



# **Health Homes in Medicaid:**

## **The Promise and the Challenge**

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## Executive Summary

Since passage of the Affordable Care Act (ACA), health care providers and insurers have been actively engaged in payment and delivery reform. They aim to improve the quality of health care while slowing growth in its costs. In both the public and private sectors, much of this reform focuses on integrating primary care and other aspects of health care. One initiative supporting this integration is the Medicaid health home, which addresses not only physical health needs but also a broad range of mental health and social needs for targeted high-cost, high-need segments of the Medicaid population.

Health homes build on several broader movements in the health policy field, including long-standing efforts to integrate physical and behavioral health care, address the social determinants of patient and population health, and develop connections across medical services, social services, and long-term services and supports. The vision for the health home model is that it will ensure coordination and continuity of care across settings and over time by providing a “cost-effective, longitudinal ‘home’ to facilitate access to an interdisciplinary array of medical care, behavioral health care, and community-based social services and supports for both children and adults with chronic conditions.”<sup>1</sup>

In this brief, we define and explore the health home concept and its potential to improve quality while reducing costs. Drawing on findings from the first year of the Urban Institute’s five-year evaluation of this new model, we then present an overview of the challenges that must be overcome to achieve the desired results.<sup>2</sup> Findings are based on document review and interviews conducted in Missouri, New York, Oregon, and Rhode Island—the first adopters of the Medicaid health home option.

In our interviews, state policymakers, stakeholders, and providers were enthusiastic about health homes’ potential to deliver higher-quality care at lower costs. But we also found that realizing this promise—particularly in the short time frame within which states are expected to produce results—poses enormous challenges. Five areas of challenge stand out from our visits with officials and providers engaged in implementation:

- Treating the “whole patient” through teamwork, coordination, and sharing information across providers not used to working with each other requires a major culture change in the delivery of medical care. How much culture actually has to change varies across states, and across practices within states. Some states were further along than others in promoting care coordination when the health home initiative began. And regardless of starting point, some states are asking more of participating providers than others in moving forward. Providers also vary in their readiness to implement—with safety net and mental health practitioners generally more accustomed than other practitioners to addressing nonmedical patient issues. Finally, getting patients to change—to engage in their own care and share in the decision-making process—also is a challenge.
- Achieving real-time and thorough communication is essential to health home operation, but it is technically, legally, and operationally complex. Establishing a habit of communication among all providers—primary care, specialists, hospitals, and community providers—with responsibilities for treating a given patient is part of the culture change. Facilitating that communication through technology requires investment in systems and training. Information systems are often weak, rules for handling sensitive information are complex, and in many cases experience is limited. Design limitations and costliness of electronic health records hamper communication. And even improved technology cannot overcome the fact that some providers (including hospitals, specialty care providers, and diagnostic providers) lack financial or other incentives to communicate in ways that prevent hospitalizations and minimize provision of unnecessary services.

- Developing the data systems and processes to target and track patients for whom coordination can reduce unnecessary service is a sizable task, and it requires substantial investment of human and financial resources. States are taking different approaches to targeting, ranging from the centralized generation of each health home's patient list to provider-generated lists submitted for state approval. Neither approach will necessarily ensure identification of all patients likely to benefit from coordination, or all those for whom coordination will prove cost-effective. And even once patients are identified, providers in all states struggle to acquire and effectively use data to monitor and improve patient care.
- Care coordination redistributes resources across providers. Developing payment mechanisms that appropriately distribute payments to those who incur new costs is a challenge facing health homes along with all other delivery reform initiatives. Of particular concern in these early stages is who will bear the start-up costs of system development. Per member per month payments may be sufficient to meet ongoing costs of new modes of care but may generate insufficient returns early on to finance the needed up-front investment. Some practitioners expressed concern that states and health plans may reap most of the benefits of practitioners' investment in change.
- As with any new program, establishing the health homes benefit presents substantial administrative and logistical challenges, both at the state and provider level. For providers, the largest administrative challenges include establishing and maintaining systems for identifying patients, tracking their care, and billing for services not previously billable under Medicaid. In addition to supporting providers in these efforts, states are also attempting to coordinate or align their health homes program with the myriad other health reform efforts underway, which requires them to juggle multiple priorities in an environment of limited resources.

These challenges indicate that it will not be easy to realize health homes' promise to deliver better-quality care at lower cost. Moreover, they highlight the need for flexibility, perseverance, and patience as implementation proceeds. Evaluating the experience of early adopters can help guide states and providers as they work to implement this promising model of care and to ensure that the investments they are making in health homes are on the right track.

## Health Homes in Medicaid: The Promise and the Challenge

Since passage of the Affordable Care Act (ACA), health care providers and insurers have been actively engaged in payment and delivery reform. They aim to improve the quality of health care while slowing growth in its costs. In both the public and private sectors, much of this reform focuses on reconfiguring primary care and integrating it with other aspects of health care. One initiative supporting this integration is the Medicaid health home. This model, established by Section 2703 of the ACA,<sup>3</sup> is intended not only to better coordinate physical health care across settings, but also to integrate physical health care with a broad range of mental health, social, and community-based services for targeted high-cost, high-need segments of the Medicaid population.

In this brief, we define and explore the health home concept and its potential to improve quality while reducing costs. We then present an overview of the challenges that must be overcome to achieve the desired results, drawing on findings from the first year of Urban Institute's five-year evaluation of this new model.<sup>4</sup> We focus on Medicaid health home implementation in Missouri, New York, Oregon, and Rhode Island—the first four states with approved programs. These findings rely on two sources: (1) reviews of the health systems and related programs in the four states and reviews of each state's Medicaid plan amendments that establish the structure of their health home benefit and (2) findings from site visits conducted over the first year of the evaluation.

### What is the Medicaid Health Homes Model?

Section 2703 of the ACA authorizes state Medicaid agencies to include six specified health home services as an optional benefit in their Medicaid programs. The services are

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

States may develop their own definitions of what those services specifically entail, subject to approval by the Centers for Medicare and Medicaid Services (CMS). As an incentive to implement this option, states receive an enhanced federal match for the specified services (90 percent, compared with an average federal match of 57 percent for other services) for eight quarters after the program's effective date.

The law also allows states considerable flexibility in the design and implementation of their health homes benefit. States may designate a wide range of health home providers, including primary care practices, mental health centers, home health agencies, and other entities, so long as the designated providers have the required systems and infrastructure in place to provide health home services and meet qualification standards. States may also designate teams of providers from partnering entities to serve as a health home. They also have flexibility in designing their payment method. Most states have adopted a per member, per month (PMPM) case rate, but these rates differ widely in terms of structure, level, and which entity receives the payment. States may also design methodologies other than PMPM case rates, subject to approval by CMS.

States must specify the populations that are eligible to receive the designated health home services. The minimum criteria for health home eligibility are having two chronic conditions, having one chronic condition and being at risk of a second, or having one serious and persistent mental health condition. States may enroll beneficiaries with conditions specified in the legislation (i.e., a mental health condition, a substance use disorder, asthma, diabetes, heart disease, or being overweight) or, with CMS approval, beneficiaries with some other serious conditions such as HIV/AIDS. States also may choose to focus on beneficiaries with a larger number of chronic conditions or greater severity than is specified in the legislation.

Unlike standard Medicaid benefits, states may offer health home benefits only in particular geographic areas, and may provide services to health home participants that are different in scope, duration, or quantity to those offered to other Medicaid beneficiaries.<sup>5</sup> However, once the eligibility criteria are established, states must offer health home enrollment to all categorically needy persons who meet them.<sup>6</sup> Table 1 provides a summary of the choices that the early adopter states have made in designing their health home initiatives.

## What Are the Origins of the Health Home Concept?

Three distinct movements came together to produce what the ACA defines and supports as a Medicaid health home. The first is the medical home movement, which dates back to 1967 and began as a pediatric care model focused on children with special health care needs. The American Academy of Family Physicians first endorsed the idea that every American should have a medical home in 2004 and was soon joined by other national associations (American Academy of Family Physicians et al. 2007). Medicaid programs seeking to go beyond traditional case management have also promoted medical homes for adults and children well before the ACA was enacted.

A parallel and more recent movement focuses on the need for coordination of primary care with behavioral health services. This movement gained momentum following the 2005 publication of the IOM report “Improving the Quality of Health Care for Mental and Substance-Use Conditions”, which was part of the *Crossing the Quality Chasm* series (Institute of Medicine 2005). A subsequent study published by the National Association of State Mental Health Directors provided further impetus, reporting that people with serious mental illness die earlier than the general population, typically from physical health problems such as cardiovascular, pulmonary, and infectious disease (Parks et al. 2006). Federal programs to integrate and coordinate behavioral and physical health care were established soon after. The Substance Abuse and Mental Health Services Administration launched the Primary and Behavioral Health Care Integration program in 2009 and, along with the Health Resources and Services Administration, cofunded the Center for Integrated Health Solutions. Both initiatives promote the integration of physical and behavioral health care—an approach often described as “whole person care”—through a combination of training, technical assistance, and grants.<sup>7</sup> As part of the health home program approval process, states are required to submit their proposed SPAs to the Substance Abuse and Mental Health Services Administration for review.

A third movement—championed by the public health community—has also promoted the health system’s role in the coordination of health services, but in ways that go well beyond traditional definitions of medical care. Public health experts have long argued—and empirical research demonstrates—that social factors such as nutrition, housing, stress load, education, and health literacy are more important contributors to health status than medical care (Institute of Medicine 2001; McGinnis et al. 2002). Whole-person care requires that providers pay attention to a patient’s social and medical circumstances and, where needed, take steps to connect patients to community services and supports that can address these social determinants of health (Garg et al. 2013; Hung et al. 2007).

A final related and long-standing policy interest is the integration of Medicare and Medicaid funding streams for persons eligible for both programs (i.e., dual eligibles), many of whom have multiple chronic physical and mental health issues and need long term services and supports. This integration promotes better coordination of care across a broad spectrum of care needs (Medicare Payment Advisory Commission 2013). Under separate provisions of the ACA, CMS is actively promoting state demonstrations to integrate Medicare's acute care and Medicaid's long-term care for dual eligibles (Cassidy 2012). States may not exclude this population from health homes, and multiple health home states are participating or have active proposals for participation in related CMS initiatives, either independently or to support their health home efforts.

All of these predecessors share the premise that applying a broader concept of health and addressing its components in a coherent, coordinated way can improve quality of care and quality of life. Moreover, through careful targeting of health home beneficiaries, it is hoped that these quality gains can be achieved without increasing cost, and in some cases decreasing it. The objective of bringing about quality improvements, reduction of inappropriate or unnecessary care, and cost savings is explicit in Section 2703 of the ACA, which authorizes the Medicaid health home benefit. As of December 2013, 14 states have approved health home programs, and 12 additional states have either submitted plans for CMS review or approval, or have made official health home planning requests.

## **How Are Health Homes Distinguished from Medical Homes?**

The recent innovations in medical care delivery have taken place under different but often related conceptual frameworks. While moving in the same general direction, different models may emphasize particular aspects of change, sometimes in response to local conditions, sometimes reflecting stakeholder preferences. The health home model has much in common with the better-known "patient-centered medical home" model but is distinct in three fundamental ways: (1) the requirement to integrate physical and behavioral health care, (2) the targeting of health home services to specific high-risk populations, and (3) the requirement to extend coordination beyond medical services to social and community supports.

## **Emphasis on Integrating Physical and Behavioral Health Care Services**

The drive to integrate behavioral and physical health care reflects a growing awareness of the interconnectedness of these two domains (Morden et al. 2008; Parks et al. 2005). Patients with a mental illness are more likely to have chronic physical conditions (Dickey et al. 2002). In turn, patients with chronic conditions such as diabetes and cardiovascular disease are more prone to mental health problems, particularly depression (Katon et al. 2010). The combination can exacerbate physical conditions and lead to higher health care utilization and adverse outcomes, including a decline in a person's ability to perform basic functions, such as walking, eating, and bathing (Chapman et al. 2005). Traditionally, physical and mental health issues have been treated by separate providers, which can lead to incomplete diagnoses and uncoordinated care. Even in cases where patients with co-occurring mental and physical conditions are accurately diagnosed and referred for treatment, they may encounter a range of financial, cultural, and structural barriers to receiving that care (Russell 2010; Unützer et al. 2013).

The goal of care integration and coordination is to systematically and simultaneously address patients' mental and physical health needs. Integration can take many forms; for example, by enhancing screening, referral, and follow-up of mental and behavioral health problems by primary care physicians or, conversely, by focusing the attention of mental health providers on identifying, tracking, and arranging treatment for the physical health problems their clients face. More intensively, it can facilitate colocation of physical and behavioral health services. When supported by information sharing and flexibility in reimbursement, these interventions have the potential to alleviate the stigma of seeking mental health

care and increase the likelihood and efficacy of treatment for both mental and physical health conditions. The desired result is improved care quality for all patients and a reduction in health disparities for the population with mental illness (Collins et al. 2010).

## Targeting Populations with Chronic Conditions

Although medical and health homes similarly emphasize the importance of care coordination for people with chronic conditions and significant care needs, health homes explicitly target defined chronic care populations, largely those with high and potentially reducible health care expenditures. Effective targeting is expected to allow programs to achieve quality goals while meeting cost savings objectives. The personnel and technology costs of coordination and other health home services can be considerable. Savings are possible only if health promotion services and timely attention to care needs are able to reduce unnecessary service use, such as inappropriate emergency department (ED) visits and avoidable inpatient admissions, for otherwise high service users (Kaiser Family Foundation 2013).

## Reaching beyond the Clinical Care Setting

Health homes, like medical homes, emphasize the value of primary care. However, health homes are expected to focus more extensively on services delivered outside of a physician's office and encompass a broader range of provider types than just primary care practices. To date, states with approved state plan amendments have designated community mental health centers (CMHCs), managed care organizations (MCOs), and home health agencies, and provider consortiums formed by lead entities, among others. Health homes are expected to look beyond medical services to identify participant needs and to link participants to appropriate community social services (including substance abuse, employment, housing, and family services) and to long-term services and supports. Maintaining the "whole person" philosophy, health homes are also required to develop a person-centered care plan for each individual that engages the individual in his or her care and integrates information on all clinical and nonclinical needs and services. The linkage to community and social support services is a key part of the preventive, public-health driven focus of the health homes approach, and it is an important component in addressing the social determinants of health.

While the differences between health homes and medical homes are clear conceptually, the two models may overlap substantially in practice. This overlap is illustrated in Oregon, which chose to build its health home program directly within its existing medical home program, the Patient-Centered Primary Care Home initiative. In Oregon, health home beneficiaries are a subpopulation of a primary care provider's panel. Aside from the difference in how their care is reimbursed, they are treated no differently than other patients in the practice who have similar care needs but do not meet the condition-specific health home eligibility requirements.

## What Are the Main Challenges to Implementing Health Homes?

Each health home program faces unique challenges, reflecting both program design and the existing health care policies and infrastructure within a given state. States have considerable flexibility in designing their health home program. Thus, there is substantial variation across states not only in the designated provider types and the populations targeted, but also in how health home services are defined and reimbursed. Even within a single state, each health home provider experiences challenges differently depending on both how much change is needed to meet health home requirements and the resources

available to it. Certain challenges are common to all states. This section provides an overview of common challenges, drawing on early experience in Missouri, Rhode Island, New York, and Oregon.

The largest challenge to achieving the benefits of health homes is the substantial change required in approach to the provision of care at all levels. The health home model implies a cultural change and new responsibilities for both providers and beneficiaries. But there are other challenges as well. Coordination requires development of new communication channels within practices and across different care settings, between providers and patients, and between medical care providers and community resources. Appropriate targeting requires good data on the characteristics of the populations to be served and reliable, secure mechanisms for sharing these data. All of these changes may imply a redistribution of costs across the system and may require realignment of payments to provide the incentive to change and to support the new services. None of these changes are trivial, and all will take time to become the new normal, regardless of any current infrastructure.

Finally, because health homes is a new benefit under Medicaid, participation in the initiative has imposed additional administrative burdens on both state Medicaid agencies and providers at a time when other substantial changes to Medicaid and the nation's health system are underway. Though all four of the early adopter states are building on existing structures and programs, aligning health homes with other reform initiatives already underway, or both, all four have struggled to make these changes.

## Culture Change

As in medical homes, health home clinicians will be required to work as teams to treat and support their patients. Thinking about patient well-being rather than patient care is an inherent shift. Also, achieving the most efficient division of tasks across team members to support patient well-being calls for all team members to understand and respect each other's abilities and limitations. This requires both knowing the capabilities of other service providers and understanding that they can contribute to patient well-being. Physicians may delegate tasks to nurse practitioners, nurses may delegate to care coordinators, and importantly, vice versa. Experience to date with medical homes has shown that teamwork must be learned and it requires a change in the approach of all team members to the task of patient care (Nutting et al. 2010).

The health home model takes the imperative for teamwork one step further and asks the medical team to be aware of social determinants of health and to call on nonmedical resources in the community to address factors that are affecting patient progress. As with other resources, all team members must be convinced of the potential for community resources to contribute to the patient's health goals. For many medical care providers, integration of this new resource may require the largest cultural shift and so may be the most challenging. The degree of challenge will depend on how the standards established for a health home compare to existing practices. Some states have designed their health home programs to closely (or exactly) match existing programs. For example, Rhode Island is targeting one of its two health home programs to children with special health needs who are served by specialized providers known as CEDARR (Comprehensive Evaluation, Diagnosis, Assessment, Referral, Re-evaluation) Family Centers. CEDARR Family Centers provide a limited number of direct services, serving primarily as care coordination and management entities for their clients. In their case, relatively little change was required to become a health home.

Mental health practitioners have long been aware of the important role of nonclinical issues in their clients' lives, so health homes based at CMHCs are more accustomed to thinking beyond the clinic walls. Getting a job or moving into an apartment can be both therapeutic for a patient and an indicator of progress. For some CMHCs, the newly required attention to physical conditions such as obesity and diabetes will require a change in approach to incorporate primary care partners or consultation. For

primarily physical health-focused health home providers, the challenge may be incorporating mental or behavioral health providers and addressing special needs of beneficiaries requiring these services.

The team approach requires an increased focus on sharing information about beneficiaries across all partners participating in care. Two prevalent formal mechanisms for information sharing are the regular care team meeting, more common in CMHCs, and the team “huddle” at medical care clinics, where team members meet briefly before a patient’s visit to identify outstanding issues and care needs. The difficulty or ease with which care teams are formed and adapt to team meetings may be an indicator of the degree to which the culture has changed. Active participation is an indication that the importance of other team members’ contributions to patient outcomes is recognized.

States have taken various approaches to defining and promoting care integration. Missouri’s approach, for example, starts with the care team. Under this model, beneficiaries with serious and persistent mental illness receive health home services through CMHCs, while those with chronic physical conditions receive them through primary care providers. The CMHC and primary care teams mirror each other; both include a director, nurse manager, and a care coordinator or administrator. In addition, CMHC care teams must include a physician consultant, while primary care teams must include a behavioral health consultant. Both types of consultants participate in treatment planning and provide brief consults with other care team members. Behavioral health consultants also conduct screening and brief interventions as necessary. Other team members—such as pharmacists, peer specialists, or dietitians—may be included if necessary.

Early experience in Missouri demonstrates that integrating physical health services into a mental health care setting requires a different approach than integrating behavioral health services into a primary care setting (Schuffman et al. 2009). Primary care and mental health providers have distinct organizational structures and processes, reflecting differences in both clinical culture and in the way that these providers are regulated and reimbursed for their services. Some states are farther along in integrating care and so may achieve the needed cultural shift more easily. Missouri, for example, is building on an existing and long-standing effort to integrate mental and physical health care. Even so, progress can be expected to be uneven because participating providers in Missouri are at different points in achieving integration.

For the greatest success in meeting health home objectives, beneficiaries also must see themselves as active participants in their health rather than as passive recipients of care. The first step in change is engagement in the health home; that is, agreeing to enroll in the initiative. For Medicaid beneficiaries who have unstable living arrangements or distrust of official systems and medical providers, this step can be difficult. In recognition of both the importance of patient engagement and the possible difficulties, New York and Oregon developed payment models that support providers’ efforts in this crucial initial task of outreach and enrollment of eligible beneficiaries.

## Communication

Communication within and across providers is fundamental to achieving the model’s aims of care integration, management, and coordination. Successful communication requires that some new channels be opened and some old channels formalized or strengthened, with particular attention to delegation between providers and across sites of care. The health homes initiative is in its early stages in all states, and communication patterns are still being developed, particularly in and across hospitals and MCOs. How many new patterns and new protocols are needed depends on how much of a change the health home model represents for the existing care system.

Improved communication is not just a function of willingness to share patient information, but also of technical ability. Practices must have the necessary communication infrastructure and staff must be

trained in how to use it effectively. In addition, a central information technology infrastructure is needed both to allow communication across sites and to push data out to practices to improve individual care management and enable a focus on population health and patient panel management.

Certain communication issues loom large, such as those related to sharing sensitive patient information and the timeliness of communication between health homes and other providers, especially hospitals. The legal restrictions on sharing patient information related to substance abuse, HIV status, and mental health diagnoses require special levels of patient consent and are governed by myriad federal and state regulations. Individual health homes have varying levels of experience coordinating and managing care for these populations and typically need to take additional steps to ensure that their consent procedures and underlying data systems are regulation compliant.

The timeliness of communication has been particularly problematic for notification of emergency department (ED) use and hospital admissions. There is a large potential for health home savings to reduce inappropriate or unnecessary ED use and inpatient care while improving care transitions to prevent avoidable readmissions. Timely knowledge of hospital and ED utilization is crucial to improving care and achieving savings. However, Medicaid patients are a small share of hospital clients, and Medicaid health home enrollees an even smaller share. Establishing alert systems tailored to these patients has not come easily for hospitals, and they lack strong external motivation to do so. Moreover, Medicare is the primary payer for beneficiaries dually enrolled in both programs, so even the best reporting systems for Medicaid hospitalizations may not work for dual eligibles. Some aspects of coordination and transitional care, notably medication reconciliation post-discharge, represent a new responsibility on both sides (for hospitals to communicate medication changes and for community providers to track these changes) and have been particularly challenging for all concerned.

Establishing communication channels between health home providers and MCOs has been easier, because MCOs share the health home goal of better care coordination and decreased hospital and ED use. Yet even this process is not without challenges. States have had to work to clearly delineate the division of care management responsibilities to avoid duplication of services.

Another important barrier to optimal communication—both within the health home and beyond—is the often substantial upfront cost of establishing better communication channels. Electronic health record (EHR) technology and regional health information organizations are still being developed in most states. Current EHRs often are not designed to support care integration, the coordination of nonclinical services, or cross-site communication. Integration of mental and physical health services is also complicated. Mental health EHRs may align poorly with primary care EHRs. Also, mental health providers such as psychiatric hospitals, community mental health centers, residential mental health treatment facilities, clinical psychologists, clinical social workers and substance use treatment providers currently are not eligible for the federal subsidies offered to physicians for EHR adoption.

Installing an EHR can be costly both for materials and training, and small providers are likely to find this investment the most burdensome. States have made some attempts to support EHR adoption and to align health home programs with broader health IT efforts. For example, both New York and Rhode Island have made additional funding and technical assistance available to health home providers. In Rhode Island, funding comes primarily through Beacon Community grants, while New York provides grants through the state's Health Care Efficiency and Affordability Law for New Yorkers Capital Grant Program.

## Targeting, Tracking, and Data

The availability and use of good data is essential for health homes to succeed. It allows Medicaid agencies to identify beneficiaries who could gain most from the model of care, allows providers to track and

coordinate care for individual patients, and provides the basis for monitoring the success of the initiative and making midcourse corrections as needed.

Identification of eligible beneficiaries has been approached in different ways by the early implementers. New York, for example, employs a centralized approach designed to identify beneficiaries who both generate the highest costs and run the greatest risk of ending up in the hospital or the ED. The state uses 3M's Clinical Risk Group software and an assignment algorithm based on claims and encounters to identify and then predict the risk of negative health outcomes for each beneficiary who meets the state's eligibility criteria. The state then applies an ambulatory connectivity measure to characterize how connected each beneficiary is to the primary care system. Eligible beneficiaries with a high level of clinical risk and low level of connectivity are given assignment priority. A centralized approach to enrollment may allow a more complete list of enrollees—particularly among beneficiaries with low degree of connection to the health care system—and may minimize opportunities for providers to cherry-pick enrollees. However, Medicaid beneficiaries, especially those with mental health or substance abuse issues and low connectivity to providers, are often hard to track. Health homes have found it difficult to find and engage many of the centrally identified beneficiaries.

Other states have adopted a decentralized system of targeting beneficiaries. In Rhode Island and Oregon, providers identify clients who meet the criteria and transmit lists to the Medicaid agency for approval. This arrangement helps minimize search costs and time but risks missing eligible beneficiaries who are not well-known to health home staff. States are evolving toward a mixed system, in which both the state and providers may identify potential health home eligible beneficiaries, who are then referred to the state for verification or to the provider for outreach.

Regardless of the approach to identification, providers in all four states noted that targeting beneficiaries by condition will inevitably exclude some high-cost, high-need beneficiaries who might benefit from health home services because they do not have the particular conditions required for eligibility. However, providers also noted that the operational changes they make will likely apply to all of their patients, regardless of their status as health home enrollees. Such diffusion may be more complete in practices where the health home enrollees are a larger share of the total client population, such as CMHCs and federally qualified health centers.

Tracking patients and coordinating their care also requires good data, specifically data that reflects all of the care that the beneficiary receives. States are working to ensure that data on Medicaid-financed care is complete and shared in a manner that is sufficiently timely to influence care decisions. Some sensitive and protected data have presented hurdles, but progress is being made. Less progress has been made in acquiring Medicare data, which is held at the federal rather than state level. The share of people in the health home population eligible for both Medicaid and Medicare varies by state and by target population. In New York and Missouri, which focus on individuals with both behavioral and chronic physical conditions, dual eligibles represent 20 and 34 percent of the overall health home eligible population, respectively. In Rhode Island, which focuses one of its programs on adults with serious and persistent mental illness, 60 percent are dual eligibles. A substantial share of care for the dual eligibles is Medicare-financed, and these data are not yet routinely available to states or health homes to use in coordinating care and tracking patient outcomes and quality of care.

Providers also have varying levels of experience using patient data to drive quality improvement or perform population management. It can be a substantial challenge to integrate those processes into a busy clinic, especially where the provider may be receiving utilization data or reports from multiple sources. To assist providers in incorporating data use into their care routines, states have offered many levels of technical assistance to support meaningful use, typically through some combination of learning collaboratives, webinars, peer-to-peer communication, or practice coaching.

## Payment Issues

Section 2703 of the ACA allows states to pay providers for services that previously were not reimbursable under Medicaid, and grants them substantial flexibility in designing the payment for those services. All four of the early adopters are relying primarily on per member per month (PMPM) payment model. These payments vary in structure and level and thus have different effects. For example, Missouri and Rhode Island both pay a flat PMPM rate based on personnel cost and caseload assumptions. CMHCs in Rhode Island are required to submit detailed encounter data supporting service provision in order to receive PMPM payments, and must provide at least one hour of service, recorded in five minute increments, to each enrollee every month. In contrast, PMPM payments in Missouri are triggered when the CMHC submits a quarterly report attesting that each enrollee has received health home services. The difference in administrative burden between these two payment mechanisms is thus substantial.

Reports from providers on the effect of health home payments ranged from mildly negative to strongly positive. Overall, providers are broadly supportive of the goals of the initiative, but fear that without adequate and sustained reimbursement they will be unable to contribute to achieving them. Concerns exist in two areas—startup costs and ongoing costs—and different approaches will be required for each. Startup costs will be lower for providers in states that are building on existing initiatives. But even in these states, providers are struggling to fully implement the initiative, and many would have liked to have seen an introductory period of 6 to 12 months. Many states have been able to tap resources and technical assistance beyond the Medicaid program, particularly from local foundations or advocacy groups, but also from state initiatives outside of Medicaid. Health IT investment has been a major issue, even in states that have phased in the IT requirements over the life of the initiative.

Providers also are wary of making investments in a program that they believe may not continue after the enhanced match ends. Further, many see the cost of investing in change falling on the health home providers, while the return on that investment is likely to accrue to the state or to health plans. Addressing the issue of the distribution of costs and benefits of the initiative may require new payment mechanisms and some assurance that the changes made will be supported over the long run. No financial incentives have so far been provided to hospitals, although the success of health homes relies heavily on hospital cooperation and reduced use of hospital services.

## Administrative Issues

As with any new program, the health homes benefit presents new logistical and administrative challenges for both state Medicaid agencies and participating providers. Identifying, enrolling, and billing for health home patients requires the establishment of new processes and can be burdensome, especially if it represents a significant change from previous practices. For a provider with only a few eligible patients, the cost of setting up and maintaining a billing process just for those patients may be a barrier to participation, especially if there are substantial documentation requirements and the expected additional revenue is low. Even comparatively simple requirements can prove challenging. Oregon providers, for example, must “attest” to providing services through quarterly submission of a list of enrolled health home patients who have received at least one health home service. This is a relatively lighter burden than Rhode Island’s requirement that CMHCs document provision of health home services in five-minute increments. However, providers in both states reported having to identify and track services manually because of difficulty in adapting their systems to do it automatically.

In addition to these and other start-up challenges, the broader reform context creates its own set of problems. In each state, the health home program is just one reform effort among dozens of initiatives, and both states and providers must juggle the demands of multiple priorities and program requirements. All four early adopter states have attempted to align their health home program with other initiatives,

with varying levels of success. The more programs underway, the greater the challenge in coordinating across them.

## Conclusion

This brief has identified some of the expected benefits of the Medicaid health home initiative authorized under Section 2703 of the ACA and some of the broad challenges identified in the first four states with approved programs. Other challenges may arise as more states respond to this new opportunity and the evaluation progresses. But these broad areas of concern we have discussed—effecting cultural change among providers and patients; establishing secure, reliable, and timely communication channels within and across sites of care; identifying data and making it available to all who need it to coordinate and monitor patient care; revamping payment models to better reflect the contributions made to the health outcomes of Medicaid beneficiaries; and managing administrative burden—will remain difficult areas to address as existing programs mature and new programs are designed and launched. Approaches to these issues will reflect the existing infrastructure, cultural context, and material and political constraints in each state. Still, other states can learn from how early adopters solve these challenges, and how those solutions reflect local attributes. Lessons may also be drawn from the missteps and program corrections along the way.

Similarly, there is much that health homes can learn from other delivery system reform experiments underway. Health homes represent an extension and refinement of the better known patient-centered medical home, and it clearly draws from other parallel movements, specifically those focusing on integration of physical health, mental health, and other supports outside the clinical setting in a whole-person approach. The vision for health homes as stated in Section 2703 is that it will ensure coordination and continuity of care across care settings and over time by providing a “cost-effective, longitudinal ‘home’ to facilitate access to an inter-disciplinary array of medical care, behavioral health care, and community-based social services and supports for both children and adults with chronic conditions.”<sup>8</sup> Attention to the whole person, recognition of the social determinants of health, team-oriented care, greater use of data-sharing technology, and a focus on patient outcomes rather than services delivered are applicable to almost all patients in some way. Health home participants may benefit from the intensive coordination authorized under Section 2703, but the diffusion of new approaches to care also have the potential to improve care and outcomes for less severely ill patients. The development of IT infrastructure and the introduction of new channels for communication are likely to benefit all patients to some degree, regardless of condition severity.

The health homes initiative is just one piece of the broader reform process set in motion by the ACA. The potential is great but the challenges are many. Changing the culture of health care delivery will take time and thus requires perseverance. Good data and careful analysis are needed to gauge how effectively the initiative makes good on its promise of gains in quality and reduced growth in cost. Also important is attention to how the challenges are met, which conditions are necessary and which are sufficient for success, and how the initiative might be adapted to fit different needs of all 50 states.

**Table 1. Key Features of Health Home Models in Four Early Adopter States**

	Rhode Island		Missouri		New York	Oregon
<b>Target population</b>	Children and youth under age 21 with serious mental illness; two chronic conditions; or one chronic condition and risk of developing another	Serious mental illness and evidence of need for supports to remain in the community	Serious mental illness, a mental health condition or substance use disorder and one other chronic condition, or a mental health condition or a substance abuse disorder and tobacco use.	Two chronic conditions, or one chronic condition and risk of developing another	2 chronic conditions, HIV/AIDS, or serious mental illness	Serious mental illness, two chronic conditions, or one chronic condition and risk of developing another
<b>Designated provider</b>	CEDARR Centers	Community mental health organizations	Community mental health centers	Primary care providers	Networks of providers collaborating to manage patient care	Patient-centered primary care homes
<b>Qualifying conditions</b>	<ul style="list-style-type: none"> <li>• Mental illness</li> <li>• Asthma</li> <li>• Developmental disability</li> <li>• Diabetes</li> <li>• Down syndrome</li> <li>• Mental retardation</li> <li>• Seizure disorder</li> </ul>	Mental illness, with a history of intensive psychiatric treatment, no or limited employment, and poor social functioning.	<ul style="list-style-type: none"> <li>• Substance use disorder</li> <li>• Mental illness</li> <li>• Asthma</li> <li>• Cardiovascular disease</li> <li>• Developmental disability</li> <li>• BMI over 25</li> <li>• Diabetes</li> <li>• Tobacco use</li> </ul>	<ul style="list-style-type: none"> <li>• Asthma</li> <li>• Cardiovascular disease</li> <li>• Developmental disability</li> <li>• BMI over 25</li> <li>• Diabetes</li> <li>• Tobacco use</li> </ul>	<ul style="list-style-type: none"> <li>• Substance use disorder</li> <li>• Respiratory disease</li> <li>• Cardiovascular disease</li> <li>• Metabolic disease</li> <li>• BMI over 25</li> <li>• HIV/AIDS</li> <li>• Other chronic conditions associated with 3M Clinical risk group categories</li> </ul>	<ul style="list-style-type: none"> <li>• Mental illness</li> <li>• Asthma</li> <li>• BMI over 25</li> <li>• Cancer</li> <li>• Chronic kidney disease</li> <li>• Chronic respiratory disease</li> <li>• Diabetes</li> <li>• Heart disease</li> <li>• Hepatitis C</li> <li>• HIV/AIDS</li> <li>• Substance use disorder</li> </ul>
<b>Enrollment process</b>	Provider identification; state verification		State identification and assignment, provider verification		State identification and assignment, provider verification	Provider identification; state verification
<b>Payment to providers</b>	Fee-for-Service for some health home services, hourly rate for others	Per member, per month (PMPM) case rate based on estimated costs	PMPM case rate based on estimated costs	PMPM case rate based on estimated costs	PMPM, adjusted for region and case mix; providers receive 80% of the PMPM to cover outreach and engagement, and the full rate following patient's enrollment	Tiered PMPM based on provider achievement of state-developed medical home certification; providers may be scored as level 1, 2, or 3

Source: Authors' analysis of Medicaid state plan amendments.



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## Notes

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2. This evaluation is funded under a contract with the Office of the Assistant Secretary for Planning and Evaluation (ASPE). For a more detailed overview of the evaluation, along with first-year findings, see Spillman et al. (2012).  
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4. For further information on evaluation methods and first year findings, see Spillman et al. (2012).
5. That is, states do not have to obtain the waiver of statewideness or comparability that typically would be required to offer health home services within targeted geographic regions or to specific types of beneficiaries.
6. Specifically, states are required to offer services to beneficiaries who are dually eligible for Medicare and Medicaid and those eligible based on receipt of services under a section 1915(c) home and community-based services waiver. States have the option of including the medically needy and persons in Section 1115 Demonstration groups.
7. Center for Medicare and Medicaid Services, “Health Homes for Enrollees.”
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