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First "Health Home" Program Gets CMS Approval
Arkansas Looking in Same Direction

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The first health home program to get approval from the Centers for Medicare and Medicaid Services offers an important roadmap for similar efforts in Arkansas, including methods for reimbursing providers. Mental health and developmental disabilities providers as well as primary care physicians and nurses play crucial roles in this model.

The Centers for Medicare and Medicaid Services (CMS) approved the Missouri program (called "Healthcare Homes") in a letter dated October 20, 2011, accompanied by a press release and news conference. The approval means that for those beneficiaries with qualifying chronic conditions, the federal government will pay 90% of their health home services for two years starting January 1, 2012. After that, the regular state-federal match will apply.

The Missouri program is the first one approved under Section 2703 of the Affordable Care Act. Arkansas Medicaid received a $500,000 planning grant under this same section of the Act back in February. The state has brought in a consultant and is in the process of hiring a health homes planning coordinator. Health homes are a popular concept, with pilots underway in the private sector as well.

The Missouri program includes several methods of reimbursement to providers for health home activities -- activities that payers do not traditionally reimburse. It also includes helpful delineations of job functions for a health home team. While Arkansas may differ in the reimbursement amounts or job titles and other details, the Missouri program is likely to serve as an important model.

The term "health homes" is sometimes used interchangeably with "medical homes." However, the term "medical home" usually refers to a primary care practice while "health homes" involves a mental health, developmental disability, or other ancillary provider with linkages to primary care physicians and other providers.

The goal is to reduce hospital admissions, ER visits, duplicate tests, and excessive referrals to specialists; reduce reliance on institutional care; improve overall health and satisfaction; and reduce costs. Care coordination and wellness activities are hallmarks of this evolving model.

Missouri estimates savings of 16% over expected costs without health homes. Missouri piloted an earlier health home model, with a study indicating that costs increase at first, but decline later as the health home efforts take hold.

To obtain the temporary 90% match under the Affordable Care Act, beneficiaries must meet the following criteria:

(1) Have two chronic conditions; or
(2) Have one chronic condition and at risk for another; or
(3) Have a serious and persistent mental illness (SMI or SED).

The Missouri program is focused on serving those beneficiaries dealing with one serious mental health condition, or less severe mental illness in conjunction with other chronic conditions, namely diabetes, chronic obstructive pulmonary disease, cardiovascular disease, obesity, tobacco use, or developmental disability. However, a state is free to target different populations, and Arkansas appears to be looking in particular at behavioral health and developmental disabilities populations for health homes. Arkansas officials also have advocated the broader use of medical homes or health homes for all Medicaid beneficiaries as part of its Payment Improvement Initiative or "Transformation."

States may vary from the requirements in the Affordable Care Act, but they will not then receive the temporary enhanced match. In the Missouri program, the state predicts that the vast majority, but not all of those in the mental health system will qualify for health home services.

Behavioral Health, Developmental Disabilities, PCPs, RNs, and LPNs

Providers in Arkansas, particularly mental health and developmental disability providers, may want to consider the health home approach for a number of reasons:

●The state's outpatient Medicaid program, called rehabilitative services for persons with mental illness (RSPMI), no longer pays for significant case management and care coordination services, which has left many individuals without needed supports, or providers without reimbursement if they provided those services anyway. These services would be reimbursable again under the health homes program.

●Arkansas Medicaid is looking at implementing another outpatient mental health program through 1915(i) of the Social Security Act for individuals with serious and chronic mental illness. Many of the coordination, care management, and community supports features in 1915(i) are well-suited to a health home.

●The state has struggled for years with how to mandate and measure quality outcomes and cost efficiency by mental health providers. Consequently, the program is now burdened by excessive layers of complex regulations and is administratively top heavy. The health homes program addresses the state's concerns in a way that might appeal to providers since it provides reimbursement for what are now considered basically unfunded mandates.

●While the Missouri model focuses on behavioral health, much of it transfers easily to the developmental disabilities population. Indeed, Missouri went out of its way to include individuals with dual diagnoses (mental illness and developmental disabilities) in its program because they are often medically fragile and high utilizers of medical care who see many different providers. The same is true in Arkansas. Developmental disabilities providers have urged Arkansas Medicaid to implement DD health homes. In addition, the state and DD providers are attempting to address a crisis at the Arkansas State Hospital involving dually diagnosed children.

No matter which populations are targeted, primary care physicians and nurses likely will be in strong demand to help guide the health homes. RNs and LPNs will be needed as full-time employees in the health homes, providing the vast majority of care coordination and wellness services. Each health home likely will have to retain a physician at least on a part-time consulting basis.

Of course, no health home program will attract sufficient provider interest unless the state comes up with an adequate reimbursement. With this new approach, which will be viewed by many providers as risky, it will be imperative that the state provide assurances that it will review reimbursement rates early after starting the program and that it will make needed rate adjustments much more quickly than the usual process.

Health Home Teams

Health home teams in the Missouri program include:

Nurse Care Managers will perform the bulk of the work. They will develop wellness and prevention initiatives; participate in initial treatment plan development for enrollees; coordinate with medical providers and hospitals for admission/discharge; provide training to staff on chronic diseases, treatments, and medications; monitor health information technology tools and reports; and monitor and report performance measures and outcomes. While some care managers may be LPNs, each health home must have at least one RN. However, it appears that in smaller organizations, an RN can serve as both care manager and health home director.

A **health home director** is in charge of the implementation and monitoring of the health home activities.

A **consulting physician** provides medical leadership by participating in treatment planning, consulting with the team psychiatrist, consulting regarding specific consumer health issues, and assisting in coordination with external providers.

Administrative support staff will be needed, especially for the extensive patient data requirements.

Payment Methodology

The payment methodology works like this, according to documents submitted to CMS and other information provided by the state:

(1) Time-limited infrastructure payments to cover the start-up costs associated with recruiting, training new and existing staff, and IT changes. Amount based on two-thirds of projected auto-enrollment.

(2) Ongoing infrastructure payments to cover the cost of the health home director and support staff. Quarterly payments for actual costs incurred.

(3) "Per member per month" (PMPM) payments for each enrollee to cover the costs for nurse care managers and the physician consultant and new support staff. These may be adjusted later or tiered based on patient condition.

Nurse Care Manager ($105,000/yr): *1 FTE per 250 enrollees.*	PMPM $35.00
Health Home Director ($115,000/yr): *1 FTE per 500 enrollees.*	PMPM $19.17
Primary Care Physician Consultant ($150/hr): *1 hour per enrollee per year or .25 FTE per year per 520 enrollees*	PMPM $12.50
Administrative Support:	PMPM $12.07

(4) Possible pay-for-performance allowing providers to share in any savings.

Missouri noted that even these payments will not cover all the training and technical assistance costs of implementing health homes, and that private foundations, providers, and state agencies are spending over $1.5 million more for the program.

Arkansas is also trying to develop bundled payments for episodes of care, so it is not clear whether the bundled payments would include the health home activities or whether the health home activities would be structured as supplemental reimbursement. Either way, costs for these services will have to be determined.

Other Features

Missouri officials and CMS worked out a number of the thorny issues that state officials and providers face as they attempt to develop health homes. Important features include the following:

- After starting services as a health home, providers will have 18 months within which to become certified as a health home by a national accrediting body or through a state program.

- Electronic health records (EHR) are not required, but providers "will be hard pressed to perform successfully as Healthcare Homes in the long run if they do not have an electronic health record."

●Whether they have their own EHR system or not, all health homes must use the state's EHR to conduct care coordination and prescription monitoring; track state-specified performance measures; utilize pharmacy management system; and complete status reports on an individual's housing, legal employment status, education, custody, etc.

●Practice transformation will be required, including open access scheduling to expedite appointments, increased patient input, significant increases in data reporting and outcomes measurements, evidence-based practices, patient registries, automatic care reminders, and exception reports.

●Health homes will use patient registries to track dates of delivered and needed services, laboratory values, and general health status; patient risk stratification; analysis of patient population health status and individual patient needs; and various other data reporting requirements.

●Health homes must submit quarterly reports documenting performance on quality measures and practice transformation, and undergo six and 12-month assessments by the state

●Clinicians in the health home are assigned "patient panels," so that a patient sees the same team of providers each time rather than whoever is available.

●Beneficiaries for whom certain types of claims were filed in each of the three previous months will be assigned to a previously accessed provider for health home auto enrollment, but will be given information on alternative health home providers and the choice to opt out of health home status.

●When an individual has more than one avoidable hospitalization within a 12-month period, he or she will be added to "a list of persons to be actively sought for engagement."

●The state will use a "disease management analytics contractor" that will process a daily list of hospital admissions and discharges against a list of those individuals on the "active engagement" list. The matches from the list will be sent to the health home for that region each day. A similar process will be followed for individuals who frequently use the ER.

●The state generates for the health home an electronic history of care on an individual for the previous three years, including prescription drug history, adherence, and interactions, plus all inpatient and outpatient clinical episodes with date, provider, diagnosis and procedure.

●A health home provides treatment and care coordination on behalf of Medicaid and is therefore entitled to Medicaid beneficiaries' protected health information without violating HIPAA.

●The state's timetable is ambitious: Training of providers started in July, with submission of the plan to CMS; health homes are to begin operating in December. However, the state had piloted a similar program ahead of this.

While Missouri is far ahead of Arkansas in this area, the Missouri program provides a wealth of ideas for how Arkansas might chart its course. More details on the Missouri program are available at: http://dmh.mo.gov/about/chiefclinicalofficer/healthcarehome.htm.