Health Homes in Medicaid

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Agenda

- What is a Health Home?
- Overview of benefit
- Approved programs
- Quality monitoring and evaluation
- Best practices and sustainability
- Questions and discussion

Health Homes
(Section 2703 of the ACA)

- Section 2703 added 1945 to the Social Security Act to allow States to elect the Health Home option under their Medicaid State plan.
- Health Home providers will coordinate all primary, acute, behavioral health and home and community-based services to treat the **“whole-person**”.

Health Homes Are…

A comprehensive system of care coordination for Medicaid beneficiaries with chronic conditions.

Key Features

- Coordination and integration of primary, acute, behavioral health, and long-term services & supports
- Whole-person perspective
- Person-centered care planning
- Multi-disciplinary team approach

Key Features

- Available to all categorically needy with selected chronic conditions
- May target geographically
- State is required to consult with SAMHSA
- States receive 90% enhanced FMAP for the first eight fiscal quarters from the effective date of the SPA

Eligibility Criteria

- Medicaid eligible individuals who have*:*
  - two or more chronic conditions;
  - one condition and the risk of developing another; or
  - at least one serious and persistent mental health condition.

Chronic Conditions Included in Section 2703

- Mental health condition
- Substance abuse disorder
- Asthma
- Diabetes
- Heart disease
- Being overweight (BMI > 25)
- Through Secretarial authority, States may add other chronic conditions in their State Plan Amendment for review and approval.

Health Home Services

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care from inpatient to other settings
- Individual and family support
- Referral to community and social support services
- Use of health information technology, as feasible and appropriate.

Health Home Provider Types

- Designated Providers
  - May be physician, clinical/group practice, rural health clinic, community health center, community mental health center, home health agency, pediatrician, OB/GYN, other.
- Team of Health Care 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
- Health Team (as defined in section 3502)
  - Must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractors, licensed complementary and alternative care provider

Enhanced Federal Match (FMAP)

- There is an increased federal matching percentage for the health home services of *90 percent* for the *first eight fiscal quarters* that a State plan amendment (SPA) is in effect.
- The 90 percent match does not apply to other Medicaid services a beneficiary may receive.
- Additional periods of enhanced 90% FMAP would be allowed for new individuals served through either a geographic expansion of an existing health home program, or separate health home designed for individuals with different chronic conditions.

Goals for Health Homes

- Improve quality and experience of care for beneficiaries
- Reduce hospital admissions, readmissions, and emergency department use
- Help shift away from the reliance on long term care facilities towards home and community-based supports
- Intended to reduce overall health care costs for the state

HCBS and Health Homes

- Role of case management
- Transitional care services
- Involvement of family and peer supports

Ensuring Care Coordination

- Specialized providers ensure that care is coordinated across a range of care settings.
  - For example, Rhode Island's SPMI team includes a hospital liaison who works with providers in the hospital setting.
- States encourage greater ties between health homes and MCOs to avoid duplication of care coordination services.
- Health IT—including EHRs, health information exchanges (HIEs), and direct secure messaging—is an important tool that Health Home teams can use to coordinate enrollees' care.
- Missouri health homes must enter into a contract or MOU with regional hospitals or health systems to formalize transitional care planning.

Key Considerations

- Engage stakeholders early and often
- Build relationships with community partners
- Educate providers and other stakeholders
- Leverage existing resources
- Ensure accountability
- Provider requirements/standards
- Consider initial start up costs
- Health Information technology - communication

Health Home Program Activity

- CMS Health Home team works with State 6 to 8 months prior to formal submission
- Many approved on first clock
- 31 Health Home programs approved in 20 States
- 20 States have approved planning requests
- 14 programs under review
- 10 additional States are drafting proposals

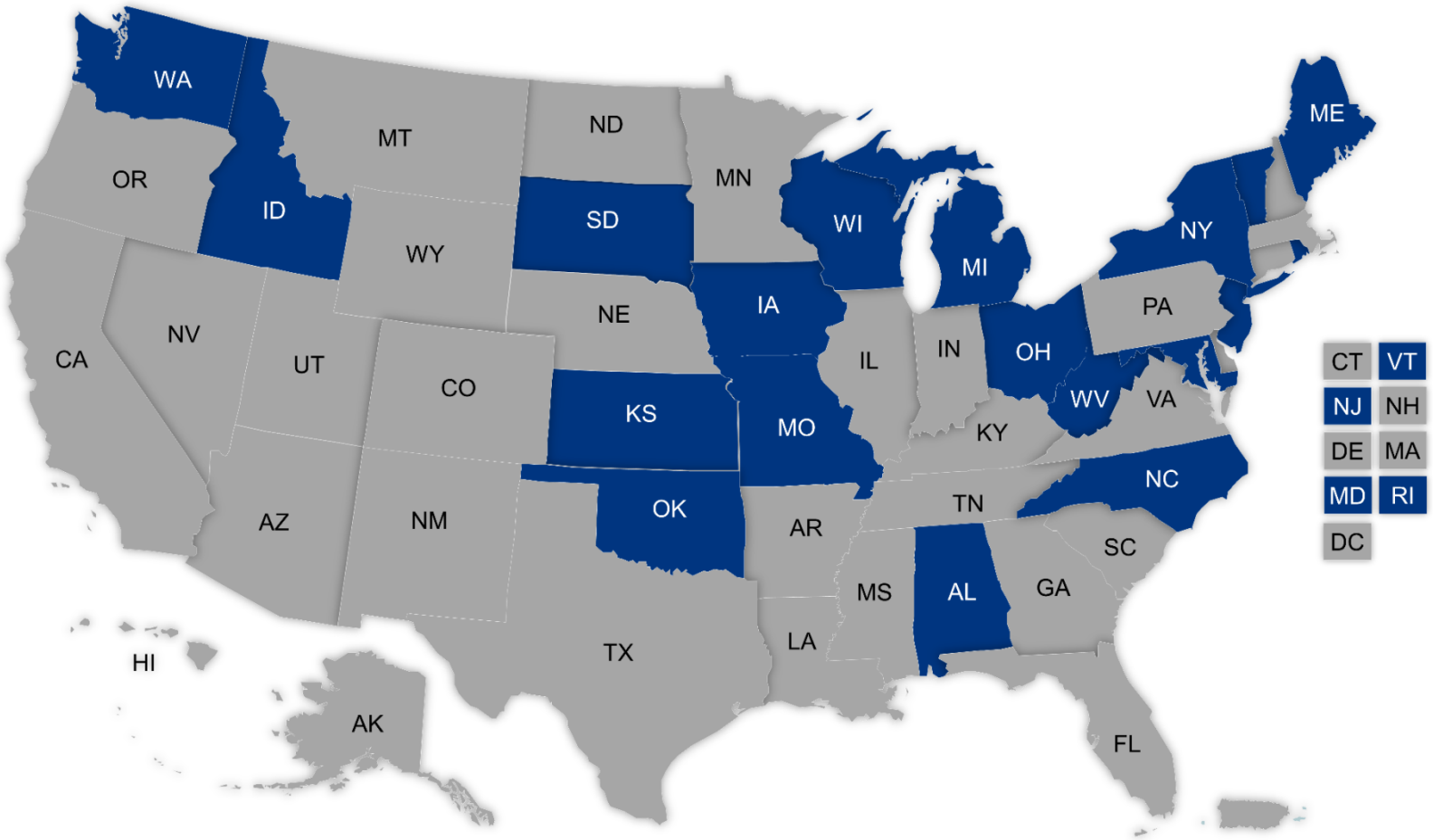
Health Home Planning Grants

- States can access Title XIX funding using their FMAP rate methodology to engage in planning activities aimed at developing and submitting a state plan amendment
- As of 5/6/15, there are 21 planning grants in 20 states totaling $8,978,278 (since 2011)

Approved Health Homes

1. Missouri
2. Rhode Island
3. New York
4. Oregon (removed)
5. North Carolina
6. Iowa
7. Ohio
8. Idaho
9. Maine
10. Wisconsin
11. Alabama
12. Washington
13. South Dakota
14. Maryland
15. Vermont
16. Kansas
17. Michigan
18. West Virginia
19. Oklahoma
20. New Jersey

Approved Medicaid Health Home State Plan Amendments



*As of July 2015

Health Home Focused Strategies

- **Serious Mental Illness** --Focused on adding primary care to SMI providers:
  - Missouri SMI – CMHCs
  - Ohio – CMHCs
  - Rhode Island SMI –CMHC
- **Broad Chronic Illness --**Focused on driving PCMH practice transformation:
  - Idaho
  - Iowa PCMH
  - Missouri PCMH
  - North Carolina
  - Oregon
  - Alabama
  - Maine

Health Home Focused Strategies

- **Broad Chronic Illness and SMI** ---Focused on building networks with specialty providers:
  - New York
  - Washington State
- **Targeted Condition** (one condition and at risk of another)
  - West Virginia (Bipolar/Hepatitis)
  - Wisconsin (HIV/AIDS)

Health Homes Quality and Evaluation

- Independent evaluation and report to Congress in 2017
- Health Home Core Measures released January 2013 in SMD
- Technical specifications manual for Health Home core measures released April 1, 2014
- States also develop and report on state-specific measures

Best Practices & Sustainability

- Uniform assessment and care planning
- Small populations to start – pilot type programs
- Phasing in and effective dates – FMAP clock
- Strategizing about identification of population in need of these services

Additional Information

- **Health Homes information can be found on Medicaid.gov**
  http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html
- **Health Homes State Medicaid Director Letter:**
  http://www.medicaid.gov/SMDL/SMD/list.asp
- **Health Home SMD on HH Core Set of Quality Measures:**
  http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-001.pdf
- **Health Home Technical Specifications for HH Core Set of Quality Measures**:
  http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/Health-home-core-set-manual-.pdf

Technical Assistance

Health Homes Mailbox:
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Health Home Core Quality Measures:
MACqualityTA@cms.hhs.gov

Questions?