that covered providers in such administering State are able to access through such program.

(g) Rule of construction

Nothing in this section prevents a State from requiring pharmacists to check the prescription drug history of covered individuals through a qualified prescription drug monitoring program before dispensing controlled substances to such individuals.

(h) Definitions

In this section:

(1) Controlled substance

The term ''controlled substance'' means a drug that is included in schedule II of section 812(c) of title 21 and, at the option of the State involved, a drug included in schedule III or IV of such section.

(2) Covered individual

The term ''covered individual'' means, with respect to a State, an individual who is enrolled in the State plan (or under a waiver of such plan). Such term does not include an individual who—

(A) is receiving—

(i) hospice or palliative care; or

(ii) treatment for cancer;

(B) is a resident of a long-term care facility, of a facility described in section 1396d(d) of this title, or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy; or

(C) the State elects to treat as exempted from such term.

(3) Covered provider

(A) In general

The term ''covered provider'' means, subject to subparagraph (B), with respect to a State, a health care provider who is participating under the State plan (or waiver of the State plan) and licensed, registered, or otherwise permitted by the State to prescribe a controlled substance (or the designee of such provider).

(B) Exceptions

(i) In general

Beginning October 1, 2021, for purposes of this section, such term does not include a health care provider included in any type of health care provider determined by the Secretary to be exempt from application of this section under clause (ii).

(ii) Exceptions process

Not later than October 1, 2020, the Secretary, after consultation with the National Association of Medicaid Directors, national health care provider associations, Medicaid beneficiary advocates, and advocates for individuals with rare diseases, shall determine, based on such consultations, the types of health care providers (if any) that should be exempted from the definition of the term ''covered provider'' for purposes of this section.

(Aug. 14, 1935, ch. 531, title XIX, § 1944, as added Pub. L. 115–271, title V, § 5042(a), Oct. 24, 2018, 132 Stat. 3967.)

Editorial Notes

REFERENCES IN TEXT

Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (c), is section 264(c) of Pub. L. 104–191, title II, Aug. 21, 1996, 110 Stat. 2033, which is set out as a note under section 1320d–2 of this title.

Statutory Notes and Related Subsidiaries

GUIDANCE

Pub. L. 115–271, title V, § 5042(b), Oct. 24, 2018, 132 Stat. 3970, provided that: ''Not later than October 1, 2019, the Administrator of the Centers for Medicare & Medicaid Services, in consultation with the Director of the Centers for Disease Control and Prevention, shall issue guidance on best practices on the uses of prescription drug monitoring programs required of prescribers and on protecting the privacy of Medicaid beneficiary information maintained in and accessed through prescription drug monitoring programs.''

DEVELOPMENT OF MODEL STATE PRACTICES

Pub. L. 115–271, title V, § 5042(c), Oct. 24, 2018, 132 Stat. 3970, provided that:

''(1) IN GENERAL.—Not later than October 1, 2020, the Secretary of Health and Human Services shall develop and publish model practices to assist State Medicaid program operations in identifying and implementing strategies to utilize data-sharing agreements described in the matter following paragraph (2) of section 1944(b) of the Social Security Act [42 U.S.C. 1396w–3a(b)], as added by subsection (a), for the following purposes:

''(A) Monitoring and preventing fraud, waste, and abuse.

''(B) Improving health care for individuals enrolled in a State plan under title XIX of such Act [42 U.S.C. 1396 et seq.] (or under a waiver of such plan) who—

''(i) transition in and out of coverage under such title;

''(ii) may have sources of health care coverage in addition to coverage under such title; or

''(iii) pay for prescription drugs with cash.

''(C) Any other purposes specified by the Secretary.

''(2) ELEMENTS OF MODEL PRACTICES.—The model practices described in paragraph (1)—

''(A) shall include strategies for assisting States in allowing the medical director or pharmacy director (or designees of such a director) of managed care organizations or pharmaceutical benefit managers to access information with respect to all covered individuals served by such managed care organizations or pharmaceutical benefit managers to access as a single data set, in an electronic format; and

''(B) shall include any appropriate beneficiary protections and privacy guidelines.

''(3) CONSULTATION.—In developing model practices under this subsection, the Secretary shall consult with the National Association of Medicaid Directors, managed care entities (as defined in section 1932(a)(1)(B) of the Social Security Act [42 U.S.C. 1396u–2(a)(1)(B)]) with contracts with States pursuant to section 1903(m) of such Act [42 U.S.C. 1396b(m)], pharmaceutical benefit managers, physicians and other health care providers, beneficiary advocates, and individuals with expertise in health care technology related to prescription drug monitoring programs and electronic health records.''

§ 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, subject to paragraph (4), 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—

(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.

(4) Special rule relating to substance use disorder health homes

(A) In general

In the case of a State with an SUD-focused State plan amendment approved by the Secretary on or after October 1, 2018, the Secretary may, at the request of the State, extend the application of the Federal medical assistance percentage described in paragraph (1) to payments for the provision of health home services to SUD-eligible individuals under such State plan amendment, in addition to the first 8 fiscal year quarters the State plan amendment is in effect, for the subsequent 2 fiscal year quarters that the State plan amendment is in effect. Nothing in this section shall be construed as prohibiting a State with a State plan amendment that is approved under this section and that is not an SUD-focused State plan amendment from additionally having approved on or after such date an SUD-focused State plan amendment under this section, including for purposes of application of this paragraph.

(B) Report requirements

In the case of a State with an SUD-focused State plan amendment for which the application of the Federal medical assistance percentage has been extended under subparagraph (A), such State shall, at the end of the period of such State plan amendment, submit to the Secretary a report on the following, with respect to SUD-eligible individuals provided health home services under such State plan amendment:

(i) The quality of health care provided to such individuals, with a focus on outcomes relevant to the recovery of each such individual.

(ii) The access of such individuals to health care.

(iii) The total expenditures of such individuals for health care.

For purposes of this subparagraph, the Secretary shall specify all applicable measures for determining quality, access, and expenditures.

(C) Best practices

Not later than October 1, 2020, the Secretary shall make publicly available on the

internet website of the Centers for Medicare & Medicaid Services best practices for designing and implementing an SUD-focused State plan amendment, based on the experiences of States that have State plan amendments approved under this section that include SUD-eligible individuals.

(D) Definitions

For purposes of this paragraph:

(i) SUD-eligible individuals

The term ''SUD-eligible individual'' means, with respect to a State, an individual who satisfies all of the following:

(I) The individual is an eligible individual with chronic conditions.

(II) The individual is an individual with a substance use disorder.

(III) The individual has not previously received health home services under any other State plan amendment approved for the State under this section by the Secretary.

(ii) SUD-focused State plan amendment

The term ''SUD-focused State plan amendment'' means a State plan amendment under this section that is designed to provide health home services primarily to SUD-eligible individuals.

(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 delivery 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; amended Pub. L. 115–271, title I, § 1006(a), Oct. 24, 2018, 132 Stat. 3913.)

Editorial Notes

REFERENCES IN TEXT

Section 5001 of Public Law 111–5, referred to in subsec. (c)(3)(B), is section 5001 of Pub. L. 111–5, div. B, title V, Feb. 17, 2009, 123 Stat. 496, which was formerly set out as a note under section 1396d of this title.

AMENDMENTS

2018—Subsec. (c)(1). Pub. L. 115–271, § 1006(a)(1), inserted ''subject to paragraph (4),'' after ''except that,''.

Subsec. (c)(4). Pub. L. 115–271, § 1006(a)(2), added par. (4).

Statutory Notes and Related Subsidiaries

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–4a. State option to provide coordinated care through a health home for children with medically complex conditions

(a) In general

Notwithstanding section 1396a(a)(1) of this title (relating to statewideness) and section 1396a(a)(10)(B) of this title (relating to comparability), beginning October 1, 2022, a State, at its option as a State plan amendment, may provide for medical assistance under this subchapter to children with medically complex conditions who choose to enroll in a health home under this section by selecting a designated provider, a team of health care professionals operating with such a provider, or a health team as the child's health home for purposes of providing the child with health home services.

(b) Health home qualification standards

The Secretary shall establish standards for qualification as a health home for purposes of this section. Such standards shall include requiring designated providers, teams of health care professionals operating with such providers, and health teams to demonstrate to the State the ability to do the following:

(1) Coordinate prompt care for children with medically complex conditions, including access to pediatric emergency services at all times.

(2) Develop an individualized comprehensive pediatric family-centered care plan for children with medically complex conditions that accommodates patient preferences.

(3) Work in a culturally and linguistically appropriate manner with the family of a child with medically complex conditions to develop and incorporate into such child's care plan, in a manner consistent with the needs of the child and the choices of the child's family, ongoing home care, community-based pediatric primary care, pediatric inpatient care, social support services, and local hospital pediatric emergency care.

(4) Coordinate access to—

(A) subspecialized pediatric services and programs for children with medically complex conditions, including the most intensive diagnostic, treatment, and critical care levels as medically necessary; and

(B) palliative services if the State provides such services under the State plan (or a waiver of such plan).