Medicaid Health Homes: Implementation Update

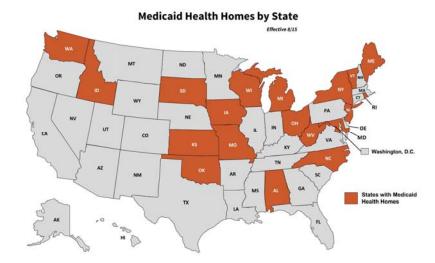
The Affordable Care Act gives states an opportunity to improve care coordination and care management for Medicaid beneficiaries with complex needs through health homes. Health homes integrate physical and behavioral health care and long-term services and supports for high-need, high-cost Medicaid populations with the goal of improving health care quality and reducing costs. Through health homes, states seek to improve quality and reduce fragmentation of care, while leveraging enhanced federal funding (90 percent federal match for the first eight quarters).

State Progress in Implementing Health Homes

As of August 2015, 19 states have Medicaid health home programs. Some states have submitted multiple health home state plan amendments (SPAs) to target different populations or conditions, with 26 health home models in operation. Nearly a dozen additional states are planning to implement health homes. More than one million Medicaid beneficiaries have enrolled in health homes thus far.

Health Homes Target Individuals with Chronic Conditions

To be eligible for a Medicaid health home, an individual must have two chronic conditions;



one chronic condition and risk for another; or a serious mental illness. States can target health home enrollment by condition, geography, and severity/risk, but health home enrollment cannot be targeted by age, delivery system, or dual eligibility status (i.e., eligible for both Medicare and Medicaid). However, states may create two health homes, each tailored to meet the needs of a different group (e.g., children and adults), but the health homes must have the same effective date.

Mandated Core Services Enhance Coordination of Care

The goal of the Medicaid health home state plan option is to promote access to and coordination of care. Health homes may be: (1) based in primary care or behavioral health providers' offices; (2) coordinated virtually; or (3) located in other settings that suit beneficiaries' needs. Providers use person-centered care planning and coordination/integration of services to reduce fragmentation of care. Health homes must provide six core services, linked as appropriate and feasible by health information technology:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care and follow-up;
- Individual and family support; and
- Referral to community and social support services.

Lessons in Program Design and Early Implementation

The first states to launch health homes have completed their third year of implementation. These early adopters of Medicaid health homes learned important lessons about designing and implementing health homes for individuals with complex care needs that could inform other states considering this model. Early adopter states found that they could use the flexibilities within the health home option to advance their policy goals. They also used their knowledge and experience working with complex populations to guide design of their health home services, and they thoughtfully aligned payment models with policy goals to advance payment modernization. Finally, as the early adopter states implemented their programs, they found they needed to support health home providers to achieve culture change and invest in access to real-time data to support effective care coordination.2

Support for States Pursuing Health Homes

Health homes can serve as a foundation to build more advanced systems of care, such as accountable care organizations, and to adopt more sophisticated payment methods, like episode-of-care or bundled payments. States may request federal planning funds – at their medical assistance service match rate – to support health home program design. For some states, this match rate is higher than they would receive through administrative match, and therefore, is worthwhile to pursue. Technical assistance is available from the Centers for Medicare & Medicaid Services' Health Home Information Resource Center to assist state Medicaid agencies in developing

Medicaid Health Home Enrollment MODEL FOCUS STATE **ENROLLEES** Alabama Chronic medical conditions and SMI 72,916 Idaho Chronic medical conditions and SMI 8,961 Chronic medical conditions 6,159 Iowa 20,900 Kansas SMI 27,234 Chronic medical conditions 50.095 Maine 2.069 Maryland SMI & SUD 4,887 Michigan SMI 475 Chronic medical conditions 17,110 Missouri SMI 21,248 SMI (adult) New Jersey SED (child) New York Chronic medical conditions and SMI 158,460 North Carolina Chronic medical conditions 559,839 Ohio 14,181 SMI (adult) 4,029 Oklahoma SED (child) 1,320 Chronic medical conditions and SMI 1,995 Rhode Island SMI 6,772 SLID 2,340 6,138 South Dakota Chronic medical conditions and SMI Vermont 4,924 Washington Chronic medical conditions and SMI 52,656 West Virginia SMI 934 HIV/AIDS 233 Wisconsin Total health home enrollees 1,045,875

SOURCE: Data as of May 2015 except for North Carolina (as of July 2013). New Jersey not yet reporting data. See: <u>Health Home Information Resource Center</u>. Note that Oreann has withdrawn its Medicaid health home SPA.

SED = serious emotional disturbance SMI = serious mental illness SUD = substance use disorder

and implementing health home models tailored to their unique goals and needs.

¹ Oregon had Medicaid health homes, but it chose to end the program at the end of its federal match period and has withdrawn its 2703 state plan amendment.

² Early adopting states were lowa, New York, Missouri, Oregon, and Rhode Island. See: Moses K. and Ensslin B. Seizing the Opportunity: Early Medicaid Health Home Lessons. Center for Health Care Strategies, March 2014. Available at: http://www.chcs.org/media/Seizing the Opportunity: Early Medicaid Health Home Lessons.pdf.

³ States interested in a planning grant should submit a *Letter of Request* of no more than two pages describing their health home planning activities, with an estimated budget to the Centers for Medicare & Medicaid Services. Letters of request should be sent via email to healthhomes@cms.hhs.gov. For more information see: Center for Medicaid and CHIP Services (CMCS). State Medicaid Director Letter #10-024. Health Homes for Enrollees with Chronic Conditions. November 16, 2010. Available at: <a href="http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMDL