Health Homes Model for At-Risk Children and their Families

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2014

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Health Homes as a Model for Addressing the Needs of At Risk Children and their Families

Introduction:
Well-coordinated, accessible health care is critical to the health and well being of all children, but it is even more important for children at risk for poor outcomes due to family circumstances, chronic health conditions, impoverished neighborhoods or other factors. The integration of systems of care that promote whole-child development and support children and families in their communities has long been a goal of child advocates. One model that shows promise in promoting effective integration is the health home, which as codified under the Affordable Care Act (ACA), provides support for coordinated services and a framework through which to address the medical, behavioral and social needs for targeted, high need segments of the Medicaid population.

The concept of the health home builds on other health reform delivery efforts including development of the patient-centered medical home, efforts to integrate physical and behavioral health care, and efforts to address the social determinants of patient and population health through coordination of services. The federal government has encouraged states seeking health home state plan amendments (SPAs) to build on existing initiatives. In this issue brief we will examine the requirements of the Medicaid health homes option created under the ACA, review state home health implementation efforts thus far, and look at Maryland initiatives, including its SPA, that could serve as the starting point for a health home designed to addresses the needs of at risk families and youth.

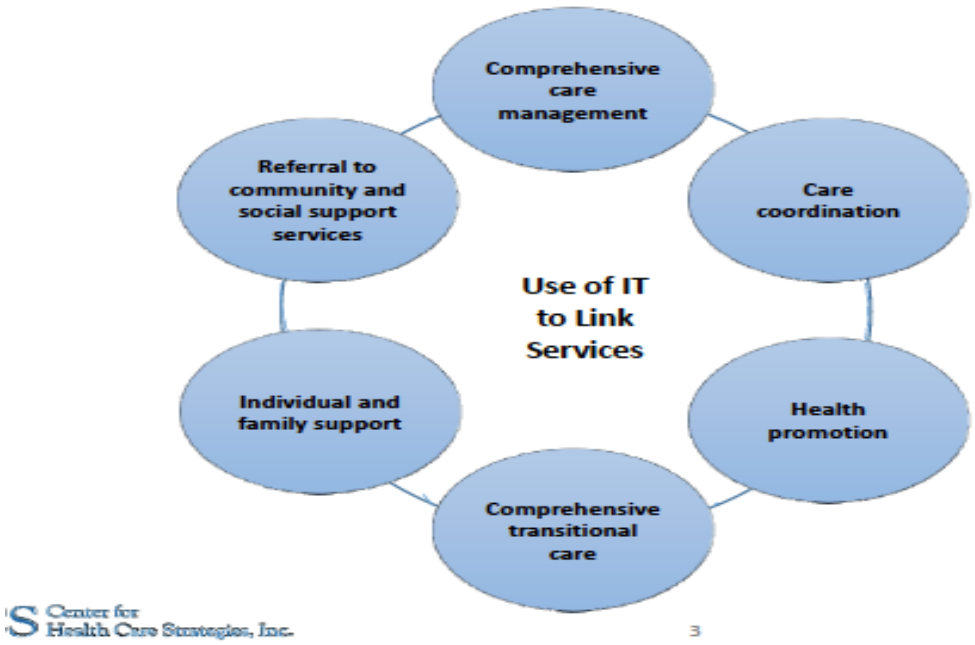
How Are Health Homes Different from Medical Homes?
The health home model has much in common with the concept of "patient-centered medical homes", but it is different in three significant ways. First, health homes focus on the integration of physical and behavioral health care. Second, health homes target services to specific high-risk populations. Finally, coordination of care in a health home includes social and community supports. Health homes are expected to look beyond medical services to identify specific needs and link participants to appropriate community social services including substance abuse, employment housing, and family services.[1] It is for this reason that they hold such potential promise for at risk families and youth in Maryland.

The ACA Medicaid Health Home Model
Medicaid health homes are designed to be person-centered systems of care that facilitate access to and coordination of the full array of primary and acute physical health services, behavioral health care, and long-term community-based services and supports.[2] The state plan option

[1] Ormond, Barbara A. "Health Homes in Medicaid: The Promise and the Challenge." (2014).
2 The Henry J. Kaiser Family Foundation, Focus on Health Reform, (2011), Medicaid's New "Health Home" Option.

created under ACA section 2703 promotes care integration across these domains by allowing state Medicaid agencies to include specified health home services in their Medicaid health home programs. An additional incentive is the enhanced 90/10 federal-match for health home services delivered to eligible Medicaid enrollees during the first eight fiscal quarters.

Under the law, all Medicaid health homes must include the six services included in the graphic below.



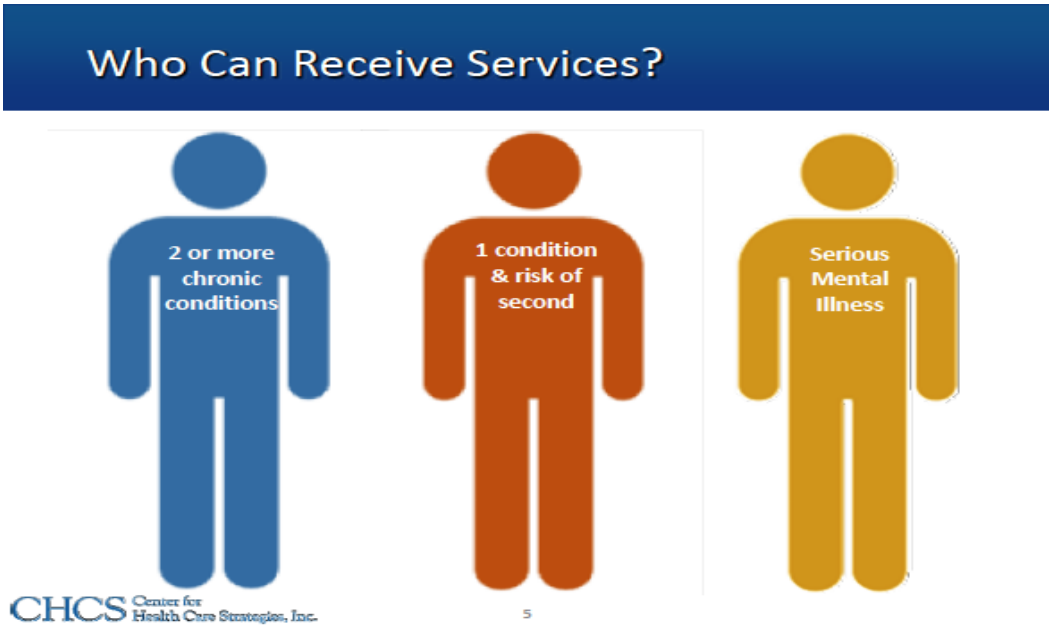
The ACA allows states considerable flexibility in defining what each of these services should entail. Descriptions of the services provided in a given state can be found in the state's SPA, along with specific activities performed under each service.

The law also gives states flexibility in how the services are delivered. It identifies three different health home provider arrangements. They include:

1. Designated provider – A physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined appropriate by the state, and that meets qualification standards to be set by the HHS Secretary.
2. Team of health care professionals operating with a designated provider – The team may include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the state. The team can be freestanding, virtual, or based in any setting determined appropriate.

3. Health team – A community-based interdisciplinary, inter-professional team of health care providers established to support primary care practices. The team may include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers, chiropractors, licensed complementary and alternative medicine practitioners, and physicians' assistants.

To qualify for health home services eligible Medicaid enrollees must meet one of three core requirements: a serious and persistent mental illness; two or more chronic conditions; or one chronic condition and the risk of developing a second. States applying for a health home SPA can choose whether to include one, two or all three eligibility categories.



The standard Medicaid requirements that all benefits be "comparable" and state wide are waived in the context of health homes. This allows states to target health home services; for example, states are allowed to cover services for the health home eligible population in a different amount, duration and scope than they do for other Medicaid beneficiaries. States can offer health home services selectively to Medicaid beneficiaries with specific chronic conditions, or to those with higher numbers of or more severe conditions. But once states define their criteria, they must offer health home services to all Medicaid beneficiaries who meet them.

To date, fourteen states have approved health home SPAs including: Alabama, Idaho, Iowa, Maryland, Maine, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island, South Dakota, Washington, and Wisconsin. Four of these states have more than one approved health home SPA; thirteen additional States have either submitted a SPA or have an approved health home planning request. Some details of the approved SPAs are included in the Appendix.

Examples of State Medicaid Health Home Approaches

North Carolina was the first of a number of states to initiate care management for Medicaid enrollees through community health teams and it has incorporated this approach into its 2012 Medicaid health home SPA. Community health teams (also known as networks, pods or hubs) are locally based care coordination teams that are shared among multiple practices. They are comprised of multidisciplinary staff from varied disciplines, such as nursing, behavioral health, pharmacy, and social work. In partnership with primary care practices, the teams connect patients, caregivers, providers, and systems through care coordination, collaborative work, and direct patient engagement.[3] While the model evolved over 25 years, the official launch of Community Care of North Carolina (CCNC) occurred in 2001. Each Community Care of North Carolina network must have a steering committee composed of representatives from primary care provider offices, hospitals, county health departments, and county social service departments. Additional groups, including specialists, area health education centers, home health providers, and schools, are often represented as well. Area primary care providers make up each network's medical management committee.[4]

Those eligible under the CMS approved health home SPA in North Carolina include Medicaid enrolled individuals with either (1) two chronic conditions, or (2) one chronic condition and at the risk of developing another. In addition to the basic list of chronic conditions enumerated in the ACA--asthma, diabetes, heart disease, and obesity--North Carolina has added chronic cardiovascular disease, chronic infectious diseases, and chronic mental and cognitive conditions to its list of qualifying conditions.[5] In addition to eligible Medicaid recipients, North Carolina includes eligible 1915(c) waiver enrollees in its health home initiative. [6]

Missouri's two approved health home SPAs are designed to address chronic health issues in two different ways. The Community Mental Health Center Health Home SPA offers services to all three categories of eligible individuals: individuals with two chronic conditions, one chronic condition and the risk of developing another; or one serious mental illness. The "two or more chronic conditions" include: mental health condition, substance use disorder, asthma, diabetes, heart disease, BMI > 25. Individuals with a serious and persistent mental illness are also eligible, as are those with a mental health condition or substance use disorder plus one other chronic

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[3] M. Takach, J. Buxbaum, "Care Management for Medicaid Enrollees Through Community Health Teams", The Commonwealth Fund, May 2013.

[4] Community Care of North Carolina, "Module 4: Building Community Networks," available at http://commonwealth.communitycarenc.org/toolkit/4/default.aspx

[5] Approved Health Home State Plan Amendments. Medicaid. Retrieved March 18, 2013. http://www.chcs.org/usr_doc/NC-11-050_Approved_Atch_3_1-H_pages_(2).pdf

[6] Approved Health Home State Plan Amendments. Medicaid. Retrieved March 18, 2013. http://www.chcs.org/usr_doc/NC-11-050_Approved_Atch_3_1-H_pages_(2).pdf

condition, as well as those individuals with a mental health condition or substance use disorder and tobacco use.

The second SPA is based on Primary Care Practice Health Home Clinics. These clinics will offer services to individuals with two chronic conditions, or with one chronic condition and the risk of developing another. The chronic conditions include: asthma, diabetes, heart disease, BMI > 25, tobacco use and developmental disabilities. Notably the Primary Care Health Home Clinics do not include mental health conditions nor substance use disorders as part of their eligibility criteria. The dichotomy stems from the recognition that adults with serious and persistent mental illness are likely to have significant chronic health conditions as well. Thus, they are better served in a setting that fully integrates and co-locates behavioral and somatic health services. The Primary Care Practice Health home clinics are designed to address patients whose needs pertain to chronic medical issue, however, they will coordinate behavioral health services where necessary.

The approval and implementation of two different health home models in Missouri holds promise for the development of health homes that can effectively serve the needs of at-risk youth and their families.

Maryland's Health Home SPA

Maryland's health home SPA went into effect on October 1, 2013. Its focus is on integration of behavioral and somatic care and improved patient outcomes for those with serious mental illness. Three categories of Medicaid enrollees are eligible for Maryland's health home program:

- Individuals with serious and persistent mental illness (SPMI) engaged with a psychiatric rehabilitation program (PRP) or Mobile Treatment Service (MTS)
- Children and adolescents with serious emotional disturbance (SED) engaged with a PRP or MTS
- Individuals with Opioid Substance Use Disorders engaged with opioid maintenance therapy, at risk for an additional chronic condition

With respect to the child and adolescent population, Maryland's health home will focus on prevention, health promotion and wellness with linkages to multiple systems and services and the involvement of family and caregivers.[7] Catholic Charities is the only provider whose sole focus is delivering health home services to children and adolescents. Catholic Charities was able to use their crisis response services as a starting point for health home services offered under the new SPA. The Baltimore Child and Adolescent Response System (B-CARS) program provides comprehensive community-based services for children in psychiatric crisis to shorten in-patient hospitalization and/or link patients to community providers. This program run by Catholic Charities has historically provided intensive individual/family therapy, psychiatric rehabilitation services, therapeutic Behavioral Support and Behavior Planning, and other supportive services.[8]

[7] Maryland Department of Health and Mental Hygiene. Provider Training: Health Homes for Children & Youth. August 7, 2013. Slides 1-11.

[8] Catholic Charities. Baltimore Child and Adolescent Response System (B-CARS). Retrieved March 23, 2013. http://www.catholiccharities-md.org/mental-health/crisis-response/

Maryland's CHIPRA Quality Demonstration Grant

In February 2010, CMS awarded ten five-year Children's Health Insurance Program Reauthorization (CHIPRA) Quality Demonstration grants. Maryland is the lead-state on a learning collaborative grant with Georgia and Wyoming to implement or expand a Care Management Entity (CME) approach to improve outcomes for Medicaid and CHIP enrolled children and adolescents with serious behavioral health needs.[9]

A CME is an organizational entity that serves as a hub to coordinate care for youth with complex behavioral health issues who are involved in multiple systems, and their families. CMEs provide: (1) a youth-guided, family driven, strengths-based approach to care; (2) intensive care coordination across public child-serving agencies and providers; and (3) access to home and community based services and peer supports as alternatives to residential and hospital care. The model employs a high fidelity wraparound approach, which is a structured, prescribed, team-based service planning and care coordination process.[10] According to the Center for Health Care Strategies, youth who can benefit from CMEs include those:

- With severe behavioral health challenges;
- In or at risk of being placed in psychiatric residential treatment facilities;
- In other out-of-home settings such as therapeutic group homes;
- On multiple psychotropic medications;
- In child welfare;
- In detention diversion

The CHIPRA Quality Demonstration Grant does not provide funding for direct care, so the collaboration partners share experiences about providing care management through other direct funding streams, which vary by state. In Maryland funding has come through:

- 1915 (c) Psychiatric Residential Treatment Facility Demonstration Waiver
- Substance Abuse and Mental Health Services Administration funded Systems of Care grants: MD CARES and RURAL CARES
- Child Welfare's Place Matters Group Home Diversion using Resource Coordinators
- Juvenile Services' Out-of-Home Diversion using Wraparound Care Coordination

Maryland became a 1915(c) Psychiatric Residential Treatment Facility (PRTF) Demonstration Waiver State in 2007, and has used CMEs to provide intensive care coordination to all waiver participants--youth who meet the medical necessity criteria for PRTC level of care. Under the waiver Medicaid covers the home and community based services utilized by participating youth. The CME team-based approach described above is used to develop a plan of individualized care and incorporates wraparound services. The 1915(c) Demonstration Waiver has closed to new

[9] Lallemand, Nicole Cafarella, et al. "How the CHIPRA quality demonstration elevated children on State health policy agendas." (2013).

[10] Center for Health Care Strategies, Inc. Technical Assistance Brief: Utilization Management Considerations for Care Management Entities. June 2013.

admissions as a result of Congress's failure to reauthorize the PRTF portion of 1915(c); but the program will not technically end until September 30, 2014, when the last enrollees are discharged.

Maryland recently submitted a 1915(i) State Plan Amendment to compensate for the loss of the 1915(c) Demonstration Waiver. Unlike the Demonstration Waiver, the 1915(i) State Plan Amendment will only cover Medicaid enrolled youth up to 150% of the federal poverty level. The State is also developing a Targeted Case Management State Plan Amendment that will be able to cover case management services (although not all therapies and other services) for Medicaid enrolled children and youth over 150% of poverty.

Maryland Choices (MD Choices) is one of the vendors that has provided CME services through the 1915(c) demonstration grant. They function as gatekeepers that manage the referrals coming from different agencies including the Department of Juvenile Services (DJS), Department of Social Services (DSS), or the school system. MD Choices serves three distinct groups:

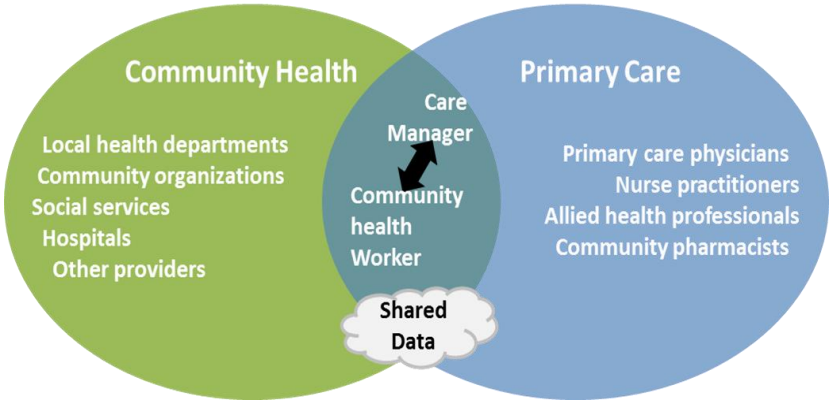
(1) Youth referred by DJS or DSS case workers to the Group Home Diversion Program. These youth are at risk of a group home placement or are stepping down from a group home to a less restrictive environment.

(2) Youth referred by their school system as a result of significant behavioral disturbances; to date only Baltimore City and Prince George's County are able to make referrals.

(3) Youth participating in a Montgomery County program called Interagency Family Preservation Services. This is a short term, 14 week, program through which youth receive wraparound services in a community setting.

Additional Models in Maryland:

Another integrated care delivery initiative that shares theoretical aspects of the health home concept is Maryland's State Innovation Model (SIM). Maryland received a planning grant from the Centers for Medicare & Medicaid Innovation to develop its Community-Integrated Medical Home initiative. This model of care will integrate patient-centered medical care with community-based resources to improve the health of individuals and their communities as a whole. Under this model, primary care providers will lead a team of health care professionals to coordinate personalized care for high-risk patients with health and social needs, and monitor community and population health. Below is a venn diagram of the contemplated SIM model:



Adapted from: CMMI Planning Grant Received by Maryland DHMH

Conclusion:

Our review of existing integrated care models and approved Medicaid health homes has confirmed our belief that health homes offer a real opportunity to address the medical, behavioral and social needs of at-risk youth and their families. We are pleased that Maryland is implementing a health home SPA, but we are also aware that this "first" initiative is primarily focused on high-end adult psychiatric patients. The State anticipates that 2,516 individuals will be served, and, based on Catholic Charities estimates fewer than 10% will be children and youth. We believe that the door is open to expand the population of youth served, either through a modification of eligibility criteria, such as inclusion of the 1915(c) PRTC population or through the development of a second health home SPA.

Advocates for Children and Youth is acutely aware that to get traction, health home advocates must seek to build on existing efforts. We believe that CMEs, especially given their successes with certain at-risk populations in Maryland, constitute one such opportunity. CMEs services resemble health home services, and can potentially bolster the health home model to improve clinical and functional outcomes for youth and their families, reduce costs, and increase access to home- and community-based services.[11] We also see particular merit in the community health team concept and believe that model could inform Maryland's work on its SIM Community-Integrated Medical Home initiative, as well as serve as a delivery mechanism for an effective health home here in Maryland.

[11] Center for Health Care Strategies Inc. Using Care Management Entities for Behavioral Health Home Providers: Sample Language for State Plan Amendment Development. October 2012.

This project is made possible by The Annie E. Casey Foundation

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State	Target Population			Other Conditions included for Eligibility MH=mental health condition HD=Heart Disease								Geo	Child focus
•2= 2 chronic conditions •1 + risk = 1 chronic condition & risk of another •SMI= Serious Mental Illness	2	1 + risk	SMI	Specific conditions not otherwise specified	Diabetes	Asthma	CVD/HD	BMI>25	Substance use/abuse	Tobacco	MH	S=state R=region	
Alabama	X	X	X	Transplants within 5 years, COPD, Cancer, HIV with a look-back of 18 months, Sickle Cell	X	X	X	X	X		X	R	
Idaho	X	X	X	Dyslipidemia, , hypertension, or diseases of the respiratory system	X	X		X		X	X	S	
Iowa	X	X		Hypertension, BMI > 85th percentile for pediatric pop, family history of a verified heritable condition in a category described above, a diagnosed co-morbidity to an above condition, exposure to a causative environmental agent	X	X	X	X	X		X	S	
Iowa: Adults and Children with SPMI	X	X	X	Psychotic Disorders, Schizophrenia, Schizoaffective disorder, Major Depression, Bipolar Disorder, Delusional Disorder, Obsessive-Compulsive Disorder	X	X	X	X	X		X	R	X
Maine	X	X		COPD, hypertension, developmental disabilities, or autism spectrum disorders, acquired brain injury, seizure disorders and cardiac and circulatory congenital abnormalities	X	X	X	X	X	X	X	S	
Maryland		X	X	The individual must be engaged with services with a PRP or MTS provider					X	X		S	X
Missouri Primary	X	X		Developmental disability	X	X	X	X		X		S	
Missouri Community MH	X	X	X	Developmental disability	X	X	X	X	X	X	X	S	
North Carolina	X	X		Blindness, congenital abnormalities , alimentary system, endocrine or metabolic disease, infectious disease, mental and cognitive conditions (not mental illness), musculoskeletal or neurological disorders and certain diagnoses	X	X	X	X				S	X
New York	X	X	X	Bi-polar disorder; conduct/ impulse control/ other disruptive behavior disorders, dementing disease, depressive and other psychoses, eating disorder, major personality disorders, psychiatric disease, schizophrenia, advanced coronary artery disease, cerebrovascular disease, congestive heart failure, hypertension, peripheral vascular disease, HIV disease	X	X		X	X		X	R	X
Ohio			X								X	R	X

Oregon	X	X	X	**BMI for under age 20 is ≥ the 85th percentile, hepatitis C, HIV/ AIDS, chronic kidney disease, chronic respiratory disease, cancer**	X	X	X	X			X	S	
Rhode Island CEDARR	X	X	X	**Developmental disability, down syndrome, mental retardation, seizure disorders**	X	X					X	S	X
Rhode Island Community MH			X	**Serious impairment to individual daily functioning: personal relations, living arrangements, employment (Not meant for long term 24-hour care in a hospital, nursing home or protective facility). Undergone psychiatric treatment more intensive than outpatient care more than once (e.g., emergency services, alternative home care, partial hospitalization or inpatient hospitalization). Experienced a single episode of continuous, structured supportive residential care other than hospitalization for a duration of at least 2 months, or have impaired role functioning. In addition, eligible individuals must meet at least 2 of the following criteria, on a continuing or intermittent basis for at least 2 years: If employed, is employed in a sheltered setting, or has markedly limited skills or a poor work history; requires public financial assistance for out-of-hospital maintenance and may be unable to procure such assistance without help; shows inability to establish or maintain a personal social support system; requires help in basic living skills; and exhibits inappropriate social behavior which results in demand for intervention by the mental health and/or judicial system.**							X	S	
Rhode Island Opioid Treatment		X		**Not limited to: poor nutrition; childhood trauma, risky sex practices, family health history**				X	X	X		S	
South Dakota	X	X	X	**COPD, hypertension, musculoskeletal and neck and back disorders, pre- diabetes, cancer, hypercholesterolemia, depression, and use of multiple medications(6 or more classes of drugs)**	X	X	X	X	X	X	X	S	
Vermont		X		**Opioid addiction**					X			R	
Washington Approved: Dec 2013		X		**Dementia or Alzheimer's disease, gastrointestinal, hematological conditions, HIV/AIDS, intellectual disability or disease, musculoskeletal conditions, neurological disease, renal failure, cerebrovascular disease, chronic respiratory conditions, coronary artery disease**	X	X	X	X	X		X	R	
Washington Approved: June 2013		X		**Cancer, cerebrovascular disease, chronic respiratory conditions, coronary artery disease, dementia or Alzheimer's disease, gastrointestinal, hematological conditions HIV/AIDS, intellectual disability or disease, musculoskeletal conditions, neurological disease, renal failure**	X	X	X		X		X	R	
Wisconsin		X		**AIDS/HIV and who have at least one other diagnosed chronic condition, or is at risk of developing another chronic condition: Individuals having a CD4 cell count of less than 200 cells/µL or CD4 cells accounting for fewer than 14 percent of all lymphocytes and or have a bmi <18.5 kg/ m2; a fasting plasma blood sugar is 100-125 mg/dL or A1C 5.7% - 6.4%; systolic pressure between 120 - 139 mm Hg; diastolic pressure between 80 – 89 mm Hg; Individuals with hyperlipidemia: Total cholesterol >200 mg/dL HDL levels <40 mg/dL for men and <50mg/dL for women; LDL levels >130 mg/dL**								R	