Health Homes

Report Prepared in Response to HCR 116 and SR 188 of the 2017 Regular Legislative Session

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April 2018

LOUISIANA DEPARTMENT OF HEALTH

Contents

Introduction

Section 2703 of the Affordable Care Act (ACA) provides for the establishment of Medicaid health home programs, which are systems of interdisciplinary care for individuals with chronic health conditions. The Medicaid health home model builds on the patient-centered "medical home" concept, which proposed a "central source of a child's pediatric records to resolve duplication and gaps in services that occur as a result of lack of communication and coordination."[i] Targeted to individuals with multiple chronic conditions, including serious mental illness (SMI), health homes are designed to go beyond traditional case management by creating systems of care for the "whole person," meaning that physical, mental, economic, and social determinants of health are taken into consideration. Furthermore, because individuals with multiple or complex chronic conditions tend to see numerous providers, communication amongst providers is emphasized to improve quality of care and reduce unnecessary or duplicative utilization.[ii]

This report is submitted in response to House Concurrent Resolution 116 and Senate Resolution 188 of the 2017 Regular Legislative Session, which requires that the Louisiana Department of Health evaluate the feasibility and desirability of implementing a health home program to provide comprehensive care coordination for Medicaid beneficiaries with SMI. Studies of early adopters were used to evaluate potential efficacy of the program and other programmatic, administrative, and fiscal impacts to the state, with special attention paid to programs focusing on specialized mental health services, including SMI.

1 What is a Health Home?

"Health Home" is a service delivery model that provides a singular "home" for an individual's records related to medical care, behavioral healthcare, and community-based social services.[iii] As defined by CMS, a health home is a "Medicaid State Plan Option that provides a comprehensive system of care coordination for Medicaid individuals with chronic conditions. Health home providers will integrate and coordinate all primary, acute, behavioral health, and long term services and supports to treat the 'whole-person' across the lifespan."[iv]

The health home model proposes that addressing all components of health in a coherent, coordinated way can improve the quality of care life. It is expected that by providing these coordinated services to the populations targeted by the program, states will realize quality improvements while maintaining or decreasing costs.[v] In order to achieve these aims, states implementing health home programs receive a temporary enhanced Federal Medical Assistance Percentage (FMAP) for the health home services described in Section 1.5.2.[vi]

1.1 Health Home Services

Section 2703 of the Affordable Care Act defines health home services as described below:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support;
- Referral to community and social support services, if relevant; and
- The use of health information technology (HIT) to link services, as feasible and appropriate.

In subsequent guidance, CMS clarified that while HIT is strongly encouraged, it is not required (as are services within the other five categories). Service definitions for each of these categories is to be submitted for CMS approval as part of the state plan amendment (SPA).

1.2 Recipient Eligibility

1.2.1 Eligible Diagnoses

Eligible populations for health home services include Medicaid beneficiaries who have:

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

Chronic conditions listed in the statute include mental health, substance use, asthma, diabetes, heart disease, and being overweight. Additional chronic conditions, such as HIV/AIDS, may be considered by CMS for approval.

States have the freedom to provide health home services based on all chronic conditions listed in the statute or to focus their health home services on particular chronic conditions. States can also choose the geographic coverage and other specialized populations for their health home programs. For example, Wisconsin's health home program focuses exclusively on enrollees with HIV/AIDS who are at risk of

developing an additional chronic condition, and Rhode Island implemented a specialized program for children and youth with special needs.[ii]

1.2.2 Identifying Eligible Beneficiaries

There are a few methods that states have used to identify eligible beneficiaries:

- State Responsible
  - State uses claims or administrative data to identify beneficiaries who qualify for health home services and auto-enroll them into the program with a designated health home provider, which the beneficiary could later modify. This method was used by only one state, which has since discontinued the practice.
- Provider Responsible
  - Providers are solely responsible for identifying and referring patients to the health home program, subject to state verification of eligibility.
- State and Provider Responsible
  - Both providers and state identify beneficiaries eligible for the health home program.
  - State uses claims or administrative data to identify beneficiaries who qualify for health home services and sends the list to providers. Providers are then responsible locating, engaging, and enrolling health home recipients.[ii]

1.3 Health Home Providers

1.3.1 Provider Arrangements

CMS guidance specifies three distinct types of health home provider arrangements that states may choose from:

- A **designated provider**, which may be a physician, clinical/group practice, rural health clinic, community health center, community mental health center, home health agency, pediatrician, OB/GYN, or other provider.
- A **team of health professionals** including physicians, nurse care coordinators, nutritionists, social workers, behavioral health professionals, and can be free-standing, virtual, hospital-based, or a community mental health center.
- A **health team**, which is an inter-disciplinary team that must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractors, licensed complementary and alternative practitioners, and physicians' assistants.

States have the ability to choose one or more of the above provider arrangements to offer. In the event that more than one of these arrangements is offered, beneficiaries are allowed to choose their preferred option.

1.3.2 Provider Recruitment and Qualifications

In most states that have implemented health home programs, providers choose to apply for health home designation. States have the ability to define provider requirements and/or qualifications for participation in the health home program, and most states with health home programs choose to require recognition as a Patient-Centered Medical Home (PMCH) from the National Committee on Quality Health (NCQA) or a similar set of equivalent standards.

1.4 Reporting Requirements

CMS stipulates that health home providers report quality measures to the state as a condition of payment. These measures help the state and federal government assess the quality and fiscal impacts of the health home program.

States are in turn required to report utilization, expenditure, and quality data to CMS for an interim survey and independent evaluation, the results of which will be reported to Congress.[iv]

A list of core quality measurements can be found in Appendix A.

1.5 Payment and Financing

1.5.1 Provider Reimbursement

Section 1945(c)(2) of the Social Security Act permits state-specific flexibility in designing reimbursement models for health home providers. CMS allows for enhanced provider reimbursement rates as an incentive for providers to assume the additional workload associated with the outreach, referral services, HIT enhancements, communication, coordination of care, and other expanded requirements of the health home program.

Most states have chosen to implement a capitated per-member-per-month (PMPM) reimbursement schedule, or a variation thereof. In states where reimbursement models were implemented with a tiered PMPM structure with higher capitation payments based on the enrollee's health status, provider case mix, or provider qualification level, providers were more likely to report that billing and reimbursement procedures were overly cumbersome. Two states also pay an additional flat fee for initial and annual patient assessment and care plan development.[iv]

A detailed table containing information regarding health home reimbursement schedules for select states can be found in Appendix B.

1.5.2 State and Federal Funding

States receive a 90% enhanced FMAP for the specific health home services listed in Section 2703 of the ACA during the first eight quarters of implementation. The enhanced match does not apply to the underlying Medicaid services also provided to health home participants.

States may receive more than one period of enhanced match provided that enhanced match is not claimed for more than eight quarters for a single beneficiary. This allows states the flexibility to incrementally implement health home programs while retaining enhanced federal funding. For example, if a state initially limits its health home program to certain geographic regions or chronic conditions, it is able to submit an additional SPA at a later date to expand the program and claim the enhanced match on the new geographic areas or chronic conditions.

1.6 Health Information Technology

Use of health information technology (HIT) is an integral component of the health home program, as it facilitates efficient communication amongst providers. While CMS does not require use of HIT in the health home program, many states require use of electronic health records (EHRs) and/or connection to a health information exchange (HIE) for providers to qualify for program participation.

Acquisition of or upgrades to HIT systems often requires substantial investments from providers, in both dollars and staffing resources. This can serve as a barrier to provider participation, especially amongst small private or independent practices. Some providers are able to achieve HIT improvements through funding from federal EHR incentive programs; however, most mental health providers are not eligible for participation, meaning that many providers who would treat Medicaid beneficiaries with SMI could face challenges funding and supporting HIT systems.

Furthermore, providers often use different EHR platforms, which are not always compatible with one another. This is especially true across different provider types like primary care physicians and hospitals, as each provider type will have an EHR that meets the individual needs of its practice. The lack of standardization of EHR platforms can obstruct the seamless communication required amongst the beneficiary's providers. This communication barrier can be particularly problematic when beneficiaries are admitted to or discharged from the hospital, as it hinders the health home's ability to provide transitional care.[ii]

2 Health Homes in Other States

While no two states or Medicaid programs are alike, it is useful to look at the characteristics of existing programs to assess possible avenues to success should Louisiana decide to pursue a health home program. As of July 2016, 19 states and the District of Columbia had a total of 28 approved Medicaid health home models. A complete list and description of all 28 programs can be found at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/hh-spa-at-a-glance-jul-2016.pdf.

This report focuses on the 13 programs in 11 states that undergo an annual evaluation commissioned by the Department of Health & Human Services (HHS) and conducted by the Urban Institute. Appendix C contains a summary table containing information regarding each program's eligibility criteria, enrollment data, provider data, and provider reimbursement methodology.

2.1 Types of Health Home Models

Other states' programs utilize one of three health home models:

- Medical home-like programs: variations on or extensions of the patient centered medical home (PCMH), providers include primary care providers (PCPs), Federally Qualified Health Centers (FQHCs), rural health clinics, and Community Mental Health Centers (CMHCs).

- Specialty provider-based programs: center on entities that traditionally serve special-needs populations such as CMHCs, while integrating specialized care and primary care.

- Care management networks: consortiums of care coordination entities which include direct physical and mental/behavioral health care providers, social services agencies, and other community organizations.[ii]

For the purposes of this report in response to HCR 116 and SR 188 which focused on the impacts of SMI on the state of Louisiana, the focus will be on specialty provider-based programs.

2.2 Ohio

As of 2016, Ohio had 10,316 health home enrollees being served by six community behavioral health center providers in five counties. In order to be eligible for Ohio's health home program, enrollees must have an SMI diagnosis. Providers are paid via site-specific PMPMs based on the site costs.

2.2.1 Health Outcomes

Ohio's health program showed it performing above the nationwide 50th percentile for the following HEDIS-based measures related to mental health:[vii]

- Initiation of alcohol and other drug dependence treatment;
- Engagement of alcholol and other drug dependence treatment; and
- Follow-up after hospitalization for mental illness.

Measures related to primary care had less impressive outcomes, scoring above the national average in only three of fourteen measures:

- Use of appropriate medications for people with Asthma;

- Adult BMI assessment; and
- Adult access to preventive/ambulatory health services.

In all but one other measure, they fell below the nation's 25th percentile.

The rating system was flipped for the following two measures, in which being in the lower percentiles is more desireable:

- Inpatient and ED utilization rate: total inpatient discharges
- Inpatient and ED utilization rate: total ED visits

For these measures, they fell below the tenth percentile and above the 75th percentile respectively.

2.2.2 Costs

To assess costs of the health home program while controling for changes not associated with the implementation of the program, Ohio used a matched comparison group. The costs for the program showed statistically significant increases across all categories. See table 2.2.2.1 below:

Table 2.2.2.1: Ohio Overall Cost Savings by Cost Category (PMPM) [vii]

Cost Category	Program Effect (Cost Savings)		Sample Treatment Group Size
Medical—Mental Health	($20)	*	
Medical—Non-Mental Health	($30)	*	
Inpatient	($34)	*	
Outpatient	($18)	*	
Emergency Department (ED)	($5)	*	
Pharmacy	($74)	*	
Average Monthly Health Home Case Rate	($333)	*	
Other	($1)	N/S	
Total†	**($516)**	*	**8,335**

A negative cost savings (shown in red) indicates an increase in cost.
N/S indicates the results were not statistically significant.
**Indicates statistical significance at the 95% confidence level or greater.*
†Total cost savings may not equal the sum of all cost categories because each cost category and total cost savings are modeled independently.

Costs for health home enrollees were higher in every medical service category, relative to their costs prior to health home enrollment, amounting to a $183 cost increase on top of the average $333 PMPM payment for health home services. Nearly 75 percent of the overall cost increase was attributable to the $333 monthly case rate for delivering health home services and a $74 increase in pharmacy costs.[viii]

In 2014, Ohio expanded its program, but at a scale smaller than initially planned with large cuts to provider payments. In 2015, Ohio began taking steps to dissolve the health home program as part of an overall behavioral system redesign.[viii]

2.3 Rhode Island

Rhode Island hasn't yet conducted internal evaluations of utilization and costs in their programs that could be found publically available. For the mental health program, the state did not begin a uniform data collection until 2014, after the enhanced match period had ended.

2.4 Missouri

Missouri serves 19,247 health home enrollees statewide through 27 providers. In order to be eligible to enroll, recipients must have one of the following: serious and persistent mental illness, mental health condition and one other chronic condition, substance use disorder and one other chronic condition, or mental health condition or a substance use disorder and tobacco use. Service is provided by CMHCs, and PMPM payment rates are adjusted annually for cost of living increases.

2.4.1 Health Outcomes

As of 2015, Missouri's CMHCs had met and surpassed benchmark goals for the following health measures:[ix]

- Metabolic syndrome screening;
- Diabetes – good cholesterol, normal blood pressure, and normal blood sugar;
- Hypertension and cardiovascular disease – good cholesterol and normal blood pressure;
- Asthma – appropriate oral controller medication prescription;
- Cholesterol reduction;
- Blood pressure reduction; and
- Blood sugar reduction.

Measures for which the benchmark goal have yet to be met include:

- Percentage of enrollees who are tobacco free;
- Discharge follow-up within 72 hours; and
- Medication reconciliation within 72 hours.

2.4.2 Costs

The 2013 internal evaluation of costs associated with the CMHC program showed an estimated $2.9 million in hospital cost savings. Total savings were $33 PMPM above the $79 PMPM for health home services, for a total of $2.4 million in Medicaid savings relative to the year prior to enrollment.[viii]

3 Considerations for Louisiana

3.1 Required Resources

Due to the limited period of enhanced FMAP, in order for health homes to be sustainably implemented in Louisiana, it is necessary to identify a long-term source of funding to cover associated costs. Several states have discontinued their health home programs after enhanced FMAP expiration. Kansas discontinued its health home program in 2016 after the enhanced FMAP period ended, citing an annual gap of $13.4 million which the state would have to cover in order to continue the program.[x] After Oregon discontinued its health home program due to the expiration of enhanced FMAP, providers expressed that they would not have been willing to expend the effort and resources required for program participation had they known that the program and associated enhanced reimbursement would be terminated.[ii]

3.2 Program Characteristics

Given that the resolutions focus on SMI, LDH recommends focusing on specialty provider-based health homes. It may be useful to further narrow serious mental illness to specific qualifying conditions, particularly during the rollout phase, to allow providers time to develop teams and systems before scaling up to meet greater patient demand.

Of the five states providing specialty provider-based health home programs evaluated by HHS, four used some variation of a PMPM care management fee. Two of the programs, Missouri and Wisconsin, indicated savings from the program in initial evaluation. Ohio showed increased costs, and Rhode Island has not yet provided data for cost evaluation.[viii]

3.3 Potential Impacts

A health home program that focuses on individuals with SMI would potentially affect a total of 182,294 current Medicaid enrollees, 70,088 of which have recent histories of both SMI and substance use disorder (SUD). A total of 50,995 of the identified population are enrolled in Medicaid through expansion. Table 3.3.1 contains a detailed breakdown of the identified population:

Table 3.3.1: Louisiana Medicaid Enrollees with Serious Mental Illness (SMI) in State Fiscal Year 2017

	Expansion			Non-Expansion			Total Population		
	SMI Only	SMI+SUD	Total	SMI Only	SMI+SUD	Total	SMI Only	SMI+SUD	Grand Total
Age 0-18	-	-	-	20,081	1,418	21,499	20,081	1,418	21,499
Age 19-64	25,506	24,618	50,124	51,064	41,178	92,242	76,570	65,796	142,366
Age 65+ *	627	244	871	14,928	2,630	17,558	15,555	2,874	18,429
Total	26,133	24,862	**50,995**	86,073	45,226	**131,299**	112,206	70,088	**182,294**

**Age is calculated based on the recipient's age as of the report date; therefore, recipients who have since "aged out" of expansion are reflected in this report.*

When considering financial impacts, inclusion of the expansion population has a neutral effect, as the state would continue to receive the enhanced expansion FMAP for services provided to these individuals.

3.4 Potential Challenges

It is important to note that of the other evaluated states with specialty provider-based health home programs, Rhode Island and Wisconsin were both able to develop their programs on top of existing, long-established, specialty provider systems that already provided health home services. Missouri and Ohio developed theirs from the ground up, but Ohio has plans to discontinue their health home program in pursuit of a less expensive and less administratively burdensome PCMH program. Given that Louisiana is not currently providing health home or health home adjacent services, the administrative burden of creating these programs and garnering provider engagement and support is increased.

Health home programs require an increase in provider responsibility, which would likely lead to resistance within the provider community. One large hurdle to the program's success would be overcoming provider perceptions of the program and its impact on their practice. As with any changes to the Medicaid system, provider buy-in will be key.

Other states have also noted that efficiently identifying, conducting outreach to, and enrolling eligible participants has proved difficult. These issues speak to a broader issue of HIT adequacy for this type of undertaking. Compatible and functional HIT systems are crucial for coordinating care across providers and facilitating communication. An assessment of the HIT system in any areas in which health homes will be implemented will provide a better window into the potential challenges this may cause.

Louisiana's managed care model of delivery imposes an additional layer of complexity, as states that utilize managed care organizations (MCOs) have noted that the additional layer of contracting with the MCOs led to administrative complication associated with service provision. These states reported difficulty in avoiding duplication of activities.

Conclusion

States face many challenges in designing and implementing health home programs that are fiscally sustainable. As enhanced federal funding expires, several states have transitioned their health home program into a medical home program. In preparing to reprocure its Healthy Louisiana managed care contracts in CY19, LDH is considering changes to managed care organization requirements for care coordination, integrated physical and behavioral health and value-based payment models, including for medical homes. See Paving the Way to a Healthier Louisiana for details on the Request for Proposals (RFP) development process. In lieu of developing a health home model, LDH recommends pursuit of alternatives within the upcoming Healthy Louisiana procurement.

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Appendix A – CMS Health Home Core Quality Measurements

Measure Title	Measure Description	Measure Steward
Adult Body Mass Index Assessment	Percentage of members 18-74 years of age who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to the measurement year.	NCQA
Prevention Quality Indicator (PQI) 92: Chronic Condition Composite	The total number of hospital admissions for chronic conditions per 100,000 health home enrollees age 18 and older.	AHRQ
Care Transition – Transition Record Transmitted to Health Care Professional	Care transitions: percentage of patients regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours.	AMA-PCPI
Follow-Up After Hospitalization for Mental Illness	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.	NCQA
Plan – All Cause Readmission	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	NCQA
Screening for Clinical Depression and Follow-Up Plan	Percentage of patients aged 19 years and older screened for clinical depression using a standardized tool AND follow-up documented.	CMS
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received the following: • Initiation of AOD treatment • Engagement of AOD treatment	NCQA
Controlling High Blood Pressure	The percentage of patients 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.	NCQA

Source: Centers for Medicare and Medicaid Services. (2012, May 3). Health Homes (Section 2703) Frequently Asked Questions. Retrieved from https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/health-homes-faq-5-3-12_2.pdf

Appendix B – Health Home Payment and Reimbursement Systems

State/Program	Payment System	Payment Level
Patient-Centered Medical Homes and Extensions		
Oregon	PMPM care management fee	PMPM fee based on the PCPCH recognition level: • **Tier 1**: $10 PMPM • **Tier 2**: $15 PMPM • **Tier 3**: $24 PMPM
Missouri (Primary care)	PMPM care management fee	$58.87
Iowa	PMPM care management fee, plus lump-sum performance-based incentive	PMPM fee varies by patient acuity tiers: • **Tier 1**: $12.80 • **Tier 2**: $25.60 • **Tier 3**: $51.21 • **Tier 4**: $76.81 Incentive pay based on achievement in 16 measures
Idaho	PMPM care management fee	$15.50
Specialty Provider-Based		
Rhode Island (CYSHCN)	FFS	Fixed rates of $347, $366, or $397, depending on the service Additional payments of either $9.50 or $16.63 made per quarter hour for 2 other services
Rhode Island (Mental health)	PMPM care management fee	Based on 9 staff hours PMPM
Missouri (Mental health)	PMPM care management fee	$78.74
Wisconsin	PMPM care management fee, plus flat fee for patient assessment	• **PMPM**: $102.95 • **Fee**: $359.00
Ohio	PMPM care management fee	Site-specific and based on costs, ranging from $270-$400 PMPM
Care Management Networks		
North Carolina	PMPM care management fee	PMPM fee based on beneficiary classification: • **Networks**: $12.85 for the ABD; $5.22 for pregnant women; $4.33 for all others • **PCPs**: $5.00 for ABD; $2.50 for all others
New York	PMPM care management fee	Paid at 2 levels depending on enrollee status, and tiered based on case-mix and geography
Alabama	PMPM care management fee	• **PCNA**: $9.50 • **PMP**: $8.50
Maine	PMPM care management fee	• **CCT**: $129.50 • **PCP**: $12.00
SOURCE: Information obtained from review of Health Home SPAs approved by CMS.		

Source: Spillman, B. C., Allen, E. H., Lallemand, N., & Hayes, E. (April 2016). Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Progress and Lessons from the First States Implementing Health Home Programs, Annual Report - Year Four. Urban Institute. Retrieved January 3, 2018, from https://aspe.hhs.gov/system/files/pdf/224581/HHOption4.pdf

Appendix C – Summary Table: Other State Health Home Programs

State (program)	Member Eligibility Criteria	Enrollment[a] (share who are dually eligible or children)	Number of Providers, Service Locations and Geographic Coverage	Providers and Payment Structures
Patient-Centered Medical Homes and Extensions				
Oregon	• 2 chronic conditions • 1 chronic condition and the risk of developing another • 1 SMI	63,402 (15% duals; 27% children)	236 providers statewide	Participating providers were PCPCHs that met standards in a 3-tiered state-developed recognition program. PMPM payment rates increased with the tier of PCPCH recognition achieved.
Missouri (primary care)	• 2 chronic conditions • 1 chronic condition and the risk of developing another	14,361 (38% duals; 2.5% children)	24 providers in 83 locations statewide	Providers include FQHCs, RHCs, and primary care clinics operated by hospitals. PMPM payment rates are adjusted annually for cost of living increases.
Iowa	• 2 chronic conditions • 1 chronic condition and the risk of developing another	5,991 (33% duals; 22% children)	48 providers in 79 locations statewide	Health home practices may include PCPs, CMHCs, FQHCs, and RHCs. The state developed 4-tiered PMPM rates based on a patient's acuity, with patients in each subsequent tier requiring more complex care.
Idaho	• 2 chronic conditions • 1 chronic condition and the risk of developing another • 1 SMI	8,266 (14% duals; 66% children)	48 providers statewide	Participating providers may include PCPs, CMHCs, community health centers, and home health agencies. The PMPM rate includes an extra $1.00 to cover the costs of NCQA recognition, as all providers must obtain at least Level 1 NCQA recognition by their second year in the health home program.
Specialty Provider-Based				
Rhode Island (CYSHCN)	• 2 chronic conditions • 1 chronic condition and the risk of developing another • 1 SMI	2,791 (0% duals; 100% children)	4 providers statewide	CEDARR Family Centers are the only designated providers. Reimbursement is a mix of FFS payments, with case rates for intake and assessment, care plan development, and annual care plan review and established rates per 15-minute increments of time for other services.
Rhode Island (mental health)	• 1 SMI	9,279[b] (48% duals; 0% children)	8 providers statewide	CMHOs and 2 CMHCs serve as designated health home providers. The monthly case rate payment reflects personnel costs and staffing ratios based on estimates of client need.
Missouri (mental health)	• SPMI • Mental health condition and 1 other chronic condition • SUD and 1 other chronic condition • Mental health condition or a SUD and tobacco use	19,247 (40% duals; 12% children)[c]	27 providers statewide	Designated providers are CMHCs. PMPM payment rates are adjusted annually for cost of living increases.

Summary Table: Other State Health Home Programs (continued)

State (program)	Member Eligibility Criteria	Enrollment[a] (share who are dually eligible or children)	Number of Providers, Service Locations and Geographic Coverage	Providers and Payment Structures
Ohio	• 1 SMI	10,316 (7% duals; 38% children)	6 providers in 5 counties	Designated health home providers are CBHCs. PMPM rates are site-specific and based on costs.
Wisconsin	• HIV/AIDS and the risk of developing another chronic condition	150 (48% duals; 0% children)	1 provider in 3 locations covering 4 counties	ARCW is the only health home provider. In addition to PMPM payments, ARCW receives a flat fee for patient assessment which may be billed annually if reassessment is needed.
Care Management Networks				
North Carolina	• 2 chronic conditions • 1 chronic condition and the risk of developing another	529,354[d] (20% duals; 52% children)	1,786 PCPs statewide	Health home services are coordinated through a pre-existing care management program, CCNC, in collaboration with PCPs. The state pays separate PMPM rates to networks and to PCPs.
New York	• 2 chronic conditions • HIV/AIDS and the risk of developing another chronic condition • 1 SMI	130,160 (75,580 enrolled and 54,580 in outreach) (30% duals; 10% children)	32 lead agencies in 48 locations Statewide	Health home lead agencies assemble a network of providers to collectively coordinate and deliver health home services. PMPM payments are tiered based on patient acuity and providers receive 80% of PMPM rate for outreach and enrollment activities.
Alabama	• 1 chronic condition and the risk of developing another (Alabama considers the presence of any of the conditions as indicating risk for another)	74,660 (0% duals; 80% children)	187 providers in 4 regions comprising 21 counties	Patient Care Networks of Alabama (PCNAs) provide wraparound care management to PCPs to deliver health home services. PCNAs and PCPs receive separate PMPM rates.
Maine (Stage A)	• 2 chronic conditions • 1 chronic condition and the risk of developing another	54,883 (11% duals; 43% children)	181 providers statewide	PCPs conduct care management for all health home enrollees, while the regional CCTs provide health home services only to the top 5% of high-cost, high-need patients referred by PCPs. The PMPM rate for CCTs is substantially higher than the rate for PCP services.

SOURCE: Information obtained from review of Health Home SPAs approved by CMS and interviews with state informants (April - July 2015).

a. Indicates the number of enrollees at the end of 8-quarter enhanced match period, unless otherwise noted.
b. Number of enrollees in 2014.
c. Missouri's Journey to Healthcare Home, April 14, 2015, http://www.cbha.net/Resources/Conference/Missouri's%20Journey%20to%20Healthcare%20Home.pdf; Progress Report: Missouri CMHC Healthcare Homes. http://dmh.mo.gov/docs/mentalillness/prnov13.pdf.
d. Number of enrollees from October 2011 - November 2012.

Source: Spillman, B. C., Allen, E. H., Lallemand, N., & Hayes, E. (April 2016). Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Progress and Lessons from the First States Implementing Health Home Programs, Annual Report - Year Four. Urban Institute. Retrieved January 3, 2018, from https://aspe.hhs.gov/system/files/pdf/224581/HHOption4.pdf

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