CENTERS FOR MEDICARE & MEDICAID SERVICES

TECHNICAL ASSISTANCE TOOL

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# Five Key Considerations for Exploring the Medicaid Health Homes Opportunity

Many Medicaid programs are considering the option of submitting a state plan amendment (SPA) for health homes. Health home services – comprehensive care management, care coordination, health promotion, care transitions, patient and family engagement, and social and community linkages – can serve as the "glue" between effective delivery of clinical services and linked by health information technology, if feasible. As a state starts to explore this opportunity, following are five key considerations that can help a state identify whether it wants to invest in health homes.

Medicaid programs that are considering emerging health homes opportunities are faced with a variety of decisions in how to design new programs within the existing infrastructure of the state's publicly financed care delivery system. This technical assistance tool outlines key considerations to help states determine whether to invest in health homes and how to get started in doing so.

1. **Educate partners about what health homes are and are not.** The state should begin the process of educating its internal and external partners about the health homes opportunity. The Medicaid agency should reach out to its sister agencies – behavioral health, long-term care, etc. – about the opportunity and what it could mean – i.e., greater integration across primary, acute, behavioral, and long-term care which, in turn, would aim to reduce costly and otherwise avoidable services. The state should also inform its provider community about the opportunity being explored and what it could mean for those providers, i.e., a mechanism to provide the "glue" services to high cost, high needs Medicaid beneficiaries, and to "raise the bar" by integrating care more effectively and eliminating existing provider silos. Providers can offer valuable insights for planning, specifically the size of the "gap" between current care management activities and what would be demanded by health homes.

2. **Identify potential building blocks for health home services.** A state should consider what existing building blocks or infrastructure are already in place that health home services could be "layered" on or added to. Building blocks might include existing investments in care management capacity, either through a patient-centered medical home initiative, physical-behavioral health integration initiatives, chronic care management programs, or other vehicles. A state can also leverage existing infrastructure, such as health information technology or an existing provider learning collaborative or quality improvement program. Special consideration should be given to risk-based managed care plans that may currently provide some care management or care coordination services and what role they will play, if any, in the support for or delivery/administration of health home services.

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3. **Mine data to understand more about the eligible population.** The state would also want to use claims data to identify the eligible beneficiary population as defined by Section 2703. Questions to answer include: How many beneficiaries would be eligible? Where are they currently receiving care? Do eligible beneficiaries "cluster" in a certain geographic area, around certain providers, or among specific chronic conditions? Among which population subsets do opportunities for reductions in avoidable emergency department and hospital utilization exist? Answering these questions can help the state strategically decide which eligible beneficiaries to enroll, what providers will be targeted, whether the program would be regional or statewide and how it might be phased in.

4. **Consider requesting Medicaid funds for health home planning.** States have the option to request a planning grant – 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.

5. **Recognize the time-limited aspect of the enhanced federal-state reimbursement rate.** On the effective date of the SPA, the state begins to receive an enhanced 90-10 federal-state match for health home services for eight consecutive quarters. However, after the eight quarters, the state's regular medical match rate kicks back in. As states consider the design features and scale of their health home programs, they should keep in mind that the state's contribution will increase down the road. Therefore, to ensure sustainability, states should consider which subpopulations may be most likely to benefit from health homes services, and what the potential payback of health homes investments might be in terms of reductions in acute care expenditures over time.