NASMHPD National Association of State Mental Health Program Directors

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Questions and Answers on Health Homes

What are Health Homes?

Health homes are designed to be person-centered systems of care that facilitate access to and coordination of the full array of primary and acute physical health services, behavioral health care, and long-term community-based services and supports. The model aims to improve health care quality and clinical outcomes as well as the patient care experience, while also reducing per capita costs through more cost-effective care.

What are Health Homes versus Medical Homes?

The health home model of service delivery expands on the traditional medical home models that many states have developed in their Medicaid programs, by building additional linkages and enhancing coordination and integration of medical and behavioral health care to better meet the needs of people with multiple chronic illnesses.

What is Medicaid's New "Health Home" Option?

Many Medicaid beneficiaries suffer from multiple or severe chronic conditions and could potentially benefit from better coordination and management of the health and long-term services they receive, often in a disjointed or fragmented way. An increasing number of states have been adopting strategies to achieve such improvements, such as health homes and enhanced primary care case management.

Who can qualify for Medicaid health home services?

To be eligible for health home services, Medicaid beneficiaries must have at least two chronic conditions, including asthma, diabetes, heart disease, obesity, mental condition, and substance abuse disorder; one chronic condition and be at risk for another; or one serious and persistent mental health condition. Both children and adults who meet these criteria are eligible for health home services; individuals who are dually eligible for Medicaid and Medicare cannot be excluded.

What are specific health home services?

Health home services include: comprehensive care management; care coordination and health promotion, comprehensive transitional care from inpatient to other settings, including appropriate follow-up; individual and family support; referral to community and social support services, if relevant; and the use of health information technology (HIT) to link services.

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What is a health home provider arrangement?

Medicaid beneficiaries may receive health home services from three distinct types of health home provider arrangements: 1) a designated provider; 2) a team of health care professionals that links to a designated provider; or 3) a health team. Designated providers include physicians or physician practices, group practices, rural health clinics, community health centers, and community mental health centers, home health agencies, and any other entity or provider determined appropriate by the state and approved by the HHS Secretary.

What does a "team of health care professionals" mean?

It may comprise of a physician and other professionals including a behavioral health professional, a nurse care coordinator, nutritionist, social worker, or any other professionals deemed appropriate by the state.

What capabilities must a health home have?

- The CMS guidance establishes standards for health homes to ensure that they have the capacity for a "whole-person" approach to care that identifies needed clinical and non-clinical services and supports, and provides or makes linkages to all such care. CMS expects health homes to perform a wide array of functions. They must provide quality-driven, cost-effective, and culturally appropriate person- and family-centered health home services.

- Health Homes are responsible for coordinating and providing access to preventive and health promotion services; mental health and substance abuse services; comprehensive care management, care coordination and transitional care across settings; chronic disease management; individual and family supports, including referrals to community and social supports; and long-term supports and services.

- As prescribed by the ACA, the CMS guidance requires states to consult and coordinate with the Substance Abuse and Mental Health Services Administration (SAMHSA) in designing their approaches to health homes.

What are the payment rules for health home services?

The federal match rate for health home services is 90% for the first eight fiscal quarters that a state's health home SPA is in effect. States have considerable flexibility in designing their payment methodology for health home services. The ACA expressly permits states to adopt a tiered payment structure that takes into account the severity of each person's conditions and the capabilities of the health home provider arrangement.

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What funding is available to help support state planning activities?

CMS will authorize state applicants to spend up to $500,000 of Medicaid funding for planning activities related to the development of a health home SPA; state spending for this purpose will be matched at the state's regular FMAP rate for Medicaid services. The funds can be spent for activities such as hiring personnel to determine feasibility and develop a health home program, outreach to obtain consumer and provider feedback, training and consultation, systems development and other infrastructure-building tasks, and associated travel. To receive funding, available beginning January 1, 2011, a state must submit a Letter of Request to CMS, outlining its planning activities.

How will Health Homes be evaluated?

HHS must survey all states that elect the home health option by January 1, 2014 to prepare an interim report to Congress. The HHS Secretary must contract for an independent evaluation of the health home model and report to Congress by January 1, 2017. States must cooperate with the entity conducting the evaluation. CMS will provide further guidance on the evaluation design to the states implementing the health home option. The evaluation must address the effect of the model on reducing hospital readmissions, emergency room visits and admissions to skilled nursing facilities. Findings from the evaluation will be used to drive system-wide improvement in the delivery of health home services.

How will Health Homes affect 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.

SBHAs should assure that financing mechanisms align with, and promote, a single, integrated point of clinical responsibility for the individual, moving away from fragmented, fee-for-service reimbursement.