CHCS
Center for
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FACT SHEET

Health Homes: Opportunities for Medicaid

March 2011

The Affordable Care Act (ACA) includes several opportunities to support Medicaid in transforming the health care delivery system. One of these is detailed in Section 2703 of ACA – health homes. This document provides an overview of the health homes provision, including a description of health homes services, who is eligible to receive these services, and who can provide the services. It also describes how health homes differ from medical homes – an important distinction.

1. What are Health Home Services?

Health homes comprise six services that Medicaid programs can provide to eligible beneficiaries:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care/follow-up;
- Patient and family support;
- Referral to community and social support services; and
- Use of health information technology (HIT) to link services, if applicable.

What is the Opportunity?

The Affordable Care Act includes several opportunities to support Medicaid in transforming the health care delivery system, including Section 2703 promoting health homes for enrollees with chronic conditions. This fact sheet provides an overview of the health homes provision, including a description of health homes services, who is eligible to receive these services, and who can provide the services.

2. Who is Eligible to Receive Health Home Services?

Medicaid beneficiaries eligible for health home services include those who have: (1) two or more chronic conditions; (2) one chronic condition and are at risk for a second; or (3) a serious and persistent mental health condition. Chronic conditions include mental health, substance abuse, asthma, diabetes, heart disease, and being overweight. Dual eligible beneficiaries cannot be excluded from health home services. Populations, diseases, and geographic locations can be targeted.

3. Who Provides Health Home Services?

States have flexibility in who is eligible to be a health home provider. An individual provider, team of health care professionals, or health team that provides the health home services and meets established standards can serve as a health home. States can adopt a mix of these three types of providers identified in the legislation:

- A designated provider: May be physician, clinical/group practice, rural health clinic, community health center, community mental health center, home health agency, pediatrician, OB/GYN, other.
- A team of health professionals: May include physician, nurse care coordinator, nutritionist, social worker, behavioral health professional, and can be free standing, virtual, hospital-based, community mental health centers, etc.
- A health team: Must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractics, licensed complementary and alternative medical practitioners, physician assistants.

The Centers for Medicare & Medicaid Services (CMS) has established some additional criteria for what health homes must be able to do and what infrastructure must be in place. For example, health homes must coordinate and provide access to preventive services, mental health and substance abuse services, comprehensive care management and care coordination, disease management, and long-term care supports

and services. Health homes must link services with HIT and establish a continuous quality improvement program. States will likely add additional requirements.

4. How Are Health Homes Paid For and Funded?

States have flexibility in how they reimburse health home services. Examples include reimbursing on a per member per month (PMPM) basis, using tier methodologies, or adjusting payments to reflect the provider's skill set and/or the patients complexity of needs. Reimbursement can flow through health plans in a managed care delivery system.

States can submit a letter of request to CMS to use Medicaid funds to plan a health home program. States will receive the regular, pre-Recovery Act medical assistance service match for planning activities. States that decide to pursue health home services will submit a state plan amendment to CMS for approval. With approval, the state will receive an enhanced 90-10 federal-state match for health home services for eight consecutive quarters, after which the regular federal-state FMAP would apply.

5. How is a Health Home Different than a Medical Home?

Health homes are not medical homes. In some instances, a primary care practice that is a medical home may not be equipped to address the requirements of a health home or may not be interested in serving as a health home. Furthermore, in some cases, beneficiaries may be better served in a "non-traditional" setting. For example, the best-suited health home for beneficiaries with serious and persistent mental illness may be a community health center. In other words, health homes may or may not be provided within the walls of a primary care practice. That said, states recognize the value of the existing infrastructure of a medical home and may choose to enhance the medical home with the new health home services.

6. How and When can Medicaid Participate?

State participation in health homes is optional. Timing – for both planning efforts and implementation/reimbursement of new services – is flexible. States can apply to use Medicaid funding to plan for health homes by submitting a letter of request to CMS. States can submit a state plan amendment when they are ready to implement and reimburse for the health home services. Both planning and program implementation can occur in phases or stages over time, by location, by targeted populations, or by chronic condition(s).

For official guidance on health homes, please see Section 2703 of ACA and/or read the November 16, 2010 letter from CMS to the State Medicaid Directors[1].

This tool was developed by the Center for Health Care Strategies through the Robert Wood Johnson Foundation's Aligning Forces for Quality *program*

[1] https://www.cms.gov/smdl/downloads/SMD10024.pdf