Consolidated 1945A Health Home Implementation Guide:
1945A Health Home Intro

Contents

1945A HEALTH HOME INTRO

POLICY CITATION

Statute: 1945A of the Social Security Act
Formal Guidance: SMDL #22-004 dated August 1, 2022

BACKGROUND

The purpose of this screen is for the state to provide an executive summary of their Health Home program including the goals and objectives of the program, the population served, provider requirements, services provided, and the service delivery model used in the program.

This section also covers general assurances related to Health Home regulatory requirements including a mandatory Mental Health consult with SAMHSA, regardless of the t chronic conditions; agreement to reporting on quality measures as a condition for payment; understanding that dual-eligible beneficiaries cannot be excluded from a Health Home program; guaranteeing that beneficiaries will be given a free choice of providers; assuring the active participation of local hospitals; and ensuring non-duplication of services.

The Medicaid Services Investment and Accountability Act of 2019 (enacted April 18, 2019), added section 1945A to the Social Security Act, creating an optional Medicaid state plan benefit for states to establish Health Home for Medicaid-eligible children with any medically complex conditions that may affect two or more organs as defined in section 1945A(i). In August 2022, a State Medicaid Director letter, which provides guidance to states on the interpretation of Section 1945A, was released to expand upon the purpose of the benefit and the requirements for implementation. The benefit is intended to enhance the integration of services and coordination of care for children with medically complex conditions. Health Home programs must operate under a "whole-person" philosophy and be responsible for coordinating primary and acute care, behavioral health (mental health) and long-term services and supports; providing wellness support and transitional services; as well as linkages to community and social support services.

Health Home programs provide an opportunity for: improved access to primary and specialty care services, including out-of-state care; 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. Health Home programs are expected to operate within a culture of continuous quality improvement to enhance health outcomes and quality of life for individuals with chronic conditions by working with all of the individual's care providers, establishing prevention strategies, and having ways to support the individual and the family by educating and developing the knowledge and activities that support wellness.

By implementing the section 1945A health home option, states can cover coordination of care for children with medically complex conditions, including coordination of the full range of pediatric specialty and subspecialty medical services and coordination of care and services from out-of-state providers

Under section 1945A(i)(1) of the Act, a "child with medically complex conditions" must be under 21 years of age and eligible for medical assistance under the state plan (or under a waiver of the state plan, which CMS interprets to include eligibility under a section 1115 demonstration).[1] Additionally, under section 1945A(i)(1)(A)(ii), a "child with medically complex conditions" must have at least:

- One or more chronic conditions that cumulatively affect three or more organ systems and severely reduces cognitive or physical functioning (such as the ability to eat, drink, or breathe independently) and that also requires the use of medication, durable medical equipment, therapy, surgery, or other treatments; or
- One life-limiting illness or rare pediatric disease (as defined in Section 529(a)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360ff(a)(3)).

A "chronic condition" is defined in section 1945A(i)(2) as "a serious, long-term physical, mental, or developmental disability or disease," including but not limited to the following:

- Cerebral palsy;
- Cystic fibrosis;
- HIV/AIDS;
- Blood diseases, such as anemia or sickle cell disease;
- Muscular dystrophy;
- Spina bifida;
- Epilepsy;
- Severe autism spectrum disorder; and/or
- Serious emotional disturbance or serious mental health illness.

CMS interprets section 1945A(i)(1) to require states electing to cover section 1945A health home services to cover these services for children who meet the eligibility criteria in section 1945A(i)(1)(A)(ii)(I) based on having any one or more of the chronic conditions listed in section 1945A(i)(2), if they choose to enroll in a section 1945A health home. States must also cover section 1945A health home services for children who meet the eligibility criteria in section 1945A(i)(1)(A)(ii)(I) based on having one or more chronic conditions that are not listed in section 1945A(i)(2) but that meet the statutory definition of a "chronic condition". Other chronic conditions apply such as, "long COVID,"[2] and other medical or mental health conditions nationally recognized by the Centers for Disease Control (CDC), National Institutes of Health (NIH) and the American Medical Association (AMA). States should document their process for ensuring other chronic conditions not listed in section 1945A(i)(2) aligns with the statutory definitions of "chronic condition" because they are serious, long-term physical, mental, or developmental disabilities or diseases and are nationally recognized. This means that states will not need to amend their approved SPA for new chronic conditions not listed in 1945A(i)(2).

[2] See information from the Centers for Disease Control and Prevention (CDC) about "long COVID," at https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects/index.html.

States may decide whether to provide their Health Home benefit statewide or only in certain geographic areas of the state.

Section 1945A of the Act provides an opportunity for a family-centered system of care that achieves improved outcomes for children with medically complex conditions by building upon the existing Health Home service delivery model authorized under section1945 of the Act. Under section 1945A, the Health Home for children with medically complex conditions also provides access to the full range of pediatric specialty and subspecialty medical services, including access to services from out-of-state providers, as medically necessary, which is critical to the achievement of enhanced outcomes for these children.

States electing the Health Home benefit will be required to cover a comprehensive package of Health Home care coordination services delivered by certain types of providers who meet specified qualifications and standards. The Health Home services are intended to be comprehensive and to enhance and be integrated into the care otherwise needed and received by the beneficiary. States electing this optional benefit are given considerable flexibility in designing and developing the delivery system for Health Home services as well as in developing a payment methodology for those services.

Health Home providers are required to report identifying provider(s) information and information on all applicable Health Home quality measures to the state as a condition of payment. The state will have to work in concert with their Health Home providers to obtain the necessary information and data. States electing the Health Home benefit will be required to submit a comprehensive report (as authorized under section 1945A(g)(2)(a) on identifying provider information; enrollment; number and prevalence of chronic conditions; delivery systems; payment models; characteristics of Health Home providers; utilization and quality data. In accordance with section 1945A(g)2(B), within 90 days of SPA approval, the state must also submit and make publicly available a report on how the state is implementing guidance on the coordination of care from out-of-state providers. Health Home quality measures are an integral part of a larger payment and care delivery reform effort that focuses on quality outcomes for enrollees. This data is reported in the CMS designated Quality Measures system.

For purposes of this Health Home, as defined in section 1945A(i)(2), a chronic condition is defined as a serious, long-term physical, mental or developmental disability or disease, such as: cerebral palsy, cystic fibrosis, HIV/AIDS, blood diseases (such as anemia or sickle cell disease), muscular dystrophy, spina bifida, epilepsy, severe autism spectrum disorder, or serious emotional disturbance or mental health illness. To be eligible for Health Home services, a beneficiary must be under 21 and have at least: one or more chronic conditions that cumulatively affects three or more body systems and severely reduces cognitive or physical functioning (such as the ability to eat, drink or breath independently) and which also requires the use of medication, durable medical equipment, therapy, surgery or other treatments; or one life-limiting illness or rare pediatric disease (as defined in the Federal Food, Drug, and Cosmetic Act), such as a form of cancer. States may request that CMS approve other chronic conditions for purposes of eligibility.

States electing the Health Home benefit will be required to cover a comprehensive package of Health Home care coordination services including: comprehensive care management; care coordination, health promotion and the provision of access to the full range of pediatric specialty and subspecialty medical services; comprehensive transitional care/follow-up; patient and family support; and referral to community and social support services. The Health Home services are intended to be comprehensive and to enhance and be integrated into the care otherwise needed and received by the beneficiary.

Section 1945A of the Social Security Act (the Act) allows states to offer Health Home services less than statewide and permits states to waive the comparability provision under the state plan at 1902(a)(10)(B) of the Act, which allows for Health Home services to be provided in a different amount, duration, and scope than services provided to individuals who are not in the targeted Health Home population. States electing the Health Home benefit must cover, at a minimum, all categorically needy eligible individuals who have the chronic conditions listed in statute, any additional chronic conditions the state selected in their SPA, and any conditions identified in accordance with the approved chronic conditions identification plan in the SPA. Section 1945A does not mandate beneficiary enrollment in the Health Home program, so beneficiary enrollment in the program is voluntary. Dual-eligibles cannot be specifically excluded from the eligible population.

Health Home services will be delivered by certain types of providers who meet specified qualifications and standards as described in section 1945A(b). States have flexibility to determine eligible Health Home providers. Health Home providers can be a designated provider; a team of health professionals; or a health team, as described in section 3502 of the Affordable Care Act. States also have considerable flexibility in designing and developing the delivery system for Health Home services as well as in developing a payment methodology/s for those services, regardless of delivery system beneficiaries must have free choice of health home providers. States may also decide whether to provide their Health Home benefit statewide or only in certain geographic areas of the state. In accordance with section 1945A(e) of the Act, CMS issued detailed guidance on October 20, 2021,[3] regarding:

- Best practices for using out-of-state providers to provide care to children with medically complex conditions;
- Coordinating care for children with medically complex conditions provided by out-of-state providers (including when provided in emergency and non-emergency situations);
- Reducing barriers that prevent children with medically complex conditions from receiving care from out-of-state providers in a timely fashion; and
- Processes for screening and enrolling out-of-state providers in the respective state plan (or a waiver of such plan), including efforts to streamline these processes or reduce the burden of these processes on these providers.

States will receive a 15 percent enhanced Federal Medical Assistance Percentage (FMAP) for the specific Health Home services under section 1945A. The enhanced match does not apply to the underlying Medicaid services also provided to individuals enrolled in a Health Home program.

[3] https://www.medicaid.gov/federal-policy-guidance/downloads/cib102021.pdf

The 15 percent enhanced match is in effect for the first 2 quarters in which the program is operational, but cannot exceed 90 percent. After the first 2 quarters, rates return to the regular service match rate. A state may receive more than one period of enhanced match by expanding the Health Home program geographically understanding that they will only be allowed to claim the enhanced match for a total of 2 quarters for one beneficiary.

States with one or more existing care management programs must assure that there will be no duplication of services and no duplicate payment for the same services as those provided through the Health Home. Potential sources of duplication may include care management and/or care coordination services provided under managed care, home and community-based services waiver programs, and targeted case management programs. States must account for care management services that are provided to Medicaid individuals through other program authorities, such as CMMI demonstrations, Targeted Case Management (TCM) and design their Health Home program to complement these services by ensuring that Health Home services are distinct and are not duplicating existing care management services.

General Assurances

States must assure that:

- Eligible individuals will be given a free choice of Health Home provider;
- It will not prevent individuals who are dually-eligible for Medicare and Medicaid from receiving Health Home services;
- It will not limit the choice of a child with medically complex conditions in selecting a Health Home provider that meets the qualification standards established under the child's Health Home.
- It will not reduce or otherwise modify the entitlement of children with medically complex conditions to EPSDT (as defined in section 1905(r)) or the informing, providing, arranging, and reporting requirements of the state under 1902(a)(43).
- Hospitals participating under the state plan will be instructed to establish procedures for, in the case of a child with medically complex conditions who is enrolled in a Health Home program and seeks treatment in the emergency department of such a hospital, notifying the Health Home of the treatment of such a child.
- FMAP for Health Home services will increase by 15%, but in no case exceed 90% for the first two fiscal quarters from the effective date of the SPA. After the first two quarters, expenditures will be claimed at the regular matching rate;
- The state will have systems in place so that only one 2-quarter period of enhanced FMAP for each Health Home enrollee will be claimed;
- There will be no duplication of services and payment for similar services provided under other Medicaid authorities. States with one or more existing care management program must assure that there will be no duplication of services and no duplicate payment for the same services as those provided through the Health Home program.

INSTRUCTIONS

Program Authority

This section displays the following:

- The statutory authority citation under which the Health Home program may be implemented (1945A of the Social Security Act).
- A statement as to the state's election to implement a Health Home.
- The name of the Health Home program either entered or selected in the Submission Summary screen will display opposite "Name of Health Home program."

Executive Summary

You must provide a summary of the Health Home program including the goals and objectives of the program; the population, providers, services and service delivery model. This summary is limited to 4000 characters.

General Assurances

In the last section, read and check the general assurances.

REVIEW CRITERIA

The state's executive summary (description/explanation) of this Health Home program must include the goals and objectives, population, providers, services and service delivery model used for this Health Home program.

1945A HEALTH HOME POPULATION AND ELIGIBILITY CRITERIA

POLICY CITATION

Statute: 1945A(i) of the Social Security Act
Formal Guidance: SMDL #22-004 dated August 1, 2022

BACKGROUND

Section 1945A of the Act gives states the option to cover health home services for Medicaid-eligible children under age 21 with medically complex conditions who choose to enroll in a section 1945A health home by selecting a designated provider, a team of health care professionals operating with a designated provider, or a health team as the child's health home services provider. Under section 1945A(i)(1) of the Act, a "child with medically complex conditions" must be under 21 years of age and eligible for medical assistance under the state plan (or under a waiver of the state plan, which CMS interprets to include eligibility under a section 1115 demonstration).[4] Additionally, under section 1945A(i)(1)(A)(ii), a "child with medically complex conditions" must have at least:

- One or more chronic conditions that cumulatively affect three or more organ systems and severely reduces cognitive or physical functioning (such as the ability to eat, drink, or breathe independently) and that also requires the use of medication, durable medical equipment, therapy, surgery, or other treatments; or
- One life-limiting illness or rare pediatric disease (as defined in Section 529(a)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360ff(a)(3)).

The purpose of this screen is for the state to identify the eligibility criteria for children with medically complex conditions as defined in section 1945A(i)(1) and (2). This includes the definition of the term "chronic condition" to mean as serious, long-term physical, mental or developmental disability or disease.

Additionally, the method for enrolling beneficiaries into the Health Home program being described (The Health Home program name was either entered or selected previously in the Submission Summary screen).

Eligible Criteria
Section 1945A of the Act permits states to waive the comparability provision under the state plan at 1902(a)(10)(B) of the Act, which allows for Health Home services to be provided in a different amount, duration, and scope than services provided to individuals who are not in the targeted Health Home population. States electing the Health Home benefit must cover, at a minimum, all Categorically Needy eligible individuals who meet the minimum eligibility criteria

[4] Generally, CMS interprets statutory references to a "waiver" of the Medicaid state plan to include section 1115 demonstrations.

as defined in 1945A(i) as a child with medically complex conditions and specified the chronic conditions noted in statute in their SPA.

Section 1945A(i) of the Act sets forth the minimum criteria that an "eligible individual with chronic conditions" must meet. The state must identify who is an "eligible individual with chronic conditions." The Statute defines the minimum criteria as follows: an individual under 21 years of age who is eligible for assistance under the state plan or under a waiver of such plan and has at least one or more chronic conditions that cumulatively affects three or more body systems and severely reduces cognitive or physical functioning (such as the ability to eat, drink or breath independently) and which also requires the use of medication, durable medical equipment, therapy, surgery or other treatments; or one life-limiting illness or rare pediatric disease (as defined in the Federal Food, Drug, and Cosmetic Act), such as a form of cancer.

Health Home services can be provided to individuals who have chronic conditions, or categories of conditions, specified under section 1945A(i)(2) of the Act, but states may choose to include other chronic conditions, as well. Specific chronic conditions, and categories of chronic conditions, authorized under section 1945A(i)(2) of the Act include the following: cerebral palsy, cystic fibrosis, HIV/AIDS, blood diseases (such as anemia or sickle cell disease), muscular dystrophy, spina bifida, epilepsy, severe autism spectrum disorder, and serious emotional disturbance or mental health illness. An individual who meets the eligibility criteria and has at least one of these chronic conditions may be eligible to enroll into a Health Home. Under Section 1945A, states must cover section 1945A health home services for a child who is eligible on the basis of having any of the chronic conditions listed in section 1945A(i)(2). States can also cover section 1945A health home services for children who meet the eligibility criteria in section 1945A(i)(1)(A)(ii) based on having one or more chronic conditions that are not listed in section 1945A(i)(2).

While all individuals served must meet the minimum statutory criteria, in accordance with section 1945A(i)(1)(B) of the Act, states may elect to have a medical necessity test that makes Health Home services available only to individuals with higher severity of chronic or mental health conditions.

A state may not submit an amendment to include additional chronic conditions in their 1945A Health Home. As long as the child meets the eligibility criteria listed in the state plan, the state may not need to amend to add conditions not listed in their approved HH SPA.

Enrollment of Participants

The Health Home benefit described in section 1945A is a voluntary benefit. The state, health care providers, and hospitals may refer individuals to the Health Home providers. Individuals may choose among qualified Health Home providers, and may change or disenroll at any time. However, individuals may only receive Health Home services from one provider at a time. Enrollment must be documented by the provider, and that documentation should, at a minimum, indicate that the individual has received required information explaining the Health Home program and has consented to receive the Health Home services noting the effective date of their enrollment.

Likewise, section 1945A does not mandate beneficiary enrollment in the Health Home program, so beneficiary enrollment in the program is voluntary. Consistent with Medicaid state plan requirements, eligible individuals must be allowed to choose a qualified Health Home provider. While states may refer eligible individuals to a qualified Health Home provider, enrollment of the individual would occur only if the individual or family consents and then is accepted by the Health Home provider. The state must permit an individual to change Health Home providers or to opt out of receiving the Health Home services at any time. This consent must be written and maintained in the health record.

Eligible individuals may receive Health Home services from any qualified and willing Health Home provider, however, an eligible individual may only be enrolled with one Health Home provider at a time. By implementing the section 1945A health home option, states can cover coordination of care for children with medically complex conditions, including coordination of the full range of pediatric specialty and subspecialty medical services and coordination of care and services from out-of-state providers. To assist individuals in obtaining services, the state may refer eligible individuals to particular Health Home providers based on geographic area, established relationship with a provider, or other criteria, but must inform individuals of the option to receive such services from other qualified providers (if there are any). Eligible individuals may also be referred to a Health Home program by a hospital or other health care provider.

The state will need to ensure that the Health Home providers maintain documentation indicating that the individual has, in fact, enrolled and given consent to participate in the Health Home program. This documentation should, at a minimum, indicate that the individual has received required information explaining the Health Home program and the individual's enrollment date. Documentation of the individual's enrollment, and of any subsequent disenrollment, must be maintained in the enrollee's health record by the Health Home provider. The Health Home provider should notify the state of the disenrollment and cease Health Home billing for the disenrolled person.

INSTRUCTIONS

Categories of Individuals and Populations Provided Health Home Services

Identify and select the categories or groups of individuals for whom the Health Home program will be available:

- The state must cover all Categorically Needy (mandatory and options for coverage) eligibility groups (i.e., CN individuals who have the chronic conditions specified by the state) in their Health Home program. The system, therefore, will automatically indicate that Health Home services will be available to all the Categorically Needy eligibility groups. (Note that the state cannot elect to cover categorically needy groups or individuals based on their age. Also, dual-eligibles cannot be excluded from the target population.)

- If the state has a Medically Needy program, and it will also be covering Medically Needy eligibility groups in its Health Home program, you must select the Medically Needy Eligibility Groups option.

- If Medically Needy Eligibility Groups is selected:
    - Mandatory Medically Needy
        - Medically Needy Pregnant Women
        - Medically Needy Children under Age 18
    - Optional Medically Needy (select the groups included in the population):
        - Families and Adults
            - Medically Needy Children Age 18 through 20
            - Medically Needy Parents and Other Caretaker Relatives
        - Aged, Blind and Disabled
            - Medically Needy Aged, Blind or Disabled
            - Medically Needy Blind or Disabled Individuals Eligible in 1973

Population Criteria

In section 1945A(i)(1), defines Child with medically complex conditions who is under 21 years of age who:

i) Is eligible for medical assistance under state plan (or under waiver of such plan) and;

ii) Has at least

(I) one or more chronic conditions that cumulatively affect three or more organ systems and severely reduces cognitive or physical functioning (such as the ability to eat, drink or breathe independently) and that also requires the use of medication, durable medical equipment, therapy, surgery, or other treatments; or

(II) one life-limiting illness or rare pediatric disease (as defined in section 529(a)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360ff(a)(3))).

In section 1945A(i)(2), the term "chronic condition" means a serious, long-term physical, mental, or developmental disability or disease, including the following:

(A) Cerebral palsy.
(B) Cystic fibrosis.
(C) HIV/AIDS
(D) Blood diseases, such as anemia or sickle cell disease.
(E) Muscular dystrophy.
(F) Spina bifida
(G) Epilepsy
(H) Severe autism spectrum disorder
(I) Serious emotional disturbance or serious mental health illness.

- All chronic conditions listed in statute will be automatically selected for this Health Home program.
    - Select "Other" if there is a chronic condition included in the program that is not listed.

- Enter the name of the chronic condition and briefly describe why it is considered chronic and how Health Home services will help improve overall care and reduce costs for these individuals. You may add more than one "Other" chronic condition.

- State must check the attestation box, "The state attests that they use the statutory definition of "chronic condition" referenced in 1945A(i)(1)(2) when identifying chronic conditions in their process described below."
- States must add a plan in the box below "Other" of how a state will identify future chronic conditions that they will serve. This plan should include acceptable methods of identification and align with the statutory definition of a chronic conditions. This plan will be reviewed at the time of SPA submission.

Enrollment of Participants

Check both assurances

Indicate which one of the following methods will be used to enroll eligible individuals into the Health Home program. Only one selection may be made.

- Opt-in to Health Home provider
  - If this is selected, describe the process used in the text box provided.
- Referral and assignment to Health Home provider with opt-out
  - If this is selected, describe the process used in the text box provided.
  - Check the assurance that the state will clearly communicate the individual's right to opt out or to change providers.
  - Upload a copy of any letters or other communications used to information individuals of their rights. At least one document must be uploaded, and more than one may be uploaded.
- Other
  - If this is selected, describe the process used in the text box provided.

In this section, describe the process used to educate families with children eligible to receive Health Home services of the availability of such services including the participation of family-to-family entities or other public or private organizations or entities who provide outreach and information on the availability of health care items and services to families of individuals eligible to receive Medicaid under the state plan or waiver of such plan.

REVIEW CRITERIA

Review Criteria for Population Criteria Section: The state's description/explanation for considering another condition, should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements.

States must check the attestation box, "The state attests that they use the statutory definition of "chronic condition" referenced in 1945A(i)(1)(2) when identifying chronic conditions in their process described below.

States must have a plan in the box below "Other" of how a state will identify future chronic conditions that they will serve. This plan should align with the statutory definition of a chronic conditions. This plan will be must be reviewed and approved by CMS at the time of SPA submission.

<u>Review Criteria for Enrollment of Participants Section:</u> During the SPA review process, states will need to explain their enrollment process including how they determine eligible enrollees and how they inform and educate eligible enrollees. For example, individuals eligible for Health Home services may be identified through claims or encounter data, referrals from providers, or any other system the state has developed to identify those who would benefit from Health Home services.

The information should clarify that selection of a Health Home provider is optional, that the individual may have other choices of Health Home providers and explain that the individual may disenroll from a Health Home provider at any time. This information should also explain that the Health Home program will not restrict access to providers or limit access to other Medicaid benefits.

Regardless of which option is selected, the enrollment is considered voluntary and the eligible individual must agree to receive Health Home services and provide consent that would be maintained in the enrollee's health record.

The state's description of the process used to educate families with children eligible to receive Health Home services of the availability of such services should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements.
The state's description of their procedures and methods for identifying future chronic conditions must be present and acceptable.

1945A HEALTH HOME GEOGRAPHIC LIMITATIONS

POLICY CITATION

Statute: 1945A of the Social Security Act
Formal Guidance: SMDL #22-004 dated August 1, 2022

BACKGROUND

The purpose of this screen is for the state to identify the geographic limitations, if any, to be imposed by the state on the population included in the Health Home program.

States are able to target their Health Home program geographically. The statewide provision at 1902(a)(1) is waived by section 1945A, so states may elect to have their Health Home program operate statewide or only in specific geographic regions (e.g. counties) of the state. Unlike traditional state plan benefits, 1945A Health Home programs do not have to be provided on a statewide basis. If the state provides a Health Home program less than statewide, the state must specify the geographic areas in which the services will be offered in the state plan. States may also choose a geographic phased-in approach for their Health Home program. States may start with the first geographic phase when they create the Health Home program and then amend their state plan to add new geographic areas over time. As new geographic areas are added to the state plan, the state receives a new period of enhanced match for the beneficiaries receiving Health Home services in only the new coverage area.

INSTRUCTIONS

Geographic Limitations

In this section, indicate if the services for this 1945A Health Home program will be provided statewide; limited to certain geographic areas, or phased-in by geographic area to eventually be statewide.

Select one of the following three options:

- Health Home services will be available statewide.
- Health Home services will be limited to the following geographic areas.
- Health Home services will be provided in a geographic phased-in approach.

If Health Home services will be limited to the following geographic areas is selected, select the option which best describes the limited geographic area.

- If county is selected, indicate in which counties the services will be available by entering the county names, one by one. As you start typing, a pop-up list will display county names for you to choose from.

- If region or other geographic area is selected, describe the region(s) or other geographic area(s).
- If city/municipality is selected, enter the name(s) of the city(ies) and/or municipality(ies).

If Health Home services will be provided in a geographic phased-in approach is selected, enter a description of each phase, one at a time, by clicking on the "Add Phase" button.

- The first phase should be entered when the program starts. Enter subsequent phases by amending the program – one additional phase per Submission Package.
- For each phase: Enter the date the phase will be implemented. Select the option which best describes the geographic area designated for that phase, following the instructions described above. Indicate whether, with this phase, Health Home services become available state-wide.
- For the phase where the answer to this question is Yes, enter the effective date of the state-wide implementation. Enter any additional information you believe would clarify how the phase will be accomplished.
- When you are ready to enter another phase (under a new Submission Package), click the "Add Phase" button and follow the steps above.

REVIEW CRITERIA

States will need to identify whether the 1945A Health Home benefit will be made available statewide or be limited to certain geographic areas in the state. In this section the state will need to be strategic about how they plan to phase-in their 1945A Health Home benefit statewide, if they intend to do so. Ensure that only one new phase is added with each submission package.

1945A HEALTH HOME PROVIDERS

POLICY CITATION

Statute: 1945A(b) of the Social Security Act
Formal Guidance: SMDL #22-004 dated August 1, 2022

BACKGROUND

The purpose of this screen is for the state to select/identify the types of providers of Health Home services to be included in its Health Home program and for the state to describe the standards and qualifications that these Health Home providers must meet in order to participate in the program. The state will also describe how its Health Home providers will be able to provide timely, comprehensive, and high-quality Health Home services and how the state will support providers in this effort.

Section 1945A 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(i)(5) of the Act; a team of health care professionals, which links to a designated provider, as defined in section 1945A(i)(6) of the Act; and a health team, as defined in section 1945(i)(7) of the Act. Note that section 1945A(i)(7) defines *health team* to have the same meaning given *health teams* in section 3502 of the ACA.

Section 1945A(i)(5) of the Act includes examples of providers that may qualify as a "designated provider," such as physicians including a pediatrician or pediatric specialty or subspecialty provider, children's hospital, clinical practices or clinical group practices, prepaid inpatient health plan or prepaid ambulatory health plan, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider that is determined by the state and approved by the Secretary to be qualified to be a Health Home for children with medically complex conditions on the basis of documentation evidencing that the entity has the systems, expertise, and infrastructure in place to provide Health Home services. The statutory list, therefore, is not an exhaustive list. States may include additional providers in this category, meeting the criteria of section 1945A(i)(5) of the Act. States will need to identify all designated providers in its SPA. As discussed in more detail below, each designated provider must have the systems and infrastructure in place to provide Health Home services and to be able to satisfy the core Health Home functions and service delivery principles.

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. Providers of Health Homes services are expected to use a pediatric family-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. Health Home providers must agree to report on the Health Home quality measures as a condition of receiving payment for Health

Home services. In addition, Health Home must have mechanisms in place to share health information, link services, facilitate communication among the interdisciplinary team members and other providers to coordinate care and improve service delivery across the care continuum. States will need to describe the provider infrastructure and how their providers will meet the Health Home core functions and service delivery requirements, and incorporate them into the state's provider standards.

> CMS encourages states to propose SPAs under section 1945A that would support a "whole-person" approach to care for children with medically complex conditions and promote continuous quality improvement. A whole-person approach identifies needed services and supports through person-centered planning[5] resulting in care and linkages to care that address individual's needs of an individual. Consistent with section 1945A(b)(2) of the Act, states must require that their providers of section 1945A health home services for children with medically complex conditions are able to use a family-centered care planning approach that accommodates patient preferences. In addition, health home providers are strongly encouraged to document the delivery of the health home services in the individual's health record.
>
> Section 1945A(b) of the Act provides that the Secretary shall establish standards for qualification as a section 1945A health home provider. Under these standards, section 1945A health home providers must demonstrate to the state the ability to do the following:

(1) Coordinate prompt care for children with medically complex conditions, including access to pediatric emergency services at all times;

(2) Develop an individualized comprehensive pediatric family-centered care plan for children with medically complex conditions that accommodates patient preferences;

(3) Work in a culturally and linguistically appropriate manner with the family of a child with medically complex conditions to develop and incorporate into such child's care plan, in a manner consistent with the needs of the child and the choices of the child's family, ongoing home care, community-based pediatric primary care, pediatric inpatient care, social support services, and local hospital pediatric emergency care;

(4) Coordinate access to—

> (A) subspecialized pediatric services and programs for children with medically complex conditions, including the most intensive diagnostic, treatment, and critical care levels as medically necessary regardless of whether they are in or out of an established network and;

[5] As discussed in an October 20, 2021 CMCS Informational Bulletin (CIB), CMS recommends that states with health homes for children with medically complex conditions encourage or require their section 1945A health home providers to develop a person-centered service plan like that described in 42 CFR 441.725(a) and (b) for children with medically complex conditions. See https://www.medicaid.gov/federal-policy-guidance/downloads/cib102021.pdf

(B) palliative services if the state provides Medicaid coverage for such services;

(5) Coordinate care for children with medically complex conditions with out-of-state providers furnishing care to such children to the maximum extent practicable for the families of such children and where medically necessary, in accordance with guidance issued under section 1945A(e)(1) and 42 CFR 431.52;[6] and

(6) Collect and report information in accordance with section 1945A(g)(1) of the Act.

CMS recommends that states describe in their section 1945A health home SPAs the infrastructure they expect to put in place to ensure that timely, comprehensive, high-quality health home services are available. A state with established medical home provider standards wishing to submit a SPA under section 1945A of the Act that would authorize the existing medical home providers to become section 1945A health home services providers should describe how its existing medical home standards align with the statutory health home provider qualifications listed above, and/or have been modified to address the specific provider qualifications and health home services required under section 1945A, including the use of health information technology and quality reporting.

CMS also recommends that states ensure that providers of health home services can perform the functions listed below, in addition to meeting the statutory standards listed above. CMS encourages states to describe in their section 1945A health home SPAs how the state will support providers of section 1945A health home services in performing the following:

- Demonstrating clinical competency for serving the complex needs of section 1945A health home enrollees;
- Demonstrating the application of person- and family-centered practices in the delivery of section 1945A health home services;
- Demonstrating application of the Life Course approach,[7] integrating services in the continuum of the child's life and assisting the family to anticipate needs as the child grows and changes;
- Providing access to timely health home services 24 hours a day, 7 days a week to address any immediate care needs of health home enrollees;
- Maintaining conflict of interest safeguards to assure that services are coordinated in accordance with enrollee needs expressed in the family-centered care plan, rather than based on financial interests or arrangements of the health home provider;
- Providing quality-driven, cost-effective, culturally appropriate, and trauma-informed health home services;
- Coordinating and providing access to high-quality health care services informed by evidence-based clinical practice guidelines;

[6] See https://www.medicaid.gov/federal-policy-guidance/downloads/cib102021.pdf.

[7] See research information: https://www.hrsa.gov/sites/default/files/ourstories/mchb75th/images/rethinkingmch.pdf and toolkit here: https://www.citymatch.org/mch-life-course/

- Coordinating and providing access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
- Coordinating and providing access to comprehensive care management, care coordination, and transitional care across settings (Note: Transitional care should include 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);
- Having protocols to assist in removing barriers, such as those posed by transportation, to ensure safe transition of care between providers. Protocols could include relationships between the health home provider and hospitals or other health care providers;
- Coordinating and providing access to chronic disease management, including self-management support for individuals and their families;
- Coordinating and providing access to behavioral health and recovery services;
- Coordinating and providing access to individual and family supports, including referral to home and community-based services, respite care and family support groups;
- Coordinating with school-based health services providers;
- Coordinating and providing access to long-term care services and supports;
- Demonstrating a capacity to use health information technology to link services as feasible and appropriate, including by facilitatingcommunication among health team members and facilitating communication among the health team, individual, and family caregivers;
- Demonstrating a capacity to use health information technology to provide feedback to providers to improve service delivery across the care continuum;
- Use of health information technology that supports interoperability through alignment with, and incorporation of, industry standards adopted by the Office of the National Coordinator for Health IT in accordance with 45 CFR part 170, subpart B, where applicable, as well as other relevant consensus-based, non-proprietary standards;[8] and
- Establishing a continuous quality improvement program, and collecting and reporting on data that permits an evaluation of increased coordination of care, efforts to advance health equity, program performance, and the management of complex conditions.

For each kind of provider/practitioner the state includes in its Health Home program, the state will need to describe the qualifications and standards that each must meet in order to participate in its program.

States are expected to describe the infrastructure in place to provide timely, comprehensive, high-quality Health Home services.

Section 1945A(b) of the Act directed the Secretary to establish standards for qualification as a designated provider of Health Home services. CMS is sharing Health Home service delivery principles that align with 1945A of the Act to assist states who are/will be submitting 1945A Health Home SPAs. In reviewing best practices and lessons learned from states with approved Health Home SPAs under 1945 of the Act, several states require designated Health Home providers to obtain certification from a national accrediting organization as a patient-centered medical home/Health Home or meet state specific certification standards similar to those of a

[8] *See* ONC's Interoperability Standards Advisory (ISA) at https://www.healthit.gov/isa/.

national accrediting organization. CMS recommends states apply this practice when implementing the new 1945A benefit option.

To support the key Health Home service delivery system principles, CMS recommends that Health Home providers use one of the following options:

- Meet state specific standards for a patient-centered medical home/Health Home which, at a minimum, encompass the Health Home delivery system requirements (listed below), or
- At state option, be accredited by a national accreditation organization that has standards equal to or more stringent than applicable state-specific standards.

CMS recommends that states describe in their section 1945A health home SPAs the infrastructure they expect to put in place to ensure that timely, comprehensive, high-quality health home services are available. A state with established medical home provider standards wishing to submit a SPA under section 1945A of the Act that would authorize the existing medical home providers to become section 1945A health home services providers should describe how its existing medical home standards align with the statutory health home provider qualifications listed above, and/or have been modified to address the specific provider qualifications and health home services required under section 1945A, including the use of health information technology and quality reporting.

Service Delivery System for Section 1945A Health Home Services

States have flexibility to determine what service delivery system or combination of systems will be used in their section 1945A health homes programs. As a reminder, section 1945A(h)(2) provides that nothing in section 1945A may be construed "to limit the choice of a child with medically complex conditions in selecting a designated provider, team of health care professionals operating with such a provider, or health team that meets the health home qualification standards established under [section 1945A(b)] as the child's health home." This means that there cannot be a closed provider network for section 1945A health home services delivered via managed care and the choice of section 1945A health home services providers through a managed care organization cannot be limited. If states' managed care contracts need to be updated to reflect this, CMS will provide technical assistance.

Finally, if the state is involved in other types of care coordination or medical home projects or initiatives, which impose additional or other requirements on the Medicaid Health Home program, the state will be asked to identify and specify these additional requirements. States are expected to describe how these standards align with the Health Home delivery system principles, and/or have been modified to address the specific Health Home services related to medically complex chronic conditions for children. States will also be asked to describe how their model will avoid duplication of services and payments with other care coordination programs.

It is important to note that each Health Home provider type arrangement must have the capability of providing all six of the Health Home services identified in the Health Home Services screen, and that all payments for Health Home services will be paid to the single entity that is qualified by the state as the Health Home provider or the entity that is permitted to receive payments on

behalf of the Health Home provider. This will be described in more detail in the Health Home Payment Methodologies and Health Home Services screens.

Provider Reporting Requirements

Section 1945A(g)(1) of the Act requires section 1945A health home services providers to report to the state the following information:

1. Provider name;
2. National Provider Identification number;
3. Provider address;
4. Specific health care services offered to children with medically complex conditions who have selected the specific provider reporting this information as their health home;
5. Information on all applicable measures (to include the Core Set and any state specific measures that a state elects to implement) for determining the quality of health home services provided by the health home services provider, including, to the extent applicable, child health quality measures and measures for centers of excellence for children with complex needs developed under titles XIX and XXI of the Act, and section 1139A of the Act; and
6. Such other information as the Secretary shall specify in guidance.

This reporting should help the state and its participating section 1945A health home providers to assess the quality of section 1945A health home services. At this time, CMS is considering the following measures for possible use, several of which are part of the current Child and/or Health Home Core Set:

1. Well-Child Visits in the First 30 Months of Life (W30-CH);
2. Child and Adolescent Well-Care Visits (WCV-CH);
3. Childhood Immunization Status (CIS-CH);
4. Immunizations for Adolescents (IMA-CH);
5. Oral Evaluation, Dental Services;
6. Ambulatory Care: Emergency Department (ED) Visits (AMB-HH); and
7. Inpatient Utilization (IU-HH).

These measures are expected to capture information on clinical and quality of care outcomes specific to the provision of section 1945A health home services. This list of measures will be added to the annual Health Home Quality Measures Core Set workgroup review process. CMS will provide more detail in future guidance on these reporting requirements.

INSTRUCTIONS

Types of Health Home Providers

Select one or more of the following three types of Health Home provider arrangements that can participate in the Health Home program:

- Designated Providers
- Teams of Health Care Professionals

- Health Teams

For each type of Health Home provider arrangement selected, select from the list provided the specific kinds of professionals/practitioners or providers who are qualified to participate in the program.

For each specific kind of professional/provider selected, describe the qualifications and standards that must be met in order for that kind of professional/provider to participate in the Health Home program, including professional degrees, certifications and licenses to practice in the state and the capability to provide all of the following required Health Home services:

> Section 1945A(b) of the Act provides that the Secretary shall establish standards for qualification as a section 1945A health home provider. Under these standards, section 1945A health home providers must demonstrate to the state the ability to do the following:
>
> (1) Coordinate prompt care for children with medically complex conditions, including access to pediatric emergency services at all times;
>
> (2) Develop an individualized comprehensive pediatric family-centered care plan for children with medically complex conditions that accommodates patient preferences;
>
> (3) Work in a culturally and linguistically appropriate manner with the family of a child with medically complex conditions to develop and incorporate into such child's care plan, in a manner consistent with the needs of the child and the choices of the child's family, ongoing home care, community-based pediatric primary care, pediatric inpatient care, social support services, and local hospital pediatric emergency care;
>
> (4) Coordinate access to—
>
> > (A) subspecialized pediatric services and programs for children with medically complex conditions, including the most intensive diagnostic, treatment, and critical care levels as medically necessary regardless of whether they are in or out of an established network; and
> >
> > (B) palliative services if the state provides Medicaid coverage for such services;
>
> (5) Coordinate care for children with medically complex conditions with out-of-state providers furnishing care to such children to the maximum extent practicable for the families of such children and where medically necessary, in accordance with guidance issued under section 1945A(e)(1) and 42 CFR 431.52;[9] and
>
> (6) Collect and report information in accordance with section 1945A(g)(1) of the Act.

- Comprehensive care management

[9] See https://www.medicaid.gov/federal-policy-guidance/downloads/cib102021.pdf.

- Care coordination, health promotion and providing access to the full range of pediatric specialty and subspecialty medical services, including services from out-of-state providers, as medically necessary
- Comprehensive transitional care from inpatient to other settings (including appropriate follow-up)
- Patient and family support (which includes authorized representatives)
- Referral to community and social support services
- Use of health information technology to link services

If the list of professionals/providers under Designated Providers or Teams of Health Care Professionals does not include a kind that is used in the program, select "Other" and enter the provider type in addition to a description of the provider qualifications and standards. You may add more than one "Other."

If Health Teams is selected, in addition to selecting one or more of the kinds of professional/provider listed, also check the assurance, "The state provides assurance that it will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945A of the Social Security Act."

Provider Infrastructure

Describe how the infrastructure of the selected health home provider arrangements will meet the 17 core functional components of a Health Home program identified by CMS in its SMD letter as being critical in assuring timely, comprehensive, and high-quality Health Home services. The 17 core functional components of a Health Home program are listed above in the Background section. In addition, states will need to address how their providers will adhere to the Health Home service delivery system principles, also listed above in the Background section.

Supports for Health Home Providers

Describe the process used to educate providers on the availability of Health Home services for children with medically complex conditions, including the process by which such providers can refer children to a Health Home provider for the purposes of establishing a Health Home.

Describe the methods by which the state will support the Health Home providers in addressing each of the 17 components of a Health Home program identified by CMS as being critical in assuring timely, comprehensive and high-quality Health Home services.

Other Health Home Provider Standards

Describe the state's requirements and expectations for Health Home providers. Indicate how these requirements align with the key Health Home expectations, and how they address specific Health Home services.

Upload Documents

At the state's option, upload any provider standards documents which support the descriptions provided of provider standards and qualifications. More than one document may be uploaded.

REVIEW CRITERIA

<u>Provider Qualifications:</u> The descriptions of the providers' qualifications and standards must include appropriate professional degrees, certifications and licenses to practice in the state, and the capability to provide all six Health Home services, as well as to meet expectation of high-quality care. The descriptions of the providers' qualifications should also include an explanation of how they are consistent with the Health Home Service Delivery System Principles, described in the Background section.

<u>Infrastructure:</u> The description of the infrastructure of provider arrangements must include how they will meet the seventeen core functional components identified as being critical in assuring timely, comprehensive and high-quality Health Home services. In addition, states will need to address how their providers will adhere to the Health Home Service Delivery System Principles. Include in the description providers who may not be employed by the Health Home program but to whom enrollees may be referred for needed services.

<u>Supports for Health Home Providers:</u> The description of the methods by which the state will support the Health Home providers must include how the state will support the providers in addressing each of the seventeen core functional components of a Health Home program identified by CMS as being critical in assuring timely, comprehensive and high-quality Health Home services.

<u>Other Health Homes Provider Standards:</u> The description of other requirements and expectations should include how the requirements align with the key Health Home expectations, and how they address specific Health Home services.

1945A HEALTH HOME SERVICE DELIVERY SYSTEMS

POLICY CITATION

Statute: 1945A of the Social Security Act
Formal Guidance: SMDL #22-004 dated August 1, 2022

BACKGROUND

The purpose of this screen is for the state to identify the type(s) of service delivery system(s) that will be used for individuals receiving Health Home services. Depending on the type of service delivery system to be used, in this screen states may also be asked to specify the payment methodology, as well as to provide assurances and descriptions of the service delivery system(s).

Health Home providers must have an infrastructure in place to provide timely, comprehensive, and high-quality Health Home services. Neither the statute nor the SMD letter requires a specific system for delivering Health Home services under section 1945A. Therefore, states are given the flexibility to determine which service delivery system or combination of systems will be used in its Health Home program. The state may use a fee-for-service, primary care case management (PCCM), risk-based managed care delivery system and/or some other model of service delivery. Regardless of the service delivery system, Health Home providers will need to meet the core Health Home functional requirements and Health Home service delivery principles as described under Provider Standards.

The Health Home statute provides states considerable flexibility to design a Health Home service delivery model appropriate to the needs of the population and each state's existing delivery system. As a reminder, section 1945A(h)(2) provides that nothing in section 1945A may be construed "to limit the choice of a child with medically complex conditions in selecting a designated provider, team of health care professionals operating with such a provider, or health team that meets the health home qualification standards". This means that a state cannot have a closed provider network for section 1945A health home services delivered via managed care and cannot limit the choice of providers through a managed care organization. If states' managed care contracts need to be updated to reflect this, CMS will provide technical assistance.

Section 1945A health home providers must demonstrate to the state the ability to do the following:

(1) Coordinate prompt care for children with medically complex conditions, including access to pediatric emergency services at all times;

(2) Develop an individualized comprehensive pediatric family-centered care plan for children with medically complex conditions that accommodates patient preferences;

(3) Work in a culturally and linguistically appropriate manner with the family of a child with medically complex conditions to develop and incorporate into such child's care

plan, in a manner consistent with the needs of the child and the choices of the child's family, ongoing home care, community-based pediatric primary care, pediatric inpatient care, social support services, and local hospital pediatric emergency care;

(4) Coordinate access to—

(A) subspecialized pediatric services and programs for children with medically complex conditions, including the most intensive diagnostic, treatment, and critical care levels as medically necessary; and

(B) palliative services if the state provides Medicaid coverage for such services;

(5) Coordinate care for children with medically complex conditions with out-of-state providers furnishing care to such children to the maximum extent practicable for the families of such children and where medically necessary, in accordance with guidance issued under section 1945A(e)(1) and 42 CFR 431.52;[10] and

(6) Collect and report information in accordance with section 1945A(g)(1) of the Act.

CMS also recommends that states ensure that providers of health home services can perform the functions listed below, in addition to meeting the statutory standards listed above. CMS encourages states to describe in their section 1945A health home SPAs how the state will support providers of section 1945A health home services in performing the following:

Health Home Service Delivery System Principles:

- Demonstrating clinical competency for serving the complex needs of section 1945A health home enrollees;
- Providing access to timely health home services 24 hours a day, 7 days a week to address any immediate care needs of health home enrollees;
- Maintaining conflict of interest safeguards are in place to assure enrollee rights and protections are not violated, and that services are coordinated in accordance with enrollee needs expressed in the family-centered care plan, rather than based on financial interests or arrangements of the health home provider;
- 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 clinical practice guidelines;
- Coordinating and providing access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
- Coordinating and providing access to comprehensive care management, care coordination, and transitional care across settings (Note: Transitional care should include 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);

[10] See https://www.medicaid.gov/federal-policy-guidance/downloads/cib102021.pdf.

- Having protocols to assist in removing barriers, such as those posed by transportation, to ensure safe transition of care between providers. Protocols could include relationships between the health home provider and hospitals or other health care providers;
- Coordinating and providing access to chronic disease management, including self-management support for individuals and their families;
- Coordinating and providing access to individual and family supports, including referral to community, social support, and recovery services;
- Coordinating and providing access to long-term care services and supports;
- Demonstrating a capacity to use health information technology to link services as feasible and appropriate, including by facilitating communication among health team members and facilitating communication among the health team, individual, and family caregivers;
- Demonstrating a capacity to use health information technology to provide feedback to providers to improve service delivery across the care continuum; and
- Establishing a continuous quality improvement program, and collecting and reporting on data that permits an evaluation of increased coordination of care, efforts to advance health equity, program performance, and the management of complex conditions.

All states with an existing Medicaid managed care delivery system that are implementing a Health Home program must compare the care coordination activities provided by the health plan to the care coordination activities required for Health Home in order to avoid duplicative payment for the same service. If the state determines that there is some duplication of activity, the state must take measures to account for that duplication and avoid duplicate payment. The most frequently observed examples seen from approved Health Home state plans include adjusting the health plan's capitation payment downward to address the duplicative care management activities or imposing additional contract requirements so that the managed care plans perform additional non-duplicative services. If a Health Home program is provided under an MCO, a PIHP, PAHP or a PCCM, the arrangements must comply with both the Health Home requirements as well as with the requirements of 42 CFR part 438 regarding Medicaid managed care.

INSTRUCTIONS

Select the service delivery system(s) that will be used for individuals in the Health Home program from the following list. One service delivery system must be selected and more than one may be selected.

- Fee-For-Service
- Primary Care Case Management (PCCM)
- Risk-Based Managed Care
- Other Service Delivery System

If Fee-for-Service is selected, no other information about this service delivery system is requested in this screen. The payment methodology will be described in the Health Home Payment Methodologies screen.

If PCCM is selected, indicate *Yes* or *No* if the PCCM will be a Designated Provider or part of a Team of Health Care Professionals.

- If *Yes* is selected (PCCM will be a Designated Provider or part of a Team of Health Care Professionals):
    - Select the option(s) which best describe on what basis the PCCM/Health Home providers will be paid:
        - Fee-for-Service methodology that is described in the Payment Methodologies screen
        - Alternative Model of Payment that is described in the Payment Methodologies screen
        - Other payment methodology. If Other is selected, describe the payment methodology.
    - Select *Yes* or *No* whether the requirements for the Health Home PCCM will be different from those of a regular PCCM.
        - If *Yes* is selected (the requirements for the Health Home PCCM will be different than those for non-Health Home PCCMs):
            - Describe how the requirements will be different.
            - Check the assurance, "The state provides assurance that these requirements will be incorporated into the next PCCM contract submitted to CMS."
        - If *No* is selected, this option is complete.
    - At your option, upload any documents which support the information/descriptions provided of the proposed PCCM system. More than one document may be uploaded.
- If *No* is selected (PCCM will NOT be a Designated Provider or part of a Team of Health Care Professionals), check the assurance, "The state provides assurance that it will not duplicate payment between its Health Home payments and PCCM payments."

If Risk Based Managed Care is selected, indicate *Yes* or *No* if the Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.

- If *Yes* is selected (Health Plans will be a Designated Provider or part of a Team of Health Care Professionals):
    - Provide a summary of the contract language imposed on the Health Plans in order to deliver Health Home services.
    - Check the assurance, "The state provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review."
    - At your option, upload a copy of the Health Plan contract.
    - Select *Yes* or *No* whether Health Home payments will be included in the Health Plan capitation rate.
        - If *Yes* is selected, check the three assurances displayed.
        - If *No* is selected, select one or more of the options to indicate which payment methodology(ies) will be used to pay the Health Plans:
            - Fee-for-Service methodology that is described in the Payment Methodologies screen

    - Alternative Model of Payment that is described in the Payment Methodologies screen
    - Other payment methodology. If Other is selected, describe the payment methodology.
- If *No* is selected (Health Plans will NOT be a Designated Provider or part of a Team of Health Care Professionals), select one or more of the options to indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be avoided:
    - The current capitation rate will be reduced.
    - The state will impose additional contract requirements on the plans for Health Home enrollees.
        - If this option is selected, provide a summary of the contract language containing these additional requirements.
    - Other
        - If this option is selected, provide a description of the other method used to avoid duplication of payment.

If Other Service Delivery System is selected:

- Describe whether or not the providers in this other delivery system will be a Designated Provider or part of the Team of Health Care Professionals and how payment will be delivered to these providers.
- Check the assurance, "The state provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review."
- At your option, upload a copy of pertinent contract requirements.

REVIEW CRITERIA

PCCM Other Payment Methodology:
The description of a different payment methodology should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements.

PCCM Requirements Different from Regular PCCM:
The description of the requirements for Health Home PCCM that are different than those for regular PCCM should include how the PCCM requirements add value or enhance the level of service activity beyond the care coordination that a regular PCCM provides. Health Home services must go above and beyond the services otherwise provided through PCCM.

Summary of Health Plan Contract Language:
Under Risk Based Managed Care, if the health plans will be a Designated Provider or part of a Team of Health Care Professionals, the state must provide a summary of the additional contract language explaining how the health plans will work with the Health Home program. This summary should include an explanation of the roles and responsibilities of health plans versus those of the Health Home providers. Specifically, it should explain what additional activities the health plans may be providing instead of adjusting the capitation rate. It should also summarize the contract language with respect to the responsibilities of the health plans providing and/or coordinating services with the Health Home providers. It is preferable that the contract have a separate addendum for Health Home.

Health Home Payments Not Included in Health Plan Capitation Rate:
Under Risk Based Managed Care, if Health Home payments will not be included in the Health Plan capitation rate, and the state indicates that it will use a payment methodology other than Fee-for-Service or Alternative Model of Payment, the description of the different payment methodology should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements.

Health Plans will NOT be a Designated Provider or part of a team of Health Care Professionals:
Under Risk Based Managed Care, if the Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals, and the state has indicated that it will avoid duplication of payment for care coordination by imposing additional contract requirements on the plans for Health Home enrollees who are also enrolled in a health plan, the state must provide a summary of the Health Plan contract language related to these additional requirements. This summary should include an explanation of the roles and responsibilities of health plans versus those of the Health Home providers which demonstrates how the state will

avoid duplication of payment. Specifically, it should explain what additional activities the health plans may be providing instead of adjusting the capitation rate. It should also summarize the contract language with respect to the responsibilities of the health plans providing and/or coordinating services with the Health Home providers. It is preferable that the contract have a separate addendum for Health Home.

<u>Other Method of Avoiding Duplication of Payment:</u>
Under Risk Based Managed Care, if the Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals, and the state has indicated that it will avoid duplication of payment for care coordination by some method other than reducing the capitation rate or adding requirements to the Health Plan contract, the state must provide a description of the other method it will use. This description of the other method to avoid duplication of payment should be sufficiently clear, detailed and complete to permit the reviewer to determine that the method meets applicable federal statutory, regulatory and policy requirements.

<u>Other Service Delivery System:</u>
If a service delivery system other than Fee-for-Service, PCCM or At Risk Managed Care is selected, the state must completely describe the other service delivery system. This description should include whether the providers will be a Designated Provider or part of a Team of Health Care Professionals and how payment will be delivered to these providers. It should distinguish between Health Home services and other similar programs and authorities and explain how the state will avoid duplication of activities, such as care coordination, between Health Home and other Medicaid services

1945A HEALTH HOME PAYMENY METHODOLOGIES

POLICY CITATION

Statute: 1945A of the Social Security Act
Formal Guidance: SMDL #22-004 dated August 1, 2022

BACKGROUND

The purpose of this screen is for the state to identify the type(s) of service delivery system(s) that will be used for individuals receiving Health Home services. Depending on the type of service delivery system to be used, in this screen states may also be asked to specify the payment methodology, as well as to provide assurances and descriptions of the service delivery system(s).

Health Home providers must have an infrastructure in place to provide timely, comprehensive, and high-quality Health Home services. Neither the statute nor the SMD letter requires a specific system for delivering Health Home services under section 1945A. Therefore, states are given the flexibility to determine which service delivery system or combination of systems will be used in its Health Home program. The state may use a fee-for-service, primary care case management (PCCM), risk-based managed care delivery system and/or some other model of service delivery. Regardless of the service delivery system, Health Home providers will need to meet the core Health Home functional requirements and Health Home service delivery principles as described under Provider Standards.

The Health Home statute provides states considerable flexibility to design a Health Home service delivery model appropriate to the needs of the population and each state's existing delivery system. As a reminder, section 1945A(h)(2) provides that nothing in section 1945A may be construed "to limit the choice of a child with medically complex conditions in selecting a designated provider, team of health care professionals operating with such a provider, or health team that meets the health home qualification standards". This means that a state cannot have a closed provider network for section 1945A health home services delivered via managed care and cannot limit the choice of providers through a managed care organization. If states' managed care contracts need to be updated to reflect this, CMS will provide technical assistance.

Section 1945A health home providers must demonstrate to the state the ability to do the following:

(7) Coordinate prompt care for children with medically complex conditions, including access to pediatric emergency services at all times;

(8) Develop an individualized comprehensive pediatric family-centered care plan for children with medically complex conditions that accommodates patient preferences;

(9) Work in a culturally and linguistically appropriate manner with the family of a child with medically complex conditions to develop and incorporate into such child's care

plan, in a manner consistent with the needs of the child and the choices of the child's family, ongoing home care, community-based pediatric primary care, pediatric inpatient care, social support services, and local hospital pediatric emergency care;

(10) Coordinate access to—

(C) subspecialized pediatric services and programs for children with medically complex conditions, including the most intensive diagnostic, treatment, and critical care levels as medically necessary; and

(D) palliative services if the state provides Medicaid coverage for such services;

(11) Coordinate care for children with medically complex conditions with out-of-state providers furnishing care to such children to the maximum extent practicable for the families of such children and where medically necessary, in accordance with guidance issued under section 1945A(e)(1) and 42 CFR 431.52;[11] and

(12) Collect and report information in accordance with section 1945A(g)(1) of the Act.

CMS also recommends that states ensure that providers of health home services can perform the functions listed below, in addition to meeting the statutory standards listed above. CMS encourages states to describe in their section 1945A health home SPAs how the state will support providers of section 1945A health home services in performing the following:

Health Home Service Delivery System Principles:

- Demonstrating clinical competency for serving the complex needs of section 1945A health home enrollees;
- Providing access to timely health home services 24 hours a day, 7 days a week to address any immediate care needs of health home enrollees;
- Maintaining conflict of interest safeguards are in place to assure enrollee rights and protections are not violated, and that services are coordinated in accordance with enrollee needs expressed in the family-centered care plan, rather than based on financial interests or arrangements of the health home provider;
- 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 clinical practice guidelines;
- Coordinating and providing access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
- Coordinating and providing access to comprehensive care management, care coordination, and transitional care across settings (Note: Transitional care should include 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);

[11] See https://www.medicaid.gov/federal-policy-guidance/downloads/cib102021.pdf.

- Having protocols to assist in removing barriers, such as those posed by transportation, to ensure safe transition of care between providers. Protocols could include relationships between the health home provider and hospitals or other health care providers;
- Coordinating and providing access to chronic disease management, including self-management support for individuals and their families;
- Coordinating and providing access to individual and family supports, including referral to community, social support, and recovery services;
- Coordinating and providing access to long-term care services and supports;
- Demonstrating a capacity to use health information technology to link services as feasible and appropriate, including by facilitating communication among health team members and facilitating communication among the health team, individual, and family caregivers;
- Demonstrating a capacity to use health information technology to provide feedback to providers to improve service delivery across the care continuum; and
- Establishing a continuous quality improvement program, and collecting and reporting on data that permits an evaluation of increased coordination of care, efforts to advance health equity, program performance, and the management of complex conditions.

All states with an existing Medicaid managed care delivery system that are implementing a Health Home program must compare the care coordination activities provided by the health plan to the care coordination activities required for Health Home in order to avoid duplicative payment for the same service. If the state determines that there is some duplication of activity, the state must take measures to account for that duplication and avoid duplicate payment. The most frequently observed examples seen from approved Health Home state plans include adjusting the health plan's capitation payment downward to address the duplicative care management activities or imposing additional contract requirements so that the managed care plans perform additional non-duplicative services. If a Health Home program is provided under an MCO, a PIHP, PAHP or a PCCM, the arrangements must comply with both the Health Home requirements as well as with the requirements of 42 CFR part 438 regarding Medicaid managed care.

INSTRUCTIONS

Select the service delivery system(s) that will be used for individuals in the Health Home program from the following list. One service delivery system must be selected and more than one may be selected.

- Fee-For-Service
- Primary Care Case Management (PCCM)
- Risk-Based Managed Care
- Other Service Delivery System

If Fee-for-Service is selected, no other information about this service delivery system is requested in this screen. The payment methodology will be described in the Health Home Payment Methodologies screen.

If PCCM is selected, indicate *Yes* or *No* if the PCCM will be a Designated Provider or part of a Team of Health Care Professionals.

- If *Yes* is selected (PCCM will be a Designated Provider or part of a Team of Health Care Professionals):
    - Select the option(s) which best describe on what basis the PCCM/Health Home providers will be paid:
        - Fee-for-Service methodology that is described in the Payment Methodologies screen
        - Alternative Model of Payment that is described in the Payment Methodologies screen
        - Other payment methodology. If Other is selected, describe the payment methodology.
    - Select *Yes* or *No* whether the requirements for the Health Home PCCM will be different from those of a regular PCCM.
        - If *Yes* is selected (the requirements for the Health Home PCCM will be different than those for non-Health Home PCCMs):
            - Describe how the requirements will be different.
            - Check the assurance, "The state provides assurance that these requirements will be incorporated into the next PCCM contract submitted to CMS."
        - If *No* is selected, this option is complete.
    - At your option, upload any documents which support the information/descriptions provided of the proposed PCCM system. More than one document may be uploaded.
- If *No* is selected (PCCM will NOT be a Designated Provider or part of a Team of Health Care Professionals), check the assurance, "The state provides assurance that it will not duplicate payment between its Health Home payments and PCCM payments."

If Risk Based Managed Care is selected, indicate *Yes* or *No* if the Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.

- If *Yes* is selected (Health Plans will be a Designated Provider or part of a Team of Health Care Professionals):
    - Provide a summary of the contract language imposed on the Health Plans in order to deliver Health Home services.
    - Check the assurance, "The state provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review."
    - At your option, upload a copy of the Health Plan contract.
    - Select *Yes* or *No* whether Health Home payments will be included in the Health Plan capitation rate.
        - If *Yes* is selected, check the three assurances displayed.
        - If *No* is selected, select one or more of the options to indicate which payment methodology(ies) will be used to pay the Health Plans:
            - Fee-for-Service methodology that is described in the Payment Methodologies screen

        - Alternative Model of Payment that is described in the Payment Methodologies screen
        - Other payment methodology. If Other is selected, describe the payment methodology.
- If *No* is selected (Health Plans will NOT be a Designated Provider or part of a Team of Health Care Professionals), select one or more of the options to indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be avoided:
    - The current capitation rate will be reduced.
    - The state will impose additional contract requirements on the plans for Health Home enrollees.
        - If this option is selected, provide a summary of the contract language containing these additional requirements.
    - Other
        - If this option is selected, provide a description of the other method used to avoid duplication of payment.

If Other Service Delivery System is selected:

- Describe whether or not the providers in this other delivery system will be a Designated Provider or part of the Team of Health Care Professionals and how payment will be delivered to these providers.
- Check the assurance, "The state provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review."
- At your option, upload a copy of pertinent contract requirements.

REVIEW CRITERIA

PCCM Other Payment Methodology:
The description of a different payment methodology should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements.

PCCM Requirements Different from Regular PCCM:
The description of the requirements for Health Home PCCM that are different than those for regular PCCM should include how the PCCM requirements add value or enhance the level of service activity beyond the care coordination that a regular PCCM provides. Health Home services must go above and beyond the services otherwise provided through PCCM.

Summary of Health Plan Contract Language:
Under Risk Based Managed Care, if the health plans will be a Designated Provider or part of a Team of Health Care Professionals, the state must provide a summary of the additional contract language explaining how the health plans will work with the Health Home program. This summary should include an explanation of the roles and responsibilities of health plans versus those of the Health Home providers. Specifically, it should explain what additional activities the health plans may be providing instead of adjusting the capitation rate. It should also summarize the contract language with respect to the responsibilities of the health plans providing and/or coordinating services with the Health Home providers. It is preferable that the contract have a separate addendum for Health Home.

Health Home Payments Not Included in Health Plan Capitation Rate:
Under Risk Based Managed Care, if Health Home payments will not be included in the Health Plan capitation rate, and the state indicates that it will use a payment methodology other than Fee-for-Service or Alternative Model of Payment, the description of the different payment methodology should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements.

Health Plans will NOT be a Designated Provider or part of a team of Health Care Professionals:
Under Risk Based Managed Care, if the Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals, and the state has indicated that it will avoid duplication of payment for care coordination by imposing additional contract requirements on the plans for Health Home enrollees who are also enrolled in a health plan, the state must provide a summary of the Health Plan contract language related to these additional requirements. This summary should include an explanation of the roles and responsibilities of health plans versus those of the Health Home providers which demonstrates how the state will

avoid duplication of payment. Specifically, it should explain what additional activities the health plans may be providing instead of adjusting the capitation rate. It should also summarize the contract language with respect to the responsibilities of the health plans providing and/or coordinating services with the Health Home providers. It is preferable that the contract have a separate addendum for Health Home.

<u>Other Method of Avoiding Duplication of Payment:</u>
Under Risk Based Managed Care, if the Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals, and the state has indicated that it will avoid duplication of payment for care coordination by some method other than reducing the capitation rate or adding requirements to the Health Plan contract, the state must provide a description of the other method it will use. This description of the other method to avoid duplication of payment should be sufficiently clear, detailed and complete to permit the reviewer to determine that the method meets applicable federal statutory, regulatory and policy requirements.

<u>Other Service Delivery System:</u>
If a service delivery system other than Fee-for-Service, PCCM or At Risk Managed Care is selected, the state must completely describe the other service delivery system. This description should include whether the providers will be a Designated Provider or part of a Team of Health Care Professionals and how payment will be delivered to these providers. It should distinguish between Health Home services and other similar programs and authorities and explain how the state will avoid duplication of activities, such as care coordination, between Health Home and other Medicaid services

1945A HEALTH HOME SERVICES

POLICY CITATION

Statute: 1945 of the Social Security Act
Formal Guidance: SMDL #22-004 dated August 1, 2022

BACKGROUND

The purpose of this screen is for the state to define the six types of Health Home services that are statutorily required to be provided by each Health Home provider arrangement and covered under the Health Home benefit. The state also will describe how health information technology will be used to link each Health Home service in a comprehensive approach across the care continuum, including a flow chart illustrating how Health Home services will be integrated into the overall care received by the beneficiary.

Section 1945A(i)(4) of the Act defines "Health Home services" as comprehensive and timely high-quality services that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team, and include:

1) comprehensive care management;
2) care coordination, health promotion, and access to the full range of pediatric specialty and subspecialty medical services, including services from out-of-state providers, as medically necessary;
3) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;
4) patient and family support (including authorized representatives);
5) referrals to community and social support services, if relevant; and
6) use of health information technology to link services, as feasible and appropriate.

The state also will describe how health information technology will be used to link each Health Home service in a comprehensive approach across the care continuum, including a flow chart illustrating how Health Home services will be integrated into the overall care received by the beneficiary. Health Home must provide all six of the required Health Home services, based on the individual's needs as appropriate:

1) <u>Comprehensive Care Management</u>
   Comprehensive Care Management means the initial and ongoing assessment and care management services aimed at the integration of primary, behavioral and specialty health care and community support services, using a comprehensive person-centered care plan which addresses all clinical and non-clinical needs and promotes wellness and management of chronic conditions in pursuit of optimal health outcomes.

   Services include, but are not limited to the following activities:
   (i) Conducting outreach and engagement activities to gather information from the enrollee, the enrollee's support member(s), and other primary and specialty care providers.

(ii) Completing a comprehensive needs assessment as
(iii) Developing an integrated person-centered care plan and updating

2) Care Coordination

Care Coordination means facilitating access to, and the monitoring of, services identified in a person-centered care plan to manage chronic conditions for optimal health outcomes and to promote wellness, which includes access to the full range of pediatric specialty and subspecialty medical services, including services from out-of-state providers, as medically necessary. Care coordination includes the facilitation of the interdisciplinary teams to perform a regular review of person-centered care plans and monitoring service delivery and progress toward goals. This is typically accomplished through face-to-face but may also be provided through telehealth and collateral contacts with the Health Home enrollee, family, informal and formal caregivers, and with primary and specialty care providers. It also includes facilitation and sharing of centralized information to coordinate integrated care by multiple providers through use of electronic health records (EHRs) that can be shared among all providers.

Care coordination includes but is not limited to:
(i) Implementing the person-centered care plan.
(ii) Continuous monitoring of progress towards goals identified in the person-centered care plan through face-to-face and collateral contacts with enrollee, enrollee's support member(s) and primary and specialty care providers.
(iii) Supporting the enrollee's adherence to prescribed treatment regimens and wellness activities.
(iv) Participating in hospital discharge processes to support the enrollee's transition to a non-hospital setting.
(v) Communicating and consulting with other providers and the enrollee and enrollee's support member, as appropriate.
(vi) Facilitating regularly scheduled interdisciplinary team meetings to review of care plans and assess progress.

3) Health Promotion

Health Promotion means the education and engagement of an individual in making decisions that promote his/her maximum independent living skills and lifestyle choices that achieve the following goals: good health, pro-active management of chronic conditions, early identification of risk factors, and appropriate screening for emerging health problems. It also provides access to the full range of pediatric specialty and subspecialty medical services, including services from out-of-state providers, as medically necessary.

Health promotion services include, but are not limited to, the following activities:

(i) Promoting enrollee's education of their chronic condition.
(ii) Teaching self-management skills.
(iii) Conducting medication reviews and regimen compliance.

(iv) Promoting wellness and prevention programs by assisting Health Home enrollees with resources that address exercise, nutrition, stress management, substance use reduction/cessation, smoking cessation, self-help recovery resources, and other wellness services based on enrollee needs and preferences.

The requirement to provide access to the full range of pediatric specialty and subspecialty medical services, including services from out-of-state providers, is new to the 1945A Health Home. Health Home providers will be expected to provide access to and coordinate care for children with medically complex conditions with out-of-state providers when appropriate (including when provided in emergency and non-emergency situations) and reduce barriers for such children receiving care from such providers in a timely fashion. Providers can refer to best practice guidance issued October 20, 2021 to determine how to best provide access to and the coordination of care between states.
Comprehensive Transitional Care from Inpatient to Other Settings (including follow-up)
Comprehensive Transitional Care means the facilitation of services for the individual and family/caregiver when the individual is transitioning between levels of care (including, but not limited to hospital, nursing facility, rehabilitation facility, community-based group home, family or self-care) or when an individual is electing to transition to a new Health Home provider. This involves developing relationships with hospitals and other institutions and community providers to ensure and to foster the efficient and effective care transitions. Health Home programs should establish a written protocol on the care transition process with hospitals (and other community-based facilities) to set up real time sharing of information and care transition records for Health Home enrollees.

4) Comprehensive transitional care services include, but are not limited to, the following activities:
(i) Establishing relationships with hospitals, residential settings, rehabilitation settings, other treatment settings, and long-term services and supports providers to promote a smooth transition if the enrollee is moving between levels of care and back into the community.
    (A) This includes prompt notification and ongoing communication of enrollee's admission and/or discharge to and from an emergency room, inpatient residential, rehabilitative or other treatment settings.
    (B) If applicable, this relationship should also include active participation in discharge planning with the hospital or other treatment settings to ensure consistency in meeting the goals of the enrollee's person-centered care plan;
(ii) Communicating and providing education to the enrollee, the enrollee's support member and the providers that are located at the setting from which the person is transitioning, and at the setting to which the individual is transitioning.
(iii) Developing a systemic protocol to assure timely access to follow-up care post discharge that includes at a minimum all of the following:
    (A) Receipt of a summary of care record from the discharging entity.
    (B) Medication reconciliation.
    (C) Reevaluation of the care plan to include and provide access to needed community support services.
    (D) A plan to ensure timely scheduled appointments.

5) Patient and Family Support (which includes authorized representatives
Patient and family support mean the coordinating of information and services to support enrollees and the enrollee's support members to maintain and promote the quality of life, with particular focus on community living options.

Patient and family support services include, but are not limited to, the following activities:
(i) Providing education and guidance in support of self-advocacy.
(ii) Providing caregiver counseling or training to include, skills to provide specific treatment regimens to help the individual improve function, obtain information about the individual's disability or conditions, and navigation of the service system.
(iii) Identifying resources to assist individuals and family support members in acquiring, retaining, and improving self-help, socialization and adaptive skills.
(iv) Providing information and assistance in accessing services such as: self-help services, peer support services; and respite services.

6) Referral to Community and Social Support Services
Referral to community/social supports means the provision of information and assistance for the purpose of referring enrollees and enrollee support members to community-based resources, regardless of funding source, that can meet the needs identified on the enrollee's person-centered care plan.

If relevant; Referrals to community/social support services include, but are not limited to, the following activities:
(i) Providing referral and information assistance to individuals in obtaining community-based resources and social support services;
(ii) Identifying resources to reduce barriers to help individuals in achieving their highest level of function and independence.
(iii) Monitoring and follow up with referral sources, enrollee sources, enrollee, and enrollee's support member, to ensure appointments and other activities, including employment and other social community integration activities, were established and enrollees were engaged in services.

7) Health Information Technology
When appropriate and feasible, quality measure reporting is to be done through the use of health information technology. CMS encourages states to utilize information technologies to provide Health Home services and improve care coordination across the care continuum and recognizes the importance of health information technology (HIT) in furthering the aims of the Health Home model of service delivery. States have the flexibility to determine how to use health information technology in their Health Home models. Section 1945A(g) of the Act states, "when appropriate and feasible, such provider, team of health care professionals, or health team, as the case may be, shall use health information technology in providing the state with such information." CMS has identified key questions for states to address in their state plan amendments to describe how they will incorporate HIT tools to achieve the objectives of their Health Home.

INSTRUCTIONS

Service Definitions

Indicate whether or not the common Health Home services definition, as noted in the background section, is used. If not, provide a detailed definition of the service, including the specific activities to be performed under the service. Regardless of which definition is used:

- Clearly explain how it will operate under a whole-person approach to care.
- Describe how the approach to care will be person-centered, taking into account each person's unique needs, culture, values and preferences, with the person involved in the care plan.
- Describe the comprehensive team-based approach to care provided by a cohesive team, including:
    - The roles and responsibilities of team members;
    - How primary and behavioral health will be integrated;
    - Describe how the team will coordinate care across all elements of the health care system and provide the linkages to medical and social resources in the community.

Describe how health information technology will be used to link each service in a comprehensive approach across the continuum of care.

Describe the scope of services, by provider types.

- Select one or more provider types that can provide the Health Home service and enter a description of each provider type selected.
- If "Other" is selected, enter the provider type in addition to a description.
- More than one "Other" provider type may be entered.

Health Home Patient Flow

Describe a typical patient's flow through the Health Home system, including how Health Home are integrated into the overall care received by the beneficiary. Upload via the "Saved Documents" feature one or more flow-charts which describe this process. At least one flow-chart is required.

REVIEW CRITERIA

The description for each of the Health Home services should clearly explain how it will operate under a whole-person approach to care. The descriptions should include how the approach to care will be person-centered, taking into account each person's unique needs, culture, values and preferences, with the person involved in the care plan. There needs to be a comprehensive, team-based approach to care provided by a cohesive team that includes a description of how the team will operate, the roles and responsibilities of each team member, and how primary and behavioral health will be integrated. The description needs to include how the team will coordinate care across all elements of the health care system and provide the linkages to medical and social resources in the community.

CMS will review state service definitions and compare them to the defined Health Home services identified above in the Background section, which were developed based upon the experience from approved Health Home programs. The activities identified under each service definition should be incorporated into the state's definitions to achieve a common approach to the delivery of Health Home services.

The state's description of how health information technology will be used to link each Health Home service should be sufficiently clear, detailed, and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements.

1945A Health Home Program - Monitoring, Quality Measurement and Evaluation

POLICY CITATION

Statute: 1945A of the Social Security Act
Formal Guidance: SMDL #22-004 dated August 1, 2022

BACKGROUND

To support continued improvement and evaluation, section 1945A(f) of the Act requires states that implement section 1945A health homes for children with medically complex conditions to include in their section 1945A health home SPAs:

> (1) A methodology for tracking reductions in inpatient days and reductions in the total cost of care resulting from improved care coordination and management under section 1945A;
>
> (2) A proposal for the use of health information technology in providing health home services under section 1945A and improving service delivery and coordination across the care continuum (including the use of wireless patient technologyto improve coordination and management of care and patient adherence to recommendations made by their provider); and
>
> (3) A methodology for tracking prompt and timely access to medically necessary care for children with medically complex conditions from out-of-state providers.

As described in more detail below, the impact of the Health Home provision will be examined in both provider and state level reporting requirements. CMS recommends states collect and report information required for the overall evaluation of the Health Home model of service delivery, and additionally 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, as well as race and ethnicity data. 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 for children with medically complex conditions. States will be asked to report on specific health equity data for the Health Home enrolled population as provided by CMS.

As part of the focus on continued improvement and evaluation, section 1945A(f) of the Act requires states that implement these Health Homes to track the following:

(1) a methodology for tracking reductions in inpatient days and reductions in the total cost of care resulting from improved care coordination and management under this section;

(2) a proposal for use of health information technology in providing Health Home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider); and

(3) a methodology for tracking prompt and timely access to medically necessary care for children with medically complex conditions from out-of-state providers.

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.

INSTRUCTIONS

Monitoring

Describe the state's methodology for calculating cost saving. The description should include:

- Savings resulting from improved coordination of care and chronic disease management, including data sources and measurement specifications.
- Savings associated with serving dual-eligibles, including if Medicare data was available to the state and used in calculating the estimate.

Quality Measurement and Evaluation

Check all assurances related to:

- Requiring providers to report to the state all applicable quality measures as a condition of receiving payment.
- Requiring States to report to CMS information to include applicable mandatory Core Set submitted by Health Home providers in accordance with all requirements in CFR §§ 437.10 and 437.15.
- Identifying measurable goals and quality measures for each goal.
- Reporting information to CMS.
- Tracking avoidable hospital readmissions and reporting annually in the Quality Measures report.
- Requiring providers to report the name, National Provider Identification number, address, and specific health care services provided to children with medically complex conditions who have selected such a provider as a condition of payment.
- Requiring providers to report information on all applicable measures for determining the quality of Health Home services, including, to the extent applicable, child health quality measures and measures for centers of excellence for children with complex needs developed under this title, Title XXI and section 1139A as a condition of payment.
- Requiring the state to provide a comprehensive report to include information as per subsection 1945A(g)(2)(A) to the Secretary (and upon request to the Medicaid and CHIP Payment Access Commission) in a manner determined by the Secretary to be reasonable and minimally burdensome.
- Requiring the state to submit to the Secretary, and make publicly available on the appropriate state website, a report on how the state is implementing guidance issued under subsection (e)(1), including any best practices adopted by the state no later than 90 days after the state plan amendment is approved.

Go to Quality Measure Reports

- States may click on this link to either view and/or update Health Home Quality Measures reporting.

REVIEW CRITERIA

Cost Savings Methodology: ***The state's description for calculating cost savings should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements. It should include the methodology used to calculate savings that result from improved coordination of care and chronic disease management achieved through the Health Home program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost savings estimates.***

Use of Health Information Technology: ***The state's description for using health information technology in providing Health Home services should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements. It should include the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider.***

Tracking reductions in inpatient days and reductions in total cost of care: ***The state's description of tracking reductions in inpatient days and reductions in the total cost of care resulting from improved care coordination and management should be sufficiently clear to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements. The state should include the methodology used to calculate savings in the total cost of care that results from care coordination and management achieved through the Health Home program including the data sources and measurement specifications.***

Tracking access to care from out-of-state providers: ***The state's methodology for tracking prompt and timely access to medically necessary care for children with medically complex conditions from out-of-state providers should be sufficiently clear to permit the reviewer to determine that the state's election meets applicable statutory, regulatory and policy requirements. The state should include the methodology used to calculate prompt and timely access to care and the standard by which it determines medically necessary care.***

Suggested Measures for 1945A Health Homes

NQF #	Measure Steward	Measure Name	Data Collection Method	Measure Description
1392	NCQA	Well-Child Visits in the First 30 Months of Life (W30-CH)	Administrative	Percentage of children who had the following number of well-child visits with a primary care practitioner (PCP) during the last 15 months. The following rates are reported: • Well-Child Visits in the First 15 Months. Children who turned age 15 months during the measurement year: Six or more well-child visits. • Well-Child Visits for Age 15 Months–30 Months. Children who turned age 30 months during the measurement year: Two or more well-child visits.
1516	NCQA	Child and Adolescent Well-Care Visits (WCV-CH)	Administrative	Percentage of children ages 3 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement year.
0038	NCQA	Childhood Immunization Status (CIS-CH)	Administrative, hybrid, or HER	Percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three Hemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure

NQF #	Measure Steward	Measure Name	Data Collection Method	Measure Description
				calculates a rate for each vaccine and nine separate combination rates.
1407	NCQA	Immunizations for Adolescents (IMA-CH)	Administrative or hybrid	Percentage of adolescents age 13 who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.
2517	DQA (ADA)	Oral Evaluation, Dental Services	Administrative	Percentage of children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year.
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-HH)	Administrative	Rate of emergency department (ED) visits per 1,000 enrollee months among Health Home enrollees.
NA	CMS	Inpatient Utilization (IU-HH)	Administrative	Rate of acute inpatient care and services (total, maternity, mental and behavioral disorders, surgery, and medicine) per 1,000 enrollee months among Health Home enrollees.

1945A HEALTH HOME PROGRAM TERMINATION – PHASE-OUT PLAN

POLICY CITATION

Statute: 1945A of the Social Security Act
Formal Guidance: SMDL #22-004 dated August 1, 2022

BACKGROUND

The purpose of this screen is to provide detailed information about the state's plans to terminate a specific Health Home program. It may be necessary to terminate a Health Home program due to state legislative action, reduction of funding or some other reason making the continuation of the program not possible. When this happens, the state may choose to terminate the program statewide as of a certain date, or may phase-out the program over time. Notifications of the program termination should be sent to all participants and providers, giving information about the program termination, how it will affect them and fair hearing rights (if applicable). Additionally, if a new program is replacing the Health Home program States need to ensure that the services are comparable and if there would be beneficiaries that would lose service. CMS must approve the states plans to terminate the program, as described in this screen.

INSTRUCTIONS

This screen can be accessed in either of the following two ways:

- There is an existing approved Health Home program and the state creates a submission package to end the program by selecting the option, "Terminate existing Health Home program" in the Medicaid State Plan reviewable unit.
- A Termination – Phase-Out Plan reviewable unit has already been completed and the submission package has been approved, and now the state has to change the information previously provided in this reviewable unit. This is done by selecting "Amend existing Health Home program" in the Medicaid state plan reviewable unit, and selecting the Health Home program – Termination – Phase-Out Plan reviewable unit.

Under "Provide a description of the phase-out or transition plan for the Health Home program that is being terminated," complete the following:

- Enter a reason the program is being terminated.
- Describe the overall approach to be used in terminating the program
- Under "Indicate the method of termination," choose whether the state will terminate all participants on the same date or phase-out the termination.
    - If you select "The state will terminate all participants from the Health Home program on the same date, you must enter the effective date of the termination.
    - If you select "The state will phase-out the termination of participation in the Health Home program:"
        - You must enter a date in two fields, to indicate the period of the phase-out:
            - Begin phase-out date
            - Complete phase-out date

    - You must also upload the state's phase-out plan. This plan must include a description of the phase-out, as well as the strategy for communicating the phase-out to participants and providers, including the dates of communication. To include any applicable fair hearings rights.
- Regardless of whether the program will be terminated for all participants at the same time or the termination is phased-out, you must describe the process that will be used to transition all of the participants and how referrals will be made to other health care providers.

Note: When terminating a Health Home program, the state must continue to submit Health Home quality measures reports covering the entire period the program was active, through to the end of the program.

REVIEW CRITERIA

***Reason for termination:** The state's description of the reason for termination should be clear and provide enough detail for the reviewer to understand the underlying causes of the decision to terminate, for example: lack of funding; provider capacity; change in administration or legislation; new service delivery systems.*

***Overall approach the state will use to terminate the program**: The state's description of the overall approach used to terminate the program should summarize the termination plan in a way that is sufficiently clear, detailed and complete to permit the reviewer to determine that it meets applicable federal statutory, regulatory and policy requirements.*

***Description of the process used to transition all participants:** The state's description of the process used to transition all beneficiaries should include how the beneficiaries may continue to access services, how referrals will be made to other services and the methods of communication that will take place to the beneficiaries, providers and other stakeholders so that the affected beneficiaries will continue to be able to access medical care and other social and supportive services.*