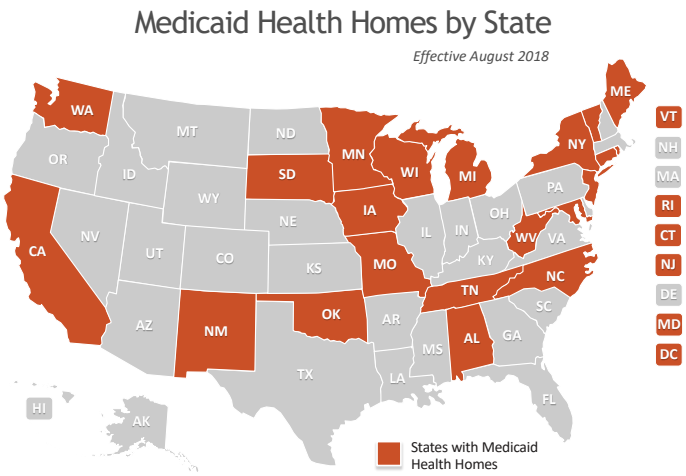
Medicaid Health Homes: Implementation Update

The Medicaid health home state plan option gives states an opportunity to improve care coordination and care management for Medicaid beneficiaries with complex needs. 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 July 2018, 21 states and the District of Columbia have Medicaid health home programs. Some states have submitted multiple health home state plan amendments (SPAs) to target different populations or conditions, with 34 health home models in operation. Nearly a dozen additional states are planning to implement health homes. More than one million Medicaid beneficiaries have enrolled in health homes thus far.



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 be at 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.

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 in Program Design and Early Implementation

The first states to launch health homes have completed their sixth year of implementation. These early adopters of Medicaid health homes learned important lessons about designing and implementing health homes for individuals with complex care needs that could inform other states considering this model. Early adopter states found that they could use the flexibilities within the health home option to advance their policy goals. They also used their knowledge and experience working with complex populations to guide design of their health home services, and they thoughtfully aligned payment models with policy goals to advance payment modernization. Finally, as the early adopter states implemented their programs, they found they needed to support health home providers to achieve culture change and invest in access to real-time data to support effective care coordination.[2]

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, is worthwhile to pursue.[3] 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.

Medicaid Health Home Enrollment[1]

State	Model Focus	Enrollees
Alabama	Chronic conditions and SMI	217,750
California	Chronic conditions	—
Connecticut	SMI	6,700
District of Columbia	SMI	1,305
	Chronic conditions	—
Iowa	Chronic conditions	13,330
	SMI/SED	25,323
Maine	Chronic conditions	53,348
	SMI/SED	5,248
	SUD	—
Maryland	SMI & SUD	4,808
Michigan	SMI/SED	701
	Chronic conditions	1,824
Minnesota	SMI/SED	1,500
Missouri	Chronic conditions	20,092
	SMI	25,787
New Jersey	SMI (adult)	515
	SED (child)	258
New Mexico	SMI/SED	350
New York	Chronic conditions and SMI	262,520
	Chronic conditions (I/DD)	—
North Carolina	Chronic conditions	540,841
Oklahoma	SMI (adult)	5,141
	SED (child)	4,340
Rhode Island	Chronic conditions and SMI	1,576
	SMI	8,247
	SUD	2,937
South Dakota	Chronic conditions and SMI	6,027
Tennessee	SMI	—
Vermont	SUD	5,664
Washington	Chronic conditions	77,511
West Virginia	SMI	714
	Chronic conditions	—
Wisconsin	HIV/AIDS	291
Total health home enrollees		**1,294,648**

***I/DD** = Intellectual/Developmental Disability* ***SMI** = Serious mental illness*
***SED** = Serious emotional disturbance* ***SUD** = Substance use disorder*

[1] *SOURCE: Health Home Information Resource Center. Data as of December 2016 except for North Carolina, which is as of May 2016. Minnesota's SPA was effective July 2016; listed enrollment is estimated. The District of Columbia's chronic conditions SPA, Tennessee's SMI SPA, and West Virginia's chronic conditions SPA are not yet reporting data. Idaho, Kansas, Ohio, and Oregon have terminated their Medicaid health home SPAs and are no longer providing services under the 2703 option.*

[2] Early adopting states were Iowa, New York, Missouri, Oregon, and Rhode Island. See: Moses K. and Ensslin B. *Seizing the Opportunity: Early Medicaid Health Home Lessons*. Center for Health Care Strategies, March 2014. Available at: http://www.chcs.org/resource/seizing-the-opportunity-early-medicaid-health-home-lessons/.

[3] 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. 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://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf.