Section 2703 Health Homes and Health Centers: Providing Care for Chronic Conditions

Emerging Issues #9

NATIONAL ASSOCIATION OF Community Health Centers

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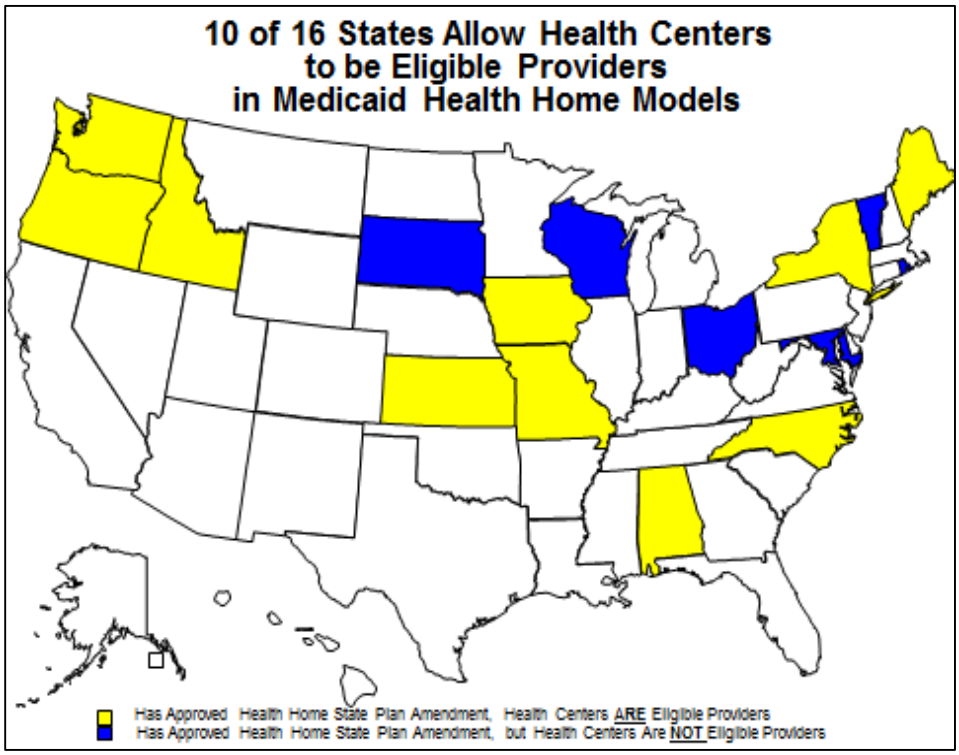
Introduction

As the prevalence of chronic conditions rise and health care costs continue to increase, state policymakers are under pressure to reform their state health care delivery systems. The Medicaid Health Home State Plan Option, authorized under the Affordable Care Act (Section 2703), provides States an opportunity for reform. The Health Home State Plan Option allows states to design health homes to specifically provide comprehensive care coordination and disease management for Medicaid beneficiaries with chronic conditions.[1]

Not to be confused with patient-centered medical homes (PCMH), health homes are specifically for Medicaid beneficiaries with chronic illnesses and have a strong focus on behavioral health care, social supports and services and the use of health information technology. However, patient-centered medical homes have provided a useful framework for health home models by increasing the breadth of providers and support services available to the beneficiaries. The PCMH model is designed to improve quality of care through care coordination, comprehensive care, increasing access to services, and partnering with patients and their families in their own care.[2] Since 2011, the Health Resources and Services Administration (HRSA) has supported health centers in their efforts to achieve PCMH recognition, and as of 2014, 54% of health centers have been recognized as PCMHs.[3] Through the Accreditation and Patient Centered Medical Home Recognition Initiative, HRSA provides resources for health centers to achieve health care accreditation and PCMH recognition through nationally recognized organizations such as the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the National Committee for Quality Assurance. As many of the components of the Section 2703 state option align with the PCMH model, states and health centers can leverage and build upon these existing efforts as they develop their health home initiatives.

[1] 42 U.S.C. Sec. 1396w-4(h)(2); http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf
[2] http://www.pcmh.ahrq.gov/page/defining-pcmh
[3] http://bphc.hrsa.gov/policiesregulations/policies/transcriptstandardsandaccredidation.PDF



As of November 2014, sixteen states have approved Medicaid health home models: AL, ID, IA, KS, ME, MD, MO, NC, NY, OH, OR, RI, SD, WA, WI, VT.[4] Some states have submitted multiple models to target different populations or phase-in regional implementation. For example, Iowa has an approved state plan amendment (SPA) that targets patients with "two chronic conditions", adding hypertension to the definition in the statute, and another that targets patients with "severe and persistent mental illness" in five counties. Ten of the sixteen states have recognized the importance of Federally Qualified Health Centers (FQHCs) and have deemed them eligible providers according to the 2014 Annual NACHC State Policy Survey of state primary care associations.[5]

In the six states where FQHCs are not participating in the health home program, the major reason is the state has targeted beneficiaries with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) because these services are outside the health center's scope of services. In Ohio, FQHCs are not eligible but are partnering with health home providers to provide primary care services.

Health Home Providers

States must provide six core services: care management; care coordination; health promotion; comprehensive transitional care and follow-up; individual and family support; and referral to community and social support services. Health home services may be provided by a designated provider or a team of health care professionals. Providers use patient-centered planning and coordination/integration of services to reduce care fragmentation. FQHCs' comprehensive team-based model may be used to extend beyond the traditional scope of primary care to include the core health home services as well as mental health and substance abuse.

Funding and Payment

Participating states receive a 90% enhanced Federal Medical Assistance Percentage (FMAP) for the health home services for the first eight quarters that the state plan amendment (SPA) is in effect. However, if there is a delay in implementation, the start date for claims received could be different from the effective date of the SPA. There is no deadline for states to submit a health home SPA to receive this enhanced match.[6] States have the flexibility in designing health home payment methodologies. States are also able to adjust health home payments to reflect patient complexity. According to the 2014 NACHC survey, seven states where health centers are eligible providers use a per-

[4] http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/hh-spa-at-a-glance-3-19-14.pdf

[5] NACHC conducted a survey of primary care associations in 50 states and the District of Columbia in July 2014. Respondents included PCA Directors and policy staff.

[6] CMS Letter to State Medicaid Directors, Re: Health Homes for Enrollees with Chronic Conditions, November 16, 2010, available at http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf.

member per-month payment. In Kansas, the Managed Care Organizations (MCOs) are given autonomy to establish payment agreements and thus far FQHCs are only contracted to provide primary care but not to provide health home services. Alabama FQHCs are eligible providers but do not participate because state funding needed to draw the federal match is not available for FQHCs.

Important Considerations for Health Centers

When asked to identify any barriers or challenges when participating in health home initiatives in the 2014 NACHC survey, several opportunities for improvement were identified by state primary care associations. For many of the state respondents, reducing the administrative burden around reporting would address a significant challenge for health centers. Other important considerations for health centers include:

- **Professional Licensing and Staffing Issues:** In some states, the design of the program is inconsistent with provider licensing. For instance, a health home can only be led by physician clinicians other than in rural or frontier areas even though other types of clinicians are allowed to function as primary care providers with indirect oversight by a physician. Another issue that has arisen is the requirement for licenses to provide some of the behavioral health aspects of the health home model since FQHCs are not licensed as mental health agencies and these may go beyond the scope of a health center's practice. States may consider developing more flexible language with regard to providers who may be able to participate in health home initiatives or staffing requirements to allow greater participation of health center providers.

- **Quality Measurement Reporting**: Health Home providers are required to report quality measures to the State as a condition for receiving payment. These measures are intended to help the State and Federal government and others learn how the health home intervention may be affecting the quality of care beneficiaries receive. Two issues that have emerged are the transmission of data, and the reporting of quality measures. Specifically, FQHCs in several states had issues interfacing or connecting with the state Health Information Exchange to pull or report outcome data on measures in order to receive bonus payments. There is a need to invest in developing systems that would allow providers to share and analyze health information securely and effectively. FQHCs may also be overburdened with reporting any quality measures that do not align with other quality improvement initiatives. In a letter to State Medicaid Directors, CMS has outlined where core quality measures are aligned with other CMS programs or with the National Quality Forum measures.[7] Furthermore, health centers may also be reporting quality measures for other purposes that include federal reporting requirements and participation in other programs. Technical assistance to health centers and improved coordination with state data systems may be helpful, as well as national initiatives to standardize or align quality measurement reporting.

- **Competition and Coordination:** Multiple health home models in a State where some providers are eligible for one model but not the other may lead to providers competing against each other. Instead of strengthening the safety net and increasing care coordination, a competitive environment is created where FQHCs and Community Mental Health Centers compete for patients that may be eligible for both models, but can only be enrolled in one. However, in some cases, health centers that may not be eligible providers based on the focus of the state's health home program, may be able to partner with eligible providers to provide primary care services, or other needed services to improve health outcomes. Encouraging collaborative efforts in the design of health home programs to address all the needs of the patient may lead to greater coordination between different health home providers.

[7] CMS Letter to State Medicaid Directors, Re: Health Home Core Quality Measures, January 15, 2013, available at http://www.medicaid.gov/federal-policy-guidance/downloads/smd-13-001.pdf.

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