

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



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Background on Medical Homes

A goal of implementing Section 2703 is 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 at their pre-Recovery act FMAP rate to engage in planning activities aimed at developing and submitting a State plan amendment.**
- **Waiver of comparability allows States to waive statewideness and offer health home services in different amount duration and scope**

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).
- Through Secretarial authority, States may add other chronic conditions in their State Plan Amendment for review and approval by CMS.

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 & 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.**
 - The 90 percent match does not apply to other Medicaid services a beneficiary may receive.

Health Home Services & Enhanced Federal Match

- A State could receive 8 quarters of 90% FMAP for health home services provided to individuals with chronic conditions, and a separate 8 quarters of enhanced FMAP for health home services provided to another population implemented at a later date.
- Additional periods of enhanced FMAP would be for new individuals served through either a geographic expansion of an existing health home program, or implementation of a completely separate health home program designed for individuals with different chronic conditions.
 - It is important to note that States will not be able to receive more than one 8-quarter period of enhanced FMAP for each health home enrollee.

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.

CCNC—NC Health Home

- **CCNC is the Health Home for NC Medicaid recipients. CCNC is responsible for the following for patients with “chronic conditions*”:**
 - Comprehensive care management
 - Care coordination/health promotion
 - Comprehensive transitional care
 - Patient and family support
 - Referrals to community and social support services
 - Use of HIT to link services
 - **including serious/persistent mental illness and substance abuse disorders as outlined in Quadrant model and roles/responsibility document*

CCNC—NC Health Home Behavioral Health Initiatives

- **14 Psychiatrists in Regional Networks**
- **Teach PCPs to address MH/SA issues in primary care**
- **Teach PCPs to collaborate with behavioral health providers**
- **Use of SBIRT & other brief screenings**
- **MDD education and treatment**
- **Atypical antipsychotic programs for children**
- **Training CCNC care managers and PCPs in Motivational Interviewing**

CCNC Health Homes & Local Management Entities (LMEs)

- **LMEs provide care management for individuals with SPMI and substance use “chronic conditions”**
- **LMEs have formed a collaborative relationship with local CCNC networks (4 Quadrant Model)**
 - LMEs will coordinate care for MH/DD/SA inpatient and ED discharge services
 - Following the roles/responsibilities document between LME/CCNC
 - LME care managers will work closely with CCNC primary care providers to insure coordinated care
- **LMEs have signed data-sharing agreements with the CCNC Informatics Center**

Next Steps

- Apply for planning grant
- Complete SPA one to include programs that currently meet the Health Home criteria to begin drawing down 90% FMAP
 - Telemonitoring
 - Tiered incentive rates for local networks and providers
- Determine scope and timeline for subsequent SPAs.
 - Consolidate CAP C/DA case management under CCNC
 - HIV case management under CCNC
 - Behavioral health 1915 B/C waiver