SECTION 2703, THE MEDICAID HEALTH HOME PROVISION OF THE AFFORDABLE CARE ACT: AN OVERVIEW

Introduction

Section 2703 of the Affordable Care Act (ACA) went into effect on January 1, 2011. It is an optional provision of the ACA. States that create Medicaid Health Homes have an opportunity to integrate primary care, mental, behavioral, and substance use services for individuals with certain chronic conditions who are enrolled in Medicaid. Health Homes also provide an opportunity for states to work towards the Triple Aim. This is a framework, developed by the Institute for Healthcare Improvement (IHI), that improves patients' quality and satisfaction of care (experience), improves population health, and reduces individuals' cost of care.[1,2]

The 2009/10 National Survey for Children with Special Health Care Needs reported that only 51.4% of children with special health care needs with public insurance who needed care coordination received effective care coordination.[3] Earlier this year, the American Academy of Pediatrics (AAP), noting the importance of care coordination for children and youth with special health care needs (CYSHCN), released a framework for supporting care coordination in a patient- and family-centered medical home. Yet, the authors acknowledge that some payment models do not reimburse for care coordination services. Their recommendations include advocating for payment for these services.[4]

Care coordination is one of the six services available to individuals who are eligible for Medicaid Health Homes, and providers receive payment for providing it. Medicaid Health Homes have the potential for ensuring Medicaid-enrolled CYSHCN with certain chronic conditions receive care coordination services, connections to community and social support services, and other benefits not generally part of the Medicaid benefit.

State Plan Amendment

States must submit a Medicaid State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) in order to implement Section 2703 of the ACA. The SPA does not have to be statewide; states may choose to serve certain geographic regions and/or implement the SPA over time in different parts of the state. There is also a waiver of comparability; states do not have to provide the six Health Home services to individuals enrolled in Medicaid who are not enrolled and/or not eligible for Health Home services.

Funding

States with approved Health Home SPAs receive a 90% enhanced federal match for two years for each Health Home SPA. States can have more than one SPA, as long as each SPA is unique and does not serve the same population, unless they are rolling out a SPA to new geographic areas. States receive their regular Federal Medicaid Assistance Percentage (FMAP) for all other Medicaid services provided to eligible individuals. [See each state's FMAP for Medicaid.*]

[1] Institute for Healthcare Improvement, The IHI Triple Aim. (n.d.). Retrieved from http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

[2] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Letter to State Medicaid Directors Re: Health Homes for Enrollees with Chronic Conditions. (2010, November 16). Retrieved from http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf

[3] National Survey of Children with Special Health Care Needs. NS-CSHCN 2009/10. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 06/26/14 from http://www.childhealthdata.org/browse/survey/results?q=1857&r=1&g=371

[4] Turchi, R., and Antonelli, R. Patient- and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth across Multiple Systems. Pediatrics. 2014;133(5); e1451-e1460. Retrieved from http://pediatrics.aappublications.org/content/133/5/e1451.full

*http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/

Benefits

The six Health Home services include:

- Care coordination that ensures access to all needed services, such as behavioral health services and preventive services
- Comprehensive Care Management that includes screenings to assess health needs, health literacy, and to develop care plans
- Health promotion that includes educating patients about the importance of immunizations and screenings, healthy eating and healthy lifestyle
- Comprehensive transitional care, for example from inpatient to other settings
- Individual and family support that includes educating and empowering patients and families to be part of the health team and to make decisions about treatment options
- Referral to community and social support services that includes communication with and referrals to other support services, such as day care for individuals with disabilities

Health Homes, Medical Homes: What's the Same, What's Different?

	Health Homes	Medical Homes
Description	Section 2703 of the ACA*	History of the Medical Home Concept†
Goal	To integrate & coordinate primary, acute, behavioral health (mental health and substance use), and long-term services and supports for individuals with certain chronic conditions across the lifespan[5]	To ensure primary care is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety[6]
Population Served	Medicaid enrollees with approved chronic conditions	All populations
Infrastructure	Can include primary care settings, hospitals, clinics, community behavioral health systems, targeted case management programs, federally qualified health centers, or other settings as designated in the state's Medicaid SPA	Generally a primary care setting
Provider Certification	Determined by each state's Medicaid agency	Recognition Programs include: The National Commission for Quality Assurance (NCQA),‡ The Joint Commission,§ and the Utilization Review Accreditation Commission (URAC).‖, [7]
Reimbursement	Per-member-per-month (PMPM) and/or fee-for-service (FFS) for the six health home services	With Medical Home Certification may receive enhanced payment for services.
Payer	Medicaid	May include commercial payers and Medicaid

Source: Adapted from National Council for Community Behavioral Healthcare, Compare and Contrast: Medicaid Health Homes and Patient Centered Medical Homes. (n.d.). Retrieved from http://www.integration.samhsa.gov/integrated-care-models/Medicaid_HH_and_Patient_Centered_Medical_Homes.pdf

[5] U.S. Department of Health and Human Services, Centers of Medicare and Medicaid Services, Letter to State Medicaid Directors Re: Health Homes for Enrollees with Chronic Conditions, State Medicaid Director's Letter. (2010, November 16). Retrieved from http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf

[6] Patient Centered Primary Care Collaborative, Defining the Medical Home: A patient-centered philosophy that drives primary care excellence. (n.d.). Retrieved from http://www.pcpcc.org/about/medical-home

[7] Learn more about Patient-Centered Medical Home Recognition & Accreditation Programs at http://www.medicalhomeinfo.org/national/recognition_programs.aspx

*http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/Health-Homes-FAQ-5-3-12_2.pdf

†http://pediatrics.aappublications.org/content/113/Supplement_4/1473.full

‡ http://www.ncqa.org/Programs/Recognition.aspx

§ http://www.jointcommission.org/certification/certification_main.aspx

‖ https://www.urac.org/accreditation-and-measurement/accreditation-programs/

Eligibility

Individuals eligible for Health Home services must be eligible for and enrolled in Medicaid. They must have at least one of the following:

- two or more chronic conditions
- one chronic condition and the risk of developing another
- at least one serious and persistent mental health condition

By statute, chronic conditions must include:

- Mental health conditions
- Substance abuse disorders
- Asthma
- Diabetes
- Heart disease
- Being overweight (BMI of > 25)

Subject to review and approval by CMS, states may add other chronic conditions. Eligibility for Health Home services is determined by specific conditions; states cannot use age as an eligibility criterion. However, in order to include CYSHCN, some states have included additional chronic conditions, such as congenital and circulatory anomalies, genetic disorders, autism spectrum disorders, and other developmental disabilities. And, because serious and persistent mental health conditions are generally adult diagnoses, states have redefined them as serious emotional disorders in order to include children and youth. States may also select provider networks for their Health Homes that serve children, such as pediatric patient-centered medical homes. Find out if there is a Section 2703 Medicaid Health Home in your state.*

Watch for future Catalyst Center publications about including children and youth with special health care needs in Health Home SPAs.

Resources

Centers for Medicare and Medicaid Services, Letter to State Medicaid Directors Re: Health Homes for Enrollees with Chronic Conditions.
http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf

Medicaid.gov: Health Homes
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html

Medicaid.gov: Health Homes (Section 2703) Frequently Asked Questions
http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/Health-Homes-FAQ-5-3-12_2.pdf

Medicaid.gov: Health Home Information Center
http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html

Pires, S. Customizing Health Homes for Children with Serious Behavioral Health Challenges. Human Services Collaborative. March 2013.
http://www.nwi.pdx.edu/pdf/CustomizingHealthHomes.pdf

Silow-Carroll, S. and Rodin, D. Health Homes for the Chronically Ill: An Opportunity for States. The Commonwealth Fund. December 2010/January 2011.
http://www.commonwealthfund.org/publications/newsletters/states-in-action/2011/jan/december-2010-january-2011/feature/feature

Turchi, R., and Antonelli, R. Patient- and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth across Multiple Systems. Pediatrics. 2014;133(5); e1451-e1460.
http://pediatrics.aappublications.org/content/133/5/e1451.full

*http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Approved-Health-Home-State-Plan-Amendments.html

This fact sheet can be found on the Web at http://hdwg.org/catalyst/publications/factsheet-2703

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