CHCS Center for Health Care Strategies, Inc.

Issue Brief

# Seizing the Opportunity: Early Medicaid Health Home Lessons

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The health homes provision of the Affordable Care Act (ACA) provides states with a significant new tool to support care coordination and care management for Medicaid beneficiaries with complex health needs. The health homes option became available in 2011 when the economy was in recession, enrollment in Medicaid programs was rising, and states were focused on cost savings. The opportunity to improve quality and reduce fragmentation of care while leveraging an enhanced federal match (90 percent federal financial participation for the first eight quarters) was and continues to be a compelling model for many states looking to reengineer service delivery, better integrate care, improve health outcomes, and reduce costly and otherwise avoidable acute care utilization.

As of March 2014, 15 states have 22 approved state plan amendments[1] (SPAs) to implement Medicaid health home models, and the earliest adopting states – including Iowa, Missouri, New York, North Carolina, Oregon, and Rhode Island – have ended or are nearing the end of the enhanced match period. These six states represent a diversity of approaches to health home design, and have collectively enrolled more than 875,000 beneficiaries as of early-2014 (see Exhibit 1).[2] Early adopter states estimated their current enrollment penetration in the range of 20 to 40 percent of their total eligible population.


## IN BRIEF

The Affordable Care Act provides states with a significant opportunity to support care coordination and care management for individuals with complex health needs through health homes. Given tight state budgets, states implementing health homes benefit from enhanced federal support for a limited time period, enabling delivery system investment and innovation that might not otherwise be within reach. Due to the time-limited nature of enhanced federal health home funding, states that implement these new models must do so with an eye toward sustainability and return on investment.

In October 2013, with support from the New York State Health Foundation and the Missouri Foundation for Health, the Center for Health Care Strategies convened states that were early health home adopters to glean implementation lessons and identify elements critical to health home sustainability. This brief summarizes these findings to inform other states looking to develop effective health home programs.


In October 2013, the Center for Health Care Strategies (CHCS) brought together these early adopter states[3] to learn about their experiences. Given the novelty of the health home model and the need to develop the evidence base for effective program design and implementation strategies, CHCS' meeting sought to identify cross-cutting themes emerging across the health home frontier. The discussion explored:

- What policy goals can health homes address?
- What key design features support program effectiveness?
- How can payment methods support policy objectives and program sustainability?
- What is the role of health homes within the context of broader system reform initiatives?

This brief synthesizes key themes from this discussion to inform health home development and implementation in additional states. To date, the total federal and state investment in health homes is substantial. In New York alone, payments to health homes have totaled more than $260 million, and this does not include the additional investment in infrastructure development, workforce training, or practice transformation. Lessons from early adopters can help all states realize the promise of health homes to provide the right care, to the right patients, at the right time.

Made possible through support from the New York State Health Foundation and the Missouri Foundation for Health.

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Exhibit 1: **Early Adopter States' Health Home Programs**

| State | Focus Area | Effective Date | Enrollees | Providers |
|---|---|---|---|---|
| Iowa | Chronic conditions* | July 2012 | 4,396 | 25 entities in 61 locations with 570 practitioners |
| | SMI | July 2013 | 16,825 | 1 lead provider with 11 facilities in 5 counties |
| Missouri | Chronic conditions | January 2012 | 15,382 | 18 FQHCs (56 sites), 6 hospitals, 14 clinics, 14 RHCs |
| | SMI | January 2012 | 19,631 | 28 CMHCs, 120 clinics/outreach offices |
| New York | Broad** | January 2012<br>April 2012<br>July 2012 | 158,460 | 32 lead providers with 48 health homes in 57 counties |
| North Carolina | Chronic conditions | October 2011 | 559,839 | 1,838 providers |
| Oregon | Broad | October 2011 | 93,253 | 198 clinics |
| Rhode Island | Broad | October 2011 | 2,855 | 4 CEDARR centers |
| | SMI | October 2011 | 6,772 | 9 provider agencies (7 CMHO and 2 other mental health clinics) |

SOURCE: January 2014 data (IA, MO, NY, OR, and RI) and July 2013 (NC). See Health Home Information Resource Center.
* Health homes focusing on chronic conditions enroll people with chronic medical conditions and potentially mental health conditions other than SMI/SED.
** Broadly focused health homes enroll people with chronic conditions, serious mental illness, and/or substance use disorders.

CEDARR = comprehensive, evaluation, diagnosis, assessment, referral, re-evaluation
CMHC = community mental health center
FQHC = federally qualified health center
RHC = rural health clinics
SMI = serious mental illness

## Health Home Design and Implementation Lessons

Through health homes, states have broad flexibility to customize the model in ways that are most useful within a given state context. The health home legislation and related guidance from the Centers for Medicare & Medicaid Services (CMS)[4] afford states ample options in determining health home team composition, selecting target conditions/populations, and waiving the Medicaid statewideness requirement to implement health homes in more targeted geographic areas. In reviewing health home designs, CMS has worked closely with states to understand their individual goals for target populations, designated providers, and reimbursement strategies in order to approve models that not only fulfill the expectations of the legislation, but also meet states' needs.

With two years of implementation experience behind them, the early adopting states were asked to identify what program design choices had been effective, and what they would consider changing to make their programs stronger and more sustainable. Key takeaways for states are described below.

### 1. Use the flexibilities within the health home option to advance policy goals.

Overwhelmingly, the early adopter states viewed health homes as an invaluable lever to move forward individual state policy goals in the context of tight budgets and limited opportunities to invest in needed delivery system enhancements. They each used the

enhanced federal match to establish a new set of services to address gaps in care for individuals with complex chronic health needs. This move to add services was in stark contrast to the rate cuts, service cuts, and other cost-savings measures that some other states were pursuing. That said, the early adopter states presented a broad array of policy objectives for their health home programs, highlighting the considerable flexibility of this model:

- **Iowa** viewed health homes as an opportunity to strengthen primary care practices and spread patient-centered medical home (PCMH) certification as a step toward both system transformation and more accountable care.
- **New York**, with a new governor and a program-wide redesign effort, saw health homes as a way to align and integrate a diverse array of existing care management initiatives. Focusing on beneficiaries with complex needs, the state used health homes to transform historically siloed programs into integrated networks of service providers under a single point of accountability.
- **Missouri** sought to use health homes to improve coordination and transitions of care, as well as to integrate primary care and behavioral health care and reduce avoidable hospital stays.
- **Oregon** sought to build and strengthen its primary care infrastructure so that every Oregonian could ultimately have access to a patient-centered primary care home, Oregon's name for the health home model.[5] Health homes also allowed Medicaid to be a key player in the state's multi-payer strategy for patient-centered primary care homes.
- **Rhode Island** structured its CEDARR (Comprehensive, Evaluation, Diagnosis, Assessment, Referral, Re-evaluation) Family Center health home SPA to move many siloed children's programs under one comprehensive umbrella, while its Community Mental Health Organization (CMHO) SPA sought to strategically improve care management and integration.

As states explore existing models and examine their own landscape, capabilities, and needs, they should consider that one size doesn't fit all with health homes. Within the statute, there is significant flexibility to target, deliver, and pay for services to best meet individual state policy goals – while staying true to the overall health home aim of providing integrated care management for individuals with complex needs.

*"Health homes provided the impetus to do what we really wanted to do at a time when budget cuts and fiscal concerns made it difficult to pursue creativity."*

*– State participant*

## Health Homes 101

The Medicaid health home state plan option (ACA Section 2703) promotes access to and coordination of primary and acute physical and behavioral health services and long-term services and supports. Health homes may be virtual or located in primary care or behavioral health providers' offices or other settings that best suit beneficiaries' needs. 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/follow-up;
- Individual and family support; and
- Referral to community and social support services.

To be eligible for health home services, an individual must be diagnosed with either: (1) two chronic conditions; (2) one chronic condition and risk for a second; or (3) a serious mental illness. States implementing Medicaid health homes receive an enhanced 90/10 federal match for the first eight fiscal quarters of the health home program.

*"Everyone deserves a health home, but not everyone needs 'intensive' care management all of the time."*

- *State participant*

## 2. Carefully define health home target populations and the health home option to achieve the greatest impact on outcomes.

To be eligible for health home services an individual must be diagnosed with either: (1) two chronic conditions; (2) one chronic condition and risk for a second; or (3) a serious mental illness.[6] States can select one or more of these general categories to include in their health home-eligible populations. Among the early adopter states, target populations range from highly focused, single condition-based approaches (e.g., Rhode Island) to broader, population-based approaches (e.g., North Carolina). Population selection is the basis for key design decisions, such as developing service definitions and provider qualifications, and is also directly related to return on investment and outcomes, which are keys to sustainability. Selection of the target population should be driven by the state's policy goals and, as early adopters indicated, should be done strategically. For example:

- **New York** is using health homes as a vehicle for providing intensive care management services to high-need individuals. Accordingly, it prioritizes health home enrollment by patient severity. A risk score is calculated for each enrollee to identify higher acuity individuals for proactive outreach and engagement by health home staff. Individuals meeting diagnostic and risk criteria may also be enrolled in health homes through a community referral process.
- **Rhode Island** is using health homes to improve integration of the full array of services for adults with behavioral health needs and for children with special health care needs. Recognizing the unique needs and provider systems for adults versus children, the state created two types of behavioral health-focused health homes – one for adults served by community mental health organizations and another for children served by its CEDARR Family Centers.

A number of early adopter states indicated that targeting by acuity enables provision of the right amount of care management at the right time, which states believe is fundamental to long-term health home sustainability. Although states are able to target specific conditions or geographic areas, all of the early adopter states indicated their preference to target models even more narrowly than is currently allowed under federal interpretation of the health homes statute. For example, if additional flexibility was available, health homes could address very specific gaps in access to care management. In some instances, states may have differing levels of health home readiness among providers serving children vs. adults, and could benefit from launching health homes for one group while building capacity for the other. However, current interpretation requires that health homes for children and adults with a given target condition must have the same effective date.

States also suggested that chronic-condition targeting rules might be more effective given a greater ability to distinguish between and prioritize among an individual's conditions. For example, an individual's developmental disability may have greater influence over his or her health care and related service needs than a comorbid medical condition like asthma or diabetes. But under current rules, if the state launched a health home model targeting these common medical conditions, the state would forego the ability to later access enhanced federal match for a future model customized for individuals with developmental disabilities.

## 3. Align payment models with policy goals to drive payment modernization.

States have the flexibility to design health home payment methods that drive core policy goals. Several states have created a tiered payment schedule, scaling either by level of member complexity or by the qualifications of the provider. For example, Iowa aims to deliver higher intensity services to individuals with more complex needs; therefore, the payment rate is tiered in one of four levels based on the number and severity of the member's

chronic conditions. One of Missouri's overarching policy goals is to strengthen the Medicaid provider network. The state's health homes pay a fee to provider organizations to support training, technical assistance, and data management. The provider organizations are thus empowered to assist the state in managing the health home system statewide.

*"We have one foot in fee-for-service and the other in flexible global PMPM payments. We need to determine if health homes are just another service or a new way of paying for care. We believe it is the latter."*

- *State participant*

Overall, health homes create an opportunity for Medicaid to align incentives with accountability for outcomes. States view health homes as a way to move away from fee-for-service models and "15-minute increments" of services and toward more meaningful value-based purchasing. Notably, health homes provide a vehicle to pay for services that have historically been difficult to reimburse – such as virtual contacts, home visits, and care coordination writ large – and almost all states are using a bundled payment approach (usually in the form of a per member per month (PMPM) payment) to pay for health home services. Moreover, the correct "dosages" of health home services needed for various subpopulations are yet to be determined. Thus, no convention exists around documenting the intensity of health home service delivery that would allow for more sophisticated payment mechanisms.

Some states have elected to include payments for health home outreach and engagement efforts. Particularly for target populations with complex medical, behavioral health, or social service needs, outreach and engagement efforts can be time-consuming and labor-intensive. To encourage comprehensive outreach and support high rates of enrollment, New York provides up to three months of payment for activities related to the location, outreach, and engagement of eligible individuals. Every four months, Missouri identifies a new cohort of high utilizers without a stable health care connection to find, engage, and enroll in health homes. Other key policy goals that states have attempted to support through health home payment incentives include: improving quality and achieving practice transformation efforts through quality withholds; integration of care for individuals with complex needs via development of a robust care plan; and linking additional payments to achieving provider enrollment targets.

A number of the early adopting states plan to pursue shared savings components within their health home payment methodologies. In some states, health homes may evolve into accountable care organizations with shared savings and shared risk; others might over time replace care management fees with more expansive global payment arrangements. Wherever these models land, states clearly see both the opportunity and imperative to leverage health homes for broader payment reforms. Even among states with distinctly different health home program designs, policymakers share the goal of designing payment models with aligned incentives and accountabilities for delivering the right care to the right people at the right time.

### 4. Use experience with (or knowledge of) complex populations to drive the definition of health home services.

One of the unique merits of the health homes option is its ability to expand and extend the reach of care beyond the walls and boundaries of the traditional physician office visit, particularly for individuals with complex care needs. Health home services provide time for building trusting relationships and understanding the psychosocial and environmental circumstances that impact a person's care. For example, some individuals with mental illness avoid going to primary care clinics because they feel judged or are deemed noncompliant by providers less familiar with their needs. To overcome this barrier to care, Rhode Island defined core services in its CMHO health home program to bring primary care into the mental health setting, or have care coordinators accompany clients to their primary care visits.

*"Health homes promote strong, ongoing relationships between complex patients and their providers."*

- *State participant*

Health home core services can also be defined to enable community-based approaches to providing supports and needed resources in addition to traditional medical and behavioral health services. Health homes also offer an opportunity to build and support team-based models of care, including use of non-licensed professionals. In Oregon, workforce capacity is a significant concern. In some areas of the state, clinics have struggled to find care coordinators with adequate skills. To help, Oregon's health home and broader health reform efforts will use community health workers, also known as traditional health workers, as part of the care team. Many states also use face-to-face visits as part of their health home services to better meet individuals where they are.

In addition, health homes can be a mechanism to support integrating services and supports across traditional disciplines of care. For example, New York's network approach requires that the health homes have a broad-based team to address individuals' most pressing needs such as housing or employment. Missouri has added behavioral health consultants to all primary care health homes and primary care physician consultants to all CMHC health homes. The early adopters' integrated care models either employ a co-located approach where nurses are stationed within the CMHC to address members' medical needs, or use a "virtual" integration approach that allows for flexibility in location but requires strong linkages and operational processes to connect primary care and behavioral health providers.

As described above, the early adopter states strategically defined health home services to meet the unique needs of their target population. Exhibit 2 (page 7) summarizes common themes across service definitions developed by early adopter states and provides examples of best practices/activities for each core service area. States interested in developing a health home program should consider their population, identify how the population's needs can be met through the health home core services, and link activities to the definition of those services.

### 5. Support health home providers to achieve culture change.

Health homes are a new way of doing business for many states, health plans, and providers. This change reverberates through the care delivery system but is most acutely felt on the front lines, at the provider level, thus this is where the culture change needs to occur. Providers may vary in their level and degree of: (1) experience working with complex populations; (2) professional culture; (3) ability to integrate services; and (4) workforce capacity. To transition to health homes, they may need support in a variety of areas, including understanding program requirements, redesigning workflows, and training in new skills (e.g., motivational interviewing). Culture change is also supported by the flexible financing structure of health home models and the enhanced federal match provided to states.

States and health plans should consider ways to support providers in transforming to health homes. One approach states might pursue is to set clear health home performance requirements for providers and support them in meeting the requirements. States and health plans should consider ways to support providers in transforming to health homes. For example, in Iowa the state employs a health care clinician to help practices understand and attain the state's health home requirements/standards. This hands-on approach was noted as essential for the state to help practices make necessary improvements and culture changes. Additionally, Oregon is pursuing an overall health system transformation that includes developing care coordination organizations as the health home and building supports for practices into the transformation process.

Exhibit 2: **Common Themes and Best Practices in Service Definitions**

| Care Service | Common Themes Among States | Best Practices |
|---|---|---|
| Comprehensive Care Management | • Individualized care plan<br>• Integration of physical and behavioral health<br>• Family involvement | • Tracking care plan goals<br>• Mental health and substance abuse screenings<br>• Periodic reassessment |
| Care Coordination | • Development and implementation of care plan<br>• Adherence to treatment/ medication monitoring<br>• Referral tracking | • Emphasis on face-to-face contacts<br>• Use of case conferences<br>• Tracking test results<br>• Requiring discharge summaries<br>• Housing coordination<br>• Automated notification of admission |
| Health Promotion | • Development of self-management plans<br>• Evidence-based wellness and promotion<br>• Patient education | • Patient engagement<br>• Addressing clinical as well as non-clinical needs<br>• Tobacco cessation training |
| Comprehensive Transitional Care | • Notification of admissions/discharge<br>• Receipt of summary care record, continuing care document, or discharge summary<br>• Medication reconciliation | • Pharmacist coordination<br>• Shift from reactive to proactive care<br>• Specialized transitions (age-related, corrections)<br>• Use of hospital liaisons<br>• Home visits |
| Individual and Family Supports | • Use of peer supports, support groups, self-care programs<br>• Facilitation of improved adherence to treatment<br>• Advocacy for individual and family needs<br>• Efforts to increase health literacy | • Use of advance directives<br>• Assistance with attaining highest level of functioning in the community<br>• Assistance with development of social networks |
| Referral to Community Resources | • Identification of community-based resources<br>• Follow-up post referral<br>• Assistance with housing | • Resource manual<br>• Emphasis on resources closest to home and least restrictive<br>• Policies, procedures, and accountabilities with community-based organizations |

*"We built on experience from existing care management programs and knew we needed to increase training opportunities. We have already trained nearly 300 care coordinators ...it is a worthy investment."*

– State participant

States can use various methods to support health home training needed for providers. Learning collaboratives are one mechanism to provide this ongoing dialogue and promote culture change. Missouri uses practice coaches and a learning collaborative to support health home providers' growth and development. New York has also engaged its health home providers in a robust learning collaborative.

Additionally, health homes also help providers adapt to new payment reforms, thereby assuming greater accountability for performance and outcomes. As some providers now receive global payments, they need support in learning how to work more effectively with those payments.

### 6. Invest in access to real-time data to support effective care coordination.

Access to real-time data on hospital admissions, emergency department visits, and medication prescription filling is essential for health homes to coordinate care. By using real-

*"Through our health home initiative, we had the opportunity to drive better use of the data we had and also collect and use new information that we didn't have before."*

- *State participant*

time data on hospital admissions and emergency department visits, care managers are able to promptly attend to their clients' needs as they arise, thus having the greatest impact.

While states are making progress toward obtaining real-time data, many state information systems still lack connectivity, particularly with emergency departments and hospitals. Through health home design and implementation, early adopter states are finding ways to bridge this connectivity gap. In Rhode Island and Missouri, managed care organizations are required to share data with health homes even though they are not part of the health home team. Also in Missouri, health homes receive automated notification of hospital admissions. In New York, hospitals are encouraged to be part of their health home network to provide real-time notifications and health homes must meet established health information technology standards. As more states create health information exchanges, there is hope that these systems will support real-time data sharing for effective care coordination.

A particular hurdle for many states is access to Medicare data for beneficiaries dually eligible for Medicare and Medicaid. Since this population cannot be excluded from Medicaid health homes, access to Medicare data is critical to providing care managers with a full picture of an individual's health and service use. Some of the states reported difficulty accessing Medicare data related to either: (1) the length of the data request process; or (2) the complexities of analyzing the data once they had obtained it. States will need to invest in data information systems to support health homes' success and sustainability.

## Next Steps toward Health Home Sustainability

The early adopter states identified for this brief have learned important lessons about designing and implementing health homes for individuals with complex care needs. However, the long-term sustainability of health homes will depend on how this new model improves quality, reduces fragmentation of care, and supports states' other health care payment and delivery reforms. In most states, health homes are being implemented within a comprehensive reform agenda, challenging states in how to best connect the various efforts being pursued within Medicaid and the broader health care deliver system. Exhibit 3 illustrates the variety of reforms that early adopter states are pursuing.

Exhibit 3: **Health Care Payment and Delivery Reforms in Health Home Early Adopter States**

| Payment/Delivery Reform | Iowa | Missouri | New York | North Carolina | Oregon | Rhode Island |
|---|---|---|---|---|---|---|
| **Primary Care Medical Homes** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Integrated Care Demonstrations** | ✓ | ✓ | ✓ | ✓ | | ✓ |
| **Managed Care Redesign** | | | ✓ | | ✓ | |
| **Medicaid Accountable Care Organizations** | ✓ | | ✓ | | ✓ | |
| **State Innovation Model Design State** | ✓ | | | | | ✓ |
| **State Innovation Model Test or Pre-Test State** | | | ✓ | | ✓ | |
| **Coverage Expansion** | ✓ | | ✓ | | ✓ | ✓ |

Early adopter states are all demonstrating efforts to sustain, improve, and, in some instances, grow their health home programs. For example, health homes in New York and Missouri show early cost savings and both states are planning further refinement and growth to their respective approaches. In New York, health homes are a key component in Medicaid reform efforts. Early data for a subset[7] of the health home population shows a 14 percent increase in primary care visits and a 23 percent decrease in hospital admissions and emergency department visits. New York has developed a set of quality, outcome, and process metrics to measure the success of its health home providers. The state is moving toward health home sustainability by: (1) bringing additional populations into the program; (2) budgeting to cover the expiring 90/10 match; and (3) using the health home structure for other efforts such as Olmstead planning and carving behavioral health into managed care. As a next step, the state will look at gain-sharing arrangements with health homes to further link quality to payment at the provider level.

Early data from both Missouri's CMHC health home and its primary care health home (PCHH) show a decrease in emergency department visits (8 percent for CMHC and 6 percent for PCHH) and a decrease in ambulatory-sensitive hospitalizations (13 percent for CMHC and 10 percent for PCHH). Missouri also has demonstrated progress toward supporting provider practice change by increasing the number of health home sites that have achieved recognition by the National Committee for Quality Assurance (for Missouri's primary care health homes) or the Council on Accreditation of Rehabilitation Facilities (for Missouri's CMHC health homes). Missouri is working to sustain its health home approach by: (1) conducting continuous quality improvement activities, such as review of measures and data; (2) reviewing requirements, credentials, and ratios of health home team members; and (3) revisiting the health home reimbursement strategy. On average Missouri's health homes are saving the state approximately $52 PMPM and will be expanding by 25 to 30 percent in 2014.[8]

Health homes play a different role in health reform in each of the early adopter states. Similarly, each state defines health home "success" differently. Ultimately, states will determine the long-term sustainability of health homes based on a combination of data, stakeholder feedback, and an examination of how well health homes help states to achieve their overarching policy goals. The lessons learned by early adopter states can help others to design and implement effective and sustainable Medicaid health homes.

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## About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

## Endnotes

[1] A state plan is an agreement between a state and the federal government that describes how the state administers its Medicaid program. In it, the state assures that it will abide by federal rules to claim federal matching funds. States submit a state plan amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) if they wish to make changes it their Medicaid programs. For more information see: http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Plan-Amendments/Medicaid-State-Plan-Amendments.html.

[2] Additional information and the states' approved SPAs can be found at: http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html.

[3] Although North Carolina Medicaid was an early adopter, the state was unable to participate in the meeting.

[4] 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.

[5] State would only claim enhanced match for those Oregonians eligible under the SPA.

[6] State Option to Provide Coordinated Care Through a Health Home for Individuals with Chronic Conditions. Sec. 1945. [42 U.S.C. 1396w-4] Available at: http://www.ssa.gov/OP_Home/ssact/title19/1945.htm#ftn490http://www.ssa.gov/OP_Home/ssact/title19/1945.htm.

[7] Preliminary analysis of a selected set of health home members who are continuously enrolled with no prior care management services.

[8] 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/.