NYAHSA | New York Association of Homes & Services for the Aging

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M E M O R A N D U M

TO: All Members

FROM: Patrick Cucinelli, Senior Director of Public Policy Solutions

DATE: February 15, 2011

SUBJECT: **Health Homes**

ROUTE TO: Administrator/Director, Medical Director, Director of Planning

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ABSTRACT: NYAHSA provides members with latest developments on health homes.

Introduction

The Centers for Medicare and Medicaid Services (CMS) has released initial guidance on the development of *health homes* in their state Medicaid director letter SMDL # 10-024/ACA #12. This letter focuses on the implementation health homes under the *Patient Protection and Affordable Care Act* and the *Health Care and Education Reconciliation Act of 2010*, together known as the *Affordable Care Act* (ACA). More specifically, this letter discusses the implementation of section 2703 of the Affordable Care Act, entitled "State Option to Provide Health Homes for Enrollees with Chronic Conditions." The concept of health homes is also featured on the CMS Center for Medicare and Medicaid Innovation (CMMI) Web site.

From NYAHSA's discussions with the Medicaid Redesign Team (MRT) and our monitoring of the proceedings of the team, it is clear that a significantly increased emphasis on care coordination and models like the health home and the current *Medicaid Medical Home* concept are going to play a prominent role in the state's plans to restructure our Medicaid system.

NYAHSA is offering this guidance to encourage our members to consider options in this area. Many of our members already have models in place that could likely be transitioned into the home health concept; many members may be looking to partner with other providers to develop such models; and other members may be just starting to explore options. In any case, this is an important area that all long-term care providers need to be following.

Background

Section 2703 of the ACA establishes a program to support states' in developing health homes for Medicaid recipients with chronic conditions and/or mental health diagnoses. Part of the incentive

for states is an enhanced Federal Medical Assistance Percentage (FMAP) of 90 percent over two years. Part of the enhanced FMAP is designed to go towards increased provider payments, similar to what occurs under the current *Medicaid Medical Home* program here in New York.

The terminology is a little fluid at this point with the terms health home, medical home and the patient centered medical homes (PCMH) being used somewhat interchangeably, although there are subtle distinctions between them. In general, all these concepts provide for more coordinated health care, improved the quality of care, enhanced access to preventative care, and the potential for an overall reduction in the costs. They essentially serve as the manager of their patients' treatment, coordinating all aspects of the patient's medical care.

Health home providers have to date been primarily physician groups or clinics, but new models are emerging that provide for considerable flexibility in the design and may open greater opportunities for our members. **Should the concept fully develop, adopting some aspect of the health home model or partnering with one may become a critical operating strategy for many chronic care providers.**

It is noteworthy that the CMS guidance letter specifically states:

> *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.*

The goals of a health home are to expand access to health care, improve health outcomes, increase patient satisfaction, reduce expenditures, and decrease duplication of services and re-hospitalizations. Included in the basic operational features of a health home are:

- patient tracking and registry functions;
- care management;
- access and communication;
- patient self-management support;
- electronic prescribing;
- test tracking;
- referral tracking;
- performance reporting and self improvement; and
- Electronic data interchange.

Accreditation: These features were developed by physician groups working with the National Committee for Quality Assurance (NCQA), which is the principle accrediting body for health home models, including the New York *Medicaid Medical Home* program. For example, under the New York Medicaid Medical Home (which predates the ACA provisions) providers undergo a voluntary credentialing process with reimbursement rates tied to three levels of compliance.

Target Populations: Section 2703 of the ACA identifies individuals with specific chronic conditions that could be enrolled in a health home initiative, including:

- Mental health condition

- Substance abuse
- Asthma
- Diabetes
- Heart disease
- Overweight, as evidenced by having a Body Mass Index (BMI) over 25

In addition, recipients must meet one of the following criteria:

- 2 chronic conditions;
- 1 chronic condition and is at risk of having a second chronic condition; or
- 1 serious and persistent mental health condition.

Health Homes for the Geriatric Population

One example of a health home that caters specifically to geriatric patients is Massachusetts General Hospital Senior Health. On Dec. 17, 2010, Massachusetts General Hospital Senior Health, a practice within the Geriatric Medicine Unit, was recognized as a Level 3 PCMH by NCQA. Senior Health provides geriatric primary care for adults over the age of 65 through the use of clinical teams. The Senior Health clinical team includes specialists in geriatric medicine, geriatric psychiatry, rehabilitation medicine, geriatric nursing, and social work that work together to develop a comprehensive care plan for each patient. Physicians work closely with teams that include nurse practitioners, social workers, geriatric psychiatrists, and pharmacists.

Senior Health focuses on preventive care, health maintenance, and helping patients and their families manage multiple chronic conditions, functional limitations, and cognitive impairment. The clinical teams follow clients throughout the continuum of care and are supported by health information technology. For example, patients that require post hospital care in a rehabilitation facility, skilled nursing facility, hospice facility, or at their home will continue to be visited and treated by the Senior Health clinical teams in those settings. Patients are also able to log into their "Patient Gateway" and view lab results, communicate via email with physicians, and make appointments.

More information about Senior Health is available by clicking here.

Health Home Certification Process

Many states, including New York, have adopted the NCQA guidance and certification of health homes for demonstration programs and other initiatives. The NCQA has developed a set of comprehensive standards and assessment tools through its PCMH Program.

The NCQA recognizes three different levels of PCMH. Physician practices are evaluated across nine standards that are scored on a scale from 0 to 100 points. The nine standards have several components in addition to 10 must pass elements. Physician practices must score at least 25 points and reach a minimum of a 50% scoring level for each must-pass element to be recognized as a Level 1 PCMH. Level 2 recognition requires a score of 50-74 points and a 100% score on must-pass elements. Level 3 recognition requires a score of 75-100 points and a 100% score on must-pass elements.

State Options

Beginning Jan. 1, 2011, states have the option to provide health home services to Medicaid enrollees with chronic conditions, as authorized by the ACA. As noted above, states receive a 90 percent

FMAP for two years for health home-related services. A state will specify the methodology that it will use for determining payment for the provision of health home services. Payment methodology is not limited to per-member per-month payments and alternative models of payment may be used, subject to approval by the federal Secretary of Health and Human Services. Payment may also be tiered to reflect the severity of an individual's chronic conditions or the capabilities of the providers.

Providers that may qualify as a designated health home provider include 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.

Member Support

We are especially interested in hearing from members who have already been involved with health homes or have models in place that could fall under the heading of a health home. NYAHSA is looking to set up opportunities for members to share information and learn from each other as New York's long-term care sector embarks upon this new initiative. Any resources that you have found helpful would also be important to share. Please contact me with any information you think would be helpful to share, or ideas on how NYAHSA should be assisting members.

Conclusion

It is clear from both federal and state initiatives that the health home concept will likely play a significant role in the reform or redesign of chronic care services. While many of the details are still to be worked out, and much will depend on the outcome of the current MRT process, providers need to be aware of these developments. We anticipate that almost all of our members will be impacted by the health home concept. Many chronic care providers will see opportunities in either adopting the health home model or partnering with one. Even providers who choose not to become directly involved in the process will likely have to begin dealing with a health home provider, similar to the way in which providers had to begin to contract with HMOs back in the late 90's.

NYAHSA is closely monitoring these developments and will be providing our members with the latest information on a state and national level. As this initiative evolves, we will be looking to develop additional resources, including educational opportunities and direct member involvement.

Please contact me with any questions at pcucinelli@nyahsa.org or call 518-867-8827.

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