

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

CMS Briefing
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Background

- 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 to engage in planning activities aimed at developing and submitting a State plan amendment.

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).

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.

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 will be 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.