

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. Managed Care Delivery Models;
- V. Quality Measurement, Reporting, Health Information Technology;
- VI. Funding and Payment; and
- VII. 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?

A: The health home services include:

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

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% enhanced match is good for the first eight 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.

- 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: A State may target the SPA geographically. State wideness is not a requirement.
- 4. 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, the State has the flexibility to propose the service definitions.
- 5. Q. Where is the SMD letter related to health homes located?**
- A: The State Medicaid Director (SMD) letter regarding health homes was issued on 11/16/2010 and can be found at the following link: <http://www.medicaid.gov>.
- 6. 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 eight fiscal quarters of this benefit?**
- A: The Territories are eligible for this provision and eligible for the 90% match, although this would have the consequence of depleting their Federal cap for Medicaid expenditures at a faster rate.
- 7. 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.
- 8. 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 State plan amendments 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 State Plan.
- 9. 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).

II. Health Home Providers

10. 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 health care 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 medicine practitioners, and physicians' assistants.

11. 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: Yes. Section 3502(b)(4) of the Affordable Care Act does require the Secretary to define the health team, but also indicates that the team should be an interdisciplinary, inter-professional team, and that the definition must include the following providers: medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers (including mental health providers, and substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians' assistants.

We are interpreting the statute to allow States to choose which provider arrangement(s) to offer, and, if more than one option is offered, the beneficiary may choose among those options. We recognize that there is diversity in provider arrangements across the States. Regardless of the provider arrangement(s) a State may offer, CMS will expect the State to embed the criteria described in the health home provider standards in its provider qualifications, and to be accountable for the providers adhering to and upholding those standards on an initial and ongoing basis.

III. Enrollment and Eligibility

12. Q. Who is eligible to receive health home services?

A: To the extent elected by the State in its approved State plan, Medicaid beneficiaries 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.

13. 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 for example, HIV/AIDS.

States may request to base eligibility on additional or different chronic conditions in a State Plan Amendment (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.

14. 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.

15. Q. Regarding 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 in the geographical area. The requirement applies to all hospitals, whether or not they participate in the particular health home provider network. It is a State plan requirement applicable to hospitals.

16. Q. Can a State use a sequenced enrollment strategy that initially focuses on the highest risk first and then moves 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. It is important for the State to understand that there can only be one effective date for a health home SPA. Thus to maximize the eight 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. Managed Care Delivery Models

17. Q. What models of health homes would be considered by CMS for a State using managed care delivery system?

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

1. 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.
 - a. The State may need to revise the plan's capitation rate to 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.
2. The managed care entity furnishes health home services directly.
 - a. To the extent that the State is seeking the 90 percent match for the first eight 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.
3. 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).
 - a. To the extent that the State is seeking the 90 percent match for the first eight 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.

18. 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 for 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. Duplicate payments are not permitted.

V. Quality Measurement, Reporting, Health Information Technology

19. 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. These measures are intended to help the State and Federal government and others learn how the health home intervention may be affecting the quality of care beneficiaries receive.

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.

20. Q. My state is able to implement some of the core measures but not all. When are we expected to implement the core set of measures?

A: CMS has developed a two-prong quality strategy for health homes that includes the core set of measures as well as state-specific goals and measures. In order to implement the core set, the state will need the technical specifications that will not be released until Spring/Summer 2012. CMS suggests waiting until those technical specifications are released to avoid instances where codes may change from the last release of technical specifications which in turn would cause the state to be collecting inaccurate data. Once, those technical specifications are released, CMS expects that states will implement as soon as possible but is offering flexibility up to around 18 months after the effective date of the SPA to have the measures fully operational. CMS requires that the state answer some feasibility questions and provide a timeline for implementation as part of the approval to delay implementation.

21. **Q. My state does not have a fully functioning electronic medical record (EMR) across all of the providers who will be participating in health homes. Does that preclude them from having to submit data on the quality measures that use an EMR?**

A: CMS recognizes that not every provider may have a fully functioning EMR, but it is expected that those providers will still provide the data from a paper chart, that could otherwise be pulled electronically from an EMR. In the feasibility questions pertaining to the core set of measures, the state should indicate this as a barrier and CMS will work in partnership with the state to develop a suitable timeline for implementation.

22. **Q. Is the use of health information technology (HIT) mandatory for the implementation and utilization of health homes 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 it will achieve the care coordination activities between multiple settings of a health home through other methods.

VI. Funding and Payment

23. **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.

24. **Q. What is the match rate for the planning funds?**

A: Planning dollars will be matched by CMS at the State's service match rate.

25. **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.

26. 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.

27. 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% enhanced match is available for the first eight quarters in which the program is effective. A State may receive more than one period of enhanced match, understanding that it will only be allowed to claim the enhanced match for a total of eight quarters for one beneficiary.

28. Q. Does the enhanced FMAP rate of 90% for the first eight 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.

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

A: CMS will 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 health home efforts to transition Medicaid individuals out of a nursing home, since that is a specific part of health home services. However, the State would need to develop coverage, payment and evaluation methods to ensure that the health home services do not duplicate ordinary nursing facility services. To the extent that health home payments were made to nursing facilities, the State would need to ensure that the health home payment was for services above the level of the services which the nursing facility was already obligated to furnish under the applicable nursing facility conditions of participation and the nursing facility payment rate. For example, the State might need to distinguish between normal nursing facility discharge planning and transitional care efforts that exceed the level of discharge planning.

30. Q. When does the enhanced match end?

A: The 90% match is available for the first eight quarters in which the health home SPA is effective. There is no “end date” for when this authority ends. A State could implement a health home initiative several years from now and still receive the 90% FMAP for the first eight 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 eight quarters for one beneficiary. If a State chooses to initially limit their health home by geographic region or specific chronic conditions, it is eligible to submit an additional SPA at a later time expanding its health home program or implementing a new health home program and will be able to claim the enhanced match for the expanded geographic areas and/or new chronic conditions.

VII. SPA, Waivers/Authorities

32. Q. Where can a State locate the health homes SPA template?

A: As of December 2015, health home SPAs are submitted through the online Medicaid and CHIP Program (MACPro) system. A State can contact the MACPro system help desk team for technical assistance regarding the health homes SPA web based system. They can be reached at MACPro_Helpdesk@cms.hhs.gov or (301) 547-4688. Resources on the web-based SPA system can also be found at the following link. <https://www.medicaid.gov/state-resource-center/medicaid-and-chip-program-portal/medicaid-and-chip-program-portal.html>

33. 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.

34. 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: Yes, 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 services and supports.

35. 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: Yes, 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 children and adults. 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 (e.g., 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 “seriously emotionally disturbed (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.

36. Q. May a State submit a health home SPA that serves a particular age group?

A. Yes, States may through their provider designation develop standards and protocols for health home providers that serve a particular age group. Through the provider designation States may develop provider standards and protocols for health home providers that serve different age groups, recognizing the fact that qualified providers and protocols may involve different approaches for children as compared to adults for the specific health home activities. Since the Health Home statute provides States with the flexibility to determine the provider arrangements, States may not specifically target by age in the SPA but through provider designation may limit who can provide the health home services.