

# **Report To Congress on the Medicaid Health Home State Plan Option**

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# TABLE OF CONTENTS

- ACKNOWLEDGMENTS .....iv
- ACRONYMS ..... v
- EXECUTIVE SUMMARY.....vi
- I. INTRODUCTION ..... 1
- II. HEALTH HOME IMPLEMENTATION ..... 2
  - Flexibility for States to Tailor Health Home Programs ..... 2
  - Health Home Beneficiaries ..... 2
  - Health Home Teams ..... 3
  - Health Home Services ..... 4
  - Support for Health Home Planning ..... 4
- III. QUALITATIVE FINDINGS: HEALTH HOME IMPACT ON PROGRAMS AND CARE DELIVERY..... 5
  - Care Management and Care Coordination..... 5
  - Care Transitions ..... 6
  - Integration of Physical and Behavioral Health..... 7
  - Access to Nonclinical Social Services and Supports ..... 8
  - Engaging Enrollees and Improving Patient Experience..... 8
  - Use of Health Information Technology and Data Analytics ..... 9
  - Targeting High Cost, High Need Beneficiaries: Impact on Utilization Patterns, Costs, and Quality ..... 9
  - Supporting Practice Transformation ..... 10
  - Use of Health Homes to Address Opioid Misuse<sup>22</sup> ..... 10
- IV. QUANTITATIVE FINDINGS: IMPACT OF HEALTH HOME ON UTILIZATION PATTERNS, COSTS, AND QUALITY ..... 12
  - Missouri ..... 12
  - Iowa ..... 13
  - Ohio ..... 13
  - Wisconsin ..... 14
  - Preliminary Results from Other States ..... 14
- V. CONCLUSIONS AND LESSONS LEARNED ..... 15
  - Conclusions ..... 15
- END NOTES ..... 17
- APPENDICES ..... 21

APPENDIX 1. STATUTORY LANGUAGE .....	21
APPENDIX 2. HEALTH HOME CORE SERVICES .....	22
APPENDIX 3. EVALUATION REPORTS .....	24
Baseline .....	24
Year 2.....	24
Year 3.....	24
Year 4.....	24
Year 5.....	24

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# ACRONYMS

The following acronyms are mentioned in this report and/or appendices.

<b>Acronym</b>	<b>Meaning</b>
A1C	Glycosylated Hemoglobin
AIDS	Acquired Immune Deficiency Syndrome
ASPE	HHS Office of the Assistant Secretary for Planning and Evaluation
BMI	Body Mass Index
CCT	Community Care Team
CEDARR	Comprehensive Evaluation, Diagnosis, Assessment, Referral, Re-evaluation
CFR	Code of Federal Regulations
CMHC	Community Mental Health Center
CMS	HHS Centers for Medicare & Medicaid Services
EHR	Electronic Health Record
FFS	Fee-For-Service
HHS	U.S. Department of Health and Human Services
HIE	Health Information Exchange
HIT	Health Information Technology
HIV	Human Immunodeficiency Virus
HRSA	HHS Health Resources and Services Administration
OTP	Opioid Treatment Program
PCMH	Patient-Centered Medical Home
PMPM	Per Member Per Month
SAMHSA	HHS Substance Abuse and Mental Health Services Administration
SPA	State Plan Amendment

## EXECUTIVE SUMMARY

This report provides early evidence of the impact of the health home program. The statute establishing the Medicaid health home option required “an independent entity or organization to conduct an evaluation.” Under contract to the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, the Urban Institute conducted the independent national program evaluation. The information in this report draws on the five annual reports from the evaluation (see Appendix 3) and summarizes the results.

The Medicaid health home option enables states to provide coordinated and integrated care for beneficiaries with chronic physical, mental, or behavioral conditions.<sup>1</sup> The health home model is related to the patient-centered medical home model but is distinct in its focus on high-need, high-cost Medicaid populations with chronic conditions and its greater emphasis on coordinated care, encompassing physical, mental, and behavioral health care as well as social supports. Coordinated care management is a critical element for integrating physical and behavioral health care services and linking patients with nonclinical services.

The evaluation covers the first 13 programs in the first 11 states to launch health homes: Alabama, Idaho, Iowa, Maine, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island, and Wisconsin. As of December 2017, 21 states and the District of Columbia had implemented a total of 32 health home programs.<sup>2</sup> The health home programs included in the evaluation report suggest the potential for improvements in care management and care coordination, care transitions, the integration and physical and behavioral health, access to nonclinical services, patient engagement, and the use of health information technology (HIT). In addition, quantitative results highlight the potential for improved utilization patterns, cost, and quality as a result of the health home program.

Key lessons learned from the implementation of health homes include:

- Using the health home state plan option allows states to target high-cost, high-need patients, and initial results suggest potential for improvements in care utilization patterns, costs, and quality based on reports from states and health home providers in the first 11 states.
- The use of multidisciplinary care teams was broadly recognized as the most important change to emerge from health homes.
- Initial and continuing assistance with practice transformation and team-based care is important, particularly to address the behavioral health needs and social determinants of health that impact patients.
- Well-developed HIT and other infrastructure is needed for care coordination and quality improvement.

- Health home programs show promise in effectively addressing needs of individuals with complex chronic physical and mental health conditions and substance use disorder, particularly those who also have high social needs.
- Most of the early health home states continue to offer the health home benefit beyond their initial enhanced match period, which suggests that states have found value and promise in the health home model for improved care for their chronically ill populations.

State officials and providers in the first 11 states to implement the health home program report that the model has served the targeted, high-need chronic condition populations well and has shown improvements in care management, care transitions, behavioral health integration, and linkages to services to address the social determinants of health. It is also important to note that the majority of Health Home states have continued past their enhanced match period, which indicates states have found value in the health home model. Quantitative results from state evaluations to date show some improvements in emergency department and inpatient admissions, costs, and quality. This new model of health care for Medicaid beneficiaries with complex physical, mental, and social conditions shows promise as a tool for improving care and achieving cost savings.

# I. INTRODUCTION

The Medicaid health home option enables states to provide coordinated and integrated care for beneficiaries with chronic physical, mental, or behavioral conditions.<sup>3</sup> The health home model is related to the patient-centered medical home (PCMH) model but is distinct in its focus on high-need, high-cost populations and its greater emphasis on coordinated care, encompassing physical, mental, and behavioral health care as well as social supports. Coordinated care management is a critical element for integrating physical and behavioral health care services and linking patients with nonclinical services.

This report provides early evidence of the impact of the health home program. The statute establishing the Medicaid health home option required “an independent entity or organization to conduct an evaluation.” Under contract to the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation (ASPE), the Urban Institute conducted the independent national program evaluation. The information in this report draws on the five annual reports from the evaluation (see Appendix 3) and summarizes the results. The statute dictates that this Report to Congress shall assess the “effect ... on reducing hospital admissions, emergency room visits, and admissions to skilled nursing facilities.”<sup>4</sup>

The report is organized into four main sections: Health Home Implementation; Qualitative Findings; Quantitative Findings; and Conclusions and Lessons Learned. Except as otherwise noted, the results draw on analysis of interviews with state officials and health home providers, State Plan Amendment (SPA) documents, and other relevant materials provided in four annual reports on the evaluation, which examined the first two years of programs in the participating states.<sup>5</sup> The quantitative findings reported here are from state evaluation activities. The evaluation covers the first 13 programs in the first 11 states to launch health homes: Alabama, Idaho, Iowa, Maine, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island, and Wisconsin.

## II. HEALTH HOME IMPLEMENTATION

As of December 2017, 21 states and the District of Columbia had implemented a total of 32 health home programs.<sup>6</sup> The health home programs included in the evaluation report suggest the potential for improvements in care management and care coordination, care transitions, the integration and physical and behavioral health, access to nonclinical services, patient engagement, and the use of health information technology (HIT). In addition, quantitative results highlight the potential for improved utilization patterns, cost, and quality as a result of the health home program.

The health home option allows states the flexibility to identify a target population of persons with chronic health or behavioral conditions and offer them six required health home services:

- Comprehensive care management.
- Care coordination and health promotion.
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up.
- Patient and family support, which includes authorized representatives.
- Referral to community and social support services, if relevant.
- The use of HIT to link services, as feasible and appropriate.

Although core principles of the program remain the same across states, there is a significant variation in structures and processes each state--and each health home provider--has put in place to meet the specific needs of its health home population and fit into larger delivery system transformation efforts. Most states have built on pre-existing structures and care coordination programs when developing and implementing their health home programs, augmenting current activities with additional support for core health home activities such as comprehensive care management.<sup>7, 8, 9</sup>

### **Flexibility for States to Tailor Health Home Programs**

The health home option allows states latitude in most components of the health home model, including the choice of conditions that are targeted, types of providers and program participation requirements, health home team composition, geographic coverage, and payment methodology and rates for health home services. The health home authority outlines basic requirements and options for states interested in establishing a health home program.<sup>10</sup> States must identify a target population of persons with chronic conditions they intend to include.

### **Health Home Beneficiaries**

To qualify for health home services, Medicaid beneficiaries must: (1) have two or more chronic conditions; (2) have one chronic condition and be at risk of developing another; or (3) have a serious and persistent mental health condition. Chronic conditions specified in the law are serious and persistent mental illness, substance use disorder, asthma, diabetes, heart disease, and obesity. States may select one or more conditions from the list, or, with approval from the HHS Centers for Medicare & Medicaid Services (CMS), other conditions such as HIV/AIDS.

States and providers generally share responsibility for identifying beneficiaries eligible for health home services and enrolling them in the program. State Medicaid departments use claims or administrative data to identify and assign beneficiaries who qualify for health home services to providers. In some states, providers receive lists of eligible Medicaid beneficiaries and are responsible for locating, engaging, and enrolling health home participants. Most states also allow providers to refer patients to the health home program, and in some states, member enrollment is entirely through provider referral, subject to state verification of eligibility. Lessons on outreach and engagement to high-need, high-cost individuals are summarized in a report from New York State, including the Top 10 “Must-Dos” to improve outreach in health homes.[11](#), [12](#)

States may limit their health home program to a targeted geographic area without having to obtain a CMS waiver of Medicaid state-wideness or comparability requirements. Health home enrollment must be offered to all persons meeting the state’s eligibility criteria who are categorically needy, regardless of age, including beneficiaries who are dually eligible for Medicare and Medicaid and those receiving services under a Section 1915(c) home and community-based services waiver. States also may choose to offer health home enrollment to the medically needy and participants in Section 1115 demonstrations.

## **Health Home Teams**

Health home providers are expected to meet state-specific requirements and 11 core expectations for care coordination, service delivery, quality improvement, monitoring, and reporting.<sup>13</sup> Health home teams often include a primary care physician, as well as other clinicians such as psychiatrists, nurses, substance use treatment providers, and social workers. Care managers and care coordinators are key members of the health home team. Health home care teams also may include other professionals including diabetes educators, nutritionists, pharmacists, vocational specialists, school personnel, and housing assistance representatives. Health home teams often include other members such as community health workers, peer specialists, and data managers.<sup>14</sup>

Often, the health home model’s person-centered, whole-person care approach requires providers to take on new roles or expand services they have been providing by developing a team-based approach to care and forming new partnerships. It is important to consider health home’s impact on practice transformation in which

providers, who have not traditionally worked together, are now focused on whole-person care, forming partnerships between primary care and behavioral health providers. The health home model also requires an enhanced level of communication and interaction with other providers than is typical in the current delivery system. State-specific criteria may include accreditation or certification, most commonly the National Committee for Quality Assurance PCMH recognition program.

Some states phased in or gradually increased certain provider requirements over time, while others fully implemented their provider standards at the inception of the health home program. To assist providers with the implementation of the health home program and practice transformation, all states have provided guidance and technical support, such as trainings, webinars, learning collaboratives, and on-site practice coaching. CMS offers technical assistance support through the Health Home Information Resource Center.<sup>15</sup> Health home providers also may use other practice transformation resources, such as those sponsored by national and local associations, commercial health systems, health foundations, and universities. In addition, some states partnered with local organizations to help oversee the implementation of the program and deliver technical assistance to providers.

## **Health Home Services**

Appendix 2 outlines the specific activities that comprise each of the six required health home services listed above. States receive a 90% federal match for these services for the first eight quarters that the health home SPA is in effect and their regular match rate thereafter. A new period of enhanced match can be triggered if states expand their health home program geographically or add new qualifying chronic conditions.

## **Support for Health Home Planning**

Planning funding is available through an administrative match based on the state's service match rate for planning activities.<sup>16</sup> To date, over \$8.9 million in planning funding has been disbursed to states. The availability of funding for planning activities allows states to study and determine the feasibility of implementing a health home program. Throughout the planning process, CMS works collaboratively with each state to provide technical assistance. Consistent with the focus of the health home model on integration of physical and behavioral health care services, all states are required to consult with the HHS Substance Abuse and Mental Health Services Administration (SAMHSA) in developing their health home programs prior to submitting their SPAs to CMS, regardless of the targeted conditions.

### **III. QUALITATIVE FINDINGS: HEALTH HOME IMPACT ON PROGRAMS AND CARE DELIVERY**

Initial assessments of the impact of health home programs on care delivery processes show heightened focus on care management, care coordination, care transitions, the integration of physical and behavioral health, access to nonclinical services, patient engagement, and the use of HIT. In addition, quantitative evidence from state evaluation activities indicates that health home programs may improve utilization patterns, cost, and, in some cases, quality as a result of the health home program.

To improve care quality and reduce inappropriate emergency department use and hospital admissions, the law requires health homes to provide comprehensive care management and coordination, including transitional care to reduce avoidable readmissions to hospitals, support services for the enrollee and family, and linkages to nonclinical supports in the community. Almost universally, state officials and health home provider teams in the first 11 states to implement health homes believe they have seen improvements in the care enrolled members are receiving because of changes made through health homes and other delivery system reforms. These findings are from: Alabama, Idaho, Iowa, Maine, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island, and Wisconsin.

Some providers mentioned seeing better outcomes for members who were continuously enrolled over a longer period of time as opposed to those exposed to the program for a shorter period. A more dramatic improvement in outcomes was also reported for patients who are highly motivated to improve their health, as well as individuals who were able to become active participants in their care.

#### **Care Management and Care Coordination**

State officials and providers in the first 11 health home states reported improvement in care coordination. The use of multidisciplinary care teams was broadly recognized as the most important change to emerge from health homes. As mentioned previously, health home's focus on whole-person team-based care has transformed how care is provided to Medicaid eligible individuals with chronic conditions. Having multiple disciplines, including primary care physicians, pharmacists, social workers, mental health professionals, and others on care teams was viewed by many respondents as an effective way to accomplish a whole-person approach and improve the coordination of care for members. Care team meetings, monthly calls, case conferencing, care plans, and referral tracking were considered helpful tools for care teams.

Educating both internal and external clinical and nonclinical providers about health homes, building trust, and developing relationships and communication arrangements with external providers in the community were considered by many as crucial to

effective care coordination. The emphasis on care coordination and collaboration across disciplines helped educate primary care and behavioral health staff on how to better work with each other and provided awareness of each other's roles in their patients' care.

To improve care management and care coordination, health home teams need timely notifications from hospitals and emergency departments. For example, MO HealthNet, Missouri's Medicaid agency, sends health homes daily notifications of emergency department visits and uses its prior authorization tool to inform providers about upcoming Medicaid hospitalizations for enrollees other than those dually eligible for Medicare and Medicaid. In some cases, health homes closely affiliated with or owned by hospital systems had an easier time with patient data exchange, which helped facilitate care coordination. Even when data exchange was not performed electronically, some health homes reported improved communications with hospitals and other providers as a result of the health home program.

In Maine, informants identified the care management system that the state developed as a particularly successful feature of the program, providing a crucial resource for primary care practices and linkages to a comprehensive array of clinical and nonclinical services for the highest-need patients. The care management system allowed for a development of new relationships and connections among previously separate provider systems and contributed to greater collaboration and coordination of care. The state is working on further HIT infrastructure development to improve access to data and information flow to sustain and advance these cross-organizational connections.<sup>17</sup>

A report from New York State identified key action steps to improve care management: increasing standardization (by developing standardized staffing plans and assessment tools and using HIT), defining the optimal staffing mix, increasing opportunities for training, including social determinants of health in the risk score used to determine reimbursement levels, regularly reassessing the needs of individuals receiving health home services, improving access to timely and actionable data, and shared access to care plans with communication among the care team supported by information technology.<sup>18</sup>

## Care Transitions

Ensuring continuity of care and assisting enrollees in transitions from one type of care setting to another is a core health home activity. Many providers believe an increased focus on follow-up and readmission prevention and new staff roles addressing these goals have improved their ability to provide effective transitional care. Some health homes created a new role on the care team for hospital coordinators. Rhode Island health homes that were based in community mental health centers (CMHCs) place liaisons in psychiatric hospitals to facilitate transitions of their patients.

It is important to note that any improvements in rates of timely follow-up after member hospitalization or emergency department visit are closely tied to a health home's ability to obtain a notification of admission in a timely manner. While some health homes struggled to get timely notification for all their patients, the health home program helped them establish and strengthen structures and processes for communicating with the major hospitals or managed care organizations in their area. So, even in the absence of health information exchange (HIE), health home providers were able to get accurate and rapid information for at least some patients through secure email, phone calls, or fax.

In Alabama, both providers and state officials mentioned the positive impact of the health home transitional care program. The program began with a single nurse and evolved to include social workers and pharmacists on transitional care teams that conduct hospital visits and assist health home members with discharge and follow-up after hospitalization. Expanding the transitional care team made it possible to better identify and address all the needs of patients while in the hospital and during the post-discharge period.

A provider in Idaho reported that the Medicare chronic care management billing codes that were created in 2014 have helped facilitate transitions for dually eligible health home enrollees. Others reported that care management and coordination were more difficult for individuals who are enrolled in Medicare as well as Medicaid, since Medicare is the primary payer and information about Medicare claims might not reach the Medicaid program or health home care teams.

## **Integration of Physical and Behavioral Health**

A key feature of the health home benefit is to integrate and coordinate physical and behavioral health needs of the health home enrollees to support whole-person care regardless of an individual's eligible condition. Approaches to integration varied, largely based on providers' capacity and previous experience. States have used various approaches. Some states employ part-time or full-time primary care or behavioral health consultants, yet others may co-locate primary care and behavioral health services in one setting. Providers also adopted new behaviors, including focus on a warm handoff model, inter-disciplinary case conferencing, shared visits, embedding care managers in practices, improved education on physical health for behavioral providers (and vice versa), and strengthened relationships between providers through ongoing communication.

The following features helped to create pathways and systems for integration: (1) shared electronic medical records between behavioral and physical health providers; (2) embedded mental health professionals in primary care and primary care consultants in mental health clinics; (3) depression and substance use screenings in primary care; and (4) co-location of behavioral and physical care within a building or clinic.

Rhode Island's mental health providers felt that the health home program made them more attentive to clients' physical health needs and reported improvements in identifying chronic health conditions and referring patients to appropriate clinical services. Rhode Island's CEDARR health homes for children with special needs also noted improved communication and coordination with primary care providers, including more focus on preventive care and better rates of follow-up after hospitalizations.<sup>19</sup>

## **Access to Nonclinical Social Services and Supports**

The whole-person approach of the health home model has brought about new, or in some cases enhanced, attention to patients' socio-economic needs, such as housing, nutrition, vocational training, and transportation. Providers of health home services are expected to use a person-centered planning approach to identifying needed services and supports, providing care and linkages to care that address all of the clinical and non-clinical needs of the individual. Most providers in the first 11 health home states reported significant growth in their ability to connect patients to nonclinical social services and supports. Availability of reliable transportation services and affordable housing were commonly identified as the highest areas of need for health home members, as well as the most challenging for providers to meet.

In terms of improved ability to diagnose the social determinants of health and link patients with the appropriate services, the effect of health home programs was reported to be stronger for health home teams that were based in local community-based provider offices. This is because specialized types of providers, such as CMHCs, home health agencies, and federally-qualified health centers, were already adept at linking patients to nonclinical services in most cases.

## **Engaging Enrollees and Improving Patient Experience**

Patient-centered care and enrollee engagement are important tenets of health homes. The importance placed on patient education and requirements for a patient-driven care plan motivated providers to adopt new strategies, such as motivational interviewing, increased patient education, and an emphasis on patient-directed goal setting and shared decision-making. In general, providers and state officials felt that efforts to better inform and involve patients in their care have increased some enrollees' ability to better manage their conditions and advocate for themselves. Greater face-to-face and telephone contact between the care team or care coordinator and the enrollee seemed to promote engagement. In Idaho and Wisconsin, health home providers reported that patient portals had contributed to greater empowerment and engagement among enrollees.

## **Use of Health Information Technology and Data Analytics**

Health home providers are encouraged to use HIT to facilitate care coordination and the integration of services, as feasible and appropriate.<sup>20</sup> Many states established HIT requirements for providers participating in their health home programs, including electronic health record (EHR) use. For example, ten out of the 11 states in our evaluation reported an increase in the use of HIT either generally or specifically among health home providers since the start of their health home program. In some states, significant changes were reported, although given the rapid pace of HIT adoption, improvements could not be attributed solely to the health home program but it contributed to the improvements. The impact of health homes on HIT use ranged from small increases in EHR adoption rates among providers to more significant changes including significant increases in EHR adoption rates, utilization of advanced EHR functionalities, and transitions to more sophisticated EHR platforms.

In addition, increased capacity for HIE activity was reported in some states, as noted above in the discussion of care management and transitional care. Specific HIE-related changes include the introduction or greater use of provider and patient portals, new hospital notification systems, and new provider connections to state or regional HIEs. However, some health home providers were still relying on faxes and telephonic calls to exchange health information with other providers.

Capturing and exchanging structured data is just the beginning. Progress in expanding the use of data analytics was also reported in six out of the first 11 health home states. One commonly cited new activity was generating and using cost, quality, and utilization reports for health home care teams. Most providers were generating their own patient reports and also receiving patient utilization data from the state. Providers and state officials in some states agreed that the implementation of robust outcomes data collection structures and processes was an important--and lasting--impact of the health home program.

Population-based health care uses data systems, such as registries or registry functionality within EHRs, to track care and monitor health status over time to assess patients' needs and improvements.<sup>21</sup> To a large extent, health home providers in the first 11 states to implement health homes report that they are actively tracking and monitoring their whole patient panel, particularly high-risk patients.

## **Targeting High Cost, High Need Beneficiaries: Impact on Utilization Patterns, Costs, and Quality**

There is early evidence of the positive impact of health homes on utilization patterns, costs, and quality. Reductions in emergency department visits among health home enrollees are documented in five states, and five states showed reductions in inpatient hospital utilization. In Iowa, Inpatient Rehabilitation Facility admissions fell, but impact on Skilled Nursing Facility admissions has not yet been documented. Five states have

realized cost savings from health home programs, for at least some types of services. Finally, four states have evidence that the health home program improved quality.

## **Supporting Practice Transformation**

Implementation of the health home program generally represented a major change for many providers: (1) adjusting to new systems and processes for member eligibility determination, enrollment, reporting, using comprehensive whole-person care plan and data for population management and tracking gaps in care and payment; (2) operating under a team-based care approach; and (3) establishing new clinical roles and procedures.

Practice transformation is a process of growth and refinement in response to new payment and delivery models, changing Medicaid rules and policies, and the increase in the proportion of patients requiring complex care. Because providers have to continue to provide services while acquiring new skills or adopting new technologies, practice transformation is often a fatiguing process. Strong state support throughout this process, including educational resources, training opportunities, and financial support, can promote smoother, more effective transformation. The need for support is greatest for behavioral health integration, connecting patients with services for the social determinants of health, and other health home activities that are significant changes from the status quo.

## **Use of Health Homes to Address Opioid Misuse<sup>22</sup>**

The Health Home benefit has allowed states to address and target specific chronic conditions within their states, which can be offered statewide or in specific areas of the state without a need for a waiver. For example, three states have health home programs targeting patients who are misusing opioids: Maryland, Rhode Island, and Vermont. All three programs focus on increasing access to medication-assisted treatment for opioid use disorder, which is an evidence-based treatment that involves medication to control cravings as well as psychosocial treatment such as talk therapy. All three opioid-focused health home programs have been implemented statewide, using SAMHSA-certified opioid treatment programs (OTPs) as health homes.<sup>23</sup> OTPs maintain independent accreditation to be able to provide medication-assisted treatment, including methadone, which can only be dispensed at this type of facility. Office-based buprenorphine prescribers are also used to increase access to treatment services in Vermont.

Key considerations for states that are developing health home programs for opioid use disorder are: [24](#)

- *The requirements for Opioid Treatment Providers can be leveraged* as the foundation of health home programs. In particular, the efforts that certified OTPs must undertake to engage patients to ensure that they return for daily methadone doses help engage patients and can be extended for care coordination.
- *Multi-agency collaboration* is needed to plan and execute opioid-focused health home programs. The Medicaid agency in each state must partner with the state substance use disorder and mental health agencies. By combining forces, the unique strengths and core competencies of each state agency can be leveraged.
- *Health home providers need support with the transformation* into health homes. Extensive technical assistance might be needed. Training is offered through regional meetings, state-supported learning collaboratives, webinars, and other opportunities; sometimes continuing medical education credits are offered. Federal technical assistance resources such as the Medicaid Learning Network, the Innovation Accelerator Program, and the SAMHSA/HRSA Center for Integrated Health Solutions are also used by health home providers. In addition to training and technical assistance, many health home providers need help with start-up costs, which are not reimbursable through the program; reimbursement is tied to the provision of health home services.
- *Information sharing among health home providers* should be supported, as called for by the health home statute. This requires obtaining patient consent or forging agreements between providers that comply with 42 CFR Part 2--the federal privacy regulation for substance use disorder treatment information--and the Health Insurance Portability and Accountability Act (HIPAA) any applicable state privacy restrictions. HIT is particularly important for care coordination across the care continuum to further the aims of improving health and wellness for individuals with chronic conditions enrolled under the health home delivery model. For example, patients with opioid use disorder, data exchange to and from prescription drug monitoring programs can be essential for patient safety.

## **IV. QUANTITATIVE FINDINGS: IMPACT OF HEALTH HOME ON UTILIZATION PATTERNS, COSTS, AND QUALITY**

Each health home program is unique, owing to the flexibility states have in designing health home programs to target high-cost, high-need individuals and build on previous initiatives. The ability to tailor each program to the distinct opportunities and challenges faced by each state appears to contribute to the success of health homes. Evidence of impact in this section is drawn from qualitative results from the independent national evaluation of the health home state plan option, and from state-led quantitative evaluation activities.

Initial results show some improvements in utilization patterns such as lower emergency department and inpatient utilization among health home enrollees. In some states, cost savings have been detected. Improvement can also be seen in clinical quality measures. Quality improvements were seen for process of care measures, such as preventive service utilization and health outcomes. In addition, patient experience improved in one state (Ohio).

While the results are encouraging, it is important to note the limitations to these findings. First, it is very difficult in some states to separate health home-specific effects from the effects of other initiatives and delivery system changes occurring at the same time. Second, results available to date are from periods early in the programs when implementation was far from complete. Third, the estimates of cost savings might be low, since the savings examined in the available studies are limited to Medicaid, and do not account for potential savings in other programs such as Medicare that might result from the improved health status of Medicaid enrollees who receive health home services. It is also important to note that the majority of health home states have continued past their enhanced match period which indicates states have found value in the health home model.

### **Missouri**

Missouri was the first state to publish information on impacts of its health home programs. A preliminary evaluation of the Missouri primary care health home program showed a 5.9 percent reduction in hospital admissions per 1,000 enrollees and a 9.7 percent reduction in emergency department use per 1,000 enrollees. The state estimated cost savings for hospitalizations totaled over \$5.7 million, and the total savings to the Medicaid program were over \$2 million, or an average of \$148 per member per month (PMPM). The evaluation also found significant improvements in blood sugar, cholesterol, and blood pressure levels among individuals receiving health home services, relative to the baseline period<sup>25</sup>.

Preliminary evaluation results for the Missouri mental health program were similar to those of the state's primary care program. Analyses indicated a 12.8 percent reduction in hospital admissions per 1,000 enrollees and an 8.2 percent reduction in emergency department use per 1,000 enrollees. In total, the mental health-focused health home program resulted in an estimated \$2.9 million in hospital cost savings. Total savings averaged \$33 PMPM above the \$79 PMPM for health home services, for a total Medicaid savings of about \$2.4 million relative to the year prior to enrollment. Steady improvement also was seen in clinical outcome measures, including diabetes control, cholesterol control among enrollees with heart disease, and hypertension control.<sup>26</sup> A subsequent report on the mental health program affirmed the reductions in inpatient and emergency department utilization, as well as the cost savings and improvements in quality outcomes.<sup>27</sup> The Year 5 report from the Urban Institute's program evaluation also found reductions in Medicaid spending, particularly for dually eligible beneficiaries. The report found greater spending reductions for individuals with longer program exposure (more than nine months).<sup>28</sup>

## Iowa

An evaluation of the Iowa health home program conducted by the University of Iowa Public Policy Center found evidence of improved patterns of health care utilization for health home enrollees. Emergency department use rates fell for health home enrollees, although they remained substantially higher than the rates for non-health home enrollees, and other outpatient use rose.<sup>29</sup>

Cost savings were also found for the first 18 months of Iowa's program. Estimates indicated that on average, \$132 in Medicaid spending was saved in the first month of each beneficiary's enrollment in the health home program. Estimated cost savings increased thereafter by about \$11 per additional month of enrollment in the health home program. In the first 18 months of the program in Iowa, total savings of about \$9.0 million were achieved, or nearly 20 percent of total projected Medicaid spending on health home enrollees.<sup>30,31</sup>

## Ohio

An evaluation of the Ohio program compared health home performance measures with national Medicaid 2013 Healthcare Effectiveness Data and Information Set benchmarks, one year into the health home program. Health homes individually and as a group scored well relative to national benchmarks with respect to initiation and engagement for alcohol and other drug dependence treatment and adult access to preventive/ambulatory services. In addition, scores on a patient experience survey were higher for enrollees in the health home program than other Medicaid beneficiaries in the state.<sup>32</sup> In addition, Ohio health home providers that were interviewed for the national evaluation were particularly happy with improvements in chronic disease management for their clients with serious mental illness, and reported results such as lower BMI and blood pressure, improving A1C levels, and greater access to primary care.<sup>33</sup>

## Wisconsin

Wisconsin's evaluation results indicate positive outcomes for 2013, the first full calendar year of health home program operation, compared with 2012.<sup>34</sup> Costs, hospital use and chronic disease diagnoses were lower for those with longer exposure to the health home provider. The work highlights the methodological challenges of confident assessment of impacts for a program focusing on a single, relatively low prevalence condition (HIV/AIDS) with few enrollees--150 as of the end of the evaluation period, 188 total--and using a single health home provider, AIDS Resource Center of Wisconsin, which had been serving roughly half the target population for some time.<sup>35</sup>

## Preliminary Results from Other States

In addition to the published quantitative findings on impact from state-led evaluation activities, discussed above, the Year 4 report from the Urban Institute's program evaluation includes information on preliminary impact assessments, as reported by state officials in Alabama, Idaho, Maine, and Rhode Island.

Idaho contracted for an independent evaluation of its health home program, and preliminary data suggests the program has been successful in reducing rates of emergency department visits and hospitalizations and lowering costs. The state also uses a PCMH assessment<sup>36</sup> tool to evaluate clinics' "medical homeness." Providers bi-annually reported on their progress along eight dimensions of care, including: team-based relationships, patient-centered interactions, quality improvement strategy, care coordination, engaged leadership, empanelment, evidence-based care, and enhanced access. The state reported that over a 24-month period, health home providers reported increasingly higher scores in all categories of care.<sup>37</sup>

Maine's community care teams (CCTs), who provide care coordination services to the top 5 percent of high service utilizers enrolled in health homes, reported seeing the positive impacts their services have on their complex-need patients, including better self-management, treatment adherence, and lower utilization of emergency and hospital services. Some CCTs who have analyzed their own data reported finding reductions of up to 50 percent in emergency department visits and hospital stays.<sup>38</sup>

Finally, Alabama's health home program has achieved favorable outcomes with respect to utilization and costs, according to preliminary analyses, and enjoys support from the state Medicaid program and the legislature. An analysis of 2014 data indicated lower rates of hospital inpatient stays and emergency department visits, improving access to care, and decreasing PMPM costs for health home members.<sup>39</sup>

## V. CONCLUSIONS AND LESSONS LEARNED

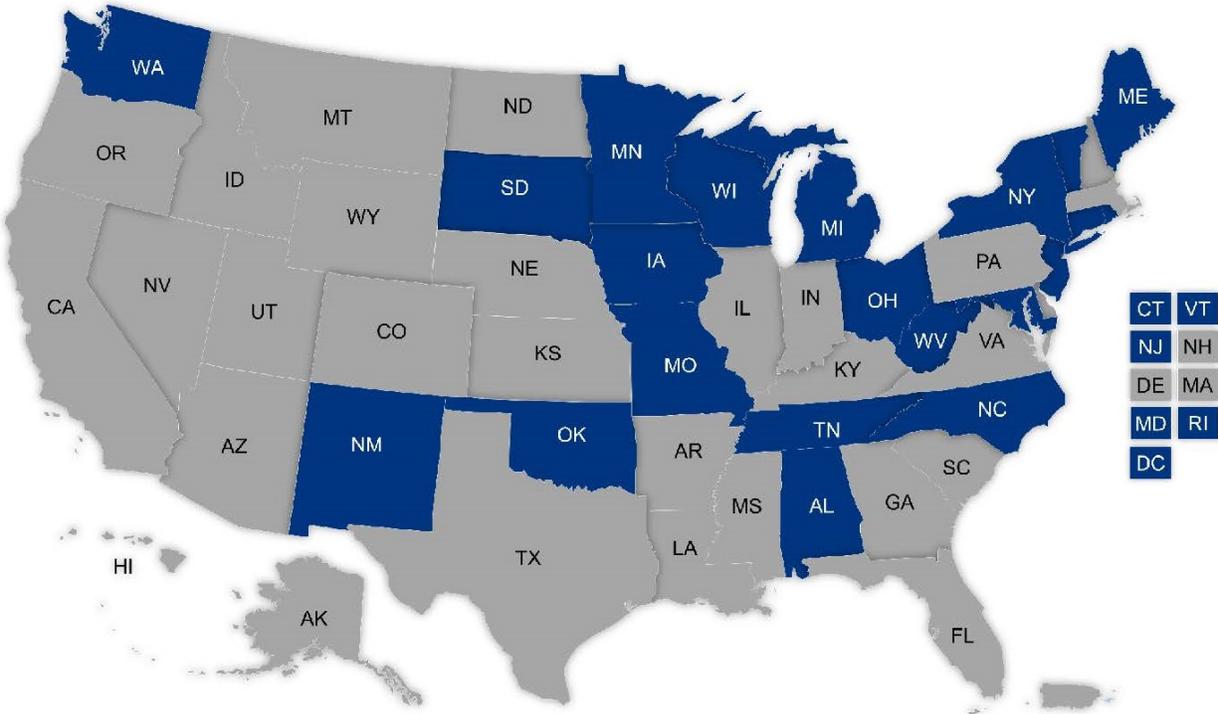
Key lessons learned from the implementation of health homes include:

- Using the health home state plan option allows states to target high-cost, high-need patients, and initial results suggest potential for improvements in care utilization patterns, costs, and quality based on reports from states and health home providers in the first 11 states.
- The use of multidisciplinary care teams was broadly recognized as the most important change to emerge from health homes.
- Initial and continuing assistance with practice transformation and team-based care is important, particularly to address the behavioral health needs and social determinants of health that impact patients.
- Well-developed HIT and other infrastructure is needed for care coordination and quality improvement.
- Health home programs show promise in effectively addressing needs of individuals with complex chronic physical and mental health conditions and substance use disorder, particularly those who also have high social needs.
- Most of the early health home states continue to offer the health home benefit beyond their initial enhanced match period, which suggests that states have found value and promise in the health home model for improved care for their chronically ill populations.

### Conclusions

State officials and providers in the first 11 states to implement the health home program report that the model has served the targeted, high-need chronic condition populations well and has shown improvements in care management, care transitions, behavioral health integration, and linkages to services to address the social determinants of health. It is also important to note that the majority of Health Home states have continued past their enhanced match period which indicates states have found value in the health home model. Quantitative results from state evaluations to date show some improvements in emergency department and inpatient admissions, costs, and quality. This new model of health care for Medicaid beneficiaries with complex physical, mental, and social conditions shows promise as a tool for improving care and achieving cost savings.

**Approved Medicaid Health Home State Plan Amendments  
(effective December 2017)**



**SOURCE:** CMS, <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/hh-map.pdf>.

**NOTES:**

As of December 2017, 21 states and the District of Columbia have a total of 32 approved Medicaid health home models.

States [shaded dark blue] with approved Health Home SPAs (number of approved health home models) are: Alabama, Connecticut, District of Columbia (2), Iowa (2), Maine (2), Maryland, Michigan (2), Minnesota, Missouri (2), New Jersey (2), New Mexico, New York, North Carolina, Ohio, Oklahoma (2), Rhode Island (3), South Dakota, Tennessee, Vermont, Washington, West Virginia (2), Wisconsin.

Idaho, Kansas, and Oregon have terminated their Medicaid health home SPAs and are no longer providing services under 1945 of the Social Security Act/Section 2703 option.

## END NOTES

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# APPENDICES

## APPENDIX 1. STATUTORY LANGUAGE

*Section 2703(b) of the Affordable Care Act requires a Report to Congress. The report shall examine the impact of the program on hospital admissions, emergency department visits, and admissions to skilled nursing facilities.*

(b) EVALUATION.--

(1) INDEPENDENT EVALUATION.--

(A) IN GENERAL.--The Secretary shall enter into a contract with an independent entity or organization to conduct an evaluation and assessment of the States that have elected the option to provide coordinated care through a health home for Medicaid beneficiaries with chronic conditions under section 1945 of the Social Security Act (as added by subsection (a)) for the purpose of determining the effect of such option on reducing hospital admissions, emergency room visits, and admissions to skilled nursing facilities.

(B) EVALUATION REPORT.--Not later than January 1, 2017, the Secretary shall report to Congress on the evaluation and assessment conducted under subparagraph (A).

## APPENDIX 2. HEALTH HOME CORE SERVICES

Note that this is not an exhaustive list. States have flexibility in defining these services. For more information see: <https://www.medicaid.gov/medicaid/ltss/health-homes/index.html>.

Core Health Home Service	Definition
<b>Comprehensive care management</b>	<p>Conducting outreach and engagement activities to gather information from the enrollee, the enrollee’s support member(s), and other primary and specialty care providers.</p> <p>Completing a comprehensive needs assessment.</p> <p>Developing a comprehensive person-centered care plan.</p>
<b>Care coordination</b>	<p>Implementing the person-centered care plan.</p> <p>Continuous monitoring of progress towards goals identified in the person-centered care plan through face-to-face and collateral contacts with enrollee, enrollee’s support member(s) and primary and specialty care providers.</p> <p>Supporting the enrollee’s adherence to prescribed treatment regimens and wellness activities.</p> <p>Participating in hospital discharge processes to support the enrollee’s transition to a nonhospital setting.</p> <p>Communicating and consulting with other providers and the enrollee and enrollee’s support member, as appropriate.</p> <p>Facilitating regularly scheduled inter-disciplinary team meetings to review care plans and assess progress.</p>
<b>Comprehensive transitional care</b>	<p>Establishing relationships with hospitals, residential settings, and rehabilitation settings, other treatment settings, and long-term services and supports providers to promote a smooth transition if the enrollee is moving between levels of care and back into the community.</p> <p>This includes prompt notification and ongoing communication of enrollee’s admission and/or discharge to and from an emergency room, inpatient residential, rehabilitative or other treatment settings.</p> <p>If applicable, this relationship should also include active participation in discharge planning with the hospital or other treatment settings to ensure consistency in meeting the goals of the enrollee’s person-centered care plan.</p> <p>Communicating and providing education to the enrollee, the enrollee’s support member and the providers that are located at the setting from which the person is transitioning, and at the setting to which the individual is transitioning.</p>

Core Health Home Service	Definition
<b>Comprehensive transitional care (continued)</b>	<p>Developing a systemic protocol to assure timely access to follow-up care post discharge that includes at a minimum all of the following:</p> <ul style="list-style-type: none"> <li>– Receipt of a summary of care record from the discharging entity.</li> <li>– Medication reconciliation.</li> <li>– Re-evaluation of the care plan to include and provide access to needed community support services.</li> <li>– A plan to ensure timely scheduled appointments.</li> </ul>
<b>Referral to community and social support services</b>	<p>Providing referral and information assistance to individuals in obtaining community-based resources and social support services.</p> <p>Identifying resources to reduce barriers to help individuals in achieving their highest level of function and independence.</p> <p>Monitoring and follow-up with referral sources, enrollee, and enrollee's support member, to ensure appointments and other activities, including employment and other social community integration activities, were established and enrollees were engaged in services.</p>
<b>Individual and family support services</b>	<p>Providing education and guidance in support of self-advocacy.</p> <p>Providing caregiver counseling or training to include, skills to provide specific treatment regimens to help the individual improve function, obtain information about the individual's disability or conditions, and navigation of the service system.</p> <p>Identifying resources to assist individuals and family support members in acquiring, retaining, and improving self-help, socialization and adaptive skills.</p> <p>Providing information and assistance in accessing services such as: self-help services, peer support services; and respite services.</p>
<b>Health promotion</b>	<p>Education and engagement of an individual in making decisions that promote his/her maximum independent living skills and lifestyle choices that achieve the following goals: good health, pro-active management of chronic conditions, early identification of risk factors, and appropriate screening for emerging health problems. Health promotion services include, but are not limited to, the following activities:</p> <ul style="list-style-type: none"> <li>– Promoting enrollee's education of their chronic condition.</li> <li>– Teaching self-management skills.</li> <li>– Conducting medication reviews and regimen compliance.</li> <li>– Promoting wellness and prevention programs by assisting health home enrollees with resources that address exercise, nutrition, stress management, substance use reduction/cessation, smoking cessation, self-help recovery resources, and other wellness services based on enrollee needs and preferences.</li> </ul>

**SOURCE:** Statute: Sec. 1945 State Option to Provide Care through a Health Homes (1945 of SSA Frequently Asked Questions, Series II. December 2015.)

## APPENDIX 3. EVALUATION REPORTS

### **BASELINE**

Spillman BC, Ormond BA, Richardson E. 2012. *Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Final Annual Report - Base Year*. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

<https://aspe.hhs.gov/basic-report/evaluation-medicaid-health-home-option-beneficiaries-chronic-conditions-final-annual-report-base-year>

### **YEAR 2**

Spillman BC, Richardson E, Spencer A, Allen E. 2014. *Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Annual Report - Year Two*. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

<https://aspe.hhs.gov/basic-report/evaluation-medicaid-health-home-option-beneficiaries-chronic-conditions-annual-report-year-two>

### **YEAR 3**

Spillman BC, Allen EH, Spencer A. 2015. *Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Annual Report - Year Three*. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

<https://aspe.hhs.gov/basic-report/evaluation-medicaid-health-home-option-beneficiaries-chronic-conditions-annual-report-year-three>

### **YEAR 4**

Spillman BC, Allen EH, Lallemand N, Hayes E. 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*. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

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### **YEAR 5**

Spillman BC, Allen EH. 2017. *Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Evaluation of Outcomes of Selected Health Home Programs, Annual Report - Year Five*. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

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