Medicaid Health Homes:
A new state option can improve patient care, save money, and capture additional federal dollars

As of January 2011, states can qualify for two years of enhanced federal funding to set up health homes to better coordinate the care of Medicaid beneficiaries with chronic physical or mental illnesses. States may elect this new option by filing an amendment to their Medicaid State plan.

Why States Should Take Up the Health Homes Option

Improve Patient Care

Some states have already set up medical homes for Medicaid beneficiaries. These states have found that the care coordination and disease management provided by health homes have improved the quality of life for chronically ill patients. For example, Medicaid enrollees with asthma in North Carolina's medical home program experienced 17 percent fewer asthma-related ER visits and 40 percent fewer asthma-related hospital admissions between fiscal year 2003 and 2006.[1]

Save Medicaid Dollars

About five percent of Medicaid beneficiaries account for nearly 60 percent of Medicaid spending.[2] The health homes state option targets these sickest enrollees — people with chronic conditions — and aims to lower their health care costs by better coordinating their complex care.

Existing Medicaid medical home initiatives have already lowered state costs by reducing unnecessary hospital admissions and ER visits, and CMS encourages these states to design their health home option to complement existing initiatives. The North Carolina medical home program saved the state between $154 and $170 million in 2006 alone.[3] Illinois saved $220 million in the first two years that its Medicaid medical home program, Illinois Health Connect, was fully implemented.[4]

Bring New Federal Funds into the State

To help states with the initial costs, CMS will pay 90 percent of health home reimbursements for the first two years. This brings new federal funds into states at a time when they are facing serious budget deficits.

Get Financial Help for Planning

CMS is offering up to $500,000 per state, available at a state's regular Medicaid matching rate, to support the planning activities for developing a state plan amendment for the health home option.

---

[1] Kaiser Family Foundation, http://www.kff.org/medicaid/upload/7899.pdf
[2] Center for Health Care Strategies, Inc. http://www.chcs.org/usr_doc/Medicaid_Best_Buys_2010.pdf
[3] http://www.communitycarenc.com/PDFDocs/Mercer%20SFY05_06.pdf
[4] http://articles.chicagotribune.com/2010-08-11/business/ct-biz-0812-notebook-health-20100811_1_medicaid-patients-health-care-medical-home

Health Home Program Requirements

Eligible Enrollees

To be eligible for health home services, a Medicaid enrollee must be diagnosed with at least one of the following:

- Two or more chronic conditions
- One chronic condition and be at risk for a second
- One serious and persistent mental health condition

Chronic conditions include: a mental health condition, a substance abuse disorder, asthma, diabetes, heart disease, having a body mass index over 25, and additional conditions approved by HHS.

States may further restrict the eligible population by specifying higher numbers or severity of chronic or mental health conditions.

Services

All designated health homes must provide at least six key services to eligible enrollees, and these are the services eligible for the 90 percent federal matching funds:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care from inpatient to outpatient settings
- Individual and family support
- Referral to community and social support services, if relevant
- The use of health information technology to link services, as feasible and appropriate

Payment Structure

States have significant flexibility in how they can reimburse health homes for these services. CMS will allow capitated, fee-for-service, or other payment models approved by CMS.

Providers

States can choose the provider arrangements that may qualify as a health home. Options include:

- *Designated providers*, such as physicians, clinical group practices, rural health clinics, community health centers, community mental health centers, home health agencies, or any other provider approved by HHS.
- *A team of health care professionals* linked to a designated provider. This team may include nurse care coordinators, nutritionists, social workers, behavioral health professionals, or any professionals approved by HHS.
- *A health team*, defined in the law as community-based interdisciplinary teams that support primary care providers in providing health home services.

Whichever arrangements states choose, all providers must meet a CMS-defined set of standards aimed at promoting a "whole-person" approach to care.

Other Resources

For more information, see CMS's guidance in a Dear State Medicaid Director letter dated November 16, 2010.