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

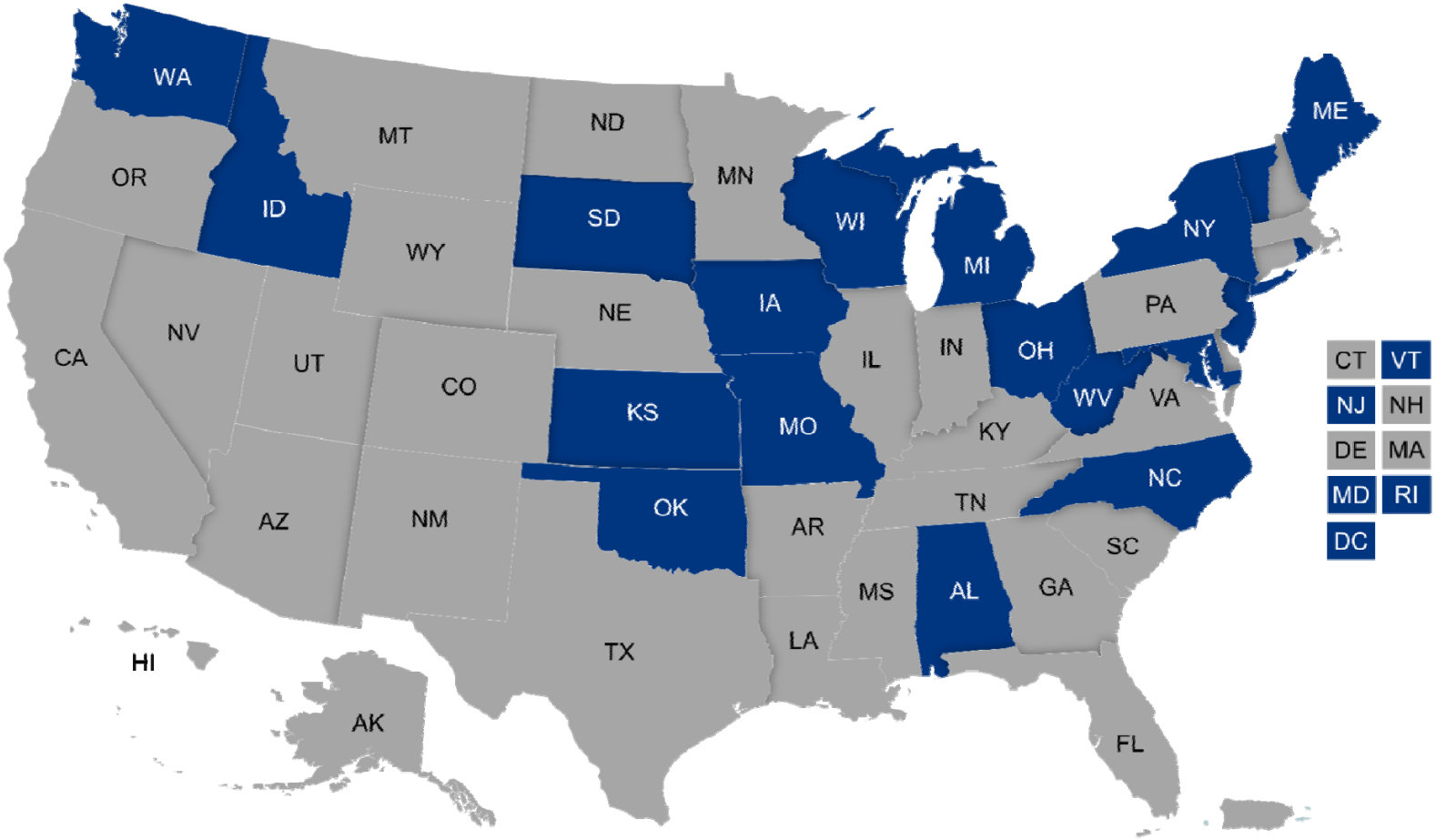
- Prevention and health promotion are integral parts of a health home model
- Health home providers are required to coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders *(State Medicaid Director Letter, November 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.

Prevention

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

Approved Medicaid Health Home State Plan Amendments



***As of March 2016, 19 states and the District of Columbia have 27 approved health home models**

Health Home Program Activity

- 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

Primary Care Focus	SMI/SED/SUD Focus	Broad: Primary Care and SMI/SED
• Iowa • Maine • Missouri • North Carolina • Wisconsin	• District of Columbia • Iowa • Kansas • Maine • Maryland • Michigan • Missouri • New Jersey • Ohio • Oklahoma • Rhode Island • Vermont • West Virginia	• Alabama • Idaho • New York • South Dakota • Washington

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

http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html

CHCS website

http://www.chcs.org/

Health Homes Mailbox:

healthhomes@cms.hhs.gov

Questions?