Medicaid Health Homes

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Agenda

• What is a Health Home?
• Overview of benefit
• Role of prevention in health homes
• Approved programs
• Key considerations 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, 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 required to consult with SAMHSA
- State receives 90% enhanced FMAP for first eight fiscal quarters from 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 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 reliance on long term care facilities towards home and community-based supports
• Reduce overall health care costs for the state
Ensuring Care Coordination

• Specialized providers ensure that care is coordinated across a range of care settings.
  – 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.
Prevention

• Prevention and health promotion are integral parts of a health home model
• Health home providers are required to coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders (*State Medicaid Director Letter, November 2010*)
• Prevention and health promotion include educational efforts by the care team to assist patients to understand their disease and learn how to self-manage their conditions.
In addition to the focus on prevention, health homes also coordinate lifestyle interventions, such as:

- Smoking cessation
- Nutritional counseling
- Cooking classes
- Weight management
- Exercise and yoga classes
*As of March 2016, 19 states and the District of Columbia have 27 approved health home models*
• 27 approved models (across 19 states plus District of Columbia)
• Approximately 10 additional states are drafting proposals
• CMS Health Home team often works with state prior to formal submission
• Consultation with SAMHSA required before state submits officially to CMS
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
• Currently, there are 21 planning grants in 20 states totaling $8,978,278 (since 2011)
## Approved Health Home Models

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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
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

Medicaid.gov

CHCS website
http://www.chcs.org/

Health Homes Mailbox:
healthhomes@cms.hhs.gov
Questions?