

gible for medical assistance under this subchapter or for child health assistance under subchapter XXI, including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.

(2) Agreements with State health insurance exchanges

The State Medicaid agency and the State CHIP agency may enter into an agreement with an Exchange established by the State under section 18031 of this title under which the State Medicaid agency or State CHIP agency may determine whether a State resident is eligible for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 (and, if applicable, advance payment of such assistance under section 18082 of this title), so long as the agreement meets such conditions and requirements as the Secretary of the Treasury may prescribe to reduce administrative costs and the likelihood of eligibility errors and disruptions in coverage.

(3) Streamlined enrollment system

The State Medicaid agency and State CHIP agency shall participate in and comply with the requirements for the system established under section 18083 of this title (relating to streamlined procedures for enrollment through an Exchange, Medicaid, and CHIP).

(4) Enrollment website requirements

The procedures established by State under paragraph (1) shall include establishing and having in operation, not later than January 1, 2014, an Internet website that is linked to any website of an Exchange established by the State under section 18031 of this title and to the State CHIP agency (if different from the State Medicaid agency) and allows an individual who is eligible for medical assistance under the State plan or under a waiver of the plan and who is eligible to receive premium credit assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 to compare the benefits, premiums, and cost-sharing applicable to the individual under the State plan or waiver with the benefits, premiums, and cost-sharing available to the individual under a qualified health plan offered through such an Exchange, including, in the case of a child, the coverage that would be provided for the child through the State plan or waiver with the coverage that would be provided to the child through enrollment in family coverage under that plan and as supplemental coverage by the State under the State plan or waiver.

(5) Continued need for assessment for home and community-based services

Nothing in paragraph (1) shall limit or modify the requirement that the State assess an individual for purposes of providing home and community-based services under the State

plan or under any waiver of such plan for individuals described in subsection (a)(10)(A)(ii)(VI).²

(Aug. 14, 1935, ch. 531, title XIX, §1943, as added Pub. L. 111-148, title II, §2201, Mar. 23, 2010, 124 Stat. 289.)

REFERENCES IN TEXT

The Internal Revenue Code of 1986, referred to in subsec. (b)(1)(C), (2), (4), is classified generally to Title 26, Internal Revenue Code.

§ 1396w-4. State option to provide coordinated care through a health home for individuals with chronic conditions

(a) In general

Notwithstanding section 1396a(a)(1) of this title (relating to statewideness), section 1396a(a)(10)(B) of this title (relating to comparability), and any other provision of this subchapter for which the Secretary determines it is necessary to waive in order to implement this section, beginning January 1, 2011, a State, at its option as a State plan amendment, may provide for medical assistance under this subchapter to eligible individuals with chronic conditions who select a designated provider (as described under subsection (h)(5)), a team of health care professionals (as described under subsection (h)(6)) operating with such a provider, or a health team (as described under subsection (h)(7)) as the individual's health home for purposes of providing the individual with health home services.

(b) Health home qualification standards

The Secretary shall establish standards for qualification as a designated provider for the purpose of being eligible to be a health home for purposes of this section.

(c) Payments

(1) In general

A State shall provide a designated provider, a team of health care professionals operating with such a provider, or a health team with payments for the provision of health home services to each eligible individual with chronic conditions that selects such provider, team of health care professionals, or health team as the individual's health home. Payments made to a designated provider, a team of health care professionals operating with such a provider, or a health team for such services shall be treated as medical assistance for purposes of section 1396b(a) of this title, except that, during the first 8 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be equal to 90 percent.

(2) Methodology

(A) In general

The State shall specify in the State plan amendment the methodology the State will use for determining payment for the provision of health home services. Such methodology for determining payment—

²Probably means subsection (a)(10)(A)(ii)(VI) of section 1396a of this title.

(i) may be tiered to reflect, with respect to each eligible individual with chronic conditions provided such services by a designated provider, a team of health care professionals operating with such a provider, or a health team, as well as the severity or number of each such individual's chronic conditions or the specific capabilities of the provider, team of health care professionals, or health team; and

(ii) shall be established consistent with section 1396a(a)(30)(A) of this title.

(B) Alternate models of payment

The methodology for determining payment for provision of health home services under this section shall not be limited to a per-member per-month basis and may provide (as proposed by the State and subject to approval by the Secretary) for alternate models of payment.

(3) Planning grants

(A) In general

Beginning January 1, 2011, the Secretary may award planning grants to States for purposes of developing a State plan amendment under this section. A planning grant awarded to a State under this paragraph shall remain available until expended.

(B) State contribution

A State awarded a planning grant shall contribute an amount equal to the State percentage determined under section 1396d(b) of this title (without regard to section 5001 of Public Law 111-5) for each fiscal year for which the grant is awarded.

(C) Limitation

The total amount of payments made to States under this paragraph shall not exceed \$25,000,000.

(d) Hospital referrals

A State shall include in the State plan amendment a requirement for hospitals that are participating providers under the State plan or a waiver of such plan to establish procedures for referring any eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

(e) Coordination

A State shall consult and coordinate, as appropriate, with the Substance Abuse and Mental Health Services Administration in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

(f) Monitoring

A State shall include in the State plan amendment—

(1) a methodology for tracking avoidable hospital readmissions and calculating savings that result from improved chronic care coordination and management under this section; and

(2) a proposal for use of health information technology in providing health home services under this section and improving service deliv-

ery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

(g) Report on quality measures

As a condition for receiving payment for health home services provided to an eligible individual with chronic conditions, a designated provider shall report to the State, in accordance with such requirements as the Secretary shall specify, on all applicable measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the State with such information.

(h) Definitions

In this section:

(1) Eligible individual with chronic conditions

(A) In general

Subject to subparagraph (B), the term “eligible individual with chronic conditions” means an individual who—

(i) is eligible for medical assistance under the State plan or under a waiver of such plan; and

(ii) has at least—

(I) 2 chronic conditions;

(II) 1 chronic condition and is at risk of having a second chronic condition; or

(III) 1 serious and persistent mental health condition.

(B) Rule of construction

Nothing in this paragraph shall prevent the Secretary from establishing higher levels as to the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services under this section.

(2) Chronic condition

The term “chronic condition” has the meaning given that term by the Secretary and shall include, but is not limited to, the following:

(A) A mental health condition.

(B) Substance use disorder.

(C) Asthma.

(D) Diabetes.

(E) Heart disease.

(F) Being overweight, as evidenced by having a Body Mass Index (BMI) over 25.

(3) Health home

The term “health home” means 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 to provide health home services.

(4) Health home services

(A) In general

The term “health home services” means comprehensive and timely high-quality services described in subparagraph (B) that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team.

(B) Services described

The services described in this subparagraph are—

- (i) comprehensive care management;
- (ii) care coordination and health promotion;
- (iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;
- (iv) patient and family support (including authorized representatives);
- (v) referral to community and social support services, if relevant; and
- (vi) use of health information technology to link services, as feasible and appropriate.

(5) Designated provider

The term “designated provider” means a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined by the State and approved by the Secretary to be qualified to be a health home for eligible individuals with chronic conditions on the basis of documentation evidencing that the physician, practice, or clinic—

- (A) has the systems and infrastructure in place to provide health home services; and
- (B) satisfies the qualification standards established by the Secretary under subsection (b).

(6) Team of health care professionals

The term “team of health care professionals” means a team of health professionals (as described in the State plan amendment) that may—

- (A) include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State; and
- (B) be free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary.

(7) Health team

The term “health team” has the meaning given such term for purposes of section 256a-1 of this title.

(Aug. 14, 1935, ch. 531, title XIX, §1945, as added Pub. L. 111-148, title II, §2703(a), Mar. 23, 2010, 124 Stat. 319.)

REFERENCES IN TEXT

Section 5001 of Public Law 111-5, referred to in subsec. (c)(3)(B), is set out as a note under section 1396d of this title.

SURVEY AND INTERIM REPORT

Pub. L. 111-148, title II, §2703(b)(2), Mar. 23, 2010, 124 Stat. 322, provided that:

“(A) IN GENERAL.—Not later than January 1, 2014, the Secretary of Health and Human Services shall survey States that have elected the option under section 1945 of the Social Security Act [42 U.S.C. 1396w-4] (as added by subsection (a)) and report to Congress on the nature, extent, and use of such option, particularly as it pertains to—

- “(i) hospital admission rates;
- “(ii) chronic disease management;
- “(iii) coordination of care for individuals with chronic conditions;
- “(iv) assessment of program implementation;
- “(v) processes and lessons learned (as described in subparagraph (B));
- “(vi) assessment of quality improvements and clinical outcomes under such option; and
- “(vii) estimates of cost savings.

“(B) IMPLEMENTATION REPORTING.—A State that has elected the option under section 1945 of the Social Security Act (as added by subsection (a)) shall report to the Secretary, as necessary, on processes that have been developed and lessons learned regarding provision of coordinated care through a health home for Medicaid beneficiaries with chronic conditions under such option.”

§ 1396w-5. Addressing health care disparities

(a) Evaluating data collection approaches

The Secretary shall evaluate approaches for the collection of data under this subchapter and subchapter XXI, to be performed in conjunction with existing quality reporting requirements and programs under this subchapter and subchapter XXI, that allow for the ongoing, accurate, and timely collection and evaluation of data on disparities in health care services and performance on the basis of race, ethnicity, sex, primary language, and disability status. In conducting such evaluation, the Secretary shall consider the following objectives:

- (1) Protecting patient privacy.
- (2) Minimizing the administrative burdens of data collection and reporting on States, providers, and health plans participating under this subchapter or subchapter XXI.
- (3) Improving program data under this subchapter and subchapter XXI on race, ethnicity, sex, primary language, and disability status.

(b) Reports to Congress

(1) Report on evaluation

Not later than 18 months after March 23, 2010, the Secretary shall submit to Congress a report on the evaluation conducted under subsection (a). Such report shall, taking into consideration the results of such evaluation—

- (A) identify approaches (including defining methodologies) for identifying and collecting and evaluating data on health care disparities on the basis of race, ethnicity, sex, primary language, and disability status for the programs under this subchapter and subchapter XXI; and
- (B) include recommendations on the most effective strategies and approaches to reporting HEDIS quality measures as required under section 1395w-22(e)(3) of this title and other nationally recognized quality performance measures, as appropriate, on such bases.

(B) include recommendations on the most effective strategies and approaches to reporting HEDIS quality measures as required under section 1395w-22(e)(3) of this title and other nationally recognized quality performance measures, as appropriate, on such bases.

(2) Reports on data analyses

Not later than 4 years after March 23, 2010, and 4 years thereafter, the Secretary shall submit to Congress a report that includes recommendations for improving the identification of health care disparities for beneficiaries under this subchapter and under subchapter XXI based on analyses of the data collected under subsection (c).