ACAP
Association for Community Affiliated Plans

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Bob Thompson, Chairman | Margaret A. Murray, Chief Executive Officer

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Ms. Cindy Mann
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Dear Ms. Mann:

We appreciate being able to meet with CMSO staff on February 22, 2012 concerning health homes in a managed care environment. This is a follow-up to our meeting and the subsequent federal guidance entitled "Health Homes for a Medicaid Managed Care Delivery System: Avoiding Duplication of Services and Payments" that was released on February 23rd. While we strongly support improved integration through enhanced case management and care coordination, we have a number of concerns about the way health homes have been implemented to date.

Our understanding of the intent of health homes, established by Section 2703 of the Affordable Care Act, is to create a state plan option designed as an *enhanced* set of services to meet the needs of individuals with multiple chronic conditions or mental illness. The concentration and intensity of services for individuals with comorbid chronic conditions as well as the enhanced match associated with health homes make it an attractive option for states.

The original guidance (SMDL #10-024 11/16/10) was sub-regulatory with no opportunity for public comment and appears to have been developed to address health homes in a fee-for-service environment. With almost one-half of Medicaid-enrolled individuals participating in fully-capitated managed care arrangements, the guidance did not provide clear expectations for the states where managed care is the predominate delivery system. Unfortunately, it was done with no input from managed care entities and did not fully consider the interaction with managed care for the increasing number of individuals with chronic conditions enrolled in a managed care delivery system. The informality of the guidance on the interaction with managed care was highlighted by stating that "*States interested in implementing a health home SPA in conjunction with using a capitated model are encouraged to work with CMS informally prior to developing an official submission.*"

According to the SMDL, health home services can be provided by a provider, health professionals or a health team. The fact that managed care plans can provide health home services directly or through primary care medical homes included in the MCO network was not addressed until the February 23rd guidance. While we appreciate the fact that the recent guidance specifically stated that MCOs can act as health homes or that the health homes can subcontract with the MCOs, we believe there are issues concerning the case management and care coordination roles that need to be more clearly addressed.

Although we recognize that the level and intensity of case management and care coordination provided by a health home may be different than the case management and care coordination activities provided by a managed care plan, we think it is imperative for CMS to clearly recognize that case management

and care coordination remain fundamental functions of MCOs. For individuals enrolled in managed care, the health home services should be viewed as supplementing NOT supplanting the care management and care coordination provided under existing managed care contracts.

Moreover, MCOs assume financial risk for the services and, therefore, need to maintain oversight for activities such as case management, care coordination and transition of care functions that have a direct impact on the risk borne by the health plan and the financial solvency of the MCO. It also raises questions about what recourse a health plan has if an unrelated health home is doing an inadequate job of case management/care coordination and who is responsible for ensuring adequacy if there is no contractual relationship between the MCO and the health home. We know through a number of programs implemented by our member plans, when health home services are provided by a patient-centered medical home that is part of the MCO network, the health home service can be closely monitored and easily integrated with the case management and care coordination provided by the managed care organization. The MCO can provide necessary oversight and gap-filling to ensure case management and care coordination needs are met.

In conclusion, we have significant concerns that the most recent guidance allows states to carve out from managed care contracts case management and care coordination activities that are an integral and fundamental component of managed care. The guidance does give states an option for not reducing capitation payments if the managed care organization is doing some enhanced level of activity. We believe this approach is backward and that the services provided by the health home are in fact the enhancement. The focus of the technical guidance on not paying twice for a service is based on the faulty assumption that that a managed care organization can effectively operate without assuring the provision of some level of case management and care coordination.

ACAP and our health plan members would like to have further discussions with CMSO staff on how health homes can be incorporated into a managed care environment and would be more than willing to work with CMSO staff in developing a guidance that recognizes the essential role of case management and care coordination as a basic function of managed care organizations.

Sincerely,

MA Murray

Margaret Murray
CEO

MM/dbk

Cc: Barbara Edwards
Mary Pat Farkas