

## 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 March 2014, 15 states have launched health homes, and the earliest adopting states have ended or are nearing the end of their enhanced federal match period. More than one million Medicaid beneficiaries have enrolled in health homes thus far. Some states have submitted multiple health home state plan amendments (SPAs) to target different populations or phase-in regional implementation, with 22 SPAs in the 15 states. Nearly a dozen additional states are planning to implement health homes.

### 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.

Medicaid Health Home Enrollment <sup>1</sup>		
STATE	FOCUS AREA	ENROLLEES
Alabama	Broad	70,206
Idaho	Broad	9,179
Iowa	Chronic conditions	4,396
	SMI	16,825
Maine	Chronic conditions	42,958
Maryland	SMI & SUD	2,516
Missouri	Chronic conditions	15,382
	SMI	19,631
New York	Broad	158,460
North Carolina	Chronic conditions	559,839
Ohio	SMI	10,312
Oregon	Broad	93,253
Rhode Island	Broad	2,855
	SMI	6,772
	SUD	2,340
South Dakota	Broad	5,655
Vermont	SUD	2,949
Washington	Broad	22,792
Wisconsin	HIV/AIDS	188
<b>Total health home enrollees</b>		<b>1,046,508</b>

SOURCE: Data from January 2014 and July 2013 (North Carolina) See: [Health Home Information Resource Center](#)

SMI = serious mental illness  
SUD = substance use disorder

### 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 from Early Implementation

The first states to launch health homes are completing their second year of implementation. Lessons from these states and others still in the design and early launch stages include:<sup>2</sup>

- Use the flexibilities within the health home option to advance policy goals.
- Carefully define health home target populations and the health home option to achieve the greatest impact on outcomes.
- Align payment models with policy goals to drive payment modernization.
- Use experience with (or knowledge of) complex populations to drive the definition of health home services.
- Support health home providers to achieve culture change.
- Invest in access to real-time data to support effective care coordination.

## Early Health Home Results

Early adopter states are beginning to see results. In New York, for example, early data for a subset of the health home population show that primary care visits increased by 14 percent, while inpatient admissions and emergency department visits decreased by 23 percent.<sup>3</sup> Early data from Missouri's community mental health center (CMHC) health home and primary care health home (PCHH) show a decrease in emergency department visits of 8 percent (CMHC) and 6 percent (PCHH) and decrease in ambulatory-sensitive hospitalizations of 13 percent (CMHC) and 10 percent (PCHH) resulting in a combined savings of approximately \$52 PMPM.<sup>4</sup>

## 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 worthwhile to pursue.<sup>5</sup> In addition, technical assistance is available from the Centers for Medicare & Medicaid Services' [Health Home Information Resource Center](#) to assist state Medicaid agencies in developing and implementing health home models tailored to their unique goals and needs.

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<sup>1</sup> Broadly-focused health homes enroll beneficiaries with chronic conditions, serious mental illnesses, and/or substance use disorders. While health homes focusing on chronic conditions only enroll beneficiaries with chronic medical conditions and potentially with mental health conditions other than SMI/SED. New York has three approved health home SPAs, all broadly-focused, but targeting different areas of the state. Similarly, Washington State has two approved SPAs that target two different geographic areas. Wisconsin's health home targets only one chronic condition – HIV/AIDS.

<sup>2</sup> Moses K. and Ensslin B. *Seizing the Opportunity: Early Medicaid Health Home Lessons*. Center for Health Care Strategies, March 2014.

<sup>3</sup> Preliminary analysis of a selected set of health home members who are continuously enrolled with no prior care management services.

<sup>4</sup> Missouri Department of Mental Health and MO HealthNet. Progress Report: Missouri CMHC Healthcare Homes. November 2013. Available at: <http://dmh.mo.gov/mentalillness/provider/HealthcareHome.htm>; Data on early results of Missouri's primary care health home forthcoming at: <http://dss.mo.gov/mhd/cs/health-homes/>.

<sup>5</sup> 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](mailto: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: <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html>.