Medicaid Health Homes: The National Landscape

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Health Home Basics

- New state plan option created under ACA Section 2703
- Overall goal: improve integration across physical health, behavioral health and long term services and supports
- Opportunity to pay for “difficult-to-reimburse” services, e.g., care management, care coordination
- Flexibility for states to develop models that address an array of policy goals
- Significant state interest in evidence-based models to improve outcomes and reduce costs
- States receive an enhanced 90/10 federal match for the first eight fiscal quarters of the health home benefit
What are health home services?

- Comprehensive care management
- Care coordination
- Use of IT to Link Services
- Health promotion
- Comprehensive transitional care/follow-up
- Individual and family support
- Referral to community and social support services
What are health home services?

• All six services must be provided

• Do not include medical/direct treatment services

• Do not need to be provided “within the walls”

• Not limited to primary care
Who can receive services?

- 2 or more chronic conditions
- 1 condition & risk of second
- Serious Mental Illness
Targeting health home populations

**Targeting Do’s**
- By condition
- By geography
- By severity/risk
- By certain eligibility categories

**Targeting Don’ts**
- By age
- By delivery system
- By dual-eligibility status
Related to, but not the same as medical home

- Medical home can be foundation
- Health homes expand on traditional medical home models by:
  - Focusing on patients with multiple chronic and complex conditions;
  - Coordinating across medical, behavioral, and long-term care; and
  - Building linkages to community and social supports.
- Focus on outcomes, including reductions in: hospital admissions, ED visits, and admissions to LTC facilities
Who can provide services and what must they do?

• Who can provide services?
  ▶ Designated providers
  ▶ Teams of health care professionals

• What requirements must be met?
  ▶ State-defined
  ▶ Key minimum federal standards include:
    ▪ Provide quality-driven, cost-effective, culturally appropriate, person/family-centered services
    ▪ Develop a person-centered care plan that coordinates/integrates clinical/non-clinical health care needs/services
    ▪ Establish a continuous QI program
How are services reimbursed?

- Significant flexibility for states around payment methods
- Per member per month (PMPM) and case rates most common
- Can tier by patient severity or by provider capabilities
- Can flow payment through a lead entity (e.g. health plan) or pay directly from state to health home providers
- Can include resources for beneficiary engagement
How are outcomes measured?

• Quality Measures
  ► Core health care quality measure set (listed)
  ► State selected measures

• Evaluation Measures
  ► Hospital admissions
  ► Emergency room visits
  ► Skilled nursing facility admissions

1. Adult BMI Assessment
2. Ambulatory Care - Sensitive Condition Admission
3. Transition Record Transmitted to Health care Professional
4. Follow-up After Hospitalization for Mental Illness
5. Plan- All Cause Readmission
6. Screening for Clinical Depression and Follow-up Plan
7. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
8. Controlling High Blood Pressure
State Health Home Activity

- **Approved Health Home State Plan Amendment (SPA)**: Alabama, Idaho, Iowa, Maine, Maryland, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island, South Dakota, Washington, Wisconsin
- **Health Home SPA "On the Clock" (officially submitted to CMS)**: Ohio (2nd SPA), Vermont (response to Request for Additional Information (RA) pending)
- **Approved Health Home Planning Request**: Alabama, Arizona, Arkansas, California, District of Columbia, Idaho, Kansas, Maine, Maryland, Minnesota, Mississippi, Nevada, New Jersey, New Mexico, North Carolina, Washington, West Virginia, Wisconsin
- **No Activity**: Alaska, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Indiana, Kentucky, Louisiana, Massachusetts, Michigan, Montana, Nebraska, New Hampshire, North Dakota, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Wyoming
# The Ticking Clock...

Date indicates when the state’s enhanced federal match ends.

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Approved Health Home Models

Primary Care Focus
- Iowa
- Maine
- Missouri
- North Carolina
- Wisconsin

SMI/SED/SUD Focus
- Iowa
- Maryland
- Missouri
- Ohio
- Rhode Island

Broad: Primary Care and SMI/SED
- Alabama
- Idaho
- New York
- Oregon
- South Dakota
- Washington
Key Considerations

- Significant flexibility in how models are developed
- Models must be free from duplication of services and payment with other Medicaid-funded services
- Cannot target by age; however health homes can be tailored to different needs across the age continuum
- Models should demonstrate true integration across primary and behavioral health
- Operational challenges for dual eligibles
- Timeframe for ROI given initial unmet service needs
- Ability to develop targeted and sustainable models
Health Home Information Resource Center

- One-on-one technical support to states
- Peer-learning collaboratives
- Webinar
- Online library of hands-on tools and resources, available at: