

NC Medicaid Health Homes Initiative

IOM New Models of Care Workgroup

May 18, 2011

Overview

- Section 2703 adds section 1945 to the Social Security Act which offers States additional Federal support to enhance the integration and coordination of primary, acute, behavioral health, and long-term care services and supports for Medicaid enrollees with chronic conditions.
- States are able to offer health home services to *eligible individuals with chronic conditions* who select a designated health home provider.
- The minimum criteria that define an *eligible individual* include having two or more chronic conditions, one condition and the risk of developing another, or at least one serious and persistent mental health condition.
- The *chronic conditions* listed in statute, include a mental health condition, a substance abuse disorder, asthma, diabetes, heart disease, and obesity (as evidenced by a BMI of > 25).
- Through Secretarial authority, States may add other chronic conditions in their State Plan Amendment for review and approval by CMS.
- The *health home services* are defined in statute, and include:
 - Comprehensive care management;
 - Care coordination and health promotion;
 - Comprehensive transitional care from inpatient to other settings;
 - Individual and family support;
 - Referral to community and social support services; and,
 - Use of health information technology, as feasible and appropriate.
- There is an increased federal matching percentage for the above health home services of 90 percent for the first eight fiscal quarters that a State plan amendment is in effect.
 - It is important to note that States will not be able to receive more than one 8-quarter period of enhanced FMAP *for each health home enrollee*.
- CCNC is the Health Home for NC Medicaid recipients. CCNC is responsible for the following for patients with “chronic conditions*”:
 - Comprehensive care management
 - Care coordination/health promotion
 - Comprehensive transitional care
 - Patient and family support
 - Referrals to community and social support services
 - Use of HIT to link services
 - **including serious/persistent mental illness and substance abuse disorders*

Update:

- Created a Steering Committee with representatives from DMA, CCNC, DMH/DD/SA, NC Provider Council, and LME Director. The first meeting was this week.
- Applied for planning grant and received approval last week for \$500,000 for an 18 month planning period effective May 2011
- Completed draft SPA to include recipients that currently meet the chronic condition definition for 2703.
- Participated in CMS regional consultation to review their comments on draft SPA. Written comments will be received by first of June. During this call it was realized that only one SPA may be needed because the 90% funding will be tracked by individuals and not by the health home provider type. (*Unless a different geographic location or chronic condition is created that was not included in SPA one, no other SPAs are needed.*)
- Participated in SAMSHA consultation on SPA draft required by federal legislation.

Next Steps:

- Determine timeline for submitting SPA and number of SPAs needed.
- Review current CCNC funding structure. (May need to be changed to be acuity based)
- Establish scope and timeline for following projects which are being moved to CCNC:
 - Telemonitoring
 - Tiered incentive rates for local networks and providers
 - Consolidate CAP C/DA case management under CCNC
 - HIV case management under CCNC
 - Behavioral health 1915 B/C waiver rollout and coordination with CCNC
- Determine resources, processes, and system (IT) changes needed to accomplish the above projects.
- Use planning money to fund resources, system changes, training and implementation.