced recovery principles, including person-centeredness. They are skilled at evidence-based treatments. They have experience using data in both clinical and quality improvement contexts, and are comfortable with information technology. Taking on the challenge of becoming a behavioral health home will push these behavioral health agencies to go further in their commitment to person-centered and evidence-based care and develop new skills in providing care that is data-driven and population-based. Organizations lacking these qualities and experience should not necessarily shy away from becoming a behavioral health home, but they should recognize the additional work required to achieve that goal.

Mental health and substance use disorder treatment agencies interested in becoming a behavioral health home are encouraged to undertake the following action steps:

1. Reach out to the relevant state agencies to express interest and begin making the case for the organization's capacity to succeed as a health home;
2. Develop an understanding of the behavioral health home's key clinical features and the system-level strategies (e.g., potential partnerships and financing strategies) that can support them;
3. Create a strategic plan, including the clinical model, budget, and implementation plan;
4. Start the change management process;
5. Establish agreements that formalize the necessary partnerships with community partners;
6. Regularly update state agencies on progress to fortify ties and demonstrate commitment and capacity;
7. Identify and include relevant stakeholders (e.g., administrators, clinicians, consumers) in the decision-making and strategizing process; and
8. Seek support and guidance/training from colleagues, experts, and leaders of relevant efforts.

Behavioral health agencies should also keep in mind resources and technical assistance available from the SAMHSA-HRSA Center for Integrated Health Solutions,❖ which will continue working to support behavioral health providers' development in pertinent areas.

❖ The Center for Integrated Health Solutions has extensive relevant resources on its website at: www.integration.samhsa.gov.

APPENDIX A
COMPENDIUM OF TOOLS REFERENCED IN REPORT

SELF-MANAGEMENT ASSESSMENT TOOLS

PATIENT ACTIVATION MEASURE

Insignia Meath

www.insigniahealth.com/solutions/patient-activation-measure

ILLNESS MANAGEMENT AND RECOVERY SCALE

Mueser, K.T., & Salyers, M.P., Illness Management and Recovery Scale, Measuring the Promise: A Compendium of Recovery Measures, pp. 32-35 (with full text of measure appended to report.)

www.power2u.org/downloads/pn-55.pdf

INTEGRATED CARE PLANS

INTEGRATED CARE PLAN

Connected Care™ Program, a joint program of Community Care Behavioral Health Organization and University of Pittsburgh Medical Center Health Plan

www.chcs.org/usr_doc/Integrated_Care_Plan_Template.pdf

www.chcs.org/usr_doc/Lovelace.pdf

INTEGRATED SUMMARY

AMERICAN ACADEMY OF FAMILY PHYSICIANS

www.aafp.org/fpm/2003/0400/p33.html

REGISTRIES

DIABETES REGISTRY TEMPLATE

Ortiz OD (2006). Using a simple patient registry to improve your chronic disease care. Family Practice Management, 13(4): 47-52.

www.aafp.org/fpm/2006/0400/p47.html

DEPRESSION REGISTRY TEMPLATE

IMPACT patient tracking tools, University of Washington. http://impact-uw.org/tools/patient.html.

JOINT PRINCIPLES OF THE PATIENT-CENTERED MEDICAL HOME

The American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association developed *Joint Principles of the Patient-Centered Medical Home* to describe the characteristics of the patient-centered medical homes. www.pcpcc.net/content/joint-principles-patient-centered-medical-home.

NCQA ACCREDITATION STANDARDS FOR THE PATIENT-CENTERED MEDICAL HOME

In early 2008, the National Committee for Quality Assurance announced the development of standards for medical practices that wish to be certified as patient-centered medical homes. The standards were updated in 2011 and include six standards for practices to meet across the following areas:

- Enhancing access and continuity
- Identifying and managing patient populations
- Planning and managing care
- Providing self-care support and community resources
- Tracking and coordinating care
- Measuring and improving practice performance

NCQA's Standards and Guidelines can be downloaded at www.ncqa.org/tabid/629/Default.aspx#pcmh

SETTING UP AGREEMENTS BETWEEN SPECIALISTS AND MEDICAL HOMES

The American College of Physicians issued a set of guidelines in 2010 for setting up agreements between medical homes and specialists: *The Patient-Centered Medical Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices.* Available at www.acponline.org/advocacy/where_we_stand/policy/pcmh_neighbors.pdf

APPENDIX B
CMS HEALTH HOMES GUIDANCE

See pages 32-45 for the November 16, 2010 Centers for Medicare and Medicaid Services State Medicaid Director and State Health Official Letter on Health Homes for Enrollees with Chronic Conditions, SMDL #10-024, ACA #12.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid, CHIP and Survey & Certification

SMDL# 10-024
ACA# 12

November 16, 2010

Re: Health Homes for Enrollees with Chronic Conditions

Dear State Medicaid Director:
Dear State Health Official:

This letter is one of a series intended to provide preliminary guidance on the implementation of the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act. Specifically, this letter provides preliminary guidance to States on the implementation of section 2703 of the Affordable Care Act, entitled "State Option to Provide Health Homes for Enrollees with Chronic Conditions."

Section 2703 adds section 1945 to the Social Security Act (the Act) to allow States to elect this option under the Medicaid State plan. This provision is an important opportunity for States to address and receive additional Federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons across the lifespan with chronic illness. This guidance outlines our expectations for States' successful implementation of the health home model of service delivery and provides initial guidance on important aspects of the health home provision.

The Centers for Medicare & Medicaid Services (CMS) is collaborating with Federal partners, including the Substance Abuse and Mental Health Services Administration (SAMHSA), the HHS Assistant Secretary for Planning and Evaluation (ASPE), the Health Resources and Services Administration (HRSA), and the Agency for Healthcare Research and Quality (AHRQ) to ensure an evidence-based approach and consistency in implementing this statutory provision. We recognize and greatly appreciate their expertise in medical home initiatives, integration of primary care and behavioral health, evaluative experience, and quality measurement.

Background

Health Home Model for Service Delivery

The health home provision authorized by the Affordable Care Act provides an opportunity to build a person-centered system of care that achieves improved outcomes for beneficiaries and better services and value for State Medicaid programs. This provision supports CMS's overarching approach to improving health care through the simultaneous pursuit of three goals: improving the experience of care; improving the health of populations; and reducing per capita costs of health care (without any harm whatsoever to individuals, families, or communities).

The health home service delivery model is an important option for providing a cost-effective, longitudinal "home" to facilitate access to an inter-disciplinary array of medical care, behavioral health care, and community-based social services and supports for both children and adults with chronic conditions. While there is still much to learn, we expect that use of the health home service delivery model will result in lower rates of emergency room use, reduction in hospital admissions and re-admissions, reduction in health care costs, less reliance on long-term care facilities, and improved experience of care and quality of care outcomes for the individual.

Health homes can play a particularly pivotal role in improving the health care delivery system for individuals with chronic conditions. Consistent with the intent of the statute, we expect States that provide this optional benefit, and the health home providers with which the State collaborates, to operate under a "whole-person" philosophy – caring not just for an individual's physical condition, but providing linkages to long-term community care services and supports, social services, and family services. The integration of primary care and behavioral health services is critical to the achievement of enhanced outcomes.

Health Homes and Medical Homes

To provide context about the genesis of the health home model, we are providing background in this letter on the medical home model. While Congress defined the term "health home" in section 2703 of the Affordable Care Act, the medical home model provides instructive history on the evolution of the health home model. In 1967, the American Academy of Physicians (AAP) *Standards of Child Health Care* envisioned the medical home as: "one central source of a child's pediatric records to resolve duplication and gaps in services that occur as a result of lack of communication and coordination." In 1992, the AAP applied the medical home term to medical care that is accessible, continuous, comprehensive, family-centered, coordinated, and compassionate; and in 2002, AAP further characterized care in a medical home as accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. The Future of Family Medicine Project expanded on the concept in 2004 when it called for every American to have a personal medical home. The American Academy of Family Physicians (AAFP) developed a related policy statement the same year, and the American College of Physicians (ACP) introduced the advanced medical home in 2006. The AAFP and ACP teamed with the AAP and the American Osteopathic Association to draft and disseminate Joint Principles of the Patient-Centered Medical Home. According to the principles, patient-centered medical homes should have these characteristics: a personal physician; physician-directed medical practice; whole-person orientation; coordinated care; quality and safety; enhanced access; and adequate payment.

In 2007, the Commonwealth Fund defined medical home as "a healthcare setting that offers patients a regular source of care, enhanced access to physicians and timely, well-organized care." Other definitions of a medical home include the use of chronic disease management, electronic health records, web-based information, and open access to scheduling. The Patient-Centered Medical Home (PCMH) is a model for care, provided by physician-led practices, that seeks to strengthen the physician-patient relationship by replacing episodic care based on illnesses and individual's complaints with coordinated care for all life stages, acute, chronic, preventive, and

end of life, and a long-term therapeutic relationship. The physician-led care team is responsible for coordinating all of the individual's health care needs, and arranges for appropriate care with other qualified physicians and support services. The individual decides who is on the team and the primary care physician makes sure team members work together to meet the individual's needs in an integrated fashion.

At the Federal level, in an effort led by the Office on Disability, agencies from across the Department of Health and Human Services (HHS), including CMS, worked together in 2008 to develop a conceptual model of the medical home to include service domains, training requirements, financing, policy, and research. The Federal workgroup concluded that the medical or health home is a conduit to lowering health care costs, increasing quality, reducing health disparities, achieving better outcomes, lowering utilization rates, improving compliance with recommended care, and coordinating a spectrum of medical and social services required by the individual across the lifespan.

Since 2009, AHRQ has convened a Federal collaborative around implementation of the PCMH, which includes CMS, SAMHSA, and HRSA. In 2010, AHRQ launched a public website, www.pcmh.ahrq.gov aimed at providing health care decision makers and researchers evidence-based resources about the medical home and its potential to transform primary care. On the site, AHRQ published its definition of the PCMH which emphasizes the importance of team-based care and recognizes that many clinicians may lead a patient-centered health care team.

In 2009, SAMHSA launched its Primary Care and Behavioral Health Care Integration (PBHCI) program. This program seeks to improve the physical health status of people with serious mental illnesses (SMI) by supporting community-based efforts to coordinate and integrate primary health care with mental health services in community-based behavioral health care settings. Better coordination and integration of primary and behavioral health care will result in: 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. SAMHSA has funded 56 sites nationally, and, in cooperation with HRSA, has co-funded a national resource center dedicated to integrating primary and behavioral health care in both behavioral health settings and primary care settings.

Many State Medicaid programs have developed medical home models and States receive Medicaid reimbursement for medical homes through a variety of authorities. Under the authority of section 1932(a) of the Act, States have implemented delivery systems beyond traditional primary care case management programs, many focusing on high-cost, high-user beneficiaries (not limited to specific diagnoses). While many of these models are physician-based, there is a growing movement toward interdisciplinary team-based approaches. Services such as care coordination and follow-up, linkages to social services, and medication compliance are reimbursed through a "per member per month" structure. In addition to the authority in section 1932(a) of the Act, some States are using full-risk managed care plans and demonstrations approved under section 1115 of the Act to implement their medical homes.

Given the prior history of Medicaid involvement in medical home models and delivery systems, and the new statutory definition of the term "health home," a goal of implementing section 2703 of the Affordable Care Act will be to expand the traditional medical home models to build linkages to other community and social supports, and to enhance coordination of medical and behavioral health care, in keeping with the needs of persons with multiple chronic illnesses. The whole-person philosophy described below is fundamental to a health home model of service delivery. CMS expects health homes to build on the expertise and experience of medical home models, when appropriate, to deliver health home services.

Coordination with Existing State Programs

The CMS recognizes that many States that are interested in this Medicaid State plan option will want to coordinate with their existing medical home initiatives, including those that utilize private insurance, Medicare, and multi-payer funding streams. CMS encourages States with existing or planned medical home initiatives to compare those programs to the definition of health home in section 2703 of the Affordable Care Act and the intent, population focus, delivery models, services, provider standards, quality measure reporting, and State monitoring required under this health home State plan option, and to design this option to complement those initiatives. CMS is available to provide technical assistance as States begin this analysis.

General Information

The State option to provide health home services to Medicaid beneficiaries with chronic conditions becomes effective on January 1, 2011. A State may elect this option through an amendment to the Medicaid State plan; however, the effective date of the State plan amendment (SPA) may not be earlier than the statutory effective date. We are issuing this letter to provide initial guidance, as well as to inform States of the ability to claim title XIX funds prior to submitting a health home SPA in order to plan and develop their health home model.

Throughout this guidance, there will be references to the "health home model of service delivery" that encompasses all the medical, behavioral health, and social supports and services needed by a beneficiary with chronic conditions. The specific activities authorized by the Affordable Care Act will be referred to as "health home services" throughout this guidance, and are addressed below. Only health home services qualify for the 90 percent Federal medical assistance percentage (FMAP) rate (for the first eight fiscal quarters that a health home State plan amendment is in effect).

We have developed a draft template for States to use in designing and developing health home SPAs that is attached to this letter. We will roll out a web-based submission process for health home SPAs in early December, which will include the same data fields as shown on the draft template screen shots. At that time, we will release a CMCS Informational Bulletin with instructions on use of the web-based tool for submission. CMS is available for technical assistance using the draft template as well as the web-based tool in the future. We strongly encourage States to use the draft template to prepare for SPA submission and the web-based tool

for actual submission, as some of the information from the SPA will be displayed on the www.healthcare.gov website and used for reporting purposes.

Initially, CMS will use the guidance in this letter to review and approve health home SPAs. States are expected to describe in their SPAs how their programs adhere to the guidance reflected in this letter. Upon the issuance of final regulations, States may need to amend their State plans, if necessary, to come into compliance with the regulatory requirements.

We have established an electronic health home mailbox for States and interested parties to use for submission of questions or comments about this provision of the law. Inquiries may be sent to healthhomes@cms.hhs.gov.

Health Home Population Criteria

Section 1945(a) of the Act permits States the option to offer health home services to "eligible individuals with chronic conditions" who select a designated health home provider. The chronic conditions described in section 1945(h)(2) of the Act include a mental health condition, a substance use disorder, asthma, diabetes, heart disease, and being overweight, as evidenced by a body mass index over 25. Section 1945(h)(2) of the Act authorizes the Secretary to expand the list of chronic conditions reflected in this provision. Further information regarding how the Secretary will use this authority will be articulated in future guidance. Additional chronic conditions, such as HIV/AIDS, will be considered for incorporation into health home models.

Section 1945(h) of the Act sets forth the minimum criteria that an "eligible individual with chronic conditions" must meet. The health home population the State elects must consist of individuals eligible under the State plan or "under a waiver of such plan" who have at least two chronic conditions, as listed in section 1945(h)(2) of the Act, one chronic condition and be at risk for another, or one serious and persistent mental health condition.

The State may elect in its State plan to provide health home services to individuals eligible to receive health home services based on all the chronic conditions listed in the statute, or provide health home services to individuals with particular chronic conditions. While all individuals served must meet the minimum statutory criteria, States may elect to target the population to individuals with higher numbers or severity of chronic or mental health conditions. The population must include all categorically needy individuals who meet the State's criteria (including those eligible based on receipt of services under a section 1915(c) home and community-based services waiver) and a State option may include individuals in any medically needy group or section 1115 demonstration population. There is no statutory flexibility to exclude dual eligible beneficiaries from receiving health home services. CMS recognizes the challenges States face in serving dual eligible beneficiaries and we are working to assist States in their efforts to more effectively integrate Medicare and Medicaid benefits.

Because the statute waives the comparability requirement at section 1902(a)(10)(B) of the Act, it allows States to offer health home services in a different amount, duration, and scope than services provided to individuals who are not in the health home population.

Service Definitions

Section 1945(h)(4) of the Act defines health home services as "comprehensive and timely high quality services," and includes the following health home services to be provided by designated health home providers or health teams:

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

CMS recognizes the importance of health information technology in furthering the aims of the health home model of service delivery. While States have the flexibility to determine how to use health information technology in their health home models, CMS encourages States to consider utilizing technologies to provide health home services and improve care coordination across the care continuum. Further information regarding how the Secretary will define these services will be articulated in future guidance.

Payment Methodologies

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. Section 1945(c)(2) of the Act requires that the State include the payment methodology in its State plan, but permits considerable flexibility in designing the payment methodology. Specifically, 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, the team of health care professionals operating with the designated provider, or the health team. In addition, section 1945(c)(2)(B) of the Act permits States to propose alternative models of payment that are not limited to per member per month payments for CMS approval.

Consistent with section 1902(a)(30)(A) of the Act, CMS will review health home SPA submissions for consistency with the goals of efficiency, economy, and quality of care, and require a comprehensive description of the rate-setting policies in the Medicaid State plan. We remind 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 42 CFR 447.205. CMS does not anticipate any conflict between the provisions described under the health home payment authority and section 1902(a)(32) of the Act, which (excepting certain employment or contractual arrangements) requires direct payments to Medicaid providers.

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 beneficiaries and help to document the evaluative measures at section 2703(b) of the Affordable Care Act. CMS encourages States to work closely with their stakeholder and provider communities and to draw upon national experience in developing reimbursement methodologies for these services. We also invite States to work with CMS prior to formally submitting a SPA to ensure that proposed payment methodologies meet these objectives and all applicable Federal and statutory requirements.

Similarly, States interested in implementing a health home SPA in conjunction with using a capitated model are encouraged to work with CMS informally prior to developing an official submission. While CMS envisions 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.

Enhanced FMAP

Section 1945(c)(1) of the Act provides that the FMAP for health home services shall be 90 percent for the first eight fiscal quarters that a SPA is in effect. Thereafter, States can claim at the regular FMAP rate used for other Medicaid services during the calendar quarter. Once CMS approves a State's health home SPA, the State can submit a claim to CMS for reimbursement using the Medicaid and Children's Budget Expenditure System (MBES/CBES) and record the expenditures on a new line item 64.9. The new line item will be called Health Homes for Enrollees with Chronic Conditions.

Expenditures claimed at the enhanced match should be recorded in line 64.9-a, and expenditures claimed at the regular match should be recorded in line 64.9-b. Please be cognizant of the requirement that the eight quarters of 90 percent FMAP begin upon the effective date of the SPA. If there is a delay in implementation, this date could be different from the first day or first quarter when health home services claims are received. There is no time limit by which a State must submit its health home SPA to receive the eight quarters of 90 percent FMAP.

Provider Infrastructure

Section 1945(a) of the Act describes three distinct types of health home provider arrangements from which a beneficiary may receive health home 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.

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. This list, therefore, is not an exhaustive

list. States may include additional providers in this category, meeting the criteria of subsection (5), including other agencies that offer behavioral health services. States should describe all designated providers in the proposed SPA, which is subject to CMS approval. As discussed in more detail below, each designated provider must have systems in place to provide health home services, and to satisfy certain qualification standards.

Section 1945(h)(6) of the Act contains examples of the providers comprising a "team of health care professionals," such as physicians and other professionals that may include a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State and approved by the Secretary, but this, too, is not an exhaustive list. These "teams of health care professionals" may operate in a variety of ways, such as free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary. The SPA should include a description of the composition of these teams.

Section 1945(h)(7) of the Act defines "health team" to have the same meaning given this term in section 3502 of the Affordable Care Act, titled "Establishing Community Health Teams to Support the Patient-Centered Medical Home." Section 3502(b)(4) of the Affordable Care Act requires the Secretary to define the health team, but also indicates that the team should be an interdisciplinary, inter-professional team, and that the definition must include the following providers: medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers (including mental health providers, and substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians' assistants.

We are interpreting the statute to allow States to choose which provider arrangement(s) to offer, and, if more than one option is offered, the beneficiary may choose among those options. We recognize that there is diversity in provider arrangements across the States. Regardless of the provider arrangement(s) a State may offer, CMS will expect the State to embed the criteria described in the provider standards below in its provider qualifications, and to be accountable for the providers adhering to and upholding those standards on an initial and ongoing basis.

Provider Standards

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 and does not compartmentalize aspects of the person, his or her health, or his or her well-being. We expect providers of health home services 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.

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Section 1945(b) of the Act requires the Secretary to establish standards for qualification as a designated provider for the purpose of being eligible to become a health home. Pending final guidance, CMS expects designated providers of health home services to address the functions listed below, which were informed by both the provider requirements defined within section 3502 of the Affordable Care Act and other well-established chronic care models. The State must describe in its SPA the methods by which it will support providers of health home services in addressing the following 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.

States are expected to describe the infrastructure in place to provide timely, comprehensive, high-quality health home services. A State with established medical home provider standards wishing to submit a SPA is requested to describe how its existing standards align with the key health homes expectations listed above, and/or have been modified to address the specific health home services.

Support for State Planning Activities

In order to provide assistance to States that would like to receive support in planning their health home SPAs, in accordance with section 1945(c)(3) of the Act, CMS will use title XIX funding to support State health home planning efforts at the State's regular, pre-Recovery Act, medical assistance service match rate. Since the purpose of the planning opportunity is to develop a SPA, such requests will only be considered prior to a State submitting a health home SPA to CMS.

Interested States should submit a *Letter of Request* of no more than two pages describing its health home planning activities, with an estimated budget for this non-competitive opportunity. The following categories would be considered by CMS as appropriate planning activities: the hiring of personnel or contractors to determine feasibility and develop the health home program; outreach initiatives to obtain consumer and provider feedback; training and consultation related to designing components of any provisions of the SPA; the development of systems for reporting and other infrastructure building tasks; and travel to accomplish such activities. A State may discover through its planning activities that a health home SPA is not feasible; under such circumstances, those planning activities are also reimbursable at the regular FMAP, in accordance with section 1945(c)(3)(B) of the Act.

Upon CMS approval of a State's *Letter of Request* outlining its health home planning activities, but not before January 1, 2011, we will authorize State applicants to spend up to $500,000 of title XIX funding for planning activities related to the development of a SPA. If a State believes that it will require in excess of $500,000 for this planning opportunity, it needs to send additional justification beyond the two-page *Letter of Request* and estimated budget to CMS for review and approval. If all States request funding above the $500,000 level, funds may be exhausted before all States have a chance to come in for this planning opportunity. A State must report its approved planning activities and subsequent expenditures on a separate expenditure line on the CMS-64.10. In accordance with section 1945(c)(3)(B) of the Act, this line will be programmed with each State's pre-Recovery Act medical assistance services matching rate. Therefore, for a State with a pre-Recovery Act FMAP of greater than 50 percent, its planning activities will be matched at the higher medical assistance service rate.

States will also be required to submit changes to their Cost Allocation Plans (CAP) to accommodate these health home planning activities. States could draw down the FMAP for planning activities before updating the CAP, as long as it is amended in a timely manner once the State obtains CMS approval for its health home planning activities. OMB Circular A-87, Attachment D, stipulates the following: State public assistance agencies are required to promptly submit amendments to the cost allocation plan to HHS for review and approval.

Letters of request should be sent via email to healthhomes@cms.hhs.gov. There is no deadline for submissions, however only expressions of interest are expected.

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Coordination with SAMHSA

Section 1945(e) of the Act requires States to consult and coordinate with SAMHSA in addressing issues of prevention and treatment of mental illness and substance use disorders for individuals who are low-income and/or have one or more chronic illnesses who are at greater risk of developing mental health and substance use disorders. In addition, individuals with mental health and substance use disorders, especially individuals with a serious mental illness, have significantly higher co-morbid conditions than the general population. When these chronic conditions go untreated, individuals often experience greater physical illnesses that require increased medical treatment, such as costly hospitalizations. Therefore, health home SPAs should address how the proposed approach will assure access to a wide range of physical health, mental health and substance use prevention, treatment, and recovery services. The approaches may include screening for alcohol and certain illegal drugs, identifying available mental health and substance abuse services, discharge planning, care planning that integrates physical and behavioral health services, person/family-centered treatment planning, referral and linkage to other specialty health and behavioral health treatment, and supports that promote recovery and resiliency.

As such, CMS is requiring States to consult with SAMHSA as they develop their approaches to health homes, prior to submitting their State plan amendments. States should send an e-mail to health.homes@SAMHSA.hhs.gov and include: a brief overview of the proposed design of the health home; the specific areas for the consultation; the State contact person; and State timeframes and availability for obtaining the consultation. SAMHSA will be sending letters to the States to further clarify the consultation process. CMS and SAMHSA also encourage States to coordinate with their State behavioral health authorities regarding efforts they are currently undertaking regarding primary care and behavioral health integration. It is important to note that, given the "whole person" approach to a health home, the behavioral health needs of individuals receiving services from a health home provider should be addressed through this model, regardless of the chronic conditions targeted by the State to determine eligibility into the health home.

State Monitoring Requirements

As described in more detail below, the impact of the health homes provision will be examined in both an interim survey of States and an independent evaluation. Both the Interim Survey and the Independent Evaluation will be subsequently followed by Reports to Congress. CMS expects States to collect and report information required for the overall evaluation of the health home model of service delivery, and recommends that States collect individual-level data for the purposes of comparing the effect of this model across sub-groups of Medicaid beneficiaries, including those that participate in the health home model of service delivery and those that do not. This evaluation, and the data gathered for it, will provide States with information that can help inform continued improvement of a State's health home model.

As part of the focus on continued improvement and evaluation, section 1945(f) of the Act requires States that implement these health homes to track avoidable hospital readmissions, calculate cost savings that result from improved coordination of care and chronic disease management, and monitor the use of health information technology to improve service delivery and coordination across the care continuum (including the use of wireless patient technology in improving coordination, management of care, and patient adherence to recommendations made by their providers). For the purposes of the overall evaluation, States are also expected to track emergency room visits and skilled nursing facility admissions.

States will be expected to describe in their SPAs the methods they will use to track, calculate, and monitor all of the above-mentioned monitoring requirements. However, in order to obtain comparable data for the evaluation, CMS plans to provide standardized methodologies for tracking avoidable hospital readmissions and calculating cost savings.

Prior to the availability of standardized methodologies, CMS encourages States to consider the following as they develop their SPAs and determine their preliminary methodologies for tracking avoidable hospital readmissions and calculating cost savings:

- In tracking avoidable hospital readmissions, States are encouraged to consult measures endorsed by the National Quality Forum. States should consider constructing a denominator that counts the total number of hospitalizations for common conditions within the Medicaid population, and a numerator that counts the total number of hospitalizations within the denominator that were followed by another hospitalization within 30 days of the previous hospital stay discharge. For both the denominator and the numerator, a transfer from one acute care hospital to another acute care hospital should be counted as one hospitalization rather than two separate stays. For the purposes of comparison, States should consider calculating hospital readmission rates for health home beneficiaries and a comparable population of non-health home beneficiaries.

- In calculating cost savings, States are encouraged to first define a comparison group. States may consider constructing a pre-/post-comparison of health home beneficiaries or an alternative comparison group of non-health home beneficiaries with similar chronic conditions and characteristics. States are also encouraged to construct a calculation of cost savings that includes a tabulation of all Medicaid expenditures incurred for the health home group and the comparison group.

Quality Measure Reporting Requirements

In order for the State and its participating providers to assess progress, section 1945(g) of the Act requires designated providers of health home services to report to the State on all applicable quality measures as a condition for receiving payment. When appropriate and feasible, quality measure reporting is to be done through the use of health information technology.

As mentioned above, CMS plans to allow States to choose which health home provider arrangement(s) to offer. States may choose to offer health home services through a designated provider, a team of health care professionals, and/or a health team. The quality measure reporting requirements for health homes apply only to designated providers and the team of health care professionals, which is comprised of at least one designated provider. The quality measure reporting requirements for the health team provider arrangement are separately identified in section 3502 of the Affordable Care Act, and include the collection and reporting of data on patient outcomes, including the collection of data on patient experience of care. States planning to operate a health team provider arrangement, in addition to one or more of the other provider arrangements authorized in section 2703 of the Affordable Care Act, are expected to describe in their SPAs how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Act.

CMS will provide further guidance on these reporting requirements. In consultation with States and others, we plan to provide States with a core set of quality measures for assessing the health home model of service delivery. CMS expects the core set to include quality measures that assess individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes. CMS is currently working to align: (1) the mandatory quality measure reporting requirements included within section 401 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA); (2) the voluntary quality measure reporting requirements within section 2701 of the Affordable Care Act; and (3) the mandatory quality measure reporting requirements within section 3502 of the Affordable Care Act.

Until such time that CMS releases a core set of quality measures, States are expected to define the measures they plan to use to assess their health home model of service delivery. The measures are expected to capture information on clinical outcomes, experience of care outcomes, and quality of care outcomes specific to the provision of health home services.

Evaluation

Section 2703(b)(2) of the Affordable Care Act requires the Secretary to survey States that have elected the health home option not later than January 1, 2014, for the purpose of preparing an Interim Report to Congress. States will be required to report to CMS on the nature, extent, and use of the health home model of service delivery, particularly as it pertains to: hospital readmission rates; chronic disease management; coordination of care for individuals with chronic conditions; assessment of program implementation; processes and lessons learned; assessment of quality improvements and clinical outcomes; and estimates of cost savings.

Section 2703(b)(1) of the Affordable Care Act requires the Secretary to enter into a contract with an independent entity or organization to conduct an evaluation and assessment of States that have elected the option to provide a health home model of service delivery. Not later than January 1, 2017, the Secretary is required to submit a Report to Congress on the independent evaluation and the effect of this model on reducing hospital readmissions, emergency room visits, and admissions to skilled nursing facilities. States are required to cooperate with the entity/organization conducting the independent evaluation and assessment. CMS will provide

subsequent guidance on the evaluation design to States implementing the health home model of service delivery.

We look forward to working with States, individually and collectively to provide assistance and to facilitate collaboration in implementing this new Medicaid State plan option. CMS would like to reiterate that this option is but one tool in a broader arsenal that States can use to improve service delivery for all people, not just those with chronic conditions or those covered by Medicaid. States interested in this option may develop a stand-alone initiative or embed it into a broader effort that promotes the goals of the health home.

If you have any questions, please contact Ms. Barbara Edwards, Director of the Disabled and Elderly Health Programs Group, at 410-786-0325. Questions or comments may also be submitted to the health home mailbox, at healthhomes@cms.hhs.gov.

Sincerely,

/s/

Cindy Mann
Director

Attachment

cc:
CMS Associate Regional Administrators
Division of Medicaid and Children's Health

Rick Fenton
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