

August 2014 | Issue Brief

## Medicaid Health Homes: A Profile of Newer Programs

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### EXECUTIVE SUMMARY

Section 2703 of the Affordable Care Act (ACA) established a new state option in the Medicaid program to implement “health homes” for individuals with chronic conditions, giving states a new tool to develop models of care designed to improve care coordination and reduce costs for high-need populations. The ACA also provided a 90% federal match rate for health home services during the first two years an approved health home program is in effect. As of this writing, 15 states have at least one health home program in place. In August 2012, the Kaiser Commission on Medicaid and the Uninsured (KCMU) issued a [brief](#) examining the first six health home programs. This update profiles health home programs in the nine states that have taken up the option in the intervening two years – Alabama, Idaho, Maine, Maryland, Ohio, South Dakota, Washington, Wisconsin, and Vermont. States implement their health home programs in their own ways, reflecting different targeting priorities, underlying delivery and payment systems, and visions of delivery system reform, as well as other state-level factors. Both diversity and themes can be seen in key areas of the more recent health home programs, as follows:

- **Geographic Scope.** While the first health home states generally implemented their initiatives statewide, several states with newer programs limited their initiatives to selected counties initially. Local factors such as the existing provider infrastructure or geographic concentration of the target population may support a more limited approach.
- **Target Population.** The newer health home states have used health homes to target both Medicaid beneficiaries with a broad cross-section of chronic conditions and narrower Medicaid populations defined by a particular chronic condition. Consistent with the vision of health homes as a tool for better integrating physical and behavioral health services for people with mental health conditions, the one constant among almost all health home states is the inclusion of individuals with serious mental illness in their target populations.
- **Health Home Providers.** States whose programs serve a Medicaid population with a particular condition typically designate a narrower set of health home provider entities with significant experience serving that population. States targeting beneficiaries with a broader spectrum of chronic conditions generally rely on their existing network of primary care providers to provide health home services, with the health home structure and payment bolstering their capacity to serve people with complex chronic care needs. Two states also make separate payments to community-based or regional care coordination teams that support primary care practices operating as health homes.

- **Payment.** While payment approaches vary, states generally pay health homes a per member per month (PMPM) rate based on the intensity of beneficiary needs and the staff resources required to meet them. Several states tier their payment rates to reflect different levels of beneficiary acuity and different interventions, and one state is implementing a payment withhold designed to incentivize provider-patient engagement and the development of care plans for health home beneficiaries. As health home programs become more firmly established and the parameters of what is approvable by CMS are more clearly defined, more states are likely to move in the direction of value-based payment.
- **Fee for service vs. managed care.** Most of the nine states profiled in this brief are implementing their health home initiatives in a fee-for-service environment, in contrast to some of earlier states, which integrated health homes into their capitated managed care programs. This shift may, in part, reflect some of the complexities inherent in sorting out roles and responsibilities between managed care plans and health homes and preventing duplication of services and payment on behalf of health home enrollees.
- **HIT.** Health home providers' use of HIT to support care coordination and other health home services varies greatly by state, reflecting variation across states in the current capacity of providers, as well as in states' ability to support health homes with HIT and their progress in developing a state HIE.

## LOOKING AHEAD

In a recent 50-state survey of Medicaid directors conducted by the KCMU, 21 states indicated that they planned to adopt or expand their use of health homes, evidence of the popularity of this new state plan option with enhanced federal financing. As state Medicaid programs continue to take action to improve health care delivery, the 90% federal match remains available for new health home programs, expansions of existing programs, and additional programs in states that already have health home programs in place. Later in 2014, the HHS Secretary is due to submit an interim Report to Congress on the five-year evaluation of the health home program required by the ACA. In the meantime, these state profiles of the health home programs now in operation illustrate how the option can be adapted to states' diverse priorities and capacities, and inform their efforts to provide better care for Medicaid beneficiaries, advance health outcome goals, and spend Medicaid dollars more effectively.

## Key Dimensions of Newer Medicaid Health Home Programs

	<b>Target Population</b>	<b>Providers</b>	<b>Payment</b>	<b>Geographic Scope</b>	<b>Enrollment</b>
<b>Alabama</b>	2 chronic conditions; one & risk for another; or SMI. ACA conditions, cancer, HIV, sickle cell anemia, organ transplant, others.	Existing Enhanced PCCM practices & Primary Care Networks of Alabama	PMPM	4 regions covering 21 of 67 counties.	70,206
<b>Idaho</b>	Diabetes & asthma; or diabetes or asthma & risk for another condition; or SMI or SED.	PCCM PCPs, if required infrastructure & provider capabilities are in place.	PMPM	Statewide	9,179
<b>Maine</b>	2 chronic conditions or one & risk for another; & SMI or SED (not yet approved by CMS). ACA conditions, tobacco use, COPD, HBP, hyperlipidemia, DD or autism spectrum disorders, acquired brain injury, others.	Qualified PCCM practices in partnership with Community Care Teams or, for SMI/SED population, in partnership with behavioral health home organizations.	PMPM. Higher rate for more complex patients.	Statewide	42,958
<b>Maryland</b>	SMI or SED; or opioid substance use disorder and risk for another condition.	Licensed psychiatric rehabilitation programs, mobile treatment services, & opioid treatment programs	One-time payment for intake & assessment, & PMPM.	Statewide	2,516
<b>Ohio</b>	SMI or SED.	Community Behavioral Health Centers (CBHC)	PMPM	5 counties initially; statewide expansion planned	10,312
<b>South Dakota</b>	2 chronic conditions; one & risk for another; or SMI or SED. ACA conditions, COPD, HBP, others.	Primary care physicians, PAs, advanced practice NPs, FQHCs, Indian Health Service Units, Rural Health Centers, & CMHCs	Tiered PMPM	Statewide	5,655
<b>Vermont</b>	Opioid addiction.	Opioid Treatment Programs & physicians licensed to prescribe buprenorphine in Office-Based Opioid Treatment settings, with PCMHs & Community Health Teams	PMPM	Statewide (in 3 phases)	2,949
<b>Washington</b>	1 chronic condition & risk for another. Most ACA conditions, cancer, chronic respiratory conditions, dementia/Alzheimer's, GI conditions, HIV/AIDS, intellectual disabilities, others.	Regional health home lead entities contract with community-based care coordination organizations (CCOs) to provide health home services.	One-time payment for outreach/care plan development, 2 PMPM levels, & incentives.	Statewide except for Duals demonstration counties (King & Snohomish)	22,792
<b>Wisconsin</b>	HIV/AIDS & another chronic condition or risk for another.	AIDS Service Organizations	One-time payment for initial assessment/care plan development, & PMPM.	4 counties with highest prevalence of HIV/AIDS	188

## INTRODUCTION

The Medicaid, the nation’s largest public health insurance program, serves more than 66 million low-income beneficiaries, many of whom have complex and chronic health care needs. Of the more than 9 million people who qualify for Medicaid based on a disability, research indicates that almost one-half suffer from mental illness and 45% have three or more diagnosed chronic conditions.<sup>1</sup> Section 2703 of the Affordable Care Act (ACA) authorized a new state option in the Medicaid program, under a new section 1945 of the Social Security Act, to implement “health homes” for individuals with chronic conditions, giving states a new tool to develop more person-centered models of care that improve care coordination and potentially reduce costs for this high-need population. To promote health homes in Medicaid, the ACA also provided enhanced federal funding for states that take up the option. States receive a 90% federal match for health home services during the first two years an approved health home State Plan Amendment (SPA) is in effect.

As states seek to improve care delivery in Medicaid and grapple with ongoing budget pressures, the health home option has attracted significant state interest. As of this writing, 15 states have at least one approved SPA to provide health home services.<sup>2</sup> In August 2012, the Kaiser Commission on Medicaid and the Uninsured (KCMU) issued a [brief](#) examining the first six approved Medicaid health home programs, with a focus on the first four states to receive CMS approval – Missouri, Rhode Island, New York, and Oregon – but also including Iowa and North Carolina. This brief provides an update describing the health home programs established in nine states that have taken up the option since then.

## KEY HEALTH HOME PARAMETERS

Under the ACA, Medicaid beneficiaries, including individuals who are dually eligible for both Medicare and Medicaid, can potentially qualify for health home services if they have at least two chronic conditions, have one chronic condition and are at risk for another, or have one serious and persistent mental health condition. The ACA specifies a list of qualifying chronic conditions – mental health condition, substance use disorder, asthma, diabetes, heart disease, and obesity (Body Mass Index (BMI)>25) – but also authorizes the HHS Secretary to approve other health conditions that state may wish to target.

Health home services are defined to include:

- comprehensive care management;
- care coordination and health promotion;
- comprehensive transitional care from inpatient to other settings;
- patient and family support;
- referral to community and social support services; and
- use of health information technology (HIT) to link services, as feasible and appropriate.

States have broad latitude to determine the providers or entities that can serve as health homes. Under the ACA, health home services may be provided by a “designated provider,” which may be a physician, practice, clinic, or other entity or provider; a team of health professionals linked to a designated provider; or a community health team. All health home providers must have the necessary systems and infrastructure to provide health home services and meet quality standards established by the Secretary. They must have the ability to provide cost-effective and culturally appropriate person-centered services, and to develop a care plan for each individual that coordinates and integrates all the clinical services and non-clinical health supports that

he or she needs. They must also use HIT to link services and foster communication among team members to the extent possible, establish a continuous quality improvement program, and report data to support program evaluation. States have considerable flexibility in establishing their payment methodologies for health home services, but must detail their payment methodology in their SPA.

## RECENTLY APPROVED MEDICAID HEALTH HOME PROGRAMS

Since this time two years ago, nine states without previous health home programs have received CMS approval of their health home SPAs and implemented them – Alabama, Idaho, Maine, Maryland, Ohio, South Dakota, Washington, Wisconsin, and Vermont.<sup>3</sup> These states' programs provide new illustrations of ways that health home programs can be structured and tailored to support chronic care management for Medicaid beneficiaries. They include models that serve beneficiaries with a range of different chronic conditions, including conditions not on the ACA list, as well as models that more narrowly target to individuals with certain conditions. They also include models that use a state's primary care case management (PCCM) infrastructure as the platform for its health homes, as well as one model distinguished by its reliance on a diverse set of administering organizations that are responsible for the provision of health home services to people with wide-ranging chronic health care needs. Following is a summary of the Medicaid health home programs in the nine states that have adopted the ACA option most recently.

### ALABAMA

**Target Population.** Alabama's health home program, which took effect in July 2012, targets Medicaid beneficiaries who have two chronic conditions, or one and a risk of developing another, or a serious mental illness (SMI). Building off the ACA list of chronic conditions, Alabama also included cancer, HIV, cardiovascular disease, chronic obstructive pulmonary disease, sickle cell anemia, and receipt of an organ transplant as qualifying conditions. As both Missouri and North Carolina did earlier, Alabama gained CMS approval to provide health home services to beneficiaries with just one of these chronic conditions based on data indicating that such individuals are *per se* at high risk of a second chronic condition.

According to the SPA, Alabama will identify individuals with a chronic condition on a monthly basis through analysis of Medicaid claims and/or Alabama Department of Mental Health payment data for the previous 18 months. In addition, the Primary Medicaid Provider (described below) or local hospital may refer a patient for enrollment. The health home program is limited to four geographic regions of Alabama that encompass 21 of its 67 counties, including Mobile and Madison Counties, two of the three largest counties in the state. Although the term of the enhanced match for health home services is set to expire in July 2014, Alabama recently submitted a Section 1115 waiver proposal to CMS that would expand health homes statewide as a bridge to implementation of capitated Regional Care Organizations, Alabama's version of accountable care organizations. These organizations would be responsible for providing health home services for Medicaid enrollees with chronic conditions, as well as care coordination and case management for all Medicaid enrollees as needed.<sup>4</sup>

**Providers.** Alabama is using its Enhanced Primary Care Case Management (EPCCM) program as a platform for providing health home services. Since 1997, under the state's Patient 1<sup>st</sup> PCCM program, most Medicaid beneficiaries have been assigned to a Primary Medicaid Provider (PMP) who serves as their medical home and

is responsible for providing necessary medical care to them either directly or through referral to other providers. Alabama subsequently enhanced its PCCM program by establishing regional Primary Care Networks of Alabama (PCNAs) to support PMPs' care coordination and other medical home activities. PCNAs have a clinical team that includes a physician clinical director, a chronic care nurse, a nurse or social worker care coordinator, and a pharmacist. The clinical teams are also required to include an individual with behavioral health expertise to serve as a liaison between PMPs and community mental health and substance abuse providers. PMPs and PCNAs are required to have agreements with the state and each other to ensure that they meet state health home standards related to access to care, comprehensiveness and continuity of care, population data management and use of HIT, and capacity to provide culturally appropriate and person- and family-centered services.

**Payment.** Alabama pays both PMPs and PCNAs a per member per month (PMPM) amount for each beneficiary who is enrolled with a PMP and identified as eligible for health home services. To receive a PMPM payment, a PMP must document in the care management system that, at a minimum, he or she has monitored an eligible patient's care management for treatment gaps or provided another health home service. The PMPM payment to the PCNA is intended to cover the cost of the health home services provided by PCNA clinical team members, including the review of individual-level data provided by the state on a monthly basis, to identify potential service gaps and take appropriate action.

**HIT.** Under a previous federal grant, the Alabama Medicaid agency developed an electronic health record (EHR) and clinical support tool called QTool. Also, the state contracts with the University of South Alabama to support Patient 1<sup>st</sup> through a web-based secure data management system called Real Time Medical Electronic Data Exchange (RMEDE), which provides timely reports on selected clinical measures, based on claims data. The Medicaid agency is responsible for developing the state Health Information Exchange (HIE) and will initially encourage the use of the HIE by implementing the federal voluntary EHR incentives, and will monitor utilization to determine whether additional steps may be necessary to encourage its adoption by PMPs.

## IDAHO

**Target Population.** Idaho received CMS approval to implement its statewide health home initiative in January 2013. Idaho's program is an outgrowth of other state efforts to foster medical homes, including the Governor's Idaho Medical Home Collaborative established in 2010. Idaho's health home program targets Medicaid beneficiaries who have a serious and persistent mental illness (SPMI) or serious emotional disturbance (SED); diabetes and asthma; or either diabetes or asthma and are at risk for another condition. Those with diabetes or asthma are considered to be at risk for another condition if they have BMI > 25, abnormal lipid levels, hypertension, or diseases of the respiratory system, or use tobacco. Medicaid beneficiaries who meet these criteria are automatically enrolled in a health home. They can also self-refer to a health home or be referred by any service provider.

**Providers.** Like Alabama, Idaho is using its PCCM program, Healthy Connections, as the foundation of its health home program. Specifically, designated health home providers must be Healthy Connection primary care providers, including physicians, clinical group practices, rural clinics, community health centers, community mental health centers, and home health agencies. However, to be designated providers, these primary care providers must have the infrastructure to provide health home services and submit an assessment

ensuring that they have adequate provider capabilities. They must also meet requirements related to access, quality improvement, care coordination, and outreach and follow-up, and have achieved or be pursuing NCQA Level 1 recognition as a patient-centered medical home (PCMH).

**Payment.** Idaho pays health home providers a PMPM amount to cover the costs associated with delivering the full range of health home services. In setting the PMPM rate, the state took into account the composition of the team of health care professionals required to provide health home services, including a primary care provider, registered nurse, behavioral health professional, and clerical staff and medical assistant, as well as the provider costs associated with achieving Level 1 NCQA accreditation.

**HIT.** Idaho has developed a set of initial and final HIT standards for health home providers. Initially, health homes must have a structured information system in place to populate a disease management database and track and manage patients with chronic conditions. They must develop a plan to achieve the final HIT standards within 24 months, which include: having a systematic process for follow-up on tests, treatments, services, and referrals in the patient’s care plan; having HIT capacity such that information on patient health and care is accessible and adequate to permit identification of gaps in care and management of population health; and employing HIT and accessing members’ data through the Idaho Health Data Exchange, the state’s HIE, to conduct other processes necessary to provide health home services, to the extent feasible.

## MAINE

**Target Population.** MaineCare, Maine’s Medicaid program, implemented “Stage A” of its statewide health home initiative in January 2013, targeting individuals with a wide range of chronic conditions. The state added the following chronic conditions to those listed in the ACA: tobacco use, chronic obstructive pulmonary disease, hypertension, hyperlipidemia, developmental disabilities or autism spectrum disorders, acquired brain injury, seizure disorders, and cardiac and circulatory congenital abnormalities. For the most part, individuals with one of the qualifying conditions are considered *per se* at risk for another chronic condition based on research evidence cited in the SPA. “Stage B” of Maine’s health home program targets adults with SMI and children with SED. Stage B implementation began in April 2014, although CMS has not yet approved the SPA. MaineCare identifies beneficiaries who are eligible for health home services based on claims data. In addition, practices can notify MaineCare of beneficiaries who, though not identified through the analysis of claims data, appear eligible for health home services based on the practice’s clinical EHR documentation.

**Providers.** For beneficiaries with chronic conditions, health home practices (HHP) and Community Care Teams (CCT) together constitute Maine’s health home teams. HHPs build on the primary care practices in Maine’s existing PCCM program; to qualify as an HHP, a primary care practice must meet a set of additional requirements, which include having NCQA recognition as a PCMH (or a commitment to achieving this status), a fully implemented EHR, and a Memorandum of Understanding with a CCT; and to enroll eligible beneficiaries, they must confirm to the state that they will be participating in the health home initiative. Within one year, HHPs must also certify that they meet ten “Core Expectations” established by the state, which include, among others, a team-based approach to care, population risk stratification and management, inclusion of patients and families in implementation of the PCMH model, connections to community resources, and integration of HIT to support plans of care, evidence-based practices, and monitoring of outcomes.

CCTs are locally based multi-disciplinary groups of health professionals that work in partnership with HHPs to identify high-cost, high-risk patients, and provide wrap-around services and supports to help HHPs manage their care, including planning and coordinating referrals for community and social supports, as needed. Generally, about 5% of an HHP's health home enrollees are offered the more intensive care coordination services provided by CCTs. Patient eligibility criteria for CCT services include a high number of inpatient admissions or (ED) visits, use of 15 or more medications for chronic care and/or multiple high-risk medications (e.g., insulin, Coumidin), high social service needs (e.g., homelessness), or identification by MaineCare as a high-risk/high-cost Medicaid enrollee. A CCT comprises a CCT manager who provides leadership and oversight, and a designated care management director and medical director. Care managers include nurses and social workers and/or behavioral health social workers, and lead care coordinators are matched to health home enrollees based on patients' individual needs. Additional CCT staff may include nutritionists, case managers, pharmacists, community health workers, and others. Currently, ten CCTs have received state approval to provide health home services.

For beneficiaries with SMI or SED, Behavioral Health Home Organizations (BHHOs) that partner with primary care practices make up health home teams. BHHOs are licensed community mental health providers that also meet other criteria established by the state. As of March 2014, Maine had approved 27 Behavioral Health Homes.

**Payment.** HHPs receive higher PMPM payments for their health home-eligible patients. (They receive lower PMPM payments for PCCM patients who are not eligible for health home services.) To receive the health home PMPM, HHPs must, at a minimum, monitor their health home patients for treatment gaps or conduct outreach and engagement activities with health home enrollees assigned to a practice. CCTs also receive PMPM payments for the health home patients they serve and must document that they have engaged or reached out to these individuals or provided a health home service consistent with the individual's care plan. In determining the PMPM amounts for HHPs and CCTs, the state estimated the staff costs associated with providing health home services, including both clinical and non-clinical staff. Given the more complex needs of the CCT patients, the health home PMPM for CCTs is considerably higher than the one for the HHPs. BHHOs and HHPs providing health home services for beneficiaries with SMI or SED also receive PMPM payments, tiered similarly to the PMPM payments for health homes for beneficiaries with chronic physical conditions.

**HIT.** As noted, HHPs are required to have fully implemented an EHR. In some cases, the HHP and CCT share a common EHR; otherwise, the HHP and CCT are expected to communicate using standardized direct secure messaging. The state has developed a Health Home Enrollment System (HHES) that both HHPs and CCTs can access to view their enrolled patients, refer new patients to health homes, attest that their patients have received the minimum required contact or services, and view reports indicating gaps in care. HHP and CCT teams can also access patient information through HealthInfoNet, Maine's HIE.

## **SOUTH DAKOTA**

**Target Population.** South Dakota's health home SPA took effect in July 2013. The chronic conditions that qualify for health home services include all those identified in the ACA, as well as chronic obstructive pulmonary disease, hypertension, and musculoskeletal and neck and back disorders. Beneficiaries with a diagnosed SMI are also eligible for health home services. Tobacco use, pre-diabetic condition, cancer,



hypercholesterolemia, depression, and use of six or more medications are all considered risk factors for another chronic condition

The state uses the Chronic Illness and Disability Payment System (CDPS) index to sort beneficiaries who have been determined eligible for health home services into four tiers based on their risk scores. Individuals with the lowest risk scores are offered the opportunity to receive health home services but are not assigned to a health home provider. Those with higher risk scores are assigned to a health home provider with whom they have an existing relationship or, absent such a relationship, are offered an opportunity to select a health home provider. In addition, health home providers can contact the state to identify beneficiaries they think should be considered eligible for health home services. Individuals who do not choose a health home provider within 30 days are auto-assigned to one.

**Providers.** In South Dakota, designated health home providers include state-licensed and Medicaid-enrolled providers who practice as primary care physicians, physician assistants, advanced practice nurse practitioners working in a clinical or group practice, federally qualified health centers (FQHC), Indian Health Service Units, rural health centers (RHC), and mental health professionals working in a community mental health center (CMHC). Providers must attest that they meet the health home provider standards set forth in the SPA and complete a health home orientation before Medicaid beneficiaries can be attributed to them. A designated health home provider leads a team that may include a behavioral health provider, a health coach/care coordinator, a pharmacist, support staff, and others as appropriate.

**Payment.** South Dakota pays health home providers on a PMPM basis, with PMPM amounts based on their beneficiaries' tiers as determined by the CDPS score. The state developed four payment tiers based on the estimated "Uncoordinated Care Costs" for individuals in each tier. These costs include claims for non-emergent use of EDs, all-cause readmissions, and hospital admissions for ambulatory care-sensitive conditions. To receive a PMPM payment, a health home provider must provide at least one health home service per quarter to an attributed member, and the service must be documented in the health home's EHR and reported to the state.

**HIT.** Health home providers are required to have an EHR. As an interim step, while the state develops its HIE, the Medicaid program is sharing monthly claims data with health home providers. These data enable them to: analyze paid claims over a two-year period for their attributed members; view the dates and providers of their inpatient, ED, and other services; and review laboratory data.

## WASHINGTON STATE

Washington's health home program is somewhat distinctive in that it encompasses Medicaid beneficiaries with a broad range of chronic conditions and relies on diverse organizations that serve as administering entities and subcontract with community-based care coordination organizations to provide health home services.

**Target Population.** Washington began the roll-out of its health home initiative in July 2013, targeting individuals with one chronic condition and at risk for another. The qualifying chronic conditions include those listed in the ACA statute (except BMI >25) as well as: cancer; cerebrovascular disease; chronic respiratory conditions; coronary artery disease; dementia/ Alzheimer's disease; gastrointestinal conditions; hematological

conditions; HIV/AIDS; intellectual disability or disease; musculoskeletal conditions; neurological disease; and renal failure. A person is considered “at risk” for a second chronic condition if he or she has a CDPS risk score of at least 1.5, indicating that his or her expected Medicaid spending is 50% higher than expected spending for beneficiaries with disabilities who qualify for Washington’s Medicaid program based on their eligibility for SSI.

The first phase of Washington’s health home initiative was limited to three areas comprising 14 counties located primarily in the southern part of the state. In October 2013, the state expanded the program to three additional areas that include the remaining counties except King County (Seattle) and Snohomish County. (Washington has received CMS approval to move forward with a capitated financial alignment demonstration for dual eligible beneficiaries in those two counties and is not implementing health homes there.)

Fee-for-service (FFS) beneficiaries who are eligible for health home services are identified by the state based on their chronic condition and risk score, and enrolled with a designated health home provider based on zip code and provider capacity. Providers can also refer potentially eligible beneficiaries by contacting the state. Designated FFS health home providers assign their health home enrollees to one of their network-affiliated Care Coordination Organizations (CCO), described below, and the CCO, in turn, assigns the beneficiary to a Care Coordinator. For Medicaid beneficiaries enrolled in managed care, managed care organizations (MCOs) that are qualified as health homes, or that contract with a health home, identify eligible beneficiaries based on their chronic condition and risk score and automatically enroll them into their health homes. Again, the health home assigns the beneficiaries to one of its network-affiliated CCOs, which then assigns each one a Care Coordinator.

**Providers.** Washington used a Request for Applications (RFA) process to qualify entities to serve as health home providers, referred to as “health home lead entities,” in each of the six geographic areas in the state. Health home lead entities are required to maintain a network of community-based care coordination organizations (CCOs) with the capacity to serve at least 1,000 to 2,000 beneficiaries, and to subcontract with these organizations to provide health home services directly to beneficiaries. CCO responsibilities include assigning care coordinators to eligible beneficiaries, ensuring beneficiary engagement in the development of a Health Action Plan, monitoring care and outcomes, initiating changes in care, and addressing the full needs of the beneficiary consistent with his or her plan of care. In addition to maintaining and overseeing a network of CCOs, each health home lead entity must be able to carry out key administrative functions, such as staffing a toll-free hotline, reporting to the state on financial, health status, and performance and outcome metrics, and paying CCOs based on the services they provide. Washington has selected four to five health home lead entities in each of the six coverage areas. They include physical health managed care organizations, behavioral health managed care organizations, two regional Area Agencies on Aging serving the northwest and southeast parts of the state, and a health care consortium composed of regional health care organizations in north central Washington.

**Payment.** Washington has three different payment tiers for different sets of health home services, as follows: Outreach, Engagement, and Health Action Plan Development; Low-Level Health Home Care Coordination; and Intensive Health Home Care Coordination. The Outreach payment is a one-time payment to the health home lead entity, triggered by the submission to the state of a Health Action Plan for an eligible beneficiary and documentation that a health home service has been provided to that person. The other two payments reflect

different levels of service intensity. Lower payments are made for Low-Level Health Home Care Coordination, which relies more heavily on telephonic than in-person encounters between providers and beneficiaries. Higher payments are made for Intensive Health Home Care Coordination, which involves a higher ratio of FTEs to health home beneficiaries.

In the Medicaid FFS program, Washington makes PMPM payments for both these levels of care coordination to health home entities, which must provide at least one health home service to an eligible individual to claim reimbursement. Both payment amounts include a withhold equal to roughly 2% of the overall PMPM amount. Although the withhold will not be applied in Year 1 of the program, in future years a health home lead entity must meet target health home participation rates, defined as the share of beneficiaries assigned to a health home who have an Outreach encounter, to receive the full PMPM payment. With respect to health home-eligible beneficiaries who are enrolled in Washington's Medicaid managed care program, health home services are included in the contracts between the state and managed care plans, and the costs of these services are built into the overall capitation rates paid to plans. Finally, in most of Washington, health home services will be provided to dual eligible beneficiaries as part of the managed FFS Fiscal Alignment Demonstration that the state has developed in partnership with CMS. Washington is eligible to share in savings realized from the demonstration if it can meet quality metrics contained in its agreement (i.e., Memorandum of Understanding) with CMS.

**HIT.** Washington provides health homes with access to its Predictive Risk Intelligence System (PRISM), a secure, web-based clinical support tool. PRISM uses predictive modeling to support identification of Medicaid beneficiaries most in need of care coordination, integrates information from medical, social, behavioral health, and long-term care data systems, and provides beneficiary health and demographic information from Medicaid administrative data sources. This resource is intended to complement existing provider-specific EHRs; information-sharing is facilitated by the Washington State's HIE, *OneHealthPort*.

## MORE TARGETED HEALTH HOME INITIATIVES

Several states have developed health home initiatives that more narrowly target beneficiaries with a single specified chronic condition and rely on a narrower group of providers with expertise in serving the targeted population.

The ACA's explicit inclusion of behavioral health conditions in the list of health home qualifying conditions and the health home program's emphasis on person-centered care management that integrates physical and behavioral health care, reflect the premise that health homes are a promising model for individuals with SMI and/or substance use disorders. Indeed, three of the first states to receive approval of their health home programs (Missouri, Rhode Island, and Iowa) targeted beneficiaries with a behavioral health condition. Maryland, Ohio, and Vermont have now launched programs targeting this population as well. Wisconsin's health home program is also narrowly targeted, to Medicaid beneficiaries with HIV/AIDS.

## MARYLAND

**Target Population.** Maryland's statewide health home program targets Medicaid beneficiaries who have a SMI or SED, and those who have an opioid substance use disorder (SUD) and are at risk of another chronic condition. Individuals who are diagnosed with an opioid SUD are eligible for health home services if they are

engaged in opioid maintenance therapy and are determined to be at risk for additional chronic conditions based on current use of tobacco, alcohol or other non-opioid substances, or a history of dependence on such substances. Maryland uses claims data to identify Medicaid beneficiaries who are potentially eligible for health home services. Managed care plans and the state's behavioral health Administrative Services Organization, or ASO (see below), may also assist the state in identifying and referring potentially eligible individuals from among their own members; behavioral health care is carved out of Medicaid managed care contracts in Maryland. Once they have obtained consent from a beneficiary, the state, managed care plan, or ASO refers the individual to a health home provider near where he or she lives.

**Providers.** Only providers licensed by the Maryland Department of Health and Mental Hygiene as a Psychiatric Rehabilitation Program (PRP), a Mobile Treatment Services (MTS) provider, or an Opioid Treatment Program (OTP) can serve as health homes. In addition, these entities must be accredited by, or in the process of gaining accreditation from, an approved health home accreditation body – currently, either the Commission on Accreditation of Rehabilitation Facilities' (CARF) Health Homes Standards or The Joint Commission's Behavioral Health Homes Certification. To provide health home services to children and youth, entities must also have a minimum of three years of experience serving this population. The SPA details the staffing infrastructure that a PRP, MTS, or OTP must have in place dedicated to health home services and establishes minimum staffing ratios. To be approved as health homes, providers must complete an application documenting that they can perform all core health home services and meet all state-defined provider standards. PRPs, MTSs, and OTPs that apply and meet these standards may enroll Medicaid beneficiaries who are participating in their programs into health home services if the beneficiary consents. The state intends to use claims data and work with its behavioral health Administrative Services Organization (ASO) to identify beneficiaries who could benefit from health home services.

**Payment.** Maryland pays health home providers a PMPM amount based on the estimated employment costs of the required health home staff. To receive payment, a health home must have provided at least two health home services to an eligible individual in the previous month and documented these services in Maryland's on-line provider portal. Health homes also receive a one-time payment for completing an initial intake and assessment for each health home enrollee.

**HIT.** Health homes have access to Maryland's e-Medicaid online provider portal through which they can report and review health home enrollees' intake and assessment information, the staff assigned to them, their clinical baselines and data relating to their chronic conditions, and health home services provided to them. Health home providers also have access to reports generated by e-Medicaid based on these data at both the participant and provider level. Finally, health home providers must be enrolled in the state's HIE, Chesapeake Regional Information System for our Patients (CRISP), to receive real-time hospital encounter alerts and access pharmacy data.

## OHIO

**Target Population.** Ohio's health home program targets Medicaid beneficiaries whose condition(s) meet the state's definition of SPMI, including adults with SMI and children with SED. Ohio intends to implement its program statewide ultimately, but initially rolled it out in five counties, including three contiguous counties in the southern part of the state – Adams, Scioto, and Lawrence Counties – as well as Butler County, and Lucas

County (Toledo), beginning in October 2012. Provider readiness and capacity to serve the SPMI population and geographic diversity (i.e., rural, urban, and suburban representation) were among the factors the state cited in selecting these counties to go first.

The designated health home providers are responsible for identifying individuals with SPMI who are currently affiliated with their site. SPMI individuals who are not affiliated with a site that is a health home provider, or who have no routine source of health care, may be identified through referral from another provider or an administrative data review and then connected to a health home to begin the comprehensive care management process.

**Providers.** Community behavioral health centers (CBHCs) are the designated health home providers in Ohio. To be designated as health homes, CBHCs must be state-certified to provide mental health services, and must also have state-defined core elements that demonstrate their capacity to integrate the full range of physical, behavioral health, and support services. For instance, CBHCs must directly provide certain medical screening and treatment services on site or have written agreements with primary care providers (PCP) to provide these services. CBHCs must also attain accreditation from one of several organizations recognized by the state for certifying integration of physical and behavioral health services.

Although CBHCs have some flexibility in to define their health home teams, the SPA envisions a multi-disciplinary team with certain core members, including a health home leader, an embedded PCP, a care manager, and a health home specialist who assists the care manager with care coordination, referrals, follow-up, family/consumer support, and health promotion services. CBHCs designated as health home providers are also required to establish partnerships with managed care plans in their area because, although most Ohio Medicaid beneficiaries are enrolled in managed care, behavioral health is carved out of the managed care contracts. CBHCs must, among other requirements, identify a single point of contact within the CBHC to work with each managed care plan, notify a plan when one of its members is referred for health home services by the CBHC itself or another provider, and include a managed care plan representative on the care management team for each health home enrollee.

**Payment.** Ohio pays CBHCs a per member per month (PMPM) rate for health home services, determined on the basis of cost information submitted by the CBHCs. To receive payment, CBHCs must submit a claim for health home services. A claim can be submitted if any of the health home service components are provided to an eligible individual. Ohio intends to incorporate a performance component in its health home PMPM rates once it has sufficient experience and baseline information to do so.

**HIT.** The state is phasing in HIT requirements. Initially, all CBHC health homes must have the ability to receive utilization data electronically. Within one year of designation as a health home provider, a CBHC must acquire a certified EHR and, by the end of the second year, it must be able to demonstrate that it is using the EHR to support all health home services, including population management. CBHC health homes are also required to participate in the statewide HIE once it is up and running in their area.

## VERMONT

**Target Population.** Vermont’s health home program, approved by CMS in March 2014, targets Medicaid beneficiaries who are receiving Medication Assisted Therapy (MAT) for opioid addiction either at regional specialty addictions treatment centers regulated as opioid treatment programs (OTP), or physician offices licensed to prescribe buprenorphine. Based on data showing that individuals with opioid addiction are at high risk of having other substance use disorders and co-occurring mental health conditions, opioid addiction alone is considered sufficient to qualify an individual as being at risk for a second chronic condition and thus eligible for health home services. Most beneficiaries who are potentially eligible for health home services are identified through providers, clinical assessment, the prior authorization process for buprenorphine prescriptions, and enrollment in methadone treatment. Vermont implemented health homes statewide in three regional phases, beginning in January 2013.

**Providers.** Vermont’s health homes build on the state’s existing provider infrastructure: specialty methadone OTPs; physicians who prescribe buprenorphine in Office-Based Opioid Treatment (OBOT) settings; and local Blueprint for Health PCMHs and Community Health Teams (CHTs) that coordinate care across the primary, acute, behavioral health and long-term care systems and typically comprise nurse care managers, health coaches, social workers, and behavioral health clinicians. Under Vermont’s “Hub and Spoke” approach, each patient in MAT will have one MAT prescriber – either a Hub OTP that provides methadone or buprenorphine to clinically complex patients, or a Spoke physician licensed to provide OBOT using buprenorphine; an established PCMH; and access to nurses and clinicians embedded at the Hub or in a CHT who are responsible for providing health home services. Vermont’s CHTs, which are funded by Vermont’s public and commercial insurers, are programmatically and operationally overseen by a single Administrative Agent (AA) within each of the 14 geographically distinct health service areas in the state.

**Payment.** Hubs and the AAs overseeing the CHTs receive reimbursement for the added staffing costs associated with the provision of health home services. Hubs are paid an enhanced monthly rate for each eligible health home enrollee to finance the provision of health home services. To submit a claim and receive payment on behalf of a health home patient, a Hub provider must be able to document provision of two services to the individual during the month – a face-to-face treatment encounter and one health home service. The state claims the 90% federal match only for the 30% share of the Hub monthly rate that is attributable to health home services. Payment for Spoke health home services are made to the AAs that oversee the Blueprint CHTs, to fund one RN care manager and one clinician case manager for every 100 buprenorphine patients within the AA’s health service area. The payments, which are made quarterly, are determined based on the average monthly number of unique patients for which Medicaid paid a buprenorphine pharmacy claim during the most recent-three month period.

**HIT.** The Blueprint for Health utilizes a central clinical registry, Covisint DocSite, a web-based registry that receives feeds of guideline-based data elements from practices and hospitals. Data sources include EMRs, hospital data systems, practice management systems, and data entered directly into the registry through Vermont’s HIE infrastructure. In addition to patient care and population management, the registry supports performance reporting with measures derived from national guidelines on health care quality and outcomes. Both HUB and Spoke health home providers document their health home services in the EMRs currently in use within each facility and practice. Vermont’s goal is that these providers will eventually be linked with the

clinical registry and the HIE. Among their responsibilities, the AAs are expected to convene working teams to encourage the exchange of health information from practice-based EMRs through the HIE to the Blueprint central clinical registry.

## WISCONSIN

**Target Population.** Approved in January 2013, Wisconsin’s health home initiative targets beneficiaries with HIV/AIDS who have or are at risk for at least one other chronic condition. An individual is considered to be at risk based on any of the following clinical indicators: a low CD4 cell count; BMI<18.5; elevated blood pressure; elevated fasting blood sugar levels; or hyperlipidemia. The SPA limits health home services to four of the six counties with the highest rates of HIV/AIDS prevalence in the state – Milwaukee, Brown (Green Bay), Dane (Madison), and Kenosha Counties.<sup>5</sup> Medicaid beneficiaries in these counties who meet the health home eligibility criteria are automatically enrolled in the program.

**Providers.** In Wisconsin, AIDS Service Organizations (ASOs) that provide life care services to individuals with HIV/AIDS in the targeted counties are the health home providers. The Division of Public Health in the state’s Department of Health Services is responsible for designating ASOs and defining the geographic regions in which they operate. ASOs must collaborate with local health departments, county human service departments, and community-based organizations in providing HIV/AIDS-related services.

**Payment.** ASOs receive two health home payments: 1) a fee for the initial comprehensive assessment of each health home enrollee’s needs and the development of an integrated care plan; and 2) a PMPM case rate for providing health home services. The initial fee is paid only for individuals eligible for health home services who consent to participate in the program. The PMPM payment is made only on behalf of beneficiaries who have completed the assessment and care plan development process and have an assigned care manager. In developing the health home payment rates, Wisconsin considered a number of factors, including the costs of developing a core health home team and the acuity and chronicity of eligible beneficiaries’ conditions. The SPA includes assurances that health home payments will not result in duplication of payments or services associated with other Medicaid programs, including managed care.

**HIT.** ASO health home providers must document all contact with beneficiaries in an EHR. The health home’s care coordinator is responsible for ensuring that patients’ treatment plans are updated in the EHR as needed, and the EHR must be accessible to all members of a patient’s care team.

## OBSERVATIONS ON NEWER HEALTH HOME PROGRAMS

Each state implements its Medicaid health home program in its own way, reflecting different perspectives on which populations drive state Medicaid costs, specifics of their underlying health care delivery and payment systems and stakeholder environments, the capacity of different providers to provide health home services, different visions of delivery system reform, and other state-level factors. (See the Appendix for a table summarizing key dimensions of the health home programs profiled in this report.) Looking across the more recent programs, both diversity and themes are evident:

- **Geographic Scope.** While the first states to establish health home programs generally implemented their initiatives statewide, several of the newer health home states are limiting their initiatives to selected

counties, at least initially. Important considerations were their current provider infrastructure (e.g., PCNAs present only in certain regions of Alabama), the geographic distribution of the target population (e.g., the counties with the highest concentration of HIV/AIDS in Wisconsin), and preferred payment/delivery model (e.g., the exclusion of counties included in Washington's capitated financial alignment demonstration for dual eligible beneficiaries). It may also be that states are proceeding cautiously with statewide implementation because of the time-limited 90% federal match for health home services.

- **Target Population.** As did most of the first health home states, several of the nine states profiled in this brief have established a broader set of qualifying chronic conditions than those listed in the ACA. At the same time, several states are more narrowly targeting individuals with particular chronic conditions. Consistent with the vision of health homes as a tool for better integrating physical and behavioral health services for people with mental health conditions, the one constant among almost all 15 health home states is their inclusion of individuals with serious mental illness in their target populations.
- **Health Home Providers.** States that have tailored their health home programs to serve a narrower Medicaid population with a particular condition have also designated a narrower set of health home provider entities with significant experience serving that population. States targeting beneficiaries with a broader cross-section of chronic conditions are generally relying on their network of primary care providers to provide health home services, with health home requirements and payments providing mechanisms to bolster their capacity to serve beneficiaries with complex chronic care needs. Two states also make separate payments to care coordination teams that support health home practices in serving high-need members (Alabama and Maine). These approaches are all similar to those taken by the first cohort of health home states. However, Washington took a somewhat distinctive approach, identifying regional health home lead entities that are responsible for maintaining a network of community-based care coordination organizations, and accountable for administering the health home program.
- **Payment.** While health home payment varies by state, states generally pay a PMPM rate that is determined based on assumptions about the composition and cost of the care team. Health home PMPM rates within a state may vary based on health home enrollees' predicted risk and the staff resources required to meet their needs. One state (South Dakota) tiers its PMPM rates based on estimates of the costs associated with *uncoordinated* care for different beneficiaries. Collectively, these payment practices are similar to those used by some of the earlier health home states. But the array of state payment approaches to achieve different objectives continues to widen. As an illustration, while Iowa (an early state) permits health homes to earn additional payments based on their performance on selected health metrics (e.g., diabetes care), Washington is implementing a payment withhold to incentivize provider-patient engagement and the development of care plans. States are also exploring other strategies to encourage quality and cost control, such as shared savings models. As health home programs become more firmly established and the parameters of what CMS will approve are more clearly defined, more states are likely to move in the direction of value-based payment.
- **FFS vs. Managed Care Context.** While several of the earlier health home states implemented their initiatives in a predominantly managed care environment, most of the states in the more recent group are implementing them in a FFS context, including two states (Maryland and Ohio) where the dominant delivery system is managed care, but behavioral health services are largely carved out of managed care contracts, posing barriers to integration of physical and behavioral health care. In part, this observed shift might reflect some of the complexities inherent in sorting out roles and responsibilities between managed care plans and health homes and preventing duplication of services and payment on behalf of health home enrollees.



- **HIT.** Health home providers' use of HIT to support care coordination and other services for health home beneficiaries varies greatly by state, reflecting variation in the current capacity of providers, as well as in states' ability to support health homes with HIT and their progress in developing a state HIE. A number of the states profiled here specifically require that health home providers use an EHR, or they make web-based tools and health information available to health homes to support better care management for their enrollees. As more states move from development to implementation of statewide HIEs, they could become more prescriptive about health home providers' use of them.

## LOOKING AHEAD

In a recent 50-state survey of Medicaid directors conducted by the KCMU, 21 states indicated that they planned to adopt or expand their use of health homes, evidence of the popularity of this new state plan option with enhanced federal financing.<sup>6</sup> The eight-quarter 90% federal match for health home services remains available prospectively to any state that decides to pursue CMS approval of a health home SPA. It also remains available for geographic expansions of current programs and for new health home SPAs in states that already have approved health home programs. As state Medicaid programs continue to improve health care delivery, the health home option is one mechanism they can adopt to advance and finance more person-centered, coordinated systems of care for those with the highest needs and costs. An interim report to Congress on the independent evaluation of the health home program required by the ACA is due in 2014. That report will provide a comprehensive assessment of Medicaid health homes, from early decision-making about their development to their impact on key health and cost outcomes and lessons learned. In the meantime, the nine programs profiled in this brief along with the six implemented earlier on illustrate how states can adapt the option to their particular priorities, needs, and capacities. Taken together, their diverse approaches can help inform the efforts of other states seeking to provide better care for Medicaid beneficiaries, achieve better health outcomes, and spend Medicaid dollars more effectively.

The authors wish to thank the following state officials, who contributed to the descriptions of the health home programs profiled in this brief: Dr. Robert Moon (AL), Matt Wimmer (ID), Michele Probert (ME), Chuck Milligan and Morgan Cole (MD), John McCarthy (OH), Kirby Stone (SD), Kelly Gordon (VT), and Mary Anne Lindeblad and Alice Lind (WA).

<sup>1</sup> *The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions*, Kronick R., Bella M., and Gilmer T., Center for Health Care Strategies, October 2009, [http://www.chcs.org/media/Faces\\_of\\_Medicaid\\_III.pdf](http://www.chcs.org/media/Faces_of_Medicaid_III.pdf)

<sup>2</sup> Health Home Information Resource Center, <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html>, accessed April 27, 2014.

<sup>3</sup> Also, although not profiled here, since our last brief, Iowa has added a new health home program for adults and children with SPMI, and Rhode Island has added health homes for treatment of opioid addiction.

<sup>4</sup> See *Section 1115 Demonstration Proposal: Alabama Medicaid Transformation*, submitted by the Alabama Medicaid Agency on May 30, 2014: [http://www.medicaid.alabama.gov/documents/2.0\\_Newsroom/2.7\\_Topics\\_Issues/2.7.3\\_RCOs/2.7.3.3\\_1115\\_Waiver/2.7.3.3\\_1115\\_Waiver\\_Application\\_5-30-14.pdf](http://www.medicaid.alabama.gov/documents/2.0_Newsroom/2.7_Topics_Issues/2.7.3_RCOs/2.7.3.3_1115_Waiver/2.7.3.3_1115_Waiver_Application_5-30-14.pdf)

<sup>5</sup> *Wisconsin Department of Health Services HIV/AIDS Surveillance Annual Review*, April 2014, <http://www.dhs.wisconsin.gov/publications/Po/P00484.pdf>

<sup>6</sup> *Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014*, Smith V., Gifford K., Ellis E., Rudowitz R., and Snyder L, Kaiser Commission on Medicaid and the Uninsured, October 2013, <http://kff.org/medicaid/report/medicaid-in-a-historic-time-of-transformation-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2013-and-2014/>

Appendix: Key Dimensions of Newer Medicaid Health Home Programs

	Target Population	Chronic Conditions	Providers	Payment Methodology	Relationship to MCOs	HIT	Geographic Scope	Enrollment*
<b>Alabama</b>	Two chronic conditions; one & risk for another; or SMI	ACA conditions, cancer, HIV, cardiovascular disease, chronic obstructive pulmonary disease (COPD), sickle cell anemia, & organ transplant.	Existing Enhanced PCCM Primary Medicaid Providers (PMPs) & Primary Care Networks of Alabama (PCNAs).	PMPM paid to both PMPs & PCNAs.	N/A	Use of state's Medicaid EHR & clinical support tool is encouraged. Secure, web-based system generates reports based on claims data.	Four regions encompassing 21 of 67 counties.	70,206
<b>Idaho</b>	Two chronic conditions; one & risk for another; or SMI or SED	SMI or SED; or diabetes & asthma; or diabetes or asthma & risk for another condition. Risk factors include BMI>25, abnormal lipid levels, hypertension, respiratory disease, or tobacco use.	PCCM PCPs, including physicians, group practices, rural clinics, CHCs, CMHCs, home health agencies, if required infrastructure & provider capabilities are in place.	PMPM based on estimated staffing costs of health home team.	N/A	Initial standards require information system to support tracking & managing chronic care patients. Final standards require use of HIT for follow-up & referral & population health management, and use of Idaho HIE as feasible.	Statewide	9,179
<b>Maine</b>	Two chronic conditions; or one & risk for another; or SMI or SED (not yet approved by CMS)	ACA list, plus tobacco use, COPD, hypertension, hyperlipidemia, developmental disabilities or autism spectrum disorders, acquired brain injury, seizure disorders, cardiac & circulatory congenital disorders.	PCCM practices qualified as Health Home Providers (HHP) in partnership with Community Care Teams (CCT). For beneficiaries with SMI/SED, PCCM practices in partnership with behavioral health home organizations are health homes.	PMPM paid to both HHPs and CCTs based on estimated staff costs; higher PMPMs paid to CCTs reflect more complex needs of CCT patients	N/A	HHPs must have fully implemented EHR. HHPs and CCTs have access to state-developed Health Home Enrollment System and Maine's HIE for patient information, tracking, & referral.	Statewide	42,958
<b>Maryland</b>	SMI or SED; or one chronic condition & risk for another	SMI or SED; or opioid substance use disorder (i.e., individuals in opioid maintenance therapy) & risk for another condition. Risk factors include current or previous tobacco, alcohol, or other non-opioid substance use.	Licensed psychiatric rehabilitation programs, mobile treatment services, & opioid treatment programs.	One-time payment for intake and assessment, and PMPM based on estimated staffing costs	Behavioral health care is carved out of managed care contracts.	Access to state's on-line e-Medicaid provider portal, and also must be enrolled in the state HIE to receive real-time hospital encounter alerts & pharmacy data.	Statewide	2,516
<b>Ohio</b>	SMI or SED	SMI or SED.	Community Behavioral Health Centers (CBHCs)	PMPM based on cost information submitted by CBHCs	Behavioral health care is carved out of managed care contracts; CBHCs must establish partnership with MCOs.	Must be able to receive utilization data electronically. Must acquire certified EHR &, by end of Year 2, use to support all health home services. Must participate in state HIE once operational in their area	Five counties initially; statewide expansion planned	10,312

	Target Population	Chronic Conditions	Providers	Payment Methodology	Relationship to MCOs	HIT	Geographic Scope	Enrollment*
<b>South Dakota</b>	Two chronic conditions; or one & risk for another; or SMI or SED	ACA conditions, COPD, hypertension, & musculoskeletal & neck & back disorders. Risk factors include tobacco use, pre-diabetic condition, cancer, hypercholesterolemia, depression, & use of >6 medications.	Primary care physicians, PAs, advanced practice NPs, FQHCs, Indian Health Service Units, Rural Health Centers, & CMHCs	Tiered PMPM rates based on patient risk score & estimated "Uncoordinated Care Costs" for enrollees in each tier	N/A	Health home providers required to have EHR; State Medicaid agency provides health homes with monthly claims data to manage care.	Statewide	5,655
<b>Vermont</b>	One chronic condition: individuals receiving Medication Assisted Therapy (MAT) for opioid addiction in specified settings	Opioid addiction.	Specialty methadone Opioid Treatment Programs (OTP) or physicians licensed to prescribe buprenorphine in Office-Based Opioid Treatment (OBOT) settings, in conjunction with PCMHs & Community Health Teams	PMPM based on added staff costs and paid to regional addictions centers and administering entities for CHTs	N/A	Hub and Spoke providers must document health home services in their EMRs & are eventually to be linked to state's web-based central clinical registry through state HIE.	Statewide (in three phases)	2,949
<b>Washington</b>	One chronic condition & risk for another	ACA conditions (except BMI >25), cancer, cerebrovascular disease, chronic respiratory conditions, coronary artery disease, dementia/Alzheimer's, gastrointestinal conditions, hematological conditions, HIV/AIDS, intellectual disabilities, musculoskeletal conditions, neurological disease, & renal failure. Risk defined as expected costs ≥150% costs for SSI population.	Regional health home lead administrative entities contract with community-based care coordination organizations (CCO) (e.g., group practices, rural clinics, FQHCs, CMHCs, case management agencies, MCOs, hospitals, SUD treatment providers) to provide health home services.	3-tiered approach: one-time payment for outreach/care plan development; different PMPM rates for low level & intensive coordination; also, 2% withhold to incentivize outreach, care plan development, & provision of health home services.	Health home services for eligible beneficiaries in MCOs are built into MCO contracts and capitation rates.	Health homes have access to state's secure, web-based clinical support tool to complement provider-specific EHRs.	Statewide except for King (Seattle) and Snohomish counties (location of Dual Eligible Demonstration)	22,792
<b>Wisconsin</b>	One chronic condition (HIV/AIDS) & another or risk for another	Risk factors include low CD4 cell count, BMI <18.5, elevated blood pressure, elevated fasting blood sugar level, and hyperlipidemia.	AIDS Service Organizations (ASO)	Fee for initial assessment & development of an integrated care plan for each health home enrollee, & PMPM rate for health home services.	State assures there will be no duplication of services or payments associated with other Medicaid programs including MCOs.	All contacts with beneficiaries must be documented & treatment plans updated in EHR, which must be accessible to all members of care team.	Four counties with highest prevalence of HIV/AIDS in state	188

\*Source: <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Approved-Health-Home-State-Plan-Amendments.html>