Health Homes (Section 2703) Frequently Asked Questions

Following are Frequently Asked Questions regarding opportunities made possible through Section 2703 of the Affordable Care Act to develop health home services for Medicaid beneficiaries with chronic conditions. This list of questions will be updated regularly. Questions are organized under the following categories:

I. General;
II. Health Home Providers;
III. Enrollment and Eligibility;
IV. Delivery Models;
V. Quality Measurement, Reporting, HIT;
VI. Funding and Payment; and
VII. State Plan Amendment (SPA), Waivers/Authorities.

I. General

1. Q. What is a Health Home?

A**:** 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. Q. What are Health Home services in Section 2703?

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care/follow-up;
- Patient and family support; and
- Referral to community and social support services;

(Using of health information technology (HIT) to link services as feasible).

3. Q. Will states be allowed to limit provision of health home services to a specific geographic area or must they be provided statewide?

A: Yes, a State may target the SPA geographically.

4. Q. What other requirements are waived within the Health Home SPA option?

A: Section 2703 of the Affordable Care Act provides for waiver of the comparability requirement to permit the State to offer health home services in a different amount, duration, and scope than services provided to individuals who are not in the health home population. Additionally, any other provision of this title for which the Secretary determines is necessary to waive in order to implement this section may be considered.

5. Q. Must a health home provide all six services outlined in the SMD letter?

A: A beneficiary enrolled in the Health Home must have access to all of the services under the health home provision, but the State has the flexibility to have different entities do different component service parts. Additionally, at this time the State has the flexibility to propose to CMS the service definitions as they see fit.

6. Q. Where is the SMD letter related to health homes located?

A: The SMD letter can be found at the following link: http://www.cms.gov/SMDL/SMD/list.asp. Select the Health Home SMD letter by date it was issued, 11/16/2010.

7. Q. Are the US Pacific Territories eligible to provide a Health Home option under section 2703 of the Affordable Care Act and receive the enhanced FMAP for the first 8 fiscal quarters of this benefit?

A: The Territories are eligible for this provision and eligible for the 90 percent match, although this would have the adverse consequence of depleting their Federal cap for Medicaid expenditures at a faster rate.

8. Q. Is there a deadline for States to apply for approval to implement a Health Homes SPA?

A: No, there is no deadline for submission of the Health Homes SPA.

9. Q. What outreach should a state engage prior to its effective date?

A: States must provide public notice to affected stakeholders (beneficiaries, providers and others) of changes in SPAs prior to the effective date of a SPA, consistent with public notice requirements (Code of Federal Regulations - 42 CFR 447.205). States must also engage in tribal consultation regarding changes to the SPA.

10. Q. What other activities should engage in prior to SPA approval?

A: In order to effectuate the changes resulting from a change to its State plan, states must have made necessary changes (including system changes and changes to State laws and regulations, when necessary). Additionally, States should begin developing draft regulations.

II. Health Home Providers

11. Q. Who can provide Health Home Services?

A: States have flexibility in who is eligible to be a health home provider. Health Home providers can be an individual provider, a team of healthcare professionals, or health team that provides the health home services and meets established standards and system infrastructure requirements.

- 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

12. Q. If a State chooses to use the "health team," must the State have all the providers on the list including; medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians' assistants?

A: The "health team" structure is described in section 3502 of the Affordable Care Act and does require a community-based interdisciplinary inter-professional team of health care providers as specified by the Secretary. The specific list of providers in the November 16, 2010 SMD letter and outlined above was furnished as guidance on the necessary members of such a team. Since the State may elect one or more of the 3 provider structures described in the SMD letter, the State does not have to choose a "health team" which appears to afford the State the flexibility around providers it is seeking.

III. Enrollment and Eligibility

13. Q. Who is eligible to receive Health Home services?

A: To the extent elected by the State in its approved State plan, Medicaid eligibles with:
(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.

14. Q. What are the Chronic Conditions identified in Statute?

A. Chronic conditions identified in statute include mental health, substance use disorder, asthma, diabetes, heart disease, and being overweight (as evidenced by a BMI of >25). States may request that CMS identify other chronic conditions for purposes of eligibility.

15. Q. What chronic conditions are permissible under the Health Homes SPA?

A: To be eligible for a Health Home, an individual must have at least 2 chronic conditions, 1 chronic condition and be at risk for another or 1 serious and persistent mental health condition. The chronic conditions outlined in Section 2703 of the Affordable Care Act include, but are not limited to: a mental health condition, substance use disorder, asthma, diabetes, heart disease, and a body mass index over 25. Within these parameters, States can identify the chronic conditions for which health home services are covered. States may request to base eligibility on additional or different chronic conditions in a SPA. While CMS approval is discretionary, this flexibility provides States the option to request to expand the chronic conditions list to include more beneficiaries or use more specific chronic conditions to target the population.

16. Q. What populations are eligible to be enrolled in a Health Home?

A: All beneficiaries eligible for Medicaid under the State Plan or a waiver of the State Plan who meet the criteria of the chronic conditions and geographic location outlined in the State's health home SPA are eligible to be enrolled in the Health Home. Eligibility is not dependent on any other factors such as age, use of a specific delivery system, or category of aid (e.g. duals). The State may, however target chronic conditions that have a higher prevalence in particular age groups.

17. Q. Hospital referrals- ACA section 2703 requires hospitals that are participating providers under the state plan or waiver to establish protocols for referring any eligible individual with chronic conditions who seeks treatment in the ER to designated providers. Does this requirement apply to only hospitals where a health home provider is available?

A: The hospital referral process as stated in section 2703 requires hospitals that are participating providers under the state plan or waiver to establish protocols for referring eligible individuals with chronic conditions who seeks treatment in the ER to designated providers. This requirement applies to hospitals where a health home provider is available**.** The requirement applies to all hospitals, whether or not they participate in the particular HH provider network. It is a State plan requirement applicable to hospitals.

18. Q. Can a State use a sequenced enrollment strategy focusing on the highest risk first and then moving to the lower risk for the targeted chronic condition within one SPA?

A**:** Yes, a State may use one SPA to phase in eligibility -based on the severity of a chronic condition. The State's enrollment strategy may be based on the individuals with higher numbers or severity of chronic conditions and the criteria established by the State would need to be detailed in the SPA as part of their population criteria. However, it is important for the State to understand that there can only be one effective date for a HH SPA, so to maximize the 8 quarters of enhanced match the State will want to make sure they are ready to begin the enrollment process when the SPA is effective.

IV. Delivery Models

19. Q. What models of Health Homes would be considered by CMS for a State using a managed care delivery system?

A: Below are three models CMS would consider for a State using a managed care delivery system and the effect to the managed care plan rate structure. A State is not limited to these models, and can propose a model that will work best for their State.

- A Health Home is a designated provider, a team of health care professionals or a Health Home team contracting with a plan or the State. The State may pay the Health Home directly or the payment may be passed through the plan.
  - The State may need to revise the plan's capitation rate to account for the extent that there will be a reduction in the care coordination services furnished by the plan, in light of the provision of care coordination services by the health home provider.
- The Managed Care Entity furnishes Health Home services directly.
  - To the extent that the State is seeking the 90 percent match for the first 8 quarters of Health Home services furnished by the plan, the State will need to develop a methodology to identify Health Home services other than care coordination services otherwise furnished by the plan to all enrollees.
- Health homes are provided in part by the plan and in part by an external contractor (e.g., plan staff participate as part of a health home team).
  - To the extent that the State is seeking the 90 percent match for the first 8 quarters of Health Home services furnished by the plan, the State will need to develop a methodology to identify Health Home services other than care coordination services otherwise furnished by the plan to all enrollees.

V. Quality Measurement, Reporting, HIT

20. Q. What are the Reporting Requirements?

A: Providers of Health Home services are required to report quality measures to the State as a condition for receiving payment.

States will need to collect and report the information required for the overall evaluation to include utilization, expenditure and quality data for an interim survey and an independent evaluation.

The Secretary is required to conduct a survey of States that have implemented Health Homes and submit an Interim Report to Congress in 2014. In addition, the Secretary shall contract with an independent entity for an Independent Evaluation and report to Congress in 2017 for the purpose of determining the effect of such option on reducing hospital admissions, emergency visits, and admission to skilled nursing facilities.

21. Q. Is the use of health information technology mandatory for the implementation and utilization of Health Home under the Affordable Care Act's definition?

A: HIT is strongly encouraged in the SMD letter, but is not required. If HIT is neither feasible nor appropriate the State will need to respond accordingly in the SPA submission. In the absence of HIT, the State will need to demonstrate how they achieve the care coordination activities between multiple settings of a health home through other methods.

VI. Funding and Payment

22. Q. Please describe your process for requesting planning funds.

A: If a State is interested in requesting a planning opportunity, a letter requesting such funds including a budget for the use of the planning dollars as well as listed activities planned will need to be sent to the health homes mailbox as outlined in the SMD letter. For an example of an approved planning request letter, please send your request to the health homes mailbox and an example will be sent to your State. The health homes mailbox address is HealthHomes@cms.hhs.gov.

23. Q. What is the match rate for the planning funds?

A: Planning dollars will be matched by CMS at the State's pre-Recovery Act service match methodology.

24. Q. Is there a deadline to submit for a planning opportunity?

A: No, there is no deadline for submission of a planning opportunity. It is noted that payments from CMS for planning funds can be no more than $25,000,000, so CMS would encourage a State to apply for planning funds at their earliest opportunity if they are expecting to implement a Health Home program.

25. Q. If a State requests a planning opportunity, must they then implement a Health Home program?

A: No, if a State uses the planning funds as outlined in their planning request letter and finds that a health home program is not feasible they will not be required to submit a SPA.

26. Q. How will the payment for Health Home services work?

A. States have flexibility in designing their payment methodology but must include their methodology in the State Plan.

States will receive a 90% enhanced FMAP for the specific health home services in Section 2703. The enhanced match does not apply to the underlying Medicaid services also provided to individuals enrolled in a health home.

The 90 percent enhanced match is good for the first 8 quarters in which the program is effective. A state may receive more than one period of enhanced match, understanding that they will only be allowed to claim the enhanced match for a total of 8 quarters for one beneficiary.

27. Q. Does the enhanced FMAP rate of 90 percent for the first 8 quarters after the effective date include all medical costs, in addition to case management fees?

A: The 90% enhanced FMAP is only for the health home services listed in section 2703 including: comprehensive care management, care coordination, health promotion, comprehensive transitional care, patient and family support and referral to community and social support services. It does not apply to the other Medicaid services provided to individuals enrolled in a health home program.

28. Q. Are there any additional payment considerations that a State must account for in a managed care delivery system?

A: As a portion of the managed care capitation rate includes care coordination, the State will be required to review whether the capitation payment from the managed care

entity for a beneficiary enrolled in a health home needs to be reduced to account for the performance of the care coordination component by the health home.

29. Q. Can a State get 90 percent match for nursing home care management services, is this allowable under the health home provision?

A**:** CMS may consider Health Home proposals that propose to improve outcomes and change the trajectory of those Medicaid individuals in a nursing home with one or more chronic conditions such as mental illness/behavioral health conditions. CMS would also support HH efforts to transition Medicaid individuals out of a nursing home, since that is a specific part of HH services. However, the State would need to develop coverage, payment and evaluation methods to ensure that the HH services do not duplicate ordinary NF services. To the extent that HH payments were made to NFs, the State would need to ensure that the HH payment was for services above the level of the services which the NF was already obligated to furnish under the applicable NF conditions of participation and the NF payment rate. For example, the State might need to distinguish between normal NF discharge planning and transitional care efforts that exceed the level of discharge planning.

30. Q. When does the enhanced match end?

A: The 90 percent match is good for the first 8 quarters in which the program is effective. But there is no "end date" for when this authority ends. A State could implement a health home program several years from now and still receive the 90% FMAP for the first 8 quarters.

31. Q. Can a State receive more than one period of enhanced match?

A: A State may receive more than one period of enhanced match, understanding that they will only be allowed to claim the enhanced match for a total of 8 quarters for one beneficiary. If a State chooses to initially limit their health home by geographic region or specific chronic conditions, they are eligible to submit an additional SPA at a later time expanding their health home or implementing a new health home and will be able to claim the enhanced match for the expanded geographic areas and/or new populations served.

VII. SPA, Waivers/Authorities

32. Q. Where can a State locate the Health Homes SPA template?

A: A State can contact Siani Kayani for technical assistance regarding the health homes SPA web based system. He can be reached at Siani.Kayani@cms.hhs.gov or (410) 786-6810. Information on the web-based SPA system can also be found in the Informational Bulletin at the following link. http://www.naph.org/Links/ADV/Web-Based-Submission-For-Health-Homes-Spas-Info-Bulletin.aspx

33. Q. May a State that currently provides medical home services include some or all of those services currently covered within the Health Homes SPA?

A: We encourage States with existing medical home programs to explore ways to build on their current programs to meet the requirements for section 2703 that include linkages to behavioral health services and long term supports.

34. Q. Children require different approaches to the delivery of health care compared to adults. Can a State target seriously emotionally disturbed (SED) and medically fragile children and how can a SPA be constructed to meet their needs?

A**:** States may have different approaches to delivering services for children as compared to adults based on the fact that treatment modalities and providers of service for these Medicaid individuals with chronic conditions may vary. All beneficiaries eligible for Medicaid under the State plan or a waiver of the State plan who have the chronic conditions and are in the geographic location outlined in the State's health home SPA are eligible to be enrolled in the Health Home. The State may target chronic conditions that have a higher prevalence in particular age groups. In addition, States may construct their SPA by explaining the specific chronic condition (serious emotional disturbances) and determine the specific provider qualifications, clearly delineating the specialty nature of the provider based on the chronic condition criteria. Then any provider who is able to meet the requirements would be permitted to be a health home provider either as a designated provider or part of the team of health care professionals. With respect specifically to "SED and medically fragile children, the State would need to identify the specific chronic conditions at issue (including the severity criteria for such conditions). Medically fragile does not appear to be a chronic condition itself but rather a severity criterion applicable to a chronic condition**.**