Federal Health Home Requirements[1]

Definitions

Health home – a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions

Eligible individual – someone eligible for Medicaid who has at least:
- Two chronic conditions;
- One chronic condition and is at risk for a second
- One serious and persistent mental health condition

Health home services –
- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care, including appropriate follow-up, from inpatient to other settings
- Patient and family support (including authorized representative)
- Referral to community and social support services, if relevant
- Use of HIT to link services

There are three distinct types of health home providers that can provide health home services:
- 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

Expectations

CMS has outlined the following expectations for successful provision of health homes within state Medicaid programs:
- Lower rates of ER use
- Reduction in hospital admissions and readmissions
- Less reliance on long-term care facilities
- Improved care and outcomes
- Reduction in health care costs

CMS also expects states to coordinate their Medicaid State Plan amendment (SPA) implementing health homes to consult and coordinate with the Substance Abuse and Mental Health Services Administration (SAMHSA) prior to submitting their SPA. There are also a number of monitoring, quality measurement and evaluation requirements.

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[1] State Medicaid Directors Letter #10-024