OVERVIEW

A medical home is a team-based model of care led by a primary care physician that provides continuous and coordinated care to maximize health outcomes. The role of the medical home is to ensure that individuals get the health care they need, either by providing those services internally or appropriately arranging services with other qualified professionals. These services include the provision of preventive services, treatment of acute and chronic illnesses, and assistance with end-of-life issues. By addressing all of the health care needs of an individual as a collaborative team, the medical home model can provide high levels of care, ensure access and communication, improve care coordination and integration, and enhance care quality and safety.

HEALTH HOMES AND THE AFFORDABLE CARE ACT

Section 2703 of the Patient Protection and Affordable Care Act (ACA) offers states the option to provide health homes for Medicaid enrollees with chronic conditions. Health homes are an evolution of the traditional medical home model, in which collaborative health teams integrate and/or provide linkages to behavioral health care and community-based services and supports, in addition to the services offered in medical homes. The ACA allows states to offer these health home services to individuals with chronic conditions in order to improve the experience of care, improve the health of populations, and reduce per capita costs of health care.

Beginning January 1, 2011, states can use a State Plan Amendment to obtain a 90 percent federal medical assistance percentage (FMAP) for eight consecutive quarters to reimburse care coordination services for Medicaid beneficiaries in health homes. States have considerable flexibility in designing and implementing health homes and are faced with many options in choosing the key features of health homes, such as the target populations, providers, and payment methodology.

On November 16, 2010, the Centers for Medicare & Medicaid Services (CMS) issued a letter providing initial guidance on how states may implement this new option. In the guidance, CMS discussed the health home services that can be offered in this program, minimum population criteria for individuals to be eligible for health home services, diseases that constitute chronic conditions, provider arrangements that can offer home health services, payment methodologies that states can implement, and quality reporting requirements that states must meet. These are all highlighted on the next few pages.

The CMS letter to states can be found here.

Health Home Services

- The six core health homes services provided by eligible professionals to individuals with chronic conditions are:
  - Comprehensive care management;
  - Care coordination and health promotion;
  - Comprehensive transitional care, including follow-up, from inpatient to other settings;
  - Patient and family support;
  - Referral to community and social support services,
  - Use of health information technology to link services, as feasible.

Minimum Population Criteria

- States may elect to target a specific population of individuals or provide health home services to eligible individuals with chronic conditions as defined by the ACA.
- The health home population must consist of eligible individuals who have:
  - At least two chronic conditions;
  - At least one chronic condition and are at risk for another; or
  - Serious and persistent mental health conditions.

Chronic Conditions

- States have the option to offer health home services to eligible individuals with chronic conditions. Chronic conditions stipulated in the law include:
  - Mental health conditions;
  - Substance abuse disorder;
  - Asthma;
  - Diabetes;
  - Heart disease;
  - Being overweight (Body Mass index over 25); and
  - Other chronic conditions as authorized by the Secretary.

Provider Infastructure

The ACA authorizes three distinct types of health home provider arrangements that states may choose to offer health home services:

1. Designated Providers:

- Designated providers refer to physicians, clinical practices or clinical group practices, rural health clinics, community health centers, home health agencies, and any other providers or entities that are determined appropriate by the State and approved by the Secretary of Health and Human Services.
- Designated providers must have the systems and infrastructure in place to provide home health services.
- These providers or entities will also be required to meet the health home qualification standards as established for health home eligibility.

2. Teams of Health Care Professionals:

- A team of health care professionals may include physicians, nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professional deemed appropriate by the state and approved by the Secretary of Health and Human Services.
- The team may operate in a variety of ways such as virtually, free standing, based at a hospital, community health center, community mental health center, home health agency, or any other entity or provider that is determined by the State and approved by the Secretary.

3. Health Teams:

- The ACA requires the Secretary of Health and Human Services to define a "health team".
- The health team should be an interdisciplinary, inter-professional team and may include: medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractors, licensed complementary and alternative medicine practitioners, and physicians' assistants.

Payment Methodologies

- States are authorized to make medical assistance payments for health home services delivered by a designated provider, a team of health care professionals operating with a designated provider, or a health team.
- States are required to submit their payment methodology with their State Plan Amandement.
- Payment methodolgies may be tiered to reflect the severity of chronic conditions.
- Payment methodolgies are not limited to per-member-per-month models and alternate models may be submitted to the Secretary for approval.

Quality Reporting

- Eligible professionals will be required to report quality measures to the State in order to receive payments.
- The quality measures will be specified by the Secrertary of Health and Human Services.