# Section 2703: State Option to Provide Health Homes for Enrollees with Chronic Conditions

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June13, 2011

# Background on Medical Homes

•The medical home model provides instructive history on the evolution of the health home model as described in statute.

•Many State Medicaid programs have developed medical home models and receive reimbursement for medical home services through a variety of authorities.

•A goal of implementing Section 2703 will be to expand upon the traditional and existing medical home models to build linkages to community and social supports, and to enhance the coordination of medical, behavioral, and long-term care.

# General Information

- Section 2703 adds section 1945 to the Social Security Act to allow States to elect this option under the Medicaid State plan.
- The provision 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.
- The effective date of the provision is January 1, 2011.
- States can access Title XIX funding using their pre-Recovery act FMAP rate methodology to engage in planning activities aimed at developing and submitting a State plan amendment.
- Waiver of  comparability allows States to waive statewideness and offer health home services in different amount duration and scope

# Eligibility Criteria

- 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.

# Designated Provider Types and Functions

- There are three distinct types of *health home providers* that can provide health home services, including designated providers, a team of health care professionals, and a health team.

- Health home providers are expected to address several functions including, but not limited to:
  - Providing quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
  - Coordinating and providing access to high-quality health care services informed by evidence-based guidelines;
  - Coordinating and providing access to mental health and substance abuse services;
  - Coordinating and providing access to long-term care supports and services.

# Health Home Services and Enhanced Federal Match

- 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.

The 90 percent match does not apply to other Medicaid services a beneficiary may receive.

# Health Home Services and Enhanced Federal Match

- A State could receive 8 quarters of 90% FMAP for health home services provided to individuals with chronic conditions, and a separate 8 quarters of enhanced FMAP for health home services provided to another population implemented at a later date.
- Additional periods of enhanced FMAP would be for new individuals served through either a geographic expansion of an existing health home program, or implementation of a completely separate health home program designed for individuals with different chronic conditions.
- 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.

# Reporting Requirements

Provider Reporting

- Designated providers of health home services are required to report quality measures to the State as a condition for receiving payment.

State Reporting

- States are required to collect utilization, expenditure, and quality data for an interim survey and an independent evaluation.

# Next Steps

- CMS is providing technical assistance to States interested in submitting a State plan amendment.
- CMS will be engaging in rapid learning activities to prepare for the release of well-informed regulations.
- CMS will continue to collaborate with Federal partners, including SAMHSA, ASPE, HRSA, and AHRQ, to ensure an evidence-based approach and consistency in implementing and evaluating the provision.

# Additional Information

- Health homes mailbox for any questions or comments - healthhomes@cms.hhs.gov
- 11/16/10 Health Homes State Medicaid Director Letter

  http://www.cms.gov/SMDL/SMD/list.asp
- 12/23/10 CMCS Informational Bulletin on Web-Based Submission Process for Health Home SPAs