# Medicaid Health Home Program Design Strategies
## Themes from Call #6: Missouri's Approach to Health Homes

*The following insights were gathered during the sixth 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.*

Missouri will likely be the first state to receive CMS approval for a state plan amendment for Medicaid health homes. The purpose of this call was to learn about this "pace car" state's approach to designing health homes. The PowerPoint slides that accompany this summary provide detail on the program design.

In short, Missouri is seeking two State Plan Amendments (SPAs): one for health homes for eligible beneficiaries with serious and persistent behavioral health conditions, and one for eligible beneficiaries enrolled in Primary Care Medical Homes (PCMH).

**Investing in Existing Building Blocks**

The state has invested in strengthening its CMHCs' infrastructure over the last five years – CMHCs have a robust disease management program and have been successful at decreasing utilization while improving health outcomes. As such, CMHC health homes will be an expansion of the existing successful program and all but two CMHCs will be participating (due to size). Rapid implementation is expected.

One of the core principles for health homes is that physical health care is a core service for people with SPMI, and behavioral health systems have a primary responsibility to ensure that patients have access to preventive services and that behavioral and physical health care are managed together and integrated.

The second strategy is based in primary care. Health home providers for eligible Medicaid beneficiaries with chronic conditions would include FQHCs, RHCs and physician practices. Health home providers would participate in a new multi-payer PCMH Learning Collaborative through the Missouri Foundation for Health.

**Provider Requirements**

The state expects to have provider applications (one for PCMH and one for CMHC providers) finalized shortly, and they will be onerous. Providers will be expected to fully commit to the program requirements and will have to go through an interview process. While it is important to strike a balance between accountability and setting the bar too high, Missouri already has a good sense of what their CMHCs' performance capabilities are. The state tracks their performance on certain measures and it will provide them with their performance compared to

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a benchmark. The CMHCs will be expected to provide a plan of correction for areas in which their performance falls below that of their peers.

**Payment Methodology**

[NOTE: The state continues to be in discussions with CMS around its SPA and specifically how to pay health home providers, so the information captured below from June 2011 may have changed in subsequent conversations.]

Payments for health home services would likely be global – on a per-member-per-month basis, as opposed to fee-for-service. Missouri global payment would include three components:

1. **An infrastructure component** would help cover start-up and administrative costs to the health home provider. This component recognizes the loss of provider productivity in participating as a health home, i.e., attending trainings, hiring a health homes director, etc. Given the cash flow challenge that health home providers would likely have, the state would try to provide a sufficient infrastructure payment up front. In fact, providers would not be able to bill an ongoing PMPM until they have demonstrated that they are 90 percent "staffed up" and therefore able to serve patients.

2. **A care management component** would include the integration of physical and behavioral health through placement of physical health nurse consultants in the behavioral health system (and vice versa). The health homes would be expected to hire more nurse managers with increased resources from PMPM payments. These dollars would also be used to "purchase" the time of a PCP for training or participation in care management, for example.

3. **A performance component** would be based on quality metrics and health home activity. To be eligible for a performance payment, the health home would be required to show savings against the predictive trend for costs; however, the payment itself will be based on quality metrics, not total savings.

In closing, the state offered three pieces of advice to Medicaid agencies working on health homes:

- Take advantage of the opportunity to partner and communicate closely with CMS and SAMHSA. Schedule calls with them, ask questions informally, and learn about other models being considered nationally.

- Develop a health homes document or diagram illustrating how a health home would look from the patient's point of view. Share this illustration with CMS. (See Missouri's example .)

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- Lastly, providers are having a hard time understanding what health homes are, what the requirements are, and what health homes might mean to them. Spend more time than expected talking with providers and getting them on board from the get-go so that they are interested, engaged, and ready to deliver services when the program is rolled out.

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