



# Medicaid Health Homes: Overview and Update on National Activity

MACPAC Commission Meeting

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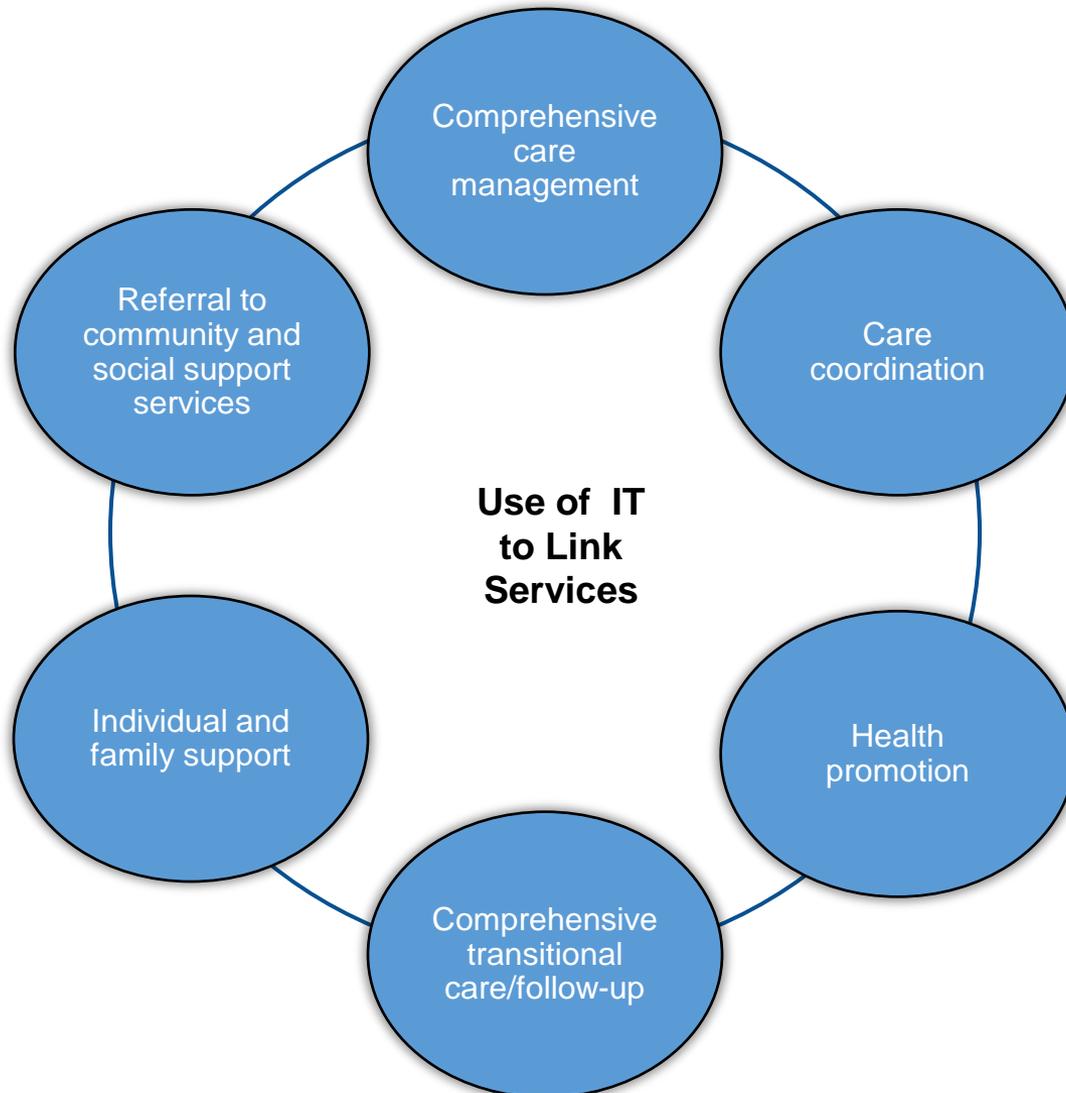
# Health Home Basics

- New state plan option created under ACA Section 2703
- OVERALL GOAL: Improve integration across physical health, behavioral health and long-term services and supports
- Opportunity to pay for “difficult-to-reimburse” services, e.g., care management, care coordination
- Flexibility for states to develop models that address an array of policy goals
- Significant state interest in evidence-based models to improve outcomes and reduce costs
- States receive an enhanced 90/10 federal match for the first eight fiscal quarters of the health home benefit

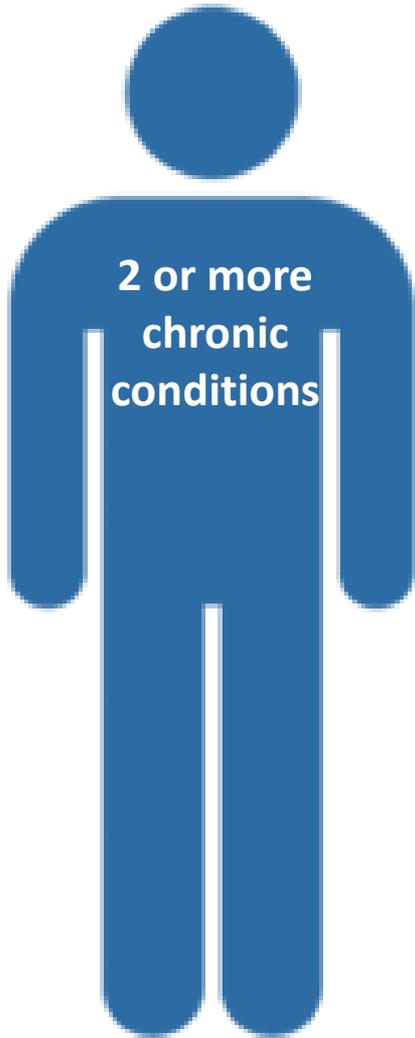
# Different from Medical Homes

- Patient Centered Medical Home can be foundation
- Health homes expand on traditional medical home models by:
  - Focusing on patients with multiple chronic and complex conditions;
  - Coordinating across medical, behavioral, and long-term care; and
  - Building linkages to community and social supports.
- Focus on outcomes, including reductions in: hospital admissions, ED visits, and admissions to LTC facilities

# What are Health Home Services?



# Who Can Receive Services?





# Approved Health Home Models

## Chronic Medical Condition Focus

- Iowa
- Maine
- Missouri
- North Carolina
- Wisconsin

## SMI/SED/SUD\* Focus

- Iowa
- Maryland
- Missouri
- Ohio
- Rhode Island
- Vermont

## Broad: Primary Care and SMI/SED

- Alabama
- Idaho
- New York
- Oregon
- Rhode Island
- South Dakota
- Washington

\*Serious mental illness (SMI), serious emotional disturbance (SED), substance abuse disorder (SUD).

# Measuring Outcomes

- Quality Measures
    - Core health care quality measure set (listed)
    - State selected measures
  - Evaluation Measures
    - Hospital admissions
    - Emergency room visits
    - Skilled nursing facility admissions
1. Adult BMI Assessment
  2. Ambulatory Care - Sensitive Condition Admission
  3. Transition Record Transmitted to Health care Professional
  4. Follow-up After Hospitalization for Mental Illness
  5. Plan- All Cause Readmission
  6. Screening for Clinical Depression and Follow-up Plan
  7. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
  8. Controlling High Blood Pressure

# Lessons from Early Adopting States

- Option offers significant flexibility to advance state-defined policy goals
- Policy goals should drive target population selection, program design and payment method
- Services should be defined to effectively engage with and care for people with complex needs
- Providers need support in their transformation to health home model
- Access to real-time data is critical for effective care coordination

# Health Home Information Resource Center

- One-on-one and group technical support to states
- Webinars
- Online library of hands-on tools and resources, available at:

<http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html>