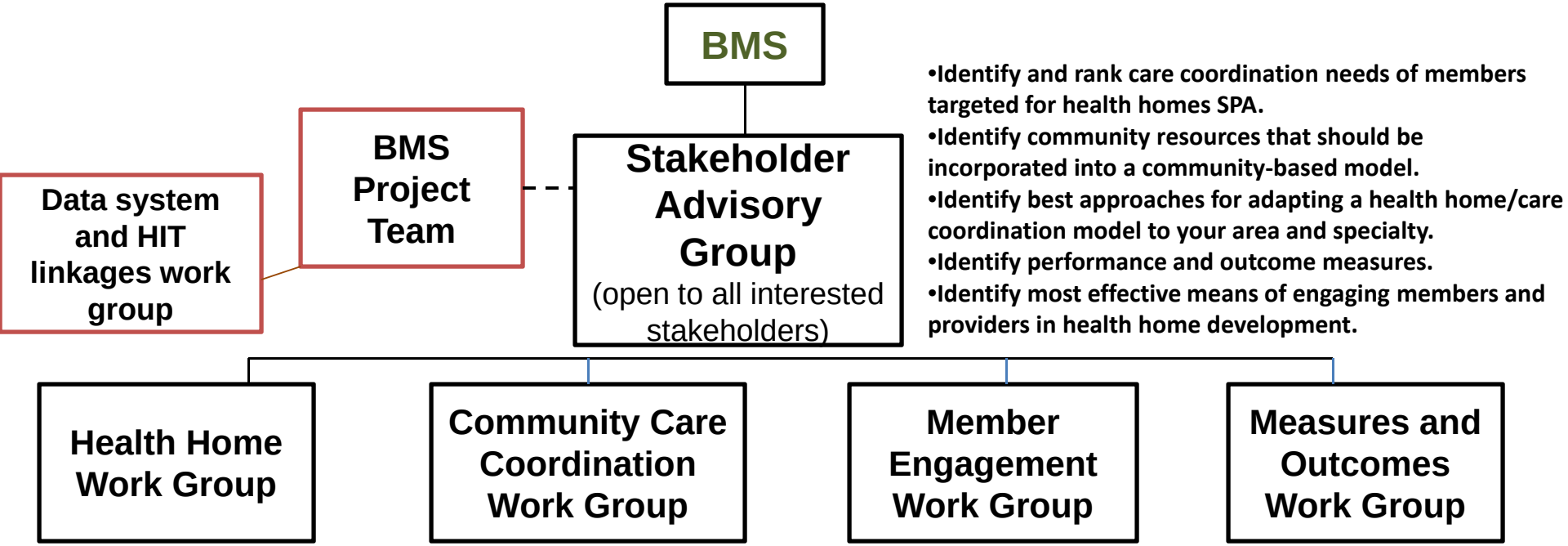
Medicaid Health Homes for Enrollees with Chronic Conditions



- Identify and rank care coordination needs of members targeted for health homes SPA.
- Identify community resources that should be incorporated into a community-based model.
- Identify best approaches for adapting a health home/care coordination model to your area and specialty.
- Identify performance and outcome measures.
- Identify most effective means of engaging members and providers in health home development.

Health Home Work Group

- Identify qualified provider standards.
- Pinpoint most effective provider infrastructure supports.
- Analyze CMS provider requirements and health home functions.
- Obtain feedback from existing "medical home" providers.
- Assess HIT role and utilization.

Community Care Coordination Work Group

- Analyze target populations' needs.
- Assess existing member experience with coordinated care.
- Map community resources and their potential integration.
- Evaluate merits of other states' models.
- Propose model(s) to accomplish 6 CMS-defined functions.
- Formulate adaptable models that comply with CMS requirements and health home functions.
- Develop behavioral health integration options.
- Assess potential HIT role and integration.

Member Engagement Work Group

- Identify an effective means to obtain initial and ongoing member and family input.
- Prepare a communications plan for SPA development and implementation.
- Develop a proposed methodology for matching members with providers.

Measures and Outcomes Work Group

- Identify measures to assess program impact that conform to CMS requirements.
- Study CMS standards and measures and propose data reporting and collection mechanics.
- Define each measure's numerator and denominator.
- Propose provider reporting requirements for both health homes and care coordination teams.