Technical Assistance Document:
Summary of Key Considerations in the Use of the Health Home & 1915(i) State Plan Amendments for Children & Youth with Intensive Behavioral Health Needs
December 20, 2012

	Health Home	1915(i)	Health Home & 1915(i)
Summary of Key Considerations	• Has as 90% Federal medical assistance percentage (FMAP) for the first 8 quarters of Maryland's 1st SMI/SED HH SPA (no time constraints on when the first SPA is submitted) • Provides a comprehensive approach to serving children and youth with SED that is consistent with behavioral health integration, primary care-behavioral health integration, and systems of care. • Can serve youth who are Medicaid eligible under the State Plan • Must cover life span • Can submit more than 1 HH SPA, but clock for 8 quarters at 90% FMAP begins upon approval of first SMI/SED SPA. Can also submit one SPA with two approaches (i.e., one for adults with SMI and one for children with SED) • Does not include all services that would be necessary to support youth with intensive needs in their homes and communities	• Opportunity to sustain Maryland's CME Model developed through a State Plan Amendment (SPA) • Has flexibility in the type, nature, and frequency of the services provided • Can have more than one 1915(i) SPA	• Both provide opportunities to serve youth in their homes and communities and received FMAP • Both are State Plan Amendments and not waivers • Both are in statute and are not time-limited in their availability to the State • Neither permit a waiting list nor slots—must enroll all eligible youth, although can phase in over time (HH can be limited geographically, while 1915(i) cannot)

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	Health Home	1915(i)
Population Criteria	Federal Population Criteria: • One SMI/SED; or • At least two chronic conditions, as listed in §1945(h)(2) or one chronic condition and be at risk for another.	May serve youth who are at an institutional level of care, but are required to serve youth who are at a lower level of care.
Eligible Providers	Section 1945(a) provides for three types of health home provider arrangements: • Designated Provider, • Team of Health Care Professionals, or • A Health Team ***See full federal definitions below.***	Not specified in the requirements. Must provide individual care planning and have quality assurance components. Under the CME Model, the CME provides the service of Care Coordination as well as responsibility for MIS, QA/QI and other administrative functions. The remaining services are provided by other providers and are available per the youth and family's individual needs as reflected in the plan of care.
Services	***HH includes specific, required services:***	***1915(i) has tremendous latitude to include services. (The following are examples of how services that are part of Maryland's model might be used to achieve similar purposes)***
	• Use of health information technology to link services (as feasible and appropriate)	In Maryland's CME Model, these 2 services are functions of the Administrative Service Organization (ASO).
	• Comprehensive care management (system level)	
	• Health promotion	In the CME Model, this HH service is a shared function between ASO and CME.
	• Care coordination (individual "face to face" level)	In the CME Model, these 3 HH services are included within Care Coordination.
	• Comprehensive transitional care/follow up	
	• Referral to community and social support services	
	• Individual and family support services	These 2 CME Model services could be included as the individual and family support services: • Peer-to-Peer Support • Family and Youth Training

	N/A	Services that are more commonly part of Maryland's CME Model that could not be included in a HH SPA might include: • Intensive In-Home Services • Mobile Crisis Response Services • Community-Based Respite Care • Out-of-Home Respite Care • Expressive and Experiential Behavioral Services
Federal medical assistance percentage (FMAP)	HH services qualify for 90% FMAP for the first eight fiscal quarters that a HH SPA is in effect. After that, the FMAP is the same as the regular rate.	The FMAP for 1915(i) services would remain the same as Maryland's current federally authorized rate.
Rate Structure	Section 1945(c)(2) permits flexibility in designing payment methodology, §1945(c)(2)(A) permits a tiered payment methodology that accounts for the severity of each individual's chronic conditions and the "capabilities" of HH provider. Also, §1945(c)(2)(B) permits proposal of alternative models of payment that are not limited to PMPM payments for CMS approval.	It is up to the State to determine the rate structure and payment methodology.

Federal Definitions for Health Home Providers:

Designated provider per §1945(h)(5) means 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 by the State and approved by the Secretary to be qualified to be a health home for eligible individuals with chronic conditions on the basis of documentation evidencing that the physician, practice, or clinic—(A) has the systems and infrastructure in place to provide health home services; and (B) satisfies the qualification standards established by the Secretary under subsection (b).

Team of Health Care Professionals per §1945(h)(6) means a team of health professionals (as described in the State plan amendment) that may (A) 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; and (B) be free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary.

Health Team per §1945(h)(7) via reference to §3502 means an interdisciplinary, inter-professional team of health care providers, as determined by the Secretary; such team may include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians' assistants.

Resources:

Center for Health Care Strategies (2012). *Using care management entities for behavioral health home providers: sample language for state plan amendment development.* Washington, DC: Center for Health Care Strategies. Available at: http://www.chcs.org/usr_doc/CMEs_as_Behavioral_Health_Homes_-_SPA_Development.pdf

Center for Health Care Strategies (2011). *Care management entities: a primer.* Washington, DC: Center for Health Care Strategies. Available at: http://www.chcs.org/usr_doc/CHIPRA_CME_Primer_v5.pdf

Hasselman, D, Bachrach, D. (2011). *Issue brief: implementing health homes in a risk-based Medicaid managed care delivery system*. Washington, DC: Center for Health Care Strategies. Available at: http://www.chcs.org/usr_doc/Final_Brief_HH_and_Managed_Care_FINAL.pdf

Social Security Act, 42 U.S.C. §1915 (2010).

State Medicaid Director Letter #10-024, ACA #12, November 16, 2010, Re: Health Homes for Enrollees with Chronic Conditions. Available at: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf