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Improving Care Coordination for Children with Medical Complexity: Exploring Medicaid Health Home State Options

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Introduction

Many states are exploring strategies to improve systems of care for children with medical complexity (CMC) and their families. Providing comprehensive care coordination for CMC is one strategy that has been shown to improve health outcomes, decrease health care costs by better coordinating high quality care, and prevent unnecessary health care encounters. [1] As a result, states are increasingly interested in identifying opportunities to support care coordination and other complementary services in their Medicaid programs. There are currently two health home policy options that states can use to enhance and expand care coordination for CMC in Medicaid: the Section 2703 Medicaid Health Home State Option, authorized under the Patient Protection and Affordable Care Act (ACA), and the new Advancing Care for Exceptional (ACE) Kids Act Health Home State Option.

What is a Health Home?

"A health home is a Medicaid State Plan Option that provides a comprehensive system of care coordination for Medicaid individuals with chronic conditions. Health home providers will integrate and coordinate all primary, acute, behavioral health and long-term services and supports to treat the "whole-person" across the lifespan."[2]

CMC are a growing population due to emerging medical advancements that have allowed for both life-sustaining and life-improving medical care not previously available to those with severe and chronic conditions. Current estimates indicate CMC make up fewer than 1% of all U.S. children.[3] While there is no standardized definition of CMC, children categorized as having medical complexity typically "have multiple significant chronic health problems that affect multiple organ systems and result in functional limitations, high health care need or utilization, and often the need for or use of medical technology."[4]

Nearly two-thirds of CMC are enrolled in Medicaid[5] and represent approximately 6%[6] of all children enrolled in Medicaid and the Children's Health Insurance Program (CHIP). Despite comprising only a small portion of enrollees, CMC account for over one-third of total pediatric health care spending for these programs. Within Medicaid and CHIP programs, CMC account for 41% of pediatric hospitalization days. [7,8]

Many CMC often require a range of primary and specialty care, services, and supports (e.g., home nursing services). Many families, however, report encountering fragmented systems that are uncoordinated or unresponsive to their child's needs. In a recent survey of families raising children with special health care needs, nearly 90% of those with more complex health needs did not receive care in a well-functioning system, and approximately half did not receive needed care coordination services. [9,10] In addition to perpetuating barriers to appropriate services and support, a lack of coordination frequently results in high levels of unmet medical needs and avoidable emergency department visits and hospitalizations among CMC. [11]

Medicaid health home options offer potential pathways to strengthen states' efforts to support the care coordination needs of CMC and their families. However, there are important considerations for state Medicaid programs, state legislatures, and state Title V programs in selecting which health home option to use, with each option having unique advantages and limitations in meeting the specific needs of CMC and their families.

Section 2703 Medicaid Health Home State Option

Though not limited to CMC, many state Medicaid programs have taken advantage of the Section 2703 Medicaid Health Home State Option in an effort to improve care coordination for eligible Medicaid beneficiaries (children and adults) with chronic health conditions through an amendment to their Medicaid State Plan. As of April 2020, twenty states and the District of Columbia have received approval from the Centers for Medicare & Medicaid Services (CMS) to implement health homes under this option. Some states have received approval for multiple health home models, resulting in 35 unique models that target a variety of chronic conditions.[12] For example, Michigan has two approved health home models that are designed to serve (1) individuals with a serious and persistent mental health condition

served by community mental health centers who reside in two specific counties; and (2) individuals with depression or anxiety and a co-occurring chronic health condition served by federally qualified health centers or tribal centers.[13,14] Washington's approved health home model targets individuals with one eligible chronic condition and at risk of developing another, such as a mental health condition, substance use disorder, asthma, diabetes, heart disease, cancer, intellectual disability, or chronic respiratory condition.[15]

Overview of Section 2703 of the Patient Protection and Affordable Care Act (ACA)

To support the coordination of care for Medicaid beneficiaries with chronic health conditions, Section 2703 of the ACA authorized the creation of the Medicaid Health Home State Option.[16,17] This option allows state Medicaid programs to submit a state plan amendment (SPA) to establish health homes to provide care coordination to children and adults across all primary, acute, behavioral health, and long-term services for eligible Medicaid beneficiaries. While health home models may vary by state, all states must cover the following six health home core services: comprehensive care management; care coordination; health promotion; comprehensive transitional care and follow-up; patient and family support; referrals to community and social support services, and use of health information technology to link services. According to CMS, the goals of providing health home services include the following: to reduce avoidable inpatient stays and emergency department visits, improve health outcomes and health care quality, and reduce costs by better coordinating care and connecting people to needed services.[18,19]

During the first eight quarters in which a health home program is in effect in a state, the state Medicaid program receives a 90% enhanced Federal Medical Assistance Percentage (FMAP) payment for specific health home services provided in Section 2703. After this period, the enhanced FMAP then reverts to the state's regular FMAP. Eligible health home providers may be a designated provider, a team of health care professionals, or a health team. See Appendix A for additional information on the Section 2703 Medicaid Health Home State Option.

Under Section 2703 of the ACA, states can limit enrollment in health homes to certain geographic areas but are not permitted to exclude Medicaid beneficiaries by age, delivery system, or dual-eligibility status.[20] State Medicaid programs, however, do have discretion in determining who is eligible to become a health home provider and may target which provider types can provide health home services. Depending on the approach, eligible health home provider types may include primary care providers or specialists, clinical practices or clinical practice groups, rural health clinics, community health centers, home health agencies, or other providers who are appropriate for meeting the needs of the targeted population.[21]

Some state Medicaid programs have used this aspect of Section 2703 to develop health home models that target enrollment to specific sub-populations who are served by designated provider types. Examples of this include CMC served by pediatric specialists, or adults with serious mental illness served by behavioral health providers. CMS has approved health home models with age-based target populations for at least six states, the majority of which focus on children with serious emotional disturbance or developmental disability.[22] Despite state Medicaid programs' ability to designate distinct health home provider types under Section 2703, there has been limited uptake of pediatric-specific state health home models using this approach.

ACE Kids Act Health Home State Option

The Advancing Care for Exceptional (ACE) Kids Act, passed as part of the Medicaid Services Investment and Accountability Act of 2019, was signed into law on April 18, 2019. The ACE Kids Act allows state Medicaid programs to seek federal approval for a Medicaid SPA to develop health homes targeted to children with medical complexity beginning October 1, 2022.[23] To complement this law, the U.S. Department of Health and Human Services (HHS) is required to provide additional guidance to states on several provisions of the ACE Kids Act prior to the implementation date.

Modeled on Section 2703 of the ACA, the ACE Kids Act Health Home State Option leverages the six core health home services to support a pediatric-centered approach to care across delivery systems (see text box below). Health home providers under the ACE Kids Act Health Home State Option are required to coordinate full access to pediatric specialty and subspecialty medical services, including palliative services and services from out-of-state providers. Additional guidance from HHS on the coordination of care from out-of-state providers under the ACE Kids Act is in development.

Under this new state option, participating health home providers must demonstrate to the state the ability to fulfill the following goals: coordinate prompt care for CMC; develop comprehensive, pediatric family-centered care plans; and work with the CMC and their family in a culturally and linguistically appropriate manner to incorporate home care, pediatric primary and emergency care, and social support services. These health home services are eligible for an enhanced FMAP of 15% (not to exceed 90%) for the initial two quarters that the health home is effective.

The Six Core Health Home Services in Section 2703 of the ACA and the ACE Kids Act

The six core health home services state Medicaid programs are required to provide under both the Section 2703 Medicaid Health Home Option and the ACE Kids Act Health Home State Option are:

1. Comprehensive case management
2. Care coordination
3. Comprehensive transitional care
4. Patient and family support
5. Referrals to community and social supports
6. Use of health information technology

Health homes under the ACE Kids Act limit enrollment to CMC who are:

- Under 21 years of age
- Eligible for Medicaid, and
- Have at least one or more chronic conditions affecting three or more body systems that severely reduces cognitive or physical functioning and which also requires the use of medication, durable medical equipment, therapy, surgery, or other treatments.

A child may also be considered eligible if they have one life-limiting illness or rare pediatric disease as defined by the Federal Food, Drug, and Cosmetic Act.[24] The criteria for defining eligible CMC under the ACE Kids Act Health Home State Option are narrower than the definition of CMC that may be used in other state programs, such as those that include behavioral health conditions.

State Medicaid programs interested in implementing this new state option will need to develop a methodology for tracking inpatient days of health home enrollees and any cost reductions, as well as collect and report data on a number of CMC-specific indicators, which may help provide valuable insight on CMC. Additional data collection information may be specified in future federal guidance. See Appendix A for a comparison of the Section 2703 Medicaid Health Home State Option and the ACE Kids Act Health Home State Option.

Lessons Learned from New York's Implementation of Health Homes Serving Children Program

In December 2016, New York launched a pediatric-centered health home model, the Health Homes Serving Children (HHSC) program, through a SPA under Section 2703 of the ACA. [25,26] The HHSC program is a component of the broader New York State Health Home Program, which provides statewide comprehensive care coordination and case management for Medicaid-enrolled individuals. Eligible individuals have two or more chronic conditions or one single qualifying chronic condition and are assessed by providers as being appropriate for the intense level of care provided by a health home.[27,28] As of October 2019, approximately 27,000 children and youth were enrolled in the HHSC program. [29]

New York's experiences with the HHSC program offer several lessons for states exploring Medicaid health home options for CMC, including a need for interoperable and standardized technology and reporting systems, CMC-specific health home referral and assessment policies, and a comprehensive education plan to support greater coordination and collaboration across the HHSC program, providers, and families. These lessons learned are informed by interviews with several state Medicaid representatives, health home providers, and family representatives who have experience under the HHSC program.

- ***The importance of interoperable technology systems.*** When New York began its New York State Health Home Program in 2012, lead health homes were required to establish an electronic health record (EHR) system either by modifying existing systems or creating their own, rather than using a designated or compatible EHR system across all health home providers. As a result, many health home providers under the HHSC program have distinct EHR, billing, and auditing systems from each other, most of which are not interoperable. Because CMC are often cared for by multiple providers, health home providers need to be able to coordinate across delivery systems. Due to compatibility limitations, some health home providers have encountered barriers when sharing necessary protected health information to assure synchronized care.[30]

- ***The need for standardized reporting systems and program management strategies.*** Non-standardized data sharing requirements across health home providers have created challenges for the New York state Medicaid agency during audits, data collection, and implementing new requirements across health home providers.[31] In the absence of an interoperable technology system among health homes, coordination among state programs has helped to support auditing and program management efforts within the HHSC program. For example, New York State's Title V Maternal and Child Health Block Grant Program, in conjunction with the state Medicaid agency, conducts periodic site visits to health home providers under the HHSC program across the state. Drawing on their expertise serving CMC, Title V staff are involved with the development of the site visit auditing process, including onsite chart review, as well as how health home providers can add expertise and build capacity. The purpose of these visits is to assess each of the health home provider's organizational structure, governance model, readiness criteria, relations and connection to adult health homes, and their knowledge/training of special populations, including CMC. [32]

- ***Establishing referral policies that are responsive to CMC.*** Health home providers under the HHSC program were initially required to accept referrals for any child eligible for the HHSC program, irrespective of the child's specific health condition and level of need. This caused some CMC enrolled in the HHSC program to be served by health homes without expertise in medical complexity. To ensure that health homes under the HHSC program are better equipped to connect children to the services they need, the state Medicaid agency made the recommendation to route referrals for health home enrollment for eligible children to health homes with specific expertise in the child's unique condition(s).[33]

- ***Ensuring assessments meet the needs of programs and CMC.*** New York has made improvements to how children are assessed upon enrollment in the HHSC program by adding CMC-specific questions and scoring considerations to the standardized Child and Adolescent Needs (CANS) assessment, including those focused on chronicity, diagnostic complexity, and intensity of treatment, at the recommendation and collaboration of some health home providers.[34] Health home providers report this modification has helped them to determine the specific care coordination needs of CMC more effectively.

- ***Education and Training.*** Some health home providers and community providers in New York expressed a lack of understanding of the broader HHSC program, contributing to challenges identifying, referring, and enrolling CMC who may benefit from health home services. As a result, at least one health home under the HHSC program has made efforts to educate community providers on the availability of health home services, in addition to developing a curriculum specific to CMC.[35] This targeted curriculum supports health home providers in coordinating the complex care required by CMC and exhibit knowledge and skills across delivery systems.

Key Considerations for States in Exploring Health Home Options

The following considerations are important for states—including Medicaid programs, their stakeholders, and partners—when exploring a Section 2703 Medicaid Health Home State Option or the new ACE Kids Act Health Home State Option to serve CMC and their families. It is important to note that these considerations may evolve or change upon the release of pending federal guidance under the ACE Kids Act.

- **Target Population:** States will want to consider which health home option best aligns with their goals and target population of CMC for coordinated care. Because the Section 2703 Medicaid Health Home State Option is broad and does not permit states to exclude Medicaid beneficiaries by age, delivery system, or dual-eligibility status, eligibility under this state option extends beyond CMC to include other Medicaid beneficiaries with chronic health conditions, as defined by a state's Medicaid SPA. As a result, health homes under this option serve a target population with broader needs, limiting the extent to which they can offer specialized care for specific sub-populations, including CMC. In contrast, the ACE Kids Act Health Home State Option is targeted to CMC only, arguably allowing states to design specialized service delivery systems that better reflect and respond to the unique needs of this population of children. Yet, because criteria for defining eligible CMC under the ACE Kids Act Health Home State Option is narrower than what may be used in other state programs, such as those that include behavioral health conditions, some CMC may not be considered eligible to enroll under this state option.

- **Federal Financial Participation:** As states face budget pressures due to the economic downturn and rising Medicaid rolls due to COVID-19, understanding the federal match for services under the different health home options is an important fiscal consideration. The Section 2703 Medicaid Health Home State Option allows states to draw an enhanced FMAP of 90% for the six core health home services during the initial eight quarters that the health home is effective, while the ACE Kids Act Health Home State Option is more limited in its FMAP. Under the ACE Kids Act Health Home State Option, state Medicaid programs may only receive an enhanced FMAP of 15% (not to exceed 90%) for the first two quarters, thereby reducing the initial amount of available federal funds to support these services. However, once the enhanced FMAP under the Section 2703 Medicaid Health Home State Option expires, the FMAP under both state options will align, resulting in a comparable rate of federal funding. In addition to weighing the availability of federal funding under each health home option, state Medicaid programs will also need to consider the larger financial context when implementing a health home, including securing the necessary state match given competing budget priorities and setting reimbursement rates for the six health home services, including care coordination.

  Because the ACE Kids Act Health Home State Option is available only to a small group of medically complex children, it has the effect of creating cost containment measures by limiting the number of Medicaid beneficiaries receiving health home services. This effect may not be available under the Section 2703 Medicaid Health Home State Option due to its broader eligibility criteria.

- **Return on Investment:** State Medicaid programs' ability to demonstrate the impact of a health home program is key to securing the buy-in necessary to implement and maintain either health home state option. While not specific to CMC or the pediatric population in general, preliminary evaluations of Section 2703 Medicaid Health Home State Option suggest some improvements in utilization patterns, quality measures, and cost savings among those enrolled in health homes.[36] For example, Missouri estimates a total cost savings of over $2 million, or an average of $148 per member per month, to its Medicaid program as a result of their health home program.[37] Similarly, Iowa estimates that in the first 18 months of its health home program, the state's cost savings totaled approximately $9 million, or nearly 20% of total projected Medicaid spending on individuals enrolled in its health home.[38,39] These savings are driven by a reduction in emergency department visits, inpatient stays, and nursing home costs, in addition to improvements in quality outcomes.[40]

  Because state Medicaid programs cannot implement the ACE Kids Health Home State Option until October 1, 2022, there is no outcome data available yet. However, preliminary findings from a three-year Center for Medicare and Medicaid Innovation Heath Care Innovation Award (HCIA) focused on improving outcomes for CMC enrolled in Medicaid suggest improvements in health care and cost savings for CMC receiving high-quality coordination services.[41] On average, awardees saw a 2.6% reduction in total cost and a 32% reduction in inpatient days among

CMC enrolled in this study.[42] While the design of this model differs slightly from the ACE Kids Health Home State Option, the findings from this HCIA model suggest the potential for cost savings among CMC receiving similar care coordination services under the ACE Kids Health Home State Option.

- **Interoperable Technology Systems:** Regardless of the health home option pursued, state Medicaid programs, their stakeholders, and partners will want to consider the role, design, and implementation of well-defined, interoperable health information technology, including EHR, auditing, and billing systems, as an integral part of a high-quality health home model. While states must submit a proposal to HHS for their approach to health information technology as part of their approved Medicaid health home SPA under both state options, this provision does not require the use of interoperable technology systems. In the absence of an interoperable technology system across health home providers, states may face barriers to streamlined care delivery and quality care coordination due to logistical challenges that make it difficult for health home providers to collaborate across systems.

- **Data and Reporting Requirements:** In recognition of state Medicaid programs' existing demands, states will want to weigh their capacity to meet the data and reporting requirements under each health home option. Both the Section 2703 Medicaid Health Home State Option and the ACE Kids Act Health Home State Option require states to submit data and reports to HHS on their health home programs. Generally speaking, the reporting requirements under the Section 2703 Medicaid Health Home State Option are less intensive and direct states to create a methodology for tracking certain measures determining payment, and collecting data on all applicable measures specified by HHS.[43] The ACE Kids Act Health Home State Option reporting requirements are more expansive. In addition to directing states to fulfill all the reporting requirements specified under the Section 2703 Medicaid Health Home State Option, the ACE Kids Act Health Home State Option also requires states to track timely access to medically necessary care from out-of-state providers and collect and report on several CMC-specific data points and quality measures developed for services provided to CMC.[44] Additional data and reporting requirements under the ACE Kids Act Health Home State Option may also be defined in future federal guidance. The ability of a state Medicaid program to satisfy these requirements is likely influenced, at least in part, by its ability to implement an interoperable health information technology plan across enrolled health home providers with well-defined data sharing requirements.[45,46]

- **Outreach and Engagement:** A core component of a successful health home program centers on the extent to which states can effectively educate and engage families, care coordinators, and providers from across delivery systems on the availability of health home services. While establishing referral procedures for hospitals is a requirement under both state health home options, only the ACE Kids Act Health Home Option requires state Medicaid programs to develop a plan to educate providers and families on the availability of health home services and enrollment processes.[47] Irrespective of the health home state option pursued, state Medicaid programs and their partners (e.g., state Title V programs) will want to consider how to ensure these education plans reflect the full scope of services CMC and their families engage with, including HCBS waiver services, school-based therapies, skilled nursing facilities, and out-of-state providers, in addition to other community supports. In doing so, states can maximize the ability of health home models to effectively coordinate care, improve outcomes, and reduce costs among CMC.

Conclusion

There is evidence supporting the benefits of comprehensive care coordination as a tool to address the unmet health care needs and fragmented delivery systems that CMC and their families frequently encounter. Because a majority of CMC are enrolled in Medicaid and CHIP programs and account for a high percentage of total pediatric health care spending, states are increasingly looking for opportunities to support care coordination and other complementary services to improve health outcomes and reduce costs among CMC. Weighing the Section 2703 Medicaid Health Home State Option and the ACE Kids Act Health Home State Option as mechanisms for coordinating care for CMC, particularly in light of pending federal guidance under the ACE Kids Act, will be a key step for states interested in pursuing Medicaid-funded health home services. In selecting a strategy, state Medicaid programs, in conjunction with their stakeholders and partners, will need to carefully consider each option's respective advantages and limitations in meeting the specific needs of CMC and their families within their state systems.

Appendix A: Comparison of Health Home State Options Serving Children with Medical Complexity

Key Considerations	Section 2703 Medicaid Health Home State Option (ACA)	ACE Kids Act Health Home State Option
Federal Approval Mechanism	State Plan Amendment	State Plan Amendment (Beginning October 1, 2022)
Eligibility	Individuals enrolled in Medicaid with two or more chronic conditions, or one chronic condition and the risk of developing another, or at least one serious and persistent mental health condition.	A child under 21 years of age who enrolled in Medicaid and has one or more chronic conditions affecting three or more body systems and severely reduces cognitive or physical functioning, 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 by the Federal Food, Drug, and Cosmetic Act.
Population Served	All populations. States are not allowed to target or exclude members based on their age, delivery system, or dual-eligibility status.	States can only target a narrowly defined group of children with medical complexities, as defined under H.R. 1839.
Federal Financial Participation	States receive an enhanced federal matching rate of 90% for the six core home health services during the **initial eight quarters.**	States receive an enhanced federal matching rate of 15% (not to exceed 90%) for the six core home health services during the **initial two quarters.**
Reporting Requirements	Participating states **must:** (1) Create a methodology for tracking reductions in inpatient days and reductions in total cost from improved care coordination and for determining payment, which may include alternate payment models. States must also include a proposal for health information technology in providing home health services. (2) Collect data on all applicable measures for determining the quality of services in accordance with such requirements, as specified by the Secretary of the HHS.	Participating states **must:** (1) Create a methodology for tracking reductions in inpatient days and reductions in total cost from improved care coordination, determining payment, determining payment (which may include alternate payment models), and tracking prompt and timely access to medically necessary care from out-of-state providers. States must also include a proposal for health information technology in providing health home services. (2) Collect and report on several CMC-specific data points, including the number of CMC enrolled in a health home, the nature and type of diagnoses, the type of delivery system and payment models used, the extent to which CMC receive services out-of-state, and the quality measures developed for services provided to CMC.
Other Requirements	Establish procedures for hospitals participating in the health home to make referrals for eligible individuals.	(1) Establish procedures for hospitals participating in the health home to make referrals for eligible individuals. (2) Develop a plan to educate providers and families on the availability of health homes. (3) Coordinate and consult on the prevention and treatment of mental illness and substance use among CMC, as appropriate.

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