

medicaid and the uninsured

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MEDICAID HEALTH HOMES FOR BENEFICIARIES WITH CHRONIC CONDITIONS

Executive Summary

Medicaid, the main public health insurance program for low-income Americans, serves many individuals with complex and chronic health care needs. Almost half the 9 million people who qualify for Medicaid on the basis of disability suffer from mental illness and 45% have three or more diagnosed chronic conditions. The Affordable Care Act (ACA) established a new state option in the Medicaid program to implement “health homes” for Medicaid beneficiaries with chronic conditions. This option has attracted significant state interest, as states both seek to improve care delivery in Medicaid and continue to grapple with budget pressures. Health homes provide an important tool for states trying to manage and coordinate care more comprehensively for high-need, high-cost beneficiaries. Also, states receive a 90% federal match rate for health home services during the first two years that a health home State Plan Amendment (SPA) is in effect. Around 20 states have demonstrated interest in health homes and six states have received federal approval for their programs, so far. This brief focuses on the first four states to receive approval for their health home SPAs: Missouri, Rhode Island, New York, and Oregon.

Medicaid health home option: key parameters

The concept of the health home builds on the patient-centered medical home model and seeks to foster a “whole-person” orientation to care for persons with chronic conditions, through enhanced integration and coordination of primary, acute, mental and behavioral health, and long-term services and supports, across the lifespan.

Under the ACA, Medicaid beneficiaries, including “dual eligibles,” are potentially eligible 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 chronic conditions (e.g., mental health condition, asthma, and diabetes), but also authorizes the HHS Secretary to expand the list to include other chronic conditions. Health home services include: comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings, including appropriate follow-up; patient and family support; referral to community and social support services; and use of health information technology (HIT) to link services. These services may be provided by a designated health provider (e.g., a physician practice, a team of health care professionals linked to a designated provider, or a community health team).

Key directions in health home initiatives

The four profiled states have taken similar paths in designing some major aspects of their health home programs, and different paths in designing others:

Geographic scope. All four states elected to implement health homes on a statewide basis, rather than in a limited geographic area. While New York initially implemented health homes in only ten counties, the plan is to phase the program in statewide in 2012.

Target populations. All four states relied heavily on the chronic conditions named in the ACA to define their target populations. All four are targeting individuals with serious and persistent mental illness, among other conditions, consistent with the vision of health homes as a mechanism for improving coordination between physical and mental health services. In addition, all four states target individuals with selected chronic conditions outside the ACA list. As required by the ACA, dual eligibles within the target population must be included in a state's health home program.

Designated health home providers. The four states have taken different approaches to designating the entities that can provide health home services. Rhode Island relies exclusively on existing statewide networks of health care providers to serve specific health home populations. Oregon's and Missouri's health home programs for individuals with chronic physical conditions permit a broader cross-section of providers to be designated health homes. A broad range of provider-led entities can potentially qualify as health homes in New York, but the state uses an application process to determine which will be designated in a given geographic area and to ensure that all designated entities meet the state's requirements.

Payment methodologies. For the most part, states pay per-member-per-month (PMPM) amounts to providers furnishing health home services. Oregon tiers its PMPM payment amounts, paying more to higher-level, more advanced health homes. New York PMPM amounts vary by region and are adjusted to account for the case mix of a health home provider. Also, New York pays a reduced share (80%) of the PMPM amount to health home providers for the first three months of a beneficiary's initial enrollment.

Coordination with managed care. In all four states, whether beneficiaries are enrolled in managed care organizations (MCO) or receive their care on a fee-for-service (FFS) basis, designated providers are responsible for coordinating care for the health home population. Missouri and Rhode Island make health home PMPM payments directly to designated health home providers. By contrast, New York and Oregon make the PMPM payments for health home services to MCOs, with the requirement that the plans pass the full amount through to the designated health home provider, unless the MCO provides some of the health home services.

Key health home challenges

State interest in adopting the health home option is significant, but states also face some challenges:

Role of health homes in evolving delivery systems. The appropriate role for health homes in the context of other evolving care delivery and payment arrangements is a key issue that states interested in implementing health homes have to address. For example, as states expand capitated Medicaid managed care, they must address how health homes will fit into or coordinate with MCOs.

Competing health reform priorities. ACA requirements related to the expanding Medicaid in 2014, establishing state-based health insurance Exchanges, and upgrading IT systems, are placing enormous pressure on Medicaid agencies at a time when state resources are limited. Even when additional federal support is available, states must prioritize the ACA opportunities they will pursue.

State budget pressures. Although the health home model and the enhanced federal match rate for health home services suggest potential cost savings for states, state timeframes for achieving savings are driven by state budget cycles, and states still must identify their 10% share of health home program spending. States must also establish a mechanism for identifying the savings attributable to their health

home initiatives to ensure continued state funding for this program at the regular match rate, once the enhanced federal match rate expires.

Looking ahead

Health homes represent a promising new addition to states' toolbox for improving care and outcomes for Medicaid beneficiaries with chronic health care needs. The different approaches that states are taking offer other states a menu that they may borrow from or adapt to their particular goals and environments. The lessons and results from the early-adopter states may also guide broader system reforms aimed at delivering more coordinated and effective care for those with the most complex needs, who have the most to gain from such progress. Finally, health homes may add an important dimension to new models of integrated care for dual eligibles that may be tested in the coming years, enhancing their ability to improve both care delivery and the patient experience.

HEALTH HOMES FOR MEDICAID BENEFICIARIES WITH CHRONIC CONDITIONS

Medicaid, the nation's largest public health insurance program, serves low-income children and some adults, seniors, and individuals with disabilities. Many Medicaid beneficiaries have complex and chronic health care needs. More than 9 million people qualify for Medicaid based on a disability, and many of these individuals have particularly complex needs – almost one-half of them suffer from mental illness and 45% are diagnosed with three or more chronic conditions.¹ Major chronic conditions are prevalent among other Medicaid beneficiaries, as well. For example, more than 1 in 10 adult Medicaid enrollees have been diagnosed with diabetes, and 82% of these beneficiaries have at least one additional chronic condition.²

Although they represent a small proportion of the Medicaid population, individuals with high health care needs account for a significant share of Medicaid expenditures – over half of all Medicaid spending is attributable to the 5% of Medicaid beneficiaries with the highest costs. Also, “dual eligibles,” low-income seniors and people with disabilities who qualify for both Medicaid and Medicare, make up 15% of all Medicaid beneficiaries but account for almost 40% of Medicaid spending. Seeking both to improve care for people with chronic conditions and disabilities and to restrain growth in Medicaid costs, states are increasingly focused on and invested in coordinating care more effectively and comprehensively. In particular, under a new federal initiative, a number of states are planning to demonstrate new, integrated models of care for dual eligibles.

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, including dual eligibles. CMS issued guidance to the states on November 16, 2010, which provides additional detail related to implementation of health homes.³ The health home option presents states with an opportunity to develop more person-centered models of care for Medicaid beneficiaries with chronic health conditions that reduce fragmentation and improve care coordination and integration, and that potentially reduce costs as well. To promote health homes, the ACA also provides 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. States are also eligible to receive federal Medicaid matching funds for state expenditures up to \$500,000 for planning activities related to the development of health homes.

As states continue to grapple with budget pressures and seek to improve care delivery in Medicaid, health homes have attracted significant state interest. Twenty or so states have demonstrated interest by formally submitting an SPA to CMS, preparing draft SPAs for discussion with the agency, or seeking planning funds. This brief focuses on the first four states to receive CMS approval for their health home SPAs: Missouri, Rhode Island, New York, and Oregon. It examines the health home programs these states have established, explores similarities and differences in their approaches, and offers observations regarding how states are moving forward in implementing health homes. As part of the comparative analysis, the brief also reviews selected aspects of the SPAs in North Carolina and Iowa, the two states to receive CMS approval most recently.

Medicaid health home option: key parameters

The concept of the health home builds on the patient-centered medical home (PCMH), which is a care delivery model designed to promote care that is patient-centered, coordinates services across the health care spectrum, and is provided by a team of professionals led by a patient's personal physician.⁴ With more than 40 states reported to have programs and policies in place that advance medical homes,

most states have some familiarity with the PCMH model.⁵ The goal of health homes, as articulated in CMS' guidance, is to expand the traditional medical home model further, to enhance the "integration and coordination of primary, acute, and behavioral health (mental health and substance abuse), and long-term services and supports, for persons with chronic conditions across the lifespan." In short, the health home model advances a "whole person" orientation to care. While physicians may play the lead role in directing health home services for an individual, the health home option also contemplates approaches in which multi-disciplinary community health teams may play this role.

Who is eligible for health home services?

Under the new section 1945 of federal Medicaid law, Medicaid beneficiaries are potentially eligible 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 chronic conditions listed in the law include: a mental health condition, a substance use disorder, asthma, diabetes, heart disease, and being overweight with a body mass index (BMI) over 25. The Secretary of the Department of Health and Human Services (HHS) is authorized to expand the list to include additional chronic conditions, such as HIV/AIDS. Eligible individuals in states adopting the health home option receive services from a health home provider, as defined further below.

Two fundamental tenets that apply generally in Medicaid – the "comparability" and "state-wideness" requirements – are waived in the context of health home programs, enabling states to target health home services. The waiver of the comparability requirement allows states to cover services for the health home population in a different amount, duration, and scope than they do for other Medicaid beneficiaries. Thus, states can offer health home services selectively to Medicaid beneficiaries with specified chronic conditions, or to those with higher numbers of or more severe conditions. Similarly, the waiver of the state-wideness requirement allows states to confine their health home programs to specific geographic areas. Once states define their criteria, they must offer health home services to all categorically needy Medicaid beneficiaries who meet them, including dual eligibles.

What are health home services?

Health home services are defined as:

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

What provider entities can qualify as health homes?

The law identifies three different health home provider arrangements:

- *Designated provider* – A physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined appropriate by the state, and that meets qualification standards to be set by the HHS Secretary.
- *Team of health care professionals operating with a designated provider* – The team may include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the state. The team can

be freestanding, virtual, or based in any setting determined appropriate by the state and approved by the HHS Secretary.

- *Health team* – A community-based interdisciplinary, interprofessional team of health care providers established to support primary care practices (as outlined in section 3502 of the ACA). The team may include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers, chiropractors, licensed complementary and alternative medicine practitioners, and physicians’ assistants.

What capabilities must a health home have?

Health home providers must provide cost-effective and culturally appropriate person- and family-centered services, and CMS expects them to perform a wide array of functions. They must develop a care plan for each person that coordinates and integrates all clinical and non-clinical services and supports required to address his or her health-related needs, including: preventive and health promotion services; mental health and substance abuse services; care management; care coordination and transitional care across settings; chronic disease management; individual and family supports, including referrals to community and social supports; and long-term services and supports. They must use HIT to link services to the maximum extent feasible, facilitate communication among providers, beneficiaries, and caregivers, and provide feedback to practices. They must also have a continuous quality improvement program, and report data to support the evaluation of health homes.

How does payment for health home services work?

The federal match rate for health home services is 90% during the first eight fiscal quarters a health home SPA is in effect. After that period, the match rate reverts to the state’s normal federal matching rate.

States have flexibility in designing their payment methodology for health home services. They can adopt a tiered payment structure based on the severity of a person’s condition or the capabilities of a health home provider. They can pay for health home services on a fee-for-service (FFS) or capitated basis, or may propose an alternative approach. The SPA must describe the state’s rate-setting policies in detail.

A look at Medicaid health home programs in four states

I. Missouri

Target population. In October, 2011, Missouri became the first state to receive CMS approval of a Medicaid health home SPA, which was followed by approval of a second, separate SPA. The state’s behavioral health SPA targets beneficiaries who have a serious and persistent mental health condition, or a mental health or substance abuse condition and another chronic condition or a risk of developing another due to tobacco use. The state’s primary care clinic health home SPA targets Medicaid beneficiaries who have two or more chronic physical conditions, or who have one chronic condition and are at risk of developing another. Missouri implemented both health home initiatives statewide, effective January 1, 2012.

Missouri uses CyberAccess, its Medicaid claims-based electronic health record (EHR), to identify beneficiaries who are eligible for health home services, and the state auto-assigns them to a health home. To be eligible for the health home program, a beneficiary must meet the state’s clinical criteria and also have health care costs that exceed a specified threshold – for the behavioral health SPA it is \$10,000 in the previous year and for the primary care clinic health home SPA it is \$2,600 in the prior

year. Beneficiaries are notified of their health home assignment, but may select an alternative health home or decline to participate in the health home program altogether. Potentially eligible beneficiaries who receive services in an emergency department or as inpatients are notified about health homes and, based on their choice, referred to one. Together, the two SPAs are expected to serve between 35,000 and 40,000 individuals at any given time during the first two years of the program.

Providers. Missouri defined different designated health home providers under its two SPAs. In the program for beneficiaries with behavioral health conditions, the designated providers are community mental health centers (CMHCs) certified by the Department of Mental Health. In the program for beneficiaries with chronic physical conditions, the designated providers are federally qualified health centers (FQHC), rural health clinics, and primary care clinics operated by hospitals. Under both SPAs, providers must meet not only the federal requirements, but also state-established criteria to qualify as a health home. These criteria include NCQA recognition as a Patient-Centered Medical Home (PCMH), requirements related to the volume of Medicaid patients, assignment of all enrollees to a physician, establishment of a Memorandum of Understanding with a regional hospital or health system for transitional care planning, and improvement on state-specified clinical indicators.

Payment. Missouri pays health homes directly, in the form of a PMPM amount for clinical care management. The PMPM payment is largely for the cost of staff principally responsible for the delivery of health home services. It also includes an administrative support component for activities including, but not limited to, referral tracking, data management and reporting, and chart audits. The PMPM payment supplements regular FFS and managed care plan payments, and is intended to fund only health home services and activities that do not duplicate other services financed through the Medicaid program.

HIT. Health homes in Missouri must use CyberAccess, which is accessible to all Missouri Medicaid providers, to collect patient demographics and to track prescriptions, utilization, place of service, and diagnoses. Health homes can also view lab tests and values using CyberAccess. Through a separate web portal, patients can access similar health information in layperson's terms.

II. Rhode Island

Target population. Like Missouri, Rhode Island has two approved health home SPAs. One is for individuals with a serious and persistent mental illness (SPMI), while the other is for children and youth under age 21 with special needs. Both initiatives were implemented statewide, effective October 1, 2011.

To be eligible for the SPMI program, a Medicaid beneficiary must have a disorder that seriously impairs functioning, and must have had intensive psychiatric treatment, experienced an episode of continuous, structured supportive residential care, or have impaired role functioning. He or she must also meet at least two of the following criteria for at least two years: be employed in a sheltered setting or have limited skills/work history; require public financial assistance for out-of-hospital maintenance; be unable to maintain personal social support system; require help with basic living skills; or exhibit inappropriate social behavior that requires intervention by the mental health/judicial system. The state estimates that roughly 5,000 Rhode Island Medicaid beneficiaries, two-thirds of whom are dual eligibles, have a SPMI.

To be eligible for the health home program for children and youth with special needs, an individual must have a diagnosis of severe mental illness or serious emotional disturbance, or have two of the following

chronic conditions, or have one and be at risk for developing another: mental health condition, asthma, diabetes, developmental disability, Down syndrome, mental retardation, or seizure disorder.

Rhode Island identifies beneficiaries who are eligible for the SPMI health home program from data supplied by Medicaid managed care organizations (MCO) and the state's Medicaid data warehouse, and auto-assigns them to a designated health home provider. As in Missouri, beneficiaries can choose an alternative designated health home provider, or opt out of the program altogether. Enrollment in the health home program for children and youth with special needs takes place through centers where children are already receiving services (described below).

Providers. Rhode Island has nine community mental health organizations (CMHOs), including two providers of specialty mental health services, that comprise the statewide mental health delivery system. The state relies exclusively on this mental health network to serve as health homes for individuals with SPMI. In addition to meeting state licensure requirements as behavioral health organizations, the CMHOs are required to meet health home certification requirements outlined in Rhode Island's SPA.

The state relies on a different existing network of providers – Comprehensive Evaluation, Diagnosis, Assessment, Referral, Re-evaluation (CEDARR) Family Centers – to serve as health homes for children and youth with special needs. Begun in 2000, CEDARR Family Centers are designed to provide a structured, statewide system for delivering the comprehensive, federally required Medicaid benefit package for children, known as EPSDT, and for making referrals to community-based services and supports that benefit child and family. The centers are led by licensed professionals and provide services primarily in the home and community-based settings. Separate from the certification standards they must meet as CEDARR Family Centers, these entities (like CMHOs) must meet additional requirements to be designated health home providers. The state estimates that 95% of the 2,700 children and youth currently served by CEDARR Family Centers meet the health home eligibility criteria.

Payment. CMHOs in the SPMI health home program receive a statewide average monthly case rate for the services they provide. The state determines a single statewide case rate based on the estimated costs of individual health home staff, health team composition, and the estimated overall caseload. The case rate replaces the payments the state previously made for services similar to health home services (e.g., community psychiatric supportive treatment services and the care coordination component of Assertive Community Treatment), and it encompasses the additional costs of oversight, monitoring, and care management required of health homes. CEDARR health home providers for children and youth with special needs are paid on a FFS basis for certain services (e.g., outreach and development of a family care plan) and an hourly rate for others.

Rhode Island pays both CMHOs and CEDARR Family Centers directly for health home services provided to beneficiaries, whether they are enrolled in MCOs or receive services on a FFS basis. To avoid duplication of services and payment for beneficiaries in managed care, the state has an operational protocol that outlines which care management responsibilities belong to designated health home providers versus MCOs.

HIT. For health home-eligible beneficiaries who are enrolled in MCOs, the MCOs supply data on these enrollees to support health homes. For beneficiaries not enrolled in MCOs (principally, the dual eligibles), the state plans to derive similar information from the Medicaid data warehouse and other sources, including CMS Medicare utilization and cost data, to provide to the designated health homes.

III. New York

New York plans to roll out health homes statewide in three phases. The state received approval for its Phase 1 health home SPA, effective January 1, 2012. The first phase includes ten counties – Bronx, Brooklyn, Nassau, Warren, Washington, Essex, Hamilton, Clinton, Franklin, and Schenectady. The remaining counties are scheduled for implementation in 2012.

Target population. New York’s health home program is targeted to beneficiaries with two or more chronic conditions; or HIV/AIDS and a risk of developing another chronic condition; or one serious mental illness. Chronic conditions are defined as including: a mental health condition, substance use disorder, asthma, diabetes, heart disease, BMI over 25, HIV/AIDS, hypertension, and other conditions associated with 3M Clinical Risk Group categories. New York estimates that, of the 5.4 million enrollees in its Medicaid program, 975,000 (including dual eligibles) are in the target population. The first phase of the health home roll-out will include approximately 278,000 Medicaid beneficiaries. Those receiving long-term care and those with intellectual disabilities are not included in this health home initiative, but New York intends to seek approval of a separate health home SPA that will focus specifically on these populations.

Providers. To qualify as a health home, a provider must meet standards developed by the state with stakeholder input, in addition to fulfilling the federal requirements for the health home model. Provider entities that may serve as health homes include primary care practitioner practices; hospitals; medical, mental, and chemical dependency treatment clinics; FQHCs; certified home health care agencies; and other providers that meet health home standards. Consistent with federal statute, health homes are expected to use a multi-disciplinary approach to providing care, involving medical, mental health, and chemical dependency treatment providers, social workers, nurses, and other providers, led by a dedicated care manager, who ensures that beneficiaries receive services and supports consistent with their care plans.

The New York Department of Health used an application process to determine which providers to designate as health homes. In reviewing applications, the state looked for provider-led partnerships that met the standards and qualifications for providing health home services, a network of provider entities sufficient to give eligible individuals choice, and the case management capacity to address the full complement of needs of the health home population. Particularly strong applications included: one or more hospital systems; multiple ambulatory care sites; connections with mental health, HIV, chronic illness, and addiction care management programs; community-based organizations, including housing programs; and managed care plans. In designating health home providers, the state also sought to control the number of health home partnerships in a given geographic area, preferring to encourage a small number of health homes with broad “bandwidth.” The state viewed this approach as a way to minimize silos, improve accountability, and ensure the financial viability of individual health homes.

New York designated 12 entities as health home providers in the Phase 1 counties, and provider-led health homes have been conditionally approved for Phase 2 and 3 of the roll-out. Medicaid beneficiaries who meet the state’s targeting criteria are auto-assigned to one of the provider-based health homes, but have an opportunity to choose a different health home or to opt out of the program entirely. In assigning beneficiaries, the state prioritizes those with the most complex chronic conditions.

Payment. New York pays health homes a PMPM amount, adjusted by region and for the case mix of those enrolled. Once more data on health home enrollees are available, the intent is to adjust PMPM payments further, based on the profile of a health home provider’s population (e.g., impairments in

physical and/or behavioral abilities and housing status). New York’s payment methodology involves two different payment tiers based on whether a beneficiary is in the “case finding” (outreach) group or the “active care management” group. The case finding group refers to beneficiaries to whom health home providers are reaching out but not yet providing health home services. The PMPM amount for beneficiaries in the case finding group is 80% of the active care management PMPM, and is available to health homes for three months as they reach out to the beneficiaries assigned to them.

In New York, a large number of beneficiaries who qualify for health home services are enrolled in Medicaid MCOs. In areas deemed to have a sufficient supply of health home providers, MCOs are required to contract with these entities to provide health home services for the eligible population, and the state makes a separate PMPM payment to the MCOs for health home services. In cases in which the health home entity provides all health home services, the MCO is expected to pass through the entire health home PMPM to the health home provider. In cases in which the MCO provides some of the health home services, the MCO may split the PMPM amount with the health home entities in proportion to their respective efforts. New York is developing MCO contract language to help ensure service delivery design and a payment methodology that do not result in duplicate payment to both health homes and MCOs for the same health home services.

HIT. New York has developed initial and final HIT standards that providers must meet to be designated as health homes. Providers must be able to meet the initial HIT standards immediately and provide a plan for achieving the final standards within 18 months of the health home program’s initial operation.

IV. Oregon

Target population. Oregon received approval for its health home SPA in March 2012. Health home services are offered statewide, and target individuals with two chronic conditions, one chronic condition and a risk of developing another, or one serious mental illness. The state’s list of chronic conditions include those identified in federal statute, as well as hepatitis C, HIV/AIDS, chronic kidney disease, chronic respiratory disease, cancer, and BMI at or above the 85th percentile for those under age 20. Oregon uses information published by the U.S. Preventive Services Task Force to determine when an individual is at risk for a chronic condition.

Providers. Providers that may be designated as Patient-Centered Primary Care Homes (PCPCHs) – Oregon’s name for health homes – include physicians (family practice physicians, general practitioners, pediatricians, gynecologists, obstetricians, and internists); certified nurse practitioners and physician assistants; clinical practices or clinical group practices; FQHCs; rural health clinics, tribal clinics, community health centers, community mental health programs, and drug and alcohol treatment programs with integrated primary care providers. To be designated and recognized as a PCPCH, entities must provide information to the Oregon Health Authority related to six core attributes: access to care; accountability; comprehensive, whole-person care; continuity of care; coordination and integration; and person- and family-centered care. Providers must satisfy minimum standards to qualify as a health home, and they are classified into three tiers based on the degree to which they satisfy additional standards. Tier 1 PCPCHs meet the basic standards, and Tiers 2 and 3 represent more advanced PCPCHs.

Assignment to a health home is voluntary and beneficiaries have the right to opt out by informing their provider or the state directly. PCPCHs submit a list of their Medicaid health home beneficiaries to the state Medicaid agency either directly or, if an individual is enrolled in managed care, through the person’s MCO. The referring provider must document beneficiary engagement and agreement with this

assignment in the patient's medical record. Oregon estimates that 118,000 of its Medicaid beneficiaries meet the eligibility criteria for health home services.

Payment. Oregon pays PCPCHs a PMPM amount for health home services that varies based on the PCPCH's tier. The PMPM is \$10 for Tier 1 PCPCHs, \$15 for Tier 2 PCPCHs; and \$24 for Tier 3 PCPCHs. As a condition of receiving PMPM payments for an enrollee, a PCPCH must provide core health home services to him or her at least quarterly. The PCPCH must document these services in the patient record and use a provider portal/panel management system to demonstrate provision of comprehensive care management.

For Medicaid beneficiaries not enrolled in MCOs, Oregon pays PCPCHs the health home PMPM directly. For individuals who are enrolled in MCOs, the state pays these amounts to the MCOs instead. The MCOs, in turn, are expected to pass these amounts through to the health home provider. To the extent that an MCO retains any portion of these funds, the dollars must be used to carry out functions related to the PCPCH and are subject to approval and monitoring by the Medicaid program.

HIT. PCPCHs are encouraged, though not required, to use HIT systems to gather and report health home-related data, and to maintain an electronic health record (EHR) for each health home enrollee. Use of an EHR and demonstration of meaningful use are among the criteria used to determine a PCPCH's tier. Meaningful use of HIT indicates a more advanced level of health homes and is likely to result in higher health home PMPM payments.

Emerging themes in health home initiatives

The four state health home programs profiled here reflect different design and implementation choices by the states (see the Appendix for a comparison across programs). Although the approaches vary, some general directions are evident.

Geographic scope. All four states elected to implement health homes on a statewide basis, rather than in a limited geographic area. While New York implemented health homes in only ten counties initially, the state's plan is to phase the program in statewide in 2012. The other three states implemented statewide immediately.

Target populations. All four states relied heavily on the chronic conditions named in the ACA and the subsequent CMS guidance to define their target populations. The inclusion of these chronic conditions in the four states' programs is not surprising, given their specific mention in the statute and their impact on Medicaid costs. The fact that all four target individuals with SPMI is consistent with the vision of health homes as a mechanism for improving coordination between physical and mental health services. It also reflects these states' recognition, based on claims data, that individuals with SPMI consume significant Medicaid resources and could benefit greatly from improved care management and coordination. For the most part, the four states also adopted all the other chronic conditions listed in the ACA as targeting criteria. The single exception is Rhode Island, which includes most but not all of the conditions in its health home program for children with special needs, but limits its other health home program to individuals with SPMI.

With CMS' approval, all four states are also using the health home option to target individuals with chronic conditions outside the ACA list. Both Missouri and Rhode Island include developmental disability as a condition that can confer eligibility for health home services. Rhode Island's SPA for children and youth with special needs also includes Down syndrome, mental retardation, and seizure disorders as chronic conditions. Missouri considers tobacco use a factor that puts an individual at risk for other

chronic conditions, such as asthma. Also, Missouri counts diabetes both as chronic condition and as a risk factor for cardiovascular disease, which makes individuals with diabetes alone eligible for health home services. New York and Oregon both include HIV/AIDS, chronic respiratory illness, and chronic kidney disease on the list of conditions that qualify beneficiaries for health home services. Oregon also includes cancer and hepatitis C as qualifying conditions.

Enrollment. To help ensure enrollment and participation in health homes, three of the four states have chosen to auto-assign beneficiaries to a health home provider, but give them an option to choose a different health home or opt out of the program entirely. Under Oregon’s approach, PCPCHs identify health home-eligible individuals, who then participate through their PCPCH. Rhode Island auto-assigns beneficiaries to health homes under its SPMI SPA and, in its health home program for children and youth with special needs, children can opt to enroll in health home services at special centers that are already serving them.

Health home provider designation. The four states have taken different approaches to designating entities to provide health home services. Rhode Island, and Missouri in its behavioral health SPA, rely exclusively on existing statewide networks of mental health providers to serve as health homes. In both states, only the existing network of community mental health organizations and specialty providers can be designated health home providers for individuals with SPMI. Similarly, in Rhode Island, only CEDARR Family Centers can serve as health homes for qualifying children and youth with special health care needs.

Oregon’s and Missouri’s health home programs for individuals with chronic physical conditions permit a broader cross-section of providers to be designated as health homes, subject to their ability to meet program requirements. For example, in Oregon, primary care providers, community health centers, and rural health clinics are just some of the entities that may qualify, provided they meet the criteria for patient-centered primary care homes. New York has taken a third approach. While a broad range of provider-led entities may potentially qualify as health homes, the state uses an application process to determine which will be designated in a given geographic area, and to ensure that all designated entities meet the state’s health home requirements.

Payment methodologies. For the most part, the four states pay PMPM amounts to health home providers. Missouri and Rhode Island (SPMI SPA only) have developed estimates of monthly staffing and administrative costs to provide health home services, and pay a standard PMPM rate to providers for these expected costs. Oregon tiers its PMPM payment amounts, paying more to higher-level, more advanced PCPCHs. New York PMPM amounts vary by region and are adjusted to account for the case mix of a health home provider. New York also pays a share (80%) of the full PMPM amount to health home providers for up to three months following a beneficiary’s enrollment with them, prior to the beneficiary’s full engagement in receiving health home services. Only Rhode Island’s health home program for children and youth with special health care needs relies on more traditional FFS payment.

Coordination with managed care. In all four states with approved health home SPAS, designated providers are responsible for coordinating care for the eligible health home population, whether these individuals are enrolled in managed care plans or receive their care on a FFS basis. Except in Missouri, the percentage of Medicaid beneficiaries who are enrolled in managed care plans is high. Under half of Missouri’s Medicaid population is enrolled in MCOs, but this represents close to 400,000 individuals. For Medicaid beneficiaries in managed care, both Missouri and Rhode Island make health home PMPM payments directly to designated health home providers. By contrast, in New York and Oregon, the PMPM payments for health home services are made to MCOs, with the requirement that plans pass the

full amount through to the designated health home provider unless the MCO provides some of the health home services. In the latter case, the MCO can only retain the fraction of the full amount that corresponds with the services it provides. For all four states, the health home payments are intended to compensate designated health home providers for their care management activities, separate and apart from those that MCOs perform. Rhode Island has developed specific protocols for inclusion in MCO contracts, and New York is following suit, to delineate the responsibilities of MCOs versus health homes.

North Carolina and Iowa

The two health home initiatives most recently approved by CMS, North Carolina's and Iowa's, share many characteristics with the four state programs highlighted here. Both define their target populations with reference to the chronic conditions listed in the statute and are implementing their programs statewide. Iowa adheres closely to the statutory list of chronic conditions, but adds hypertension and BMI over the 85th percentile for children. North Carolina goes further, adding ten qualifying conditions to the list, including blindness, congenital anomalies, and chronic neurological diseases. Also, North Carolina considers certain diagnoses, such as diabetes, to place a person at risk for other qualifying conditions, making these diagnoses sufficient by themselves to make Medicaid beneficiaries eligible for health home services. Certain pregnancy-related conditions (e.g., gestational diabetes) are also considered risk factors; thus, in combination with another qualifying chronic condition, these conditions make a woman eligible for health home services. However, mental illness and substance abuse are not among the qualifying conditions for health home services.

In designating health home providers, North Carolina will rely on existing providers in its PCCM program, Community Cares of North Carolina. The 14 regional networks and the local primary care providers will receive a PMPM amount, which will be higher for beneficiaries who are aged, blind or disabled. In Iowa, health home providers may be primary care practices, community mental health centers, FQHCs, rural health clinics, or other providers that adhere to state health home standards and, at a minimum, fill certain positions needed to perform health home responsibilities, such as designated primary care providers, care coordinators, and health coaches. Health home providers will receive a PMPM amount, tiered based on the number of chronic conditions a beneficiary has. Iowa has also incorporated a pay-for-performance program that will allow health homes to earn incentive payments based on specified quality measures related to prevention, management of diabetes, asthma, hypertension, and mental health, and total cost of care.

Key health home challenges

Role of health homes in evolving delivery systems. The appropriate role for health homes in the context of other evolving care delivery and payment arrangements is an issue that states interested in implementing health homes will have to define. The four health home states profiled here had to hammer out the relationship between health homes and MCOs, in terms of both service delivery and payment. Decisions about that relationship are particularly critical as states expand capitated managed care to include many of the same Medicaid populations the health home option targets.

Health homes and integrated care for dual eligibles. Roughly half the states have submitted proposals to CMS to participate in the federal initiative to demonstrate new models of integrated care for dual eligibles. Because dually eligible individuals cannot be excluded from health home programs, if a state that has adopted the health home option and also obtained federal permission to test an integrated care model for dual eligibles, the state would need to consider how to fit the two programs together. Harmonizing the health home and dual eligible initiatives so that they meet the guidelines and

requirements set by CMS for each, will require partnership between the federal government and the states. Meshing health homes with the new integrated care models may enhance these systems' ability to deliver care better and improve the patient experience for dual eligibles, who include many of the most medically complex and frail individuals in the nation.

Competing health reform priorities and state budget pressures. The ACA requirements related to expanding Medicaid in 2014, establishing state-based exchanges, and upgrading IT systems, are stretching Medicaid agencies at a time when many states' resources and administrative capacity have been sharply cut. In such an environment, even when additional federal support is available, states may have to prioritize the ACA opportunities they will pursue. The 90% federal match for health home services for two years provides a salient incentive for states and significantly mitigates the fiscal risk involved in investing in a program whose savings are uncertain – although the evidence is strong that better care management for individuals with chronic conditions, as health homes envision, can improve outcomes and reduce costs.⁶ At the same time, state timeframes for achieving savings are driven by state budget cycles, and states still must identify their 10% share of health home program spending. To help ensure continued state funding when the 90% match expires, states must also develop a mechanism for identifying savings attributable to their health home programs.

Looking ahead

Health homes are a promising new addition to states' toolbox for improving care and outcomes for Medicaid beneficiaries with chronic health care needs. The states that have adopted the health home option so far provide an indication of some of the different ways in which health homes may be designed, structured, and integrated with other health care delivery and payment arrangements. The approaches they have taken give other states a menu that they can borrow from or adapt in light of their particular goals and environments. Wedding health homes to systems of integrated care for dual eligibles may enhance the performance and impact of these arrangements.

As states accumulate data from their health home programs, evaluation of their impact on beneficiaries' access and utilization, quality of care, patient experience, health and social outcomes, and Medicaid costs will help inform state policy and programmatic choices going forward. CMS will also continue to learn over time and be better able to provide technical assistance and guidance to states interested in this opportunity. The lessons and results from the early-adopter states may also guide broader system reforms aimed at delivering more coordinated and highly effective care, particularly for those with the most complex needs, who have the most to gain from such progress.

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APPENDIX: MEDICAID HEALTH HOMES FOR BENEFICIARIES WITH CHRONIC CONDITIONS

	Missouri Community Mental Health Center SPA	Missouri Primary Care Clinic SPA	Rhode Island SPMI SPA	Rhode Island SPA for Children and Youth with Special Needs	New York	Oregon
Target Population	Individuals with a serious and persistent mental illness (SPMI); or a mental health or substance use disorder and one other chronic condition or risk of developing one based on tobacco use.	Individuals with two or more chronic physical health conditions; or one chronic physical health condition and risk of another.	Individuals with SPMI.	Children and youth under age 21 with serious mental health condition; or two chronic conditions; or one chronic condition and risk of developing another.	Individuals with two or more chronic conditions; or HIV/AIDS and risk of developing another chronic condition; or one serious mental illness.	Individuals with two chronic conditions; or one chronic condition and risk of developing another; or one serious mental illness.
Chronic Conditions	Chronic conditions listed in ACA* plus developmental disability.	Asthma, diabetes, cardiovascular disease, BMI >25, and developmental disability; diabetes and tobacco use defined as placing an individual at risk of another chronic condition.	SPMI.	Mental health condition, asthma, diabetes, developmental disability, mental retardation, Down syndrome, seizure disorders.	ACA chronic conditions plus HIV/AIDS, hypertension, and other conditions associated with 3M Clinical Risk Group categories.	ACA chronic conditions, as well as Hepatitis C, HIV/AIDS, chronic kidney disease, and cancer.
Providers	Community mental health centers (CMHC).	FQHCs, rural health clinics (RHC), and primary care clinics operated by hospitals.	State network of nine community mental health organizations (CMHOs), including two specialty mental health service providers.	State network of Comprehensive Evaluation, Diagnosis, Assessment, Referral, Re-Evaluation, (CEDARR) Family Centers.	State uses application process to select provider-led health home entities. PCP practices, hospitals, medical, and behavioral health treatment clinics; FQHCs, home health agencies, and other providers meeting health home standards may qualify as health homes.	Physicians, clinical practices, certified nurse practitioners, FQHCs, RHCs, community health centers (CHC), CMHCs, tribal clinics, and drug and alcohol treatment clinics meeting Oregon Patient-Centered Primary Care Home (PCPCH) standards.
Payment Methodology	PMPM based on estimated health home staffing and other administrative costs.	PMPM based on estimated health home costs.	Monthly case rate based on estimated health home costs.	FFS for some health home services and hourly rate for others.	PMPM adjusted for region and case mix; tiered payment structure, with higher payment for those actively engaged in care management.	Tiered PMPM based on whether health home is classified as a Level 1, 2, or 3 PCPCH; more advanced PCPCHs receive higher PMPM.
Relationship to MCOs	State pays CMHCs directly for health home services provided to managed care enrollees.	State pays health home providers directly for health home services provided to managed care enrollees.	State pays monthly case rate directly to health home providers for managed care enrollees.	State pays CEDARR Family Centers directly for health home services provided to managed care enrollees.	State pays health home PMPM to MCOs for plan enrollees; MCOs must pass PMPM through to health home providers unless MCO provides portion of health home services.	State pays PMPM to MCOs for plan enrollees; MCO must pass PMPM through to PCPCHs and may only retain part to extent it performs health home functions, subject to state approval.
HIT	Health homes must use Cyber Access, the Missouri Medicaid HIT system.	Health homes use state Medicaid HIT system.	MCOs/Medicaid database will be used to support health homes.	MCOs/Medicaid database used to support health homes.	Health homes must meet initial HIT standards and, within 18 months of program start-up, final standards.	Meaningful use of HIT is among elements used to gauge PCPCH level, which determines tiered payment.
Geographic Scope	Statewide.	Statewide.	Statewide.	Statewide.	Phase 1 roll-out in ten counties, with expansion state-wide in 2012.	Statewide.

*Chronic conditions listed in ACA statute are: mental health condition, substance abuse disorder, asthma, diabetes, heart disease, and BMI over 25.

Endnotes

¹ Kronick, R., et al. "The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions," *Center for Health Care Strategies*, October 2009.

² Garfield, R. and Damico, A. "Medicaid Expansion Under Health Reform May Increase Service Use And Improve Access for Low-Income Adults With Diabetes," *Health Affairs*, January 2012.

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⁴ "Joint Principles of the Patient-Centered Medical Home," *American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA)*, February 2007.

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