

# Medicaid Health Homes – Qualifying Core Elements

Qualifying Core Elements	Health Home Services					
	Compre- hensive care management	Care coordination & health promotion	Compre- hensive transitional care	Individual and family support	Referral to community and social supports	Use of HIT to link services
A Medicaid Health Home must:						
1. Operate as a Patient Centered Medical Home (NCQA PCMH Recognition Level 1 to qualify, achieve level 3 w/ in 24 months of start date*) including:						
a. Enhance Access & Continuity of Care		✓		✓		✓
b. Plan and Manage Care						
i. Perform care management activities – identify high risk patients; use of a health risk/health assessment tools; and develop/update care treatment plan	✓			✓		✓
ii. Use a Team of Health Care Professionals to deliver Health Home Services - may include physicians, nurse care managers, nutritionists, social workers, BH professionals, etc., at one practice or multiple practices in collaboration. Assign team members roles and responsibilities, including a dedicated person responsible for the overall management of the patient's care plan.	✓	✓	✓	✓	✓	
iii. Utilize an embedded nurse* care manager who is a member of the Team of Healthcare Professionals and works side-by-side with the primary care provider in performing care management/coordination functions	✓	✓	✓	✓	✓	

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A Medicaid Health Home must:						
c. Monitor and Coordinate Care						
i. Implement a single care treatment plan - track utilization, make referrals, monitor adherence to clinical guidelines, etc.		✓		✓		
ii. Tracking tests/referrals and follow up care		✓		✓		✓
iii. Coordinate with facilities and manage transitions between care settings, including LTC services		✓	✓	✓		✓
d. Include patients and their families in the delivery of health home services, including self management supports	✓	✓	✓	✓	✓	
e. Integrate Community Resources – refer patients/families to social and recovery support services & verify services received		✓		✓	✓	
f. Quality Improvement						
i. Operate a Continuous Quality Improvement Program with a practice site leader designated as the champion for each quality improvement initiative.	✓	✓	✓			✓
ii. Participate in the Medicaid Health Homes Learning Collaborative	✓	✓	✓		✓	✓
iii. Use data for population management: Use patient information and clinical data to remind patients about services needed for preventive/chronic care meds, and patients not recently seen	✓	✓	✓			✓
iv. Commit and develop capacity to perform Data Collection/ Measurement/ Reporting at the patient level (i.e., all health homes working on the same set of measures/initiatives)				✓		✓

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A Medicaid Health Home must:						
2. Integrate physical/behavioral health care	✓	✓	✓		✓	
3. Acquire Electronic Health Records						
a. Use Electronic Health Records meaningfully	✓	✓	✓			✓
b. Exchange Health Information via Statewide HIE (Summer 2012)	✓		✓			✓
4. Meet additional Health Home Qualifications:						
a. Enrolled in the Ohio Medicaid Program and agree to comply with all Medicaid program requirements						
b. Contractual relationship with the applicable Health Homes Program Administrators						
c. Deliver care in a Primary Care or Behavioral Health care setting with formal arrangements with all members serving on the Team of Health Care Professionals						
d. Financial Management: Maintain financial stability under a risk-adjusted, multi-tiered pmpm reimbursement method based on Health Risk Assessments & Claims History						
e. Size: Meet Minimum number of Health Home Eligibles served (75 – 150)						
f. Capacity: Serve all Medicaid Health Home eligibles in the community						
g. Staffing: Hire/Pay/Support embedded nurse care manager						

\*These core elements are under evaluation for the delivery of Health Home services to individuals with SMPI in a Behavioral Health Care Setting.