WEBINAR

Children and the Medicaid Health Home State Plan Option (Section 2703) of the Affordable Care Act

In partnership with and supported by the Health Resources and Services Administration Maternal and Child Health Bureau

We will begin shortly.
Brief Notes About the Technology

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Today’s call will be recorded.
About the Presenters

**Moderator:** Karen VanLandeghem, AMCHP and Meg Comeau, The Catalyst Center

**Welcoming Remarks:** Michael Fraser, CEO, AMCHP; Marie Mann and Lynda Honberg, MCHB/HRSA

**Presenters:**
- **Mary Takach**, National Academy for State Health Policy
- **Mary Pat Farkas**, Division of Integrated Health Systems, Disabled and Elderly Health Programs Group, Center for Medicaid, CHIP, and Survey & Certification, Centers for Medicare & Medicaid Services
- **Deborah Florio**, Center for Child and Family Health, Rhode Island Department of Human Services, and **Deborah Garneau**, Office of Children with Special Health Care Needs, Rhode Island Department of Health
Delivery Models that Support Vulnerable Populations

Children and the Medicaid Health Home State Plan Option (Section 2703) of the Affordable Care Act

December 7, 2011

Webinar supported by AMCHP and Catalyst Center in partnership with Health Resources and Services Administration Maternal and Child Health Bureau

Mary Takach, MPH, RN
National Academy for State Health Policy
Program Director
NASHP

- 24-year-old non-profit, non-partisan organization
- Offices in Portland, Maine and Washington, D.C.
- Academy members
  - Peer-selected group of state health policy leaders
  - No dues—commitment to identify needs and guide work
- Working together across states, branches and agencies to advance, accelerate and implement workable policy solutions that address major health issues
A Few NASHP Projects Supporting States on Medical Homes and Primary Care

- The Commonwealth Fund: Advancing Medical Homes in Medicaid
  - Round I 2007-2009 (CO, ID, LA, MN, NH, OK, OR, WA)
  - Round II 2009-2010 (AL, IA, KS, MD, MT NE, TX, VA)
  - Round III 2011-2012 (AL, CO, MD, MA, MI, MN, NM, NY, NC, OK, OR, RI, VT, WA)

- Centers for Medicare and Medicaid Services
  - With RTI, evaluation for the multi-payer Medicare Advanced Primary Care Practice Demonstration
  - With NORC, interim evaluation to Congress for Section 2703 Health Homes

- US Department HHS Health Resources and Services Administration (HRSA) 2011-2014
  - National Organization of State and Local Officials Cooperative Agreement to engage Medicaid Directors and HRSA grantees
Presentation goals

- Discuss the kinds of delivery models that are being implemented in states—in “evolutionary order”
- Discuss how ACA Section 2703 Health Homes can support the development and improvement of all phases of these models
Seventeen “Leading” Medical Homes States


Support for this research came from The Commonwealth Fund.
Patient Centered Medical Homes

Key model features:

- Multi-stakeholder partnerships
- Qualification standards aligned with new payments
- Data & feedback
- Practice Education
- Health Information Technology

Graphic Source: Ed Wagner. Presentation entitled “The Patient-centered Medical Home: Care Coordination.” Available at:

www.improvingchroniccare.org/downloads/care_coordination.ppt
Expanding the medical home model

Making room for teams and new services

Key model features:

- Dedicated care coordinators
- Integrated primary care/behavioral health services
- Multi-disciplinary community health teams
- Shared services
Neighborhood models

Key model features:
- Community-based team members
- Provider criteria emphasizing/requiring linkages to other providers
- Referral to community & social services
- Individual & family support
- Data sharing & information exchange
Integrated delivery models

Key model features:
- Central management
- Community or regional networks
- High-performing primary care providers
- Population management tools
- Health information technology & exchange
- Shared goals & risk
ACA Section 2703 is spurring new state interest and activity

- Patient Centered Medical Homes
- Expanded medical homes
- Medical home neighborhoods
- Integrated delivery systems
Closing thoughts

- Do your homework: know your state, know other states
  - www.nashp.org
  - www.statereforum.org
  - www.pcpcc.net
  - mtakach@nashp.org

- Most states are considering Health Home 2703 SPAs. Stakeholder groups offer opportunities for input.

- Stay posted for other opportunities from ACA
Section 2703: State Option to Provide Health Homes for Enrollees with Chronic Conditions

Division of Integrated Health Systems
Disabled and Elderly Health Programs Group
Center for Medicaid, CHIP, and Survey & Certification
Centers for Medicare & Medicaid Services
A goal of implementing Section 2703 will be to expand upon the traditional and existing medical home models to build linkages to community and social supports, and to enhance the coordination of medical, behavioral, and long-term care.

Health Home is a new Medicaid State Plan Option that provides a comprehensive system of care coordination for Medicaid individuals with chronic conditions.

Health Home providers will coordinate all primary, acute, behavioral health and long term services and supports to treat the “whole-person”.
Section 2703 adds section 1945 to the Social Security Act to allow States to elect this option under the Medicaid State plan.

The provision offers States additional Federal support to enhance the integration and coordination of primary, acute, behavioral health, and long-term care services and supports for Medicaid enrollees with chronic conditions.

The effective date of the provision is January 1, 2011.

States can access Title XIX funding using their FMAP rate methodology to engage in planning activities aimed at developing and submitting a State plan amendment.

- Cannot exclude Duals or target by Age
- Waiver of comparability 1902(a)(10)(B)
- Waiver of statewideness 1902(a)(1)
Eligibility Criteria

- Medicaid eligible individual having:
  - two or more chronic conditions,
  - one condition and the risk of developing another,
  - or at least one serious and persistent mental health condition.
Chronic Conditions in 2703

• The *chronic conditions* listed in statute include:
  – mental health condition,
  – substance abuse disorder,
  – asthma,
  – diabetes,
  – heart disease, and
  – being overweight (as evidenced by a BMI of > 25).

• Through Secretarial authority, States may add other chronic conditions in their State Plan Amendment for review and approval by CMS.
Health Home Services

- Comprehensive Care Management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care from inpatient to other settings;
- Individual and family support;
- Referral to community and social support services;

- Use of health information technology, as feasible and appropriate.
There are three distinct types of health home providers that can provide health home services:

- designated providers,
- a team of health care professionals, and
- a health team.
Health Home Providers

As noted in the November 16, 2010 SMD letter Health Home providers are expected to address several functions including, but not limited to:

- Providing quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
- Coordinating and providing access to high-quality health care services informed by evidence-based guidelines;
- Coordinating and providing access to mental health and substance abuse services;
- Coordinating and providing access to long-term care supports and services.
Enhanced Federal Match

There is an increased federal matching percentage for the health home services of 90 percent for the first eight fiscal quarters that a State plan amendment is in effect.

The 90 percent match does not apply to other Medicaid services a beneficiary may receive.
Enhanced Federal Match

- A State could receive 8 quarters of 90% FMAP for health home services provided to individuals with chronic conditions, and a separate 8 quarters of enhanced FMAP for health home services provided to another population implemented at a later date.

- Additional periods of enhanced FMAP would be for new individuals served through either a geographic expansion of an existing health home program, or implementation of a completely separate health home program designed for individuals with different chronic conditions.

- It is important to note that States will not be able to receive more than one 8-quarter period of enhanced FMAP for each health home enrollee.
Reporting Requirements

Provider Reporting
• Designated providers of health home services are required to report quality measures to the State as a condition for receiving payment.

State Reporting
• States are required to collect utilization, expenditure, and quality data for an interim survey and an independent evaluation.

Reports to Congress
• Survey of States & Interim Report to Congress 2014
• Independent Evaluation & Report to Congress 2017
Status of Health Home SPAs

States with Approved SPA as of 12/1/11:

- Missouri (one Approved SPA - CMHCs)
- Rhode Island (two Approved SPAs)

States with SPAs on the Clock:

- Oregon
- Missouri’s – 2nd SPA
- Washington
- North Carolina
- New York

13 States Approved Health Home Planning requests:

Arizona, West Virginia, Mississippi, Arkansas, Nevada, New Jersey, New Mexico, North Carolina, California, Washington, Idaho, Alabama, Wisconsin
Next Steps

• CMS is providing technical assistance to States interested in submitting a State plan amendment.

• CMS will be engaging in rapid learning activities to prepare for the release of well-informed regulations.

• CMS will continue to collaborate with Federal partners, including SAMHSA, ASPE, HRSA, and AHRQ, to ensure an evidence-based approach and consistency in implementing and evaluating the provision.
Additional Information

- Health Homes mailbox for any questions or comments - healthhomes@cms.hhs.gov or contact the Integrated Care Resource Center at www.integratedcareresourcecenter.com for TA

- 11/16/10 Health Homes State Medicaid Director Letter
  http://www.cms.gov/SMDL/SMD/list.asp

- 12/23/10 CMCS Informational Bulletin on Web-Based Submission Process for Health Home SPAs contact Health Homes mailbox.
Rhode Island CYSHCN Services & Supports

AMCHP and The Catalyst Center
Children and the Medicaid Health Home State Plan Option

December 7, 2011

Deborah Garneau, Special Needs Director
Division of Community, Family Health & Equity
Rhode Island Department of Health
Email: deborah.garneau@health.ri.gov; Phone: 401-222-5929
CYSHCN in RI

VT: 15.0
CT: 16.0
MA: 16.4
NH: 16.6
RI: 17.2
ME: 17.7
US: 13.9
CYSHCN in RI

- Role of Title V CYSHCN Program
  - No Direct Service
  - Quality Assurance to larger system of care
  - Support families of CYSHCN

- Direct Service Providers
  - High Health Insurance Rates
  - Medicaid Managed Care – RItteCare
  - Certified Provider Contracts
Title V & Health Homes

The PPEP Initiative


- Employing Family Resource Specialists in Pediatric Primary and Specialty Care Practices to link families with community and state resources
Title V & Health Homes

Family Leadership Development Initiative
- Supporting families employed as family liaison workers, system navigators, peer resource specialists
- [http://www.ripin.org/fldi.html](http://www.ripin.org/fldi.html)

Interdepartmental Program Oversight
- Department of Human Services / OHHS
- Department of Health
- Department of Education
- Department of Children, Youth & Families
Rhode Island Health Home Initiative

AMCHP and The Catalyst Center
Children and the Medicaid Health Home State Plan Option

December 7, 2011

Deborah J. Florio, Administrator
Medicaid Division
Rhode Island Executive Office of Health and Human Services
Why These Populations?

- Both populations (CYSHCN and SPMI) have complex medical, behavioral health and psychosocial needs
- Both are at greater risk of developing secondary conditions than the general Medicaid population
- Both have higher utilization of Emergency Department and Inpatient Care
- 7,000+ adults with SPMI and 12,000+ CYSHCN
Why These Populations (cont’d)

- Some Infrastructure already in place
  - Community Mental Health Centers (CMHOs) (Adults with SPMI)
  - CEDARR Family Centers (CFCs) (CYSHCNs)
- Opportunity for further innovation
- Promote natural transitions between child and adult systems of care
Other Opportunities

- Harness unique capabilities of CMHOs and CFCs “boots on the ground”
- Enhance connections between Health Homes and PCPs and specialists
- Take advantage of data collected by Medicaid Managed Care Organizations (MCOs) and Medicare claims to inform delivery of care
CEDARR Family Centers for Children and Youth with Special Health Care Needs

- Comprehensive, Evaluation, Diagnosis, Assessment, Referral and Re-evaluation

- Started in 2000

- Teams led by Licensed Clinicians (LICSW, RN, Psychologist)

- Family Centered Practice Approach

- Statewide Coverage

- 95% of work done in Child’s home or in a community setting
History of CEDARR

- Launched as part of a broader initiative to address the needs of CYSHCN and their families

- Broad based stakeholder involvement in entire development and implementation process (advocates, family members, providers, state agencies)
Goals of the CEDARR Initiative

- Decrease fragmentation within and between the systems serving children with special health care needs and their families through care management including the coordination and integration of services

- Assure that services are provided through a strength-based and person-oriented system of care

- Support families to their fullest potential and provide direct services, where necessary

- Assure a flexible and responsive delivery system with adequate staffing, equipment and educational resources
CEDARR Today

- Approximately 2,700 children and youth enrolled at any point in time
- Birth to 21 Years of age
- 30% Developmental Disabilities, 50% Behavioral Health, 20% Physical Health conditions
CEDARR Responsibilities

- Assessment of Need
- Identification of, and referral to resources
- Integration of services provided through different systems (LEA, Medicaid Fee-for-Service, Medicaid Managed Care, Child Welfare)
- Oversight of Medicaid Fee-for-Service specialized Home and Community based services
- Re-Assessment and adjustment of Treatment Plans on an annual basis
Why CEDARR as a Health Home?

- Required Home Health Services is the core foundation of CEDARR
  - Comprehensive Care Management
  - Care Coordination and Health Promotion
  - Transitional Services
  - Individual and Family support
  - Referral to Community and Social Support Services

- 95% of current population meets HH diagnostic criteria
Enhancements to CEDARR practice as a result of Health Homes

- Enhanced screening for secondary conditions (yearly BMI and Depression screening)
- Additional re-imbursement to PCP’s to engage in Care Planning and dashboard report developed to share CEDARR information with PCPs
- Enhanced Information sharing between CEDARR and Medicaid Managed Care Plans
CEDARR Rate Development Process

Primary Factors Considered
- The average number of hours of effort required of the CEDARR Family Center service team in order to perform the specific service
- The relative contribution to the total effort by various team members
- The qualification requirements of various staff members and the associated prevailing wages for such personnel
- Adjustments for the cost of benefits
- Adjustments for net efficiency or “billability”
- Allocation for overhead

Flat Rates were developed for three CEDARR Services;
- Initial Family Intake and Needs Assessment (IFIND),
- Family Care Plan development (FCP), and
- Family Care Plan Review (FCPR).

<table>
<thead>
<tr>
<th>Service</th>
<th>Clinician ($66.50/hr) (Hrs.)</th>
<th>FSC ($38/hr) (Hrs.)</th>
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<tr>
<td><strong>IFIND ($366.00)</strong></td>
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<td></td>
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<tr>
<td>Travel</td>
<td>0.75</td>
<td>0.75</td>
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<tr>
<td>Meeting time w/family inc. Work Plan &amp; Crisis Plan</td>
<td>1.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Prep and follow up activities</td>
<td>1.25</td>
<td>1.25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3.5</strong></td>
<td><strong>3.5</strong></td>
</tr>
<tr>
<td><strong>FCP ($347.00)</strong></td>
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<td></td>
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<tr>
<td>Travel</td>
<td>0.75</td>
<td>0.75</td>
</tr>
<tr>
<td>Meeting time w/family</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Follow up activities</td>
<td>0</td>
<td>1.25</td>
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<tr>
<td>Plan Development</td>
<td>1.75</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
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<td><strong>3.0</strong></td>
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<tr>
<td><strong>FCPR ($397.00)</strong></td>
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<tr>
<td>Travel</td>
<td>0.75</td>
<td>0.75</td>
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<tr>
<td>Meeting time w/family</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Follow up activities</td>
<td>0</td>
<td>1.25</td>
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<tr>
<td>Plan Review and Revision</td>
<td>2.5</td>
<td>0</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>4.25</strong></td>
<td><strong>3.0</strong></td>
</tr>
</tbody>
</table>
Other CEDARR Services:

**Health Needs Coordination:** Per 15 minutes of effort, two rates based upon qualifications

- Masters Degree and above- $16.63 per unit ($66.52 per hour)
- Less than Masters Degree- $9.50 per unit ($38.00 per hour)

**Therapeutic Consultation:** Per 15 minutes of effort, performed by Clinician $16.63 per unit ($66.52 per hour)
How will we measure success?

Traditional Methods

- Decrease in ED utilization for ACS Conditions
- Reduction in Re-Admissions
- Provision of services within required time frames
- Medical follow-up after ED visit
- HH Services provided within required time-frames
- Collaboration between PCP and/or MCO in development of Care Plan
How will we measure success? Cont’d

➢ Outcomes Based measurements

➢ Child/Youth/Family Satisfaction with service delivery, content of services, appropriateness of interventions

➢ Child and Family Outcomes

- Knowledge of Condition and available services and resources
- Child’s participation in age appropriate, peer group activities
- Ability of family to engage in “normal family activities”
Engagement with Federal Partners

Process followed

- SMD Letter issued November 2010
- Internal Discussion and Identification of service models December and January
- Draft SPA submitted April 2011
- Final SPA submitted August 26
- SPA Approval November 23, 2011
  - RI is the second state in the nation with Health Home approval
  - RI is the first state in the nation to receive Health Home approval focused on children with chronic conditions

Federal partnership throughout the process

- Multiple conference calls with CMS HH Team on:
  - Services
  - Program Design
  - Rate Methodology
  - Quality and Measurement
- Conference Call with SAMHSA
Next Steps for Implementation

- Engage Physician Champion
- Amendment to certification standards
- Training of CEDARR Staff
- Outreach to Pediatricians
- Outreach to Acute Care Facilities (Medical and Psychiatric)
Thank you

Questions

Contact Information:
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Selected National Resources

• **Association of Maternal and Child Health Programs** at [www.amchp.org](http://www.amchp.org)

• **The Catalyst Center** at [http://hdwg.org/catalyst/](http://hdwg.org/catalyst/)

• **Centers for Medicare and Medicaid Services** at [www.cms.gov](http://www.cms.gov)
Selected National Resources


- Health Resources and Services Administration, Maternal and Child Health Bureau at [www.mchb.hrsa.gov](http://www.mchb.hrsa.gov)
  - *Collaboration and Action: A Toolkit for State Policymakers*

- The National Academy for State Health Policy at [www.nashp.org](http://www.nashp.org)


- The Patient Centered Primary Care Collaborative at [http://www.pcpcc.net/](http://www.pcpcc.net/)
Thank You!

We appreciate your participation today and value your feedback.

At the end of this webinar, you will be directed to a brief evaluation.