The Hilltop Institute

analysis to advance the health of vulnerable populations

Health Home Evaluation Report: 2013-2016

January 17, 2019

Executive Summary

The Affordable Care Act (ACA) of 2010[1] presented an opportunity for states to improve care coordination for Medicaid participants with chronic conditions by providing care through the Health Home model. Under this legislation, each state can develop a program that offers a person-centered approach to providing enhanced care management and care coordination. The Maryland Department of Health responded to this initiative and submitted a Medicaid State Plan Amendment (SPA) that was approved by the Centers for Medicare & Medicaid Services (CMS) in October 2013.

This report is an update to the 2016 Health Home Evaluation Report[2] and the 2015 Joint Chairmen's Report on Patient Outcomes for Participants in Health Homes.[3] Its purpose is to describe the outcomes of participants in the Maryland Health Home program. Maryland's Health Home program targets Medicaid participants with a serious and persistent mental illness (SPMI) and/or an opioid substance use disorder (SUD) and risk of additional chronic conditions due to tobacco, alcohol, or other non-opioid substance use; as well as children with serious emotional disturbances (SED). Individuals can participate in a Health Home if they are eligible for and engaged with a psychiatric rehabilitation program (PRP), mobile treatment service (MTS), or an opioid treatment program (OTP) that has been approved by the Department to function as a Health Home provider.

The goal of the Health Home program is to improve health outcomes for individuals with chronic conditions by providing an enhanced level of care management and care coordination while reducing costs. This evaluation summarizes health care utilization patterns while participants were enrolled in the Health Home program during calendar years (CYs) 2013 through 2016. The lengths of enrollment were calculated as of the end of CY 2016. As of December 31, 2016, the average length of enrollment in the Health Home program was 40 months. The results of this preliminary analysis suggest that Health Home participants had a strong demand for the Health Home social services, such as care coordination and health promotion. This analysis further shows that longer enrollment in a health home is associated with declines in the average number of emergency department (ED) visits and non-emergent ED visits. The rate of inpatient hospital admissions per participant also declined the longer participants were enrolled in the Health Home Program.

The Maryland Health Home Program

The Maryland Health Home program builds on statewide efforts to integrate somatic and behavioral health services, with the aim of improving health outcomes and reducing avoidable

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[1] ACA § 2703(a) (42 USC § 1396w-4(a)).
[2] https://mmcp.health.maryland.gov/SiteAssets/SitePages/Health%20Home%20Program%20Evaluation%20and%20Outcomes/health_home_2016_evaluation_report.pdf.
[3] https://mmcp.health.maryland.gov/Documents/JCRs/chronichealthhomeJCRfinal11-15.pdf.

hospital utilization. The program targets populations with behavioral health needs who are at high risk for additional chronic conditions, offering them enhanced care coordination and support services by providers from whom they regularly receive care. The program focuses on Medicaid participants with a serious and persistent mental illness (SPMI); Medicaid participants with an opioid SUD and risk of additional chronic conditions due to tobacco, alcohol, or other non-opioid substance use; and children with SED (CMS, 2013). In the Health Home, the center of a patient's care, instead of being in a somatic care setting, is a psychiatric rehabilitation program (PRP), mobile treatment service (MTS), or an opioid treatment program (OTP). This service delivery method is intended to include nurses and somatic care consultants into these programs and to make sure individuals in PRPs, MTS, and OTPs receive improved somatic care.

Participating Health Homes receive an initial intake and assessment fee of $106.46[4] when they enroll a new individual into the program. Health Home providers are also eligible for a $106.46 monthly rate per participant for each month in which an enrollee receives at least two qualified Health Home services.[5] If a participant receives fewer than two services, the Health Home is ineligible for that payment that month. Health Home services include care coordination, care management, health promotion, and referrals to community and social support services. The state received a 90 percent enhanced Federal Medical Assistance Percentage (FMAP) for the provision of Health Home services during the first 13 quarters of the program.

Medicaid participants can enroll in Health Homes if they are eligible for and engaged with a PRP, MTS, or an OTP that the Department has approved to function as a Health Home provider. Instead of auto-enrollment into the program, Maryland requires participants to actively choose to enroll and complete an intake procedure. In order to improve care coordination, when enrolling into the Health Home, Medicaid participants must consent to share their data with the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange (HIE) serving Maryland and the District of Columbia. Individuals are excluded from Health Home participation if they are currently receiving other Medicaid-funded services that may duplicate those provided by Health Homes, such as targeted mental health care management.

A Health Home provider must be enrolled as a Maryland Medicaid provider and accredited as a Health Home. A dedicated care manager must be assigned to each participant, and providers are required to maintain certain staffing levels based on the number of participants. The Health Home staff must include a Health Home director, physician, and nurse practitioner. They must notify each participant's other providers of the participant's goals and the types of services an

[4] Health Homes are reimbursed at a rate of $106.46 during State Fiscal Year (SFY) 2019. Reimbursement was set at $102.86 in SFY18 and $100.85 in SFY17.

[5] Previous reports and presentations by the Department have referred to this payment as a "per member per month (PMPM)" payment. Since receipt of the monthly payment is not guaranteed and is contingent on the provision of at least two health home services by the enrollee, the characterization of the payment as a PMPM is not strictly accurate. Program staff are in the process of updating the state's SPA, regulations, and related documents to reflect this nuance.

individual is receiving via the Health Home, as well as encourage participation in care coordination efforts.

Health Homes are responsible for documenting all delivered services, participant outcomes, and social indicators in the eMedicaid care management system. eMedicaid is a secure web-based portal that allows health care practitioners to enroll as a Medicaid provider, verify recipient eligibility, and obtain payment information. It also serves as a care management tracking tool for providers participating in Maryland's Health Home program. Within eMedicaid, providers enroll participants and document participants' diagnoses, outcomes, and services rendered.

Figures 1a and 1b display the number of participating Health Home providers (1a) and provider sites (1b) by month. These data only include Health Home provider organizations that had at least one participant enrolled during that month. A small number of providers were active at the inception of the program. Within the first six months, the number of providers tripled. This number of participating providers remained stable in the second half of 2014, increased by six providers in 2015, and increased gradually until December 2016.

Figure 1a. Number of Participating Health Home Providers, by Month

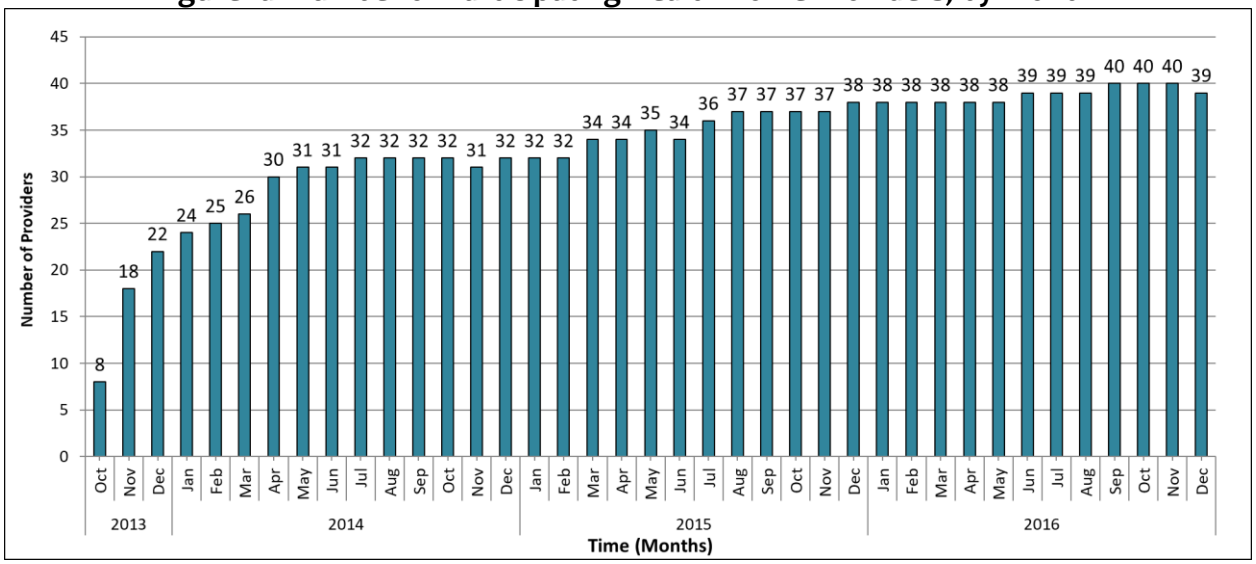
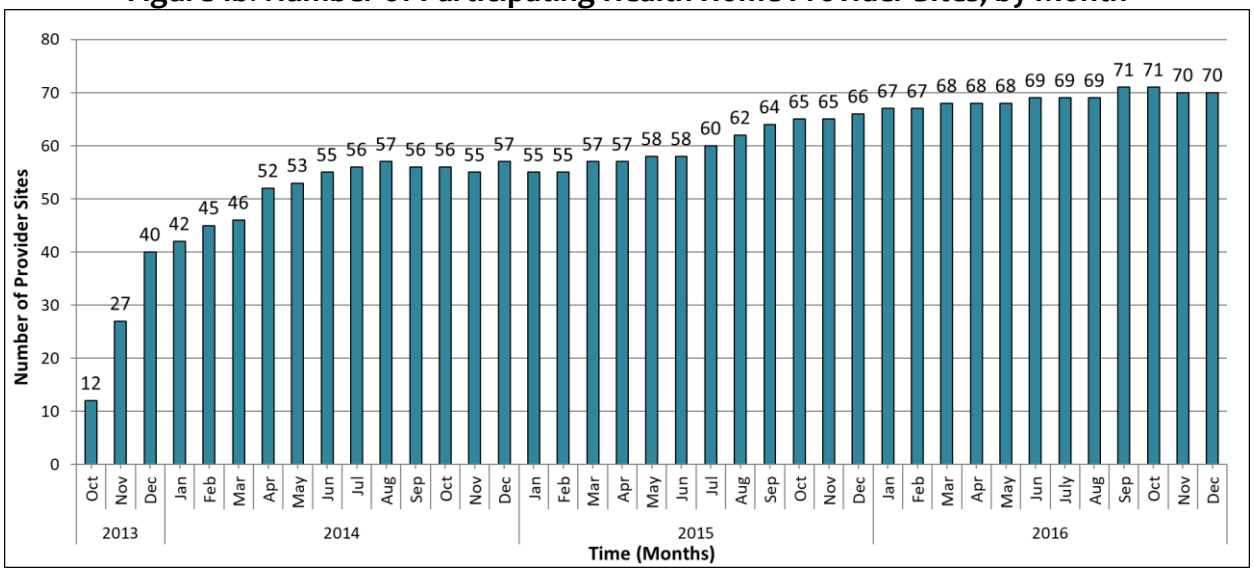


Figure 1b displays the number of participating Health Home providers by month according to the number of individual sites that are operational. These data only include Health Home sites that had at least one participant enrolled during that month. A small number of providers were active at the inception of the program: 8 providers across 12 sites. Within the first six months, the number of Health Home provider sites more than tripled to 40. The number of participating sites continued to increase in 2014 and through 2015. In 2016, the number of Health Home provider sites gradually increased from 67 to 71 by October. However, this number decreased slightly at the end of 2016.

Figure 1b. Number of Participating Health Home Provider Sites, by Month



Participant Characteristics

Figure 2 presents enrollment data for the first 13 quarters of the program. Enrollment is determined using data Health Home providers reported into the eMedicaid care management system as of November 16, 2017. Figure 2 shows that a large portion of participants enrolled near the start of the program. While the enrollment of new participants dropped after the months immediately following implementation, new participants were continuously added every quarter, resulting in enrollment more than doubling between Quarters 1 and 7. Since the first quarter of the program, an average of almost 600 new participants joined the program each quarter. This increase in Health Home enrollment is primarily due to the introduction of new provider sites, as the sizes of individual provider sites tend to remain stable after an initial ramp-up period.

Figure 2. Number of Health Home Participants, by Enrollee Type and Quarter

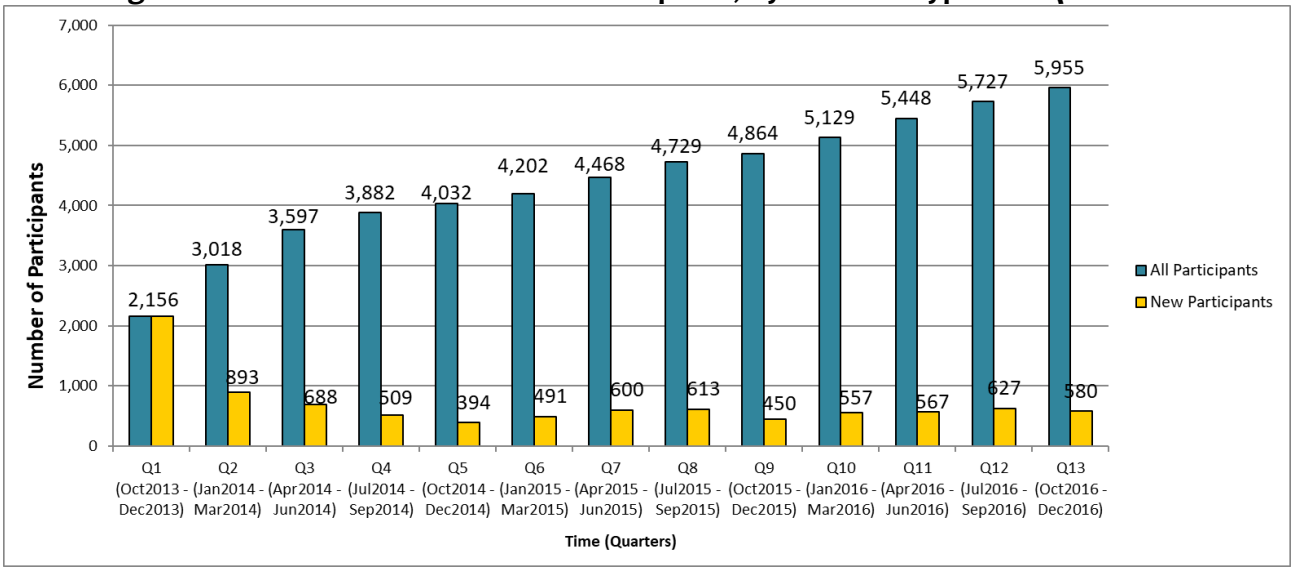


Figure 3 presents enrollment data by program type: PRP, MTS, or OTP. PRP providers consistently enrolled the largest share of Health Home participants: between 71.8 percent and 82.9 percent of participants across all 13 quarters. The percentage of participants enrolled in the MTS program ranged between 3.0 percent and 6.6 percent across the intervention quarters. The OTP enrollment drastically increased across all quarters, starting at 10.5 percent in Quarter 1 and increasing to 25.1 percent in Quarter 13. As of Quarter 13, only 4 of the 39 providers offered care to participants through multiple program types. The majority of providers offered services through one program type.

Figure 3. Number of Health Home Participants, by Program Type and Quarter

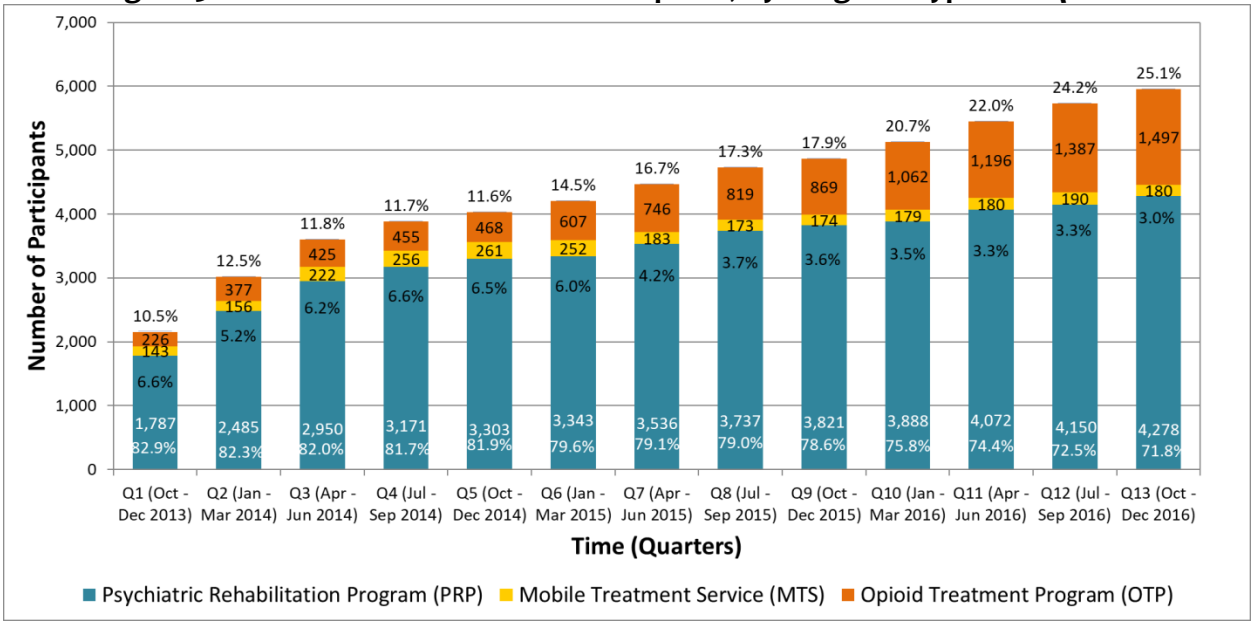


Table 1 presents the percentage of Health Home participants enrolled as of December 31, 2016, by various demographic characteristics. The largest proportion of participants was aged 40 to 64 years (56.1 percent), followed by those aged 21 to 39 years (24.9 percent). Approximately 14 percent of the participants were under the age of 21 years. Table 1 also shows that the vast majority of the Health Home population identified as either White (39.6 percent) or Black (48.2 percent). Those who identified as Other/Unknown, Asian, or Hispanic made up a small proportion (12.3 percent) of total participants. A slight majority of Health Home participants were male (54.5 percent). The region with the majority (66.0 percent) of participants was the Baltimore metropolitan area. The next most common areas of residence were the Eastern Shore (16.8 percent) and Montgomery and Prince George's Counties (9.9 percent).

A person's comorbidity level is estimated based on the Johns Hopkins Adjusted Clinical Groups (ACG) methodology, which uses claims data to classify individuals based on their projected and/or actual utilization of health care services. Approximately 58.0 percent of participants were categorized as having a very high or high comorbidity level, 36.5 percent were classified as having a moderate comorbidity level, and only 5.8 percent were classified as having a low comorbidity level. Home Health participants eligible for both Medicare and Medicaid were approximately 31 percent of the participant group.

Table 1. Demographic and Clinical Characteristics of Health Home Participants

Demographic/Clinical Characteristics	Health Home Participants	
	Number	Percentage
Age Group (Years)		
3 to 9	183	2.2%
10 to 14	557	6.5%
15 to 20	393	4.6%
21 to 39	2,125	24.9%
40 to 64	4,779	56.1%
65 and older	489	5.7%
Race/Ethnicity		
Asian	98	1.2%
Black	4,108	48.2%
White	3,377	39.6%
Hispanic	66	0.8%
Other/Unknown	877	10.3%
Gender		
Female	3,880	45.5%
Male	4,646	54.5%
Region		
Baltimore Metro	5,627	66.0%
Eastern Shore	1,436	16.8%
Montgomery and Prince George's Counties	842	9.9%
Southern Maryland	13	0.2%
Western Maryland	586	6.9%
Out of State	22	0.3%

ACG Comorbidity Level		
Low Co-Morbidity	493	5.8%
Moderate Co-Morbidity	3,113	36.5%
High Co-Morbidity	2,337	27.4%
Very High Co-Morbidity	2,583	30.3%
Dual Medicaid-Medicare Eligibility		
No	5,882	69.0%
Yes	2,644	31.0%
Total	**8,526**	

Health Home Services

Health Homes are required to provide at least two services to a participant in a given month in order to qualify for a $100.85 monthly rate per participant. Health home services include care coordination, care management, health promotion, and referrals to community and social support services. Categories of services include the following:

- Comprehensive care management to assess, plan, monitor, and report on participant health care needs and outcomes
- Care coordination to ensure appropriate linkages, referrals, and appointment scheduling across different providers
- Health promotion to aid participants in implementation of their care plans
- Comprehensive transitional care to ease the transition when discharged from inpatient settings and ensure appropriate follow-up
- Individual and family support services to provide support and information that is language, literacy, and culturally appropriate
- Referral to community and social support services

Figure 4 displays the percentage of participants by the number of services received per month. During the first month of the program, 12.6 percent of participants received two or more services and 75.2 percent of participants did not receive any services. As time progressed, the number of participants receiving two or more services per month increased, ranging from 63.1 to 83.5 percent. The number of participants who did not receive any services decreased steadily after the first month of the program until June 2015. From June 2015 to December 2016, the average amount of Home Health participants who did not receive any services was 11.4 percent.

Figure 4. Percentage of Health Home Participants Receiving 0, 1, or 2 or More Services, by Month

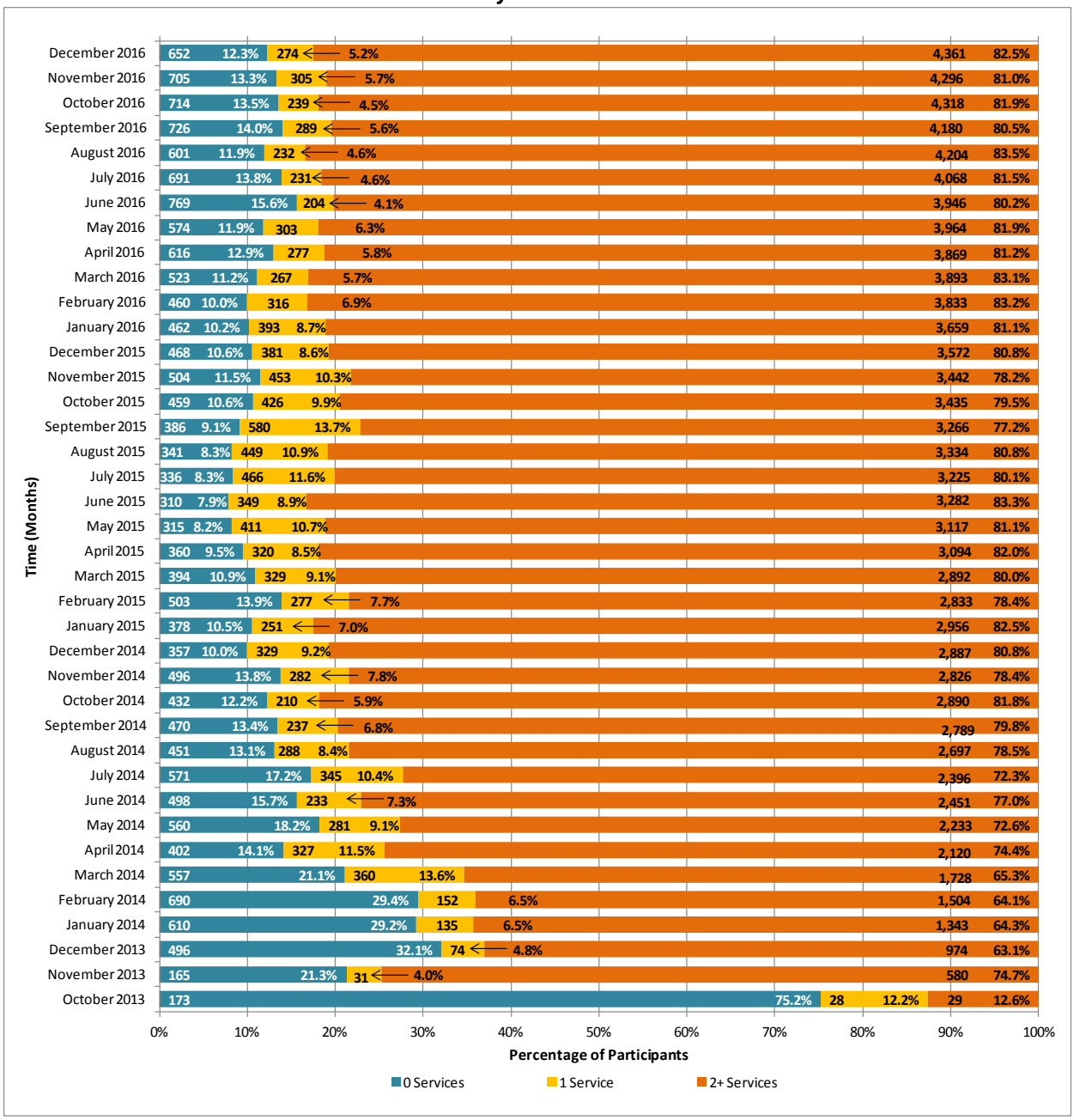


Figure 5 presents the average number of services among Health Home participants who received at least one service during the quarter. The average number of services increased as the program progressed, ranging from 3.0 in Quarter 1 to 6.3 in Quarter 8. After Quarter 8, the average number of services decreased slightly to 5.6 in Quarter 11; after that, the average number of services remained steady.

Figure 5. Average Number of Services Received by Health Home Participants, by Quarter

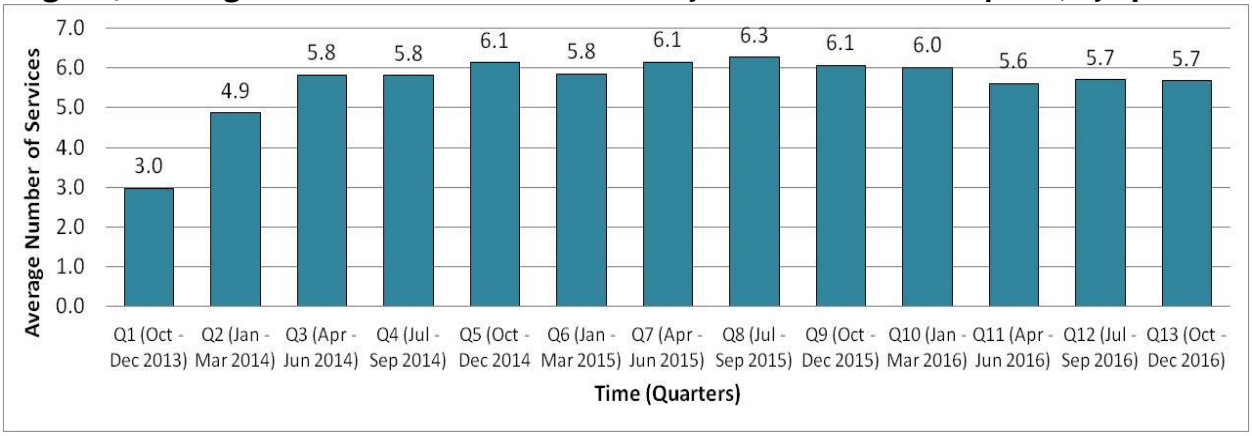
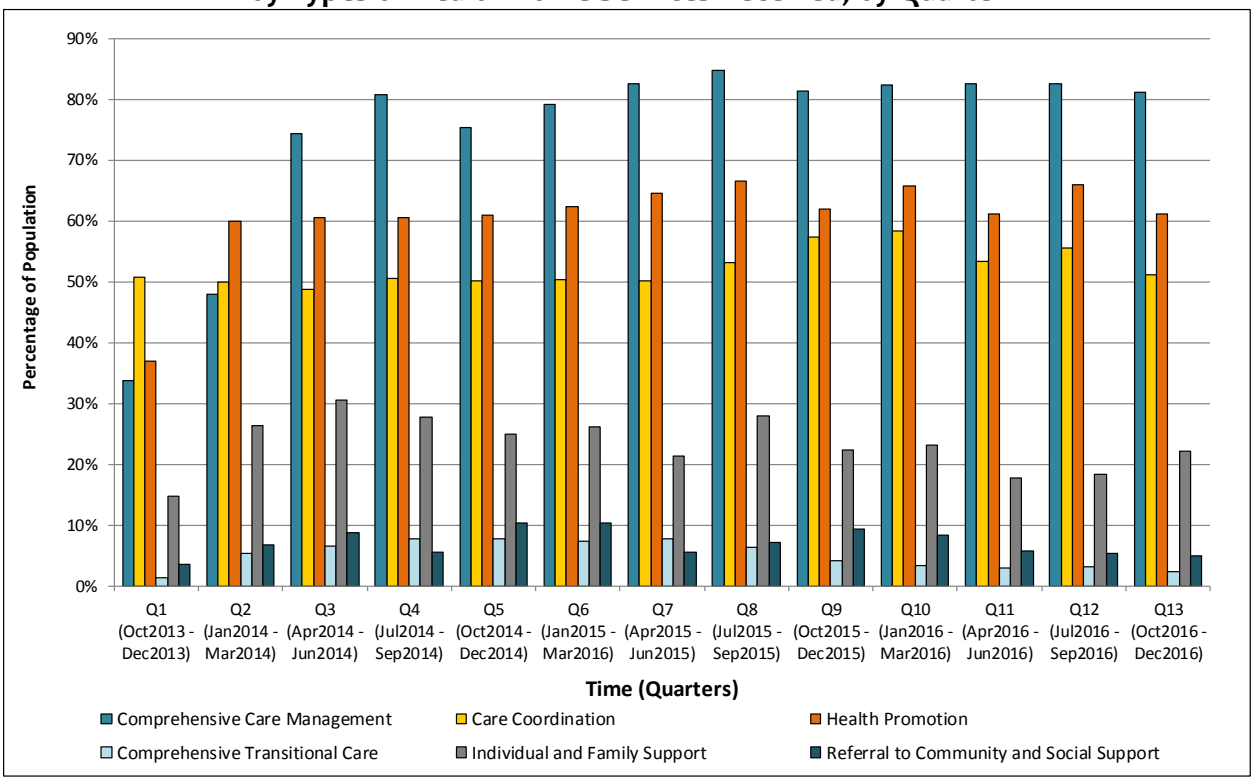


Figure 6 shows the percentage of participants who received at least one type of Health Home service required by CMS. The figure demonstrates a strong demand for social services. Care coordination was consistently received at least once per quarter by approximately half of the participants. The proportion of participants receiving a comprehensive care management service increased from 33.6 percent in Quarter 1 to 84.7 percent in Quarter 8. The average of the proportion of participants receiving a comprehensive care management service from Quarter 8 onward decreased slightly and then remained relatively steady, ranging between 81.1 percent and 82.5 percent. Receipt of health promotion services was 36.9 percent in Quarter 1; for the remainder of the program, the percentage of participants receiving this service increased and ranged between 59.9 and 66.5 percent. Comprehensive transitional care and referral to community and social support services were consistently received by the smallest proportion of participants.

Figure 6. Percentage of Health Home Participants by Types of Health Home Services Received, by Quarter



Health Home Participants' Health Care Utilization by Length of Enrollment

The tables in this section summarize health care utilization patterns while participants were enrolled in the Health Home program. The lengths of enrollment were calculated as of the end of CY 2016. As of December 31, 2016, the average length of enrollment in the Health Home program was 40 months.

The enrollment spans were estimated using the first enrollment date of each participant, even if there were gaps in the overall Health Home enrollment. If a person had no gaps in enrollment, their enrollment span equals the number of days from their enrollment date until December 31, 2016. For the participants with gaps in enrollment (that is those having more than one enrollment span), the total enrollment was calculated by combining time periods of each of the enrollment spans. For example, if a participant enrolled in a Health Home program, left the program after 6 months of enrollment, rejoined after 3 months for 4 months and left again until at least the end of CY2016, the total length of enrollment for this person at the end of CY2016, is only 10 months.

This person would be counted in the category of participants with '7 to 12 months' of enrollment and also in the category of participants with '0 to 6 months' of enrollment.[6]

Emergency Department Visits

Table 2 presents emergency department (ED) utilization rates per participant by length of enrollment in a Health Home program. ED utilization rates were highest during a participant's first six months of enrollment, with 39.5 percent of total participants visiting the ED at least one time during that enrollment span. The ED utilization rate declined the longer those participants stayed in the Health Home program. Participants who were in a Health Home program 37 to 42 months had the lowest ED utilization rate at 15.2 percent of participants with at least one ED visit during that enrollment span. Furthermore, the average number of ED visits per participant decreased the longer participants were enrolled in the program: from 1.03 during the first six months of enrollment to 0.29 when participants were enrolled 37 to 42 months.

Table 2. ED Utilization Rates per Participant, by Length of Enrollment

Length of Enrollment	Total Participants	Number with Any ED Visit	ED Utilization Rates	Number of ED Visits	Average ED Visits per Participant
0 to 6 Months	8,526	3,367	39.5%	8,769	1.03
7 to 12 Months	6,656	2,358	35.4%	5,749	0.86
13 to 18 Months	5,011	1,669	33.3%	3,960	0.79
19 to 24 Months	3,738	1,183	31.6%	2,955	0.79
25 to 30 Months	2,782	886	31.8%	2,215	0.80
31 to 36 Months	2,149	474	22.1%	1,514	0.70
37 to 42 Months	1,151	175	15.2%	338	0.29

Inpatient Hospital Admissions

Table 3 presents the inpatient utilization rates per participant by length of enrollment in a Health Home program. Inpatient utilization rates were highest during participants' first six months in the program; 12.5 percent of total participants had a hospital stay during that enrollment span. The inpatient utilization rate declined overall the longer participants were enrolled in the Health Home program with two exceptions: those enrolled for 19 to 24 months and 31 to 36 months had higher utilization rates than those enrolled for 13 to 18 months and 25 to 30 months, respectively. Participants who remained in a Health Home program for 37 to 42 months had the lowest inpatient utilization rate, at 5.3 percent of total participants with any inpatient visit.

[6] If a participant was discharged from the Health Home program, later had a visit, and subsequently re-enrolled in the program, then that visit is not included in the tables below.

Table 3. Inpatient Hospital Admission Rates per Participant, by Length of Enrollment

Length of Enrollment	Total Participants	Number with Any Inpatient Visit	Inpatient Utilization Rates
0 to 6 Months	8,526	1,062	12.5%
7 to 12 Months	6,656	784	11.8%
13 to 18 Months	5,011	502	10.0%
19 to 24 Months	3,738	413	11.0%
25 to 30 Months	2,782	275	9.9%
31 to 36 Months	2,149	221	10.3%
37 to 42 Months	1,151	61	5.3%

Ambulatory Care Visits

An ambulatory care visit is defined as contact with a doctor or nurse practitioner in a clinic, physician's office, or hospital outpatient department.[7] Ambulatory care utilization often serves as a measure of access to care. Higher rates of ambulatory care can offer an alternative to less efficient care for non-emergent conditions in an ED visit setting, as well as prevent a condition from becoming exacerbated to the extent that it requires an inpatient admission. Table 4 presents ambulatory care visit rates per participant by length of enrollment in a Health Home program. Ambulatory care visit rates were highest during a participant's first six months of enrollment, with 86.5 percent of total participants having an ambulatory care visit at least one time during that enrollment span. Participants who were in a Health Home program 37 to 42 months had the lowest ambulatory care visit rate, at 65.2 percent of participants having ambulatory care visit during that enrollment span.

[7] This definition excludes ED visits, hospital inpatient services, substance use treatment, mental health, home health, x-ray, and laboratory services.

Table 4. Ambulatory Care Visit Rates per Participant, by Length of Enrollment

Length of Enrollment	Total Participants	Number with Any Ambulatory Care Visit	Ambulatory Care Utilization Rates
0 to 6 Months	8,526	7,371	86.5%
7 to 12 Months	6,656	5,576	83.8%
13 to 18 Months	5,011	4,237	84.6%
19 to 24 Months	3,738	3,138	84.0%
25 to 30 Months	2,782	2,379	85.5%
31 to 36 Months	2,149	1,789	83.3%
37 to 42 Months	1,151	750	65.2%

Nursing Home Stays

Table 5 presents nursing home stays per participant by length of enrollment in a Health Home program. The frequencies of people with any nursing home visit were relatively small, and there was no obvious trend in utilization rates according to length of enrollment. During a participant's first six months of enrollment, with 0.9 percent of total participants had at least one nursing home stay during that enrollment span. Participants who were in a Health Home program 37 to 42 months had the lowest nursing home stay rate during that span, at 0.4 percent of participants.

Table 5. Nursing Home Stays per Participant, by Length of Enrollment

Length of Enrollment	Total Participants	Number with Any Nursing Home Stay	Nursing Home Utilization Rates
0 to 6 Months	8,526	73	0.9%
7 to 12 Months	6,656	66	1.0%
13 to 18 Months	5,011	54	1.1%
19 to 24 Months	3,738	47	1.3%
25 to 30 Months	2,782	27	1.0%
31 to 36 Months	2,149	28	1.3%
37 to 42 Months	1,151	*	0.4%

Non-Emergent Emergency Department Visits

One widely used methodology to evaluate the appropriateness of care in the ED setting is based on classifications developed by the NYU Center for Health and Public Service Research (Billings et al., 2000). The algorithm assigns probabilities of likelihoods that the ED visit falls into one of the following categories:

1. *Non-emergent*: Immediate care was not required within 12 hours based on patient's presenting symptoms, medical history, and vital signs
2. *Emergent but primary care treatable*: Treatment was required within 12 hours, but it could have been provided effectively in a primary care setting (e.g., CAT scan or certain lab tests)
3. *Emergent but preventable/avoidable*: Emergency care was required, but the condition was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness (e.g., asthma flare-up)
4. *Emergent, ED care needed, not preventable/avoidable*: Ambulatory care could not have prevented the condition (e.g., trauma or appendicitis)
5. *Injury*: Injury was the principal diagnosis
6. *Alcohol-related*: The principal diagnosis was related to alcohol
7. *Drug-related*: The principal diagnosis was related to drugs
8. *Mental-health related*: The principal diagnosis was related to mental health

9. *Unclassified*: The condition was not classified in one of the above categories

Table 6 presents the "non-emergent" ED visit rates per participant by length of enrollment in a Health Home program according to the NYU classification. If a visit is classified as more than 50 percent likely to fall into Categories 1 or 2 as described below, then it is considered "non-emergent." The estimates presented in the table therefore show the percentage of participants who went to the ED when either immediate care was not required within 12 hours or when it could have been provided in a primary care setting.

Non-emergent rates were highest during participants' first six months in the program; 20.7 percent of total participants had a non-emergent ED visit during that enrollment span. The non-emergent ED utilization rate declined overall the longer participants were enrolled in the Health Home program. Participants who remained in a Health Home program for 37 to 42 months had the lowest non-emergent ED utilization rate, at 5.8 percent of total participants with any avoidable ED visit. The number of non-emergent ED visits declined as length of enrollment increased, and the average number of non-emergent ED visits per participant declined the longer participants were enrolled in the Health Home program. From the shortest to the longest enrollment span, the average number of non-emergent ED visits during the period dropped from 0.38 to 0.1 non-emergent ED visits.

Table 6. Non-Emergent ED Visits per Participant, by Length of Enrollment

Length of Enrollment	Total Participants	Number with Any Non-Emergent ED Visits	Percentage with Non-Emergent ED Visits	Number of Non-Emergent ED Visits	Average Non-Emergent ED Visits per Participant
0 to 6 Months	8,526	1,764	20.7%	3,233	0.38
7 to 12 Months	6,656	1,187	17.8%	2,027	0.30
13 to 18 Months	5,011	818	16.3%	1,374	0.27
19 to 24 Months	3,738	561	15.0%	960	0.26
25 to 30 Months	2,782	428	15.4%	782	0.28
31 to 36 Months	2,149	274	12.8%	514	0.24
37 to 42 Months	1,151	67	5.8%	115	0.10

Avoidable Hospitalizations

Hospital stays for ambulatory care sensitive conditions, also referred to as avoidable hospitalizations, are inpatient admissions that may have been prevented if proper ambulatory care had been provided in a timely and effective manner to prevent complications or more severe diseases. High numbers of avoidable admissions may indicate problems with access to primary care services or deficiencies in outpatient management and follow-up. The Department monitors potentially avoidable admissions using The Agency for Healthcare Research and Quality's (AHRQ's) Prevention Quality Indicators (PQIs) methodology, which looks for specific primary diagnoses in hospital admission records indicating the conditions listed in each PQI.

Table 7 presents PQI rates per participant by length of enrollment in a Health Home program. PQI rates were highest during a participant's first six months of enrollment, with 0.93 percent of total participants having the PQI at least one time during that enrollment span. The PQI rate declined the longer those participants stayed in the Health Home program. The rate rose a little for the participants who were in a Health Home program for 31 to 36 months but declined again for the participants who stayed longer. Participants who were in a Health Home program for 37 to 42 months had the lowest PQI rate at 0.52 percent of participants having PQI during that enrollment span. The average number of PQI visits per participant stayed the same due to presence of small numerators in all the enrollment spans.

Table 7. Avoidable Hospitalizations per Participant, by Length of Enrollment

Length of Enrollment	Total Participants	Number with Any PQI	Percentage with PQI Utilization
0 to 6 Months	8,526	79	0.93%
7 to 12 Months	6,656	53	0.80%
13 to 18 Months	5,011	39	0.78%
19 to 24 Months	3,738	26	0.70%
25 to 30 Months	2,782	17	0.61%
31 to 36 Months	2,149	19	0.88%
37 to 42 Months	1,151	*	0.52%

30-Day All-Cause Hospital Readmissions

The 30-day all-cause hospital readmission rate, based on National Committee for Quality Assurance (NCQA) definitions, was calculated as the percentage of acute inpatient stays during the measurement year that were followed by an acute inpatient readmission for any diagnosis within 30 days. The HEDIS 2017 specifications identify inclusion criteria for types of stays and hospitals. The HEDIS specifications also limit the population to people continuously enrolled in Medicaid with respect to the date of discharge.

Table 8 presents rates hospital readmission rates per participant by length of enrollment in a Health Home program. The likelihood of a hospital readmission was highest after a participant had was enrolled 31 to 36 months, with 1.21 percent of total participants having the PQI at least one time during that enrollment span. Hospital readmission rates show no clear trend according to how long participants were enrolled in the program. During the initial 18 months of enrollment, rates of hospital readmissions declined the longer those participants stayed in the Health Home program; however, for those that remained in the program, readmission rates after that point increased the longer the person remained in the program up until the 31 to 36 month enrollment span.

Table 8. All-Cause Hospital Readmissions per Participant, by Length of Enrollment

Length of Enrollment	Total Participants	Number with Any PQI	Percentage with PQI Utilization
0 to 6 Months	8,526	42	0.49%
7 to 12 Months	6,656	22	0.33%
13 to 18 Months	5,011	13	0.26%
19 to 24 Months	3,738	17	0.45%
25 to 30 Months	2,782	22	0.79%
31 to 36 Months	2,149	26	1.21%
37 to 42 Months	1,151	*	0.26%

Conclusion

Health Homes are intended to improve health outcomes for individuals with chronic conditions by providing patients with an enhanced level of care management and care coordination. The Maryland Health Home program focuses on Medicaid participants with either an SPMI and/or an opioid SUD or risk of additional chronic conditions due to tobacco, alcohol, or other non-opioid SUD, and children with SED. The information presented in this report provides evidence that Health Homes successfully tie this extremely vulnerable population to social and somatic care services, improving their access to preventive care.

The results of this preliminary analysis suggest that Health Home participants had a strong demand for the Health Home social services, such as care coordination and health promotion. This analysis further shows that longer enrollment in a health home is associated with declines in the average number of emergency department (ED) visits and non-emergent ED visits. The rate of inpatient hospital admissions per participant also declined the longer participants were enrolled in the Health Home Program.