Medicaid Health Home Program Design Strategies

Themes from Call #4: Identifying Health Home Providers

The following insights were gathered during the fourth call in a series of health home program design calls hosted by the Center for Health Care Strategies (CHCS). The series is open to states participating in CHCS initiatives -- Arizona, California, Colorado, Illinois, Maine, Michigan, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Tennessee and Washington.

Section 2703 of ACA identifies three distinct types of health home provider arrangements including designated providers, a team of health care professionals, and a community health team, as further defined by Section 3502 of the ACA. Initial guidance from CMS on health homes implementation, as published in the November 16, 2010 State Medicaid Director letter, lists a number of qualifications that providers of health home services must meet – namely, that they:

- Provide quality-driven, cost-effective, culturally appropriate, person-/family-centered services;
- Coordinate/provide access to: high-quality, evidence-based services; preventive/health promotion services; MH/SA services; comprehensive care management/ coordination/ transitional care across settings; DM; individual/family supports; LTC supports and services;
- Develop a person-centered care plan that coordinates/integrates clinical/non-clinical health care needs/services;
- Link services with HIT, communicate across team, individual and family caregivers, and provide feedback to practices; and
- Establish a continuous QI program.

With these starting points, states are now in the process of further defining health home provider standards. Key steps that states are taking include:

1. Identifying which providers are currently serving larger percentages of eligible beneficiaries;
2. Creating a subset of common standards that overlap between health home providers and PCMH providers (or any other program in place);
3. Identifying a core set of critical health home provider standards for initial implementation with the strategy of expanding expectations over time as health home providers gain more experience and infrastructure;
4. Phasing in contracting with health home providers, starting with early adopters and larger providers who are more likely to already have needed infrastructure in place (e.g., HIT, care management staff, other staff resources, etc.);
5. Identifying what additional supports smaller and rural providers might need to become health homes;
6. Establishing different tiers for provider standards and resulting payments depending on the level of complexity of the targeted patient population; and

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7. Outreaching to the provider community to assess level of interest in being a health home, existing infrastructure, and gaps in infrastructure that will need to be addressed over time.

States are acutely aware that they need to strike the right balance between setting a high bar for participation (and potentially reducing the number of eligible providers) versus not setting the bar high enough and missing the opportunity to transform how care is managed and coordinated. Along the same lines, states are considering how many provider standards are needed without becoming overwhelming to providers or to the entities overseeing, credentialing and auditing health homes.

The state of Oregon was featured in this call and shared a PowerPoint presentation and draft set of standards summarizing how it is identifying health home providers and developing standards. These documents will soon be available on the CHCS website.

Additional questions that states are considering include:

- Will providers who are targeted to be health homes be interested in becoming health homes?
- Will access to health homes be sufficient to include all eligible beneficiaries?
- Will health plans be allowed to add additional standards if they contract with health homes?

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