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## FACT SHEET ON HEALTH HOMES

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### Introduction

- The definition of a health home varies by source, but the general idea and construct remains consistent. The health home model promotes a team-based approach to care of a patient through a spectrum of disease states and across the various stages of life.
- Overall coordination of care is led by a personal physician with the patient serving as the focal point of all medical activity.
- In 2007, under the leadership of the American Academy of Family Physicians, four physician organizations developed seven joint principles to describe the characteristics of a patient-centered health home

### Goal of Health Homes

- The goal in the health home model is for a team of providers to care for a patient, seamlessly and efficiently, while managing costs.
- In a health home, the primary care physician assists patients who need specialty care, maintains electronic records of all patient/provider interactions, communicates with all of a patient's clinical caregivers, and tracks the patient's progress.

### What is the Difference between a Health Home and an Accountable Care Organization (ACO)?

- Rather than tackling payment reform in isolation of care delivery, health homes and Accountable Care Organizations offer a consolidated approach to both issues. While the models are still developing, various pilot programs are being implemented around the country.
- Health homes are similar to Accountable Organizations in that they consolidate multiple levels of care for patients. However, health homes take the approach of having the primary physician lead the "care delivery" team."
- Simplistically, an ACO consists of many coordinated practices while a health home is a single practice.

### Opportunities for States in Implementing Health Homes

- As states look for ways to improve health care for people with chronic conditions in order to enhance outcomes and contain long-term costs, the Patient Protection and Affordable Care Act offers an important opportunity. Section 2703 of the ACA provides

- enhanced federal funding for two years for health homes serving Medicaid beneficiaries with chronic conditions.
- Under Section 2703, states can offer health home services to eligible Medicaid beneficiaries with chronic conditions who select a designated health home provider. The legislation defines chronic conditions to include a mental health condition, a substance use disorder, asthma, diabetes, heart disease, and being overweight.
  - States may elect to include other chronic conditions such as HIV/AIDS, subject to CMS approval. A state's designated health home population must include individuals who have at least two of these chronic conditions, one chronic condition and be at risk for another, or one serious and persistent mental health condition.
  - To select a health home population, states should conduct an analysis of their Medicaid beneficiaries and model their data to project the likely effect of comprehensive care coordination on medical spending for different populations that meet the Section 2703 chronic care criteria.

### **Health Home Providers**

- The health home's main function is to coordinate—not provide—the array of medical and behavioral health services needed to treat the “whole person.” The health home is not required to have its own network of providers; most services will come from typical community-based Medicaid providers.
- However, state plan amendments are expected to describe the infrastructure in place to provide timely, comprehensive, high-quality health home services.

### **Services Provided**

- There has been some confusion among states about which services are eligible for the 90 percent federal match. CMS clarified that the enhanced payment applies to the six health home services listed above (including care management, care coordination, and transitional care).
- All of the medical, behavioral health, and other services needed for addressing the “whole person” are reimbursed at each state's regular Medicaid rate; states have flexibility in defining health home services such as care coordination and in doing so may include additional, specific activities.
- CMS will give states flexibility in defining the six core health home services delineated in the statute if they can explain how these definitions contribute to the health home model.

### **Health Homes and Behavioral Healthcare**

- In 2008, NASMHPD called for the creation of a "patient-centered medical home" for individuals who have mental illnesses, as these consumers so often have co-morbid substance use and other serious medical conditions such as diabetes and heart conditions.
- The call is contained in a report, "*Measurement of Health Status for People with Serious Mental Illnesses.*" The report describes the health home as a platform for bringing together a primary care/physical health provider and specialty behavioral health services practitioners to provide collaborative care using disease management strategies based on the chronic care model.