# Health Homes In Medicaid:

## Challenges and Opportunities for Advocates

*Part of a series designed to help advocates prioritize consumer needs in the development of Health Homes*

From Families USA • November 2012

Our current health care system does a poor job of caring for some of the most vulnerable consumers: low-income people with multiple chronic conditions, mental illness, or substance use disorders. These individuals need care from a range of medical and non-medical providers, including primary care doctors, mental health professionals, specialists, and social workers. Because providers often do not coordinate their care, patients may receive conflicting diagnoses or treatments. This lack of coordination can lead to preventable hospitalizations, treatment complications, adverse drug reactions, duplication of tests, poor health outcomes, and higher costs.[1]

To meet the needs of patients with chronic conditions and complex health care needs, we need to change the way health care is delivered. In many cases, simple, non-medical services can dramatically improve the health and well-being of those with complex health problems. If a patient gets appointment reminder calls from a care manager or help applying for food assistance, it can make a big difference in his or her health. Currently, providers are not usually reimbursed for these important services.

The Affordable Care Act changes that by offering states a number of ways to improve their health care delivery systems by incentivizing coordinated, patient-centered care.[2] The Medicaid Health Home is one of the coordinated care models that states can pursue with funding from the Affordable Care Act.

This brief is the first in a series of three pieces that are designed to help advocates prioritize consumer needs in the development of Health Homes. It defines Health Homes, and it discusses the potential for Health Homes to improve care for vulnerable

patients, the role that advocates can play, and challenges that states and advocates will face. It also includes a chart that summarizes key details of Health Homes in each of the following states: Iowa, Missouri, New York, North Carolina, Ohio, Oregon, and Rhode Island (see page 14).

The second brief reviews consumer concerns in Health Home design in more depth, and the third brief looks at Health Home payment models and quality measures.

# Health Homes 101

## What is a Health Home?

Health Homes were created by the Affordable Care Act as a new way for states to provide care to Medicaid enrollees with multiple chronic conditions. A Health Home is a provider or group of providers who treat the whole person by coordinating all aspects of patient care, including primary, acute, behavioral health, and long-term care.

To develop Health Homes, states must amend their Medicaid plans. And because the treatment and prevention of mental illness and substance use disorders is a key part of the Health Home model, states must consult with the Substance Abuse and Mental Health Services Agency (SAMHSA) to ensure that the Health Home meets these needs. After consulting with SAMHSA, states can submit a state plan amendment to the Centers for Medicare and Medicaid Services (CMS) for approval.

For more information about state plan amendments, see Families USA's *State Plan Amendments and Waivers: How States Can Change Their Medicaid Programs,* available online at http://familiesusa2.org/assets/pdfs/medicaid/State-Plan-Amendments-and-Waivers.pdf.

## Who can be enrolled in a Health Home?

The Affordable Care Act lists the following six chronic conditions that can qualify a Medicaid beneficiary for enrollment in a Health Home:

- A mental health condition
- A substance use disorder
- Asthma
- Diabetes
- Heart disease
- Body mass index (BMI) over 25 (overweight)

States have the flexibility to design Health Homes for enrollees with just one or two of these conditions, or they can develop a Health Home that would serve people with other conditions. For example, Oregon's Health Homes include patients with cancer, HIV/AIDS, and Hepatitis C along with the six conditions listed in the health care law, while Ohio's

Health Home focuses only on those with mental health conditions and/or substance use disorders.[3] States also have the flexibility to set up Health Homes in select counties rather than statewide.

## What services do Health Homes provide?

The Affordable Care Act lists six services that Health Homes must provide, but it leaves it up to the states to define what each service means in practical terms. The six services are:

1. Comprehensive care management
2. Care coordination
3. Health promotion
4. Comprehensive transitional care
5. Individual and family support services
6. Referrals to community and social support services

States are strongly encouraged to use health information technology (IT) to provide and track these six services.

*The second brief in this series includes a discussion of what state advocates should look for in the definition of each service, and it discusses the use of health IT in Health Homes.*

## Which providers can form a Health Home?

States have a degree of flexibility in deciding which providers to use. States also have the opportunity to designate non-traditional providers, such as supportive housing programs, to provide Health Home services. Many states are relying heavily on safety net providers, such as community mental health clinics, to serve as Health Home providers.

## How will Health Homes be funded?

The Affordable Care Act provides funding for states to develop and implement the early stages of Health Homes. State Medicaid agencies can get planning grants of up to $500,000 to fund exploration of the Health Home option. Additionally, for the first two years of each Health Home, the state will receive an enhanced federal Medicaid match of 90 percent for Health Home services. The enhanced match applies only to the six Health Home services that are listed above, not to any other aspect of patient care that may be provided by the Health Home.

Each new Health Home qualifies for its own two-year enhanced match period. This means that if a state receives funding to set up Health Homes that are only for patients with serious mental health conditions and substance use disorders in 2013, for example, that state would still be eligible for a separate, two-year enhanced match period if it chooses to establish Health Homes for people with diabetes and hypertension in 2014. Expanding Health Homes to new geographic areas also qualifies states for a full two years of enhanced federal funding. There is no limit on the number of Health Homes a state can set up.

## Are Health Homes the same as Patient-Centered Medical Homes?

While Patient-Centered Medical Homes (PCMH)[4] and Medicaid Health Homes have similar goals, Health Homes provide two important services that are not found in most Patient-Centered Medical Homes. First, Health Homes must coordinate with behavioral health providers. Mental illness and substance use disorders can make preventing and managing chronic illness very difficult, and, at the same time, those with multiple chronic illnesses are at greater risk for depression and anxiety. In order to address this connection between mental and physical well-being and to care for the whole person, each Health Home must address behavioral health.

Second, Health Homes are required to help enrollees obtain non-medical supports and services, such as public benefits, housing, transportation, legal services, and social support.[5] Patient-Centered Medical Homes focus on the coordination of medical care, while Health Homes must go deeper to address both the medical and non-medical barriers to good health.

Health Homes also differ from Patient-Centered Medical Homes because Health Homes can move coordination beyond primary care. While Patient-Centered Medical Homes are based in primary care practices, Health Homes can be centered on any type of provider. This flexibility allows states to choose the best providers to serve as Health Homes based on the needs of Medicaid enrollees. For example, in order to provide the best possible services to those with substance use disorders or mental health conditions, several states are designating behavioral health providers, such as community mental health centers, as Health Homes for these particular groups.

*The second brief in this series provides a more detailed discussion of what kinds of providers might make good Health Homes.*

# The Role of Advocates in Developing Health Homes

Consumer advocates can play a number of important roles before, during, and after the development of a Health Home. In states that are not already considering the Health Home option, advocates can make the case for Health Homes as a way to improve care, reduce health disparities, address the needs of those with serious mental illnesses, change the way health care is delivered, and cut costs.

As a state develops a Health Home, advocates should weigh in on the state's proposals and suggest ways to make Health Homes better for consumers. Once a Health Home is in place, advocates should help monitor its success, educate patients and their families about this option, and, where they have been successful, push for the state to create additional Health Homes. In states where Health Homes have not worked, advocates can work with the state to make needed changes and improvements.

## Making the Case for Health Homes

In states that are not currently planning to take advantage of the Health Home option, advocates should encourage their state legislators and Medicaid officials to do so. In states that are reluctant to pursue the Health Home option, advocates should emphasize the flexibility of the model. For example, a state that is not ready to develop Health Homes for all the conditions listed in the Affordable Care Act could initially limit Health Homes to a smaller population or geographic area that would particularly benefit from coordinated care. Additionally, advocates should highlight the potential for Health Homes to do the following:

- **Improve Care**
  If done properly, Health Homes can offer a number of benefits for both patients and providers. For patients, Health Homes can provide high-quality care for the whole person, leading to better management of multiple, complex chronic conditions. Health Homes are intended to engage patients so that their care reflects their goals and values. Health Homes also pay providers for the important work they do to improve health that goes beyond medical treatment, such as working with a patient's other providers, and connecting a patient's family members to resources such as support groups and respite care.

- **Reduce Health Disparities**
  Health Homes have the potential to improve health outcomes, particularly for low-income people of color. Communities of color often experience inadequate access to primary care physicians, as well as higher rates of chronic disease and preventable hospitalizations.[6] Health care delivery models that are similar to Health Homes have reduced or even eliminated racial disparities in access to care and disease prevention.[7]

- **Address the Needs of Those with Serious Mental Illnesses and Substance Use Disorders**
  Health Homes are a promising model for meeting the needs of those with mental health and substance use disorders. An estimated 70 percent of these people have at least one chronic health condition, and nearly 50 percent have two or more chronic conditions.[8] Mental health and substance use disorders can complicate the treatment of other chronic conditions, which helps explain why life expectancy for people with serious mental illness is 25 years less than for the general population.[9] Health Homes offer the opportunity to bring together all of a patient's providers, including behavioral health providers and those offering social support, to deal with the patient's needs holistically.

- **Change the Way Health Care Is Delivered**
  Health Homes offer states the opportunity to change the way that health care is delivered with a model that can be tailored to meet the needs of the state and its Medicaid enrollees. Each state can identify those who would benefit the most from coordinated care, and it can use the strengths of the current delivery system to design Health Homes that will provide the best care for these patients.

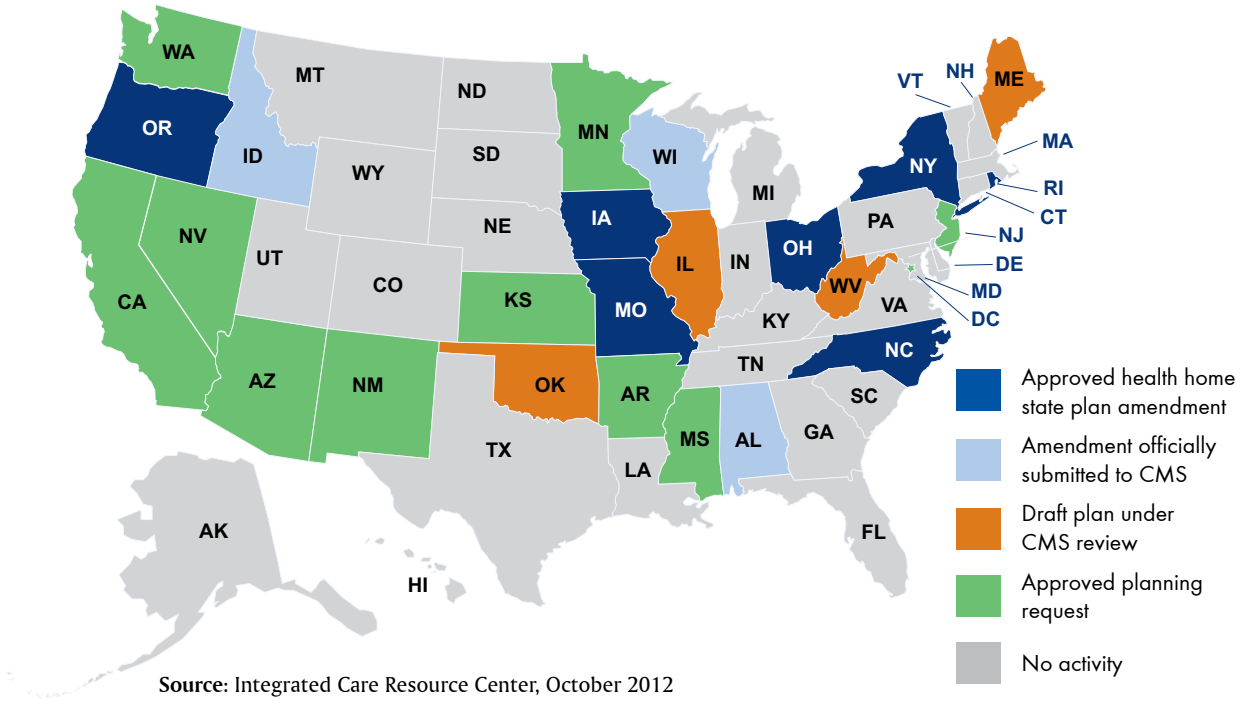
- **Control Costs**
  The patients who would be served by Health Homes are some of the most expensive to treat. Many states are looking for ways to control the costs of caring for this population, and one option for doing so is to enroll these patients in managed care. However, some managed care organizations cut costs by offering small networks of providers and limiting access to care. Restricted access to care is particularly problematic for those with multiple chronic conditions because it can disrupt existing patient-provider relationships and create additional barriers to receiving timely, appropriate care.

  If done well, Health Homes offer a way to use Medicaid funding more efficiently and effectively by getting patients the right care at the right time, thereby reducing costly and unnecessary emergency department visits, hospital admissions, and nursing facility admissions. Early examples have shown that care coordination is most beneficial for patients with complex chronic conditions, so Health Homes are well positioned to improve the quality of care for this population.[10]

  While Health Homes have the potential to save money, it is important to be realistic about cost reductions, particularly during the early years of Health Home implementation. Many of those who are eligible for Health Homes have been sick for years, and poor-quality, uncoordinated care has exacerbated their conditions. Therefore, their care is likely to remain expensive. In addition, most providers will have to make significant upfront investments in staffing, health IT improvements, and training to become Health Homes. States that are considering this option must be ready to support Health Homes over the long term, and they should not expect high savings up front.

## Designing the Best Health Homes

Twenty-six states have either taken advantage of the planning funds provided by the Affordable Care Act or started developing state plan amendments (see map).[11] Advocates in these states can play a key role in ensuring that Health Homes prioritize the needs of patients.




**Source:** Integrated Care Resource Center, October 2012

The first task for advocates is to urge the state to include a strong consumer voice in Health Home planning meetings. CMS has not laid out a specific stakeholder engagement process for the development of Health Homes. Stakeholder groups in states that are already working on Health Homes frequently include state Medicaid officials, payer representatives, and providers, but they often lack a robust consumer voice. While providers who serve the targeted Health Home population do have insights into the care needs of their patients, actual consumers and non-provider consumer representatives are best positioned to protect patients' needs, values, and preferences. Advocates should encourage state officials to include strong consumer voices, and advocates should recruit those who work directly with the target populations (for example, community-based mental health, disability, and/or senior organizations) for stakeholder meetings.

Advocates should also provide feedback on the proposals that are being developed. Opportunities to offer suggestions may include attending stakeholder meetings or sending comments on state plan amendments to the state Medicaid agency and/or to CMS.[12]

The Affordable Care Act requires that all Health Homes integrate behavioral health, whether the Health Home will specifically serve those with mental health conditions or not. States must consult with SAMHSA, so state advocates should submit their concerns related to behavioral health to SAMHSA as well.[13]

## Improving and Expanding Health Homes

Advocates should continue to be involved after a Health Home has been approved. They should highlight consumer concerns during implementation and work to solve any problems. If the initial Health Homes are successful, advocates should push for the development of new Health Homes for people with different conditions or in new geographic areas. If a Health Home needs improvement, advocates should work with providers and/or the state to make changes.

Once a state has received approval for a Health Home state plan amendment, the state needs to recruit and screen potential Health Home providers. A state may issue a request for information about how to calculate per-member, per-month payments or an application for Health Home providers. Advocates should look at these state materials to ensure that key consumer needs, such as network adequacy and a robust capacity to offer care coordination, are addressed. If these materials are lacking, advocates should work with the state, CMS, or SAMHSA to improve them. Advocates also need to ensure that the state agency is approving only providers who meet the criteria that the state develops for Health Home providers.

Stakeholder meetings should continue after Health Homes are operational, not only to ensure that they are functioning smoothly, but also to explore possible expansion and improvement of Health Homes. For example, several states have indicated that they intend to develop performance payments that reward providers for certain outcomes, processes, or quality measures.[14] Advocates should push states to include robust quality measurements, including measures of patient experience, and minimum performance requirements in determining which providers receive performance payments.

Advocates can also encourage states to expand Health Homes to additional populations. Some states are limiting their initial state plan amendments to patients with just one or two of the chronic conditions that are listed in the Affordable Care Act, with the hope of offering additional Health Homes later. The two-year enhanced federal funding for Health Home services applies to each new state plan amendment, so states should use the lessons learned from their first Health Homes to expand care coordination to additional groups of Medicaid enrollees.

Advocates can also play an important role in educating consumers about Health Homes. States are training providers on their new roles and responsibilities with regard to Health Home services, and patients can benefit from this kind of education as well. For example,

the National Association of Mental Illness in Ohio and the Ohio Empowerment Coalition are working with their state Department of Mental Health to design consumer education materials and events for Health Home patients and their families that is focused on empowering patients to take an active role in getting good care.

## Challenges to Creating Good Health Homes

Improving the quality of care for Medicaid enrollees with multiple chronic conditions involves addressing a range of health care delivery problems that disproportionately affect those with complex care needs. States that are developing Health Homes must make a number of important decisions about who can receive Health Home services, which providers can form Health Homes, how the state will define each Health Home service, how to measure and pay for quality care, and how to ensure the sustainability of Health Homes in the long run. This section highlights a number of important considerations that advocates should keep in mind as they work with states to develop Health Homes.

### 1. Designing Health Homes that Meet the Target Population's Needs

States face a number of choices about which patients and which providers will be a part of Health Homes.

- **Eligible Population**
  States must decide what segment of the Medicaid population would benefit most from Health Homes. Many states are initially focusing on those with serious mental illnesses and substance use disorders because of the increased rates of chronic conditions in this population and the high need for integrated care. Other states are focusing on patients with a range of complex conditions, going beyond the six that are listed in the Affordable Care Act. Whatever population a state decides to focus on, it should take advantage of the flexibility granted in the Health Home program to best meet the needs of that group.

- **Geographic Scope**
  If a state is unable to launch Health Homes statewide, it may begin with a specific geographic area. States with limited statewide capacity, infrastructure, and experience with care coordination may want to consider launching initial Health Homes in counties with high-need populations and a strong provider network. Expanding a Health Home geographically qualifies the new areas for their own two years of enhanced federal matching funds for Health Home services, so states can establish new Health Homes using the lessons learned from the initial geographic area.

- **Provider Selection**
  The best Health Home providers will be those who have existing relationships with the community, care coordination experience, health IT systems, and referral relationships with a wide range of providers. Continuity of care is critical, particularly for those with chronic conditions that require ongoing monitoring.

  Early state plan amendments have relied primarily on safety net providers, many of which already serve Health Home populations.[15] Safety net providers also tend to have case management experience, strong provider networks, and a focus on preventive care, all of which may ease the transition to a Health Home. Some states have also considered allowing managed care organizations (MCOs) to be Health Homes, or contracting with other providers to offer Health Home services. While managed care organizations perform basic care management and use health IT, most have several limitations that would need to be addressed to ensure they are effective in delivering Health Home services. These limitations include reliance on phone calls for care management rather than in-person visits, closed provider networks, limited formularies, and lack of experience coordinating behavioral health care and long-term supports and services.

  *The second brief in this series takes a closer look at who should be eligible for Health Homes and which providers will make the best Health Homes.*

## 2. Defining Health Home Services

While the Affordable Care Act establishes the six categories of Health Home services (see page 3), it allows states to define the specifics of what each category will include. Advocates should push for service definitions that effectively integrate the values, needs, and preferences of patients. The definitions should also address both medical and non-medical needs. As states develop the definitions of each Health Home service category, advocates should ensure that the definitions reflect the following best practices:[16]

- **Patient Engagement**
  Rather than making treatment decisions for the patient, the provider's role in the Health Home is to work with the patient to choose care that is in line with her values and preferences and to give her the tools and supports she needs to manage her own conditions. Each service must be designed to reflect the priorities of the patient.
- **Use of Specially Trained Care Managers**
  For most providers, becoming a Health Home will mean hiring new staff to take responsibility for care coordination. Each patient should have an assigned care coordinator who builds rapport with the patient, coordinates care for the patient's medical and non-medical needs, and facilitates communication with providers.[17]

- **In-Person Contact**
  Research has shown that in-person contact increases the effectiveness of care coordination for patients with complex care needs. While telephone contact may be sufficient for some Health Home activities, regular face-to-face contact between a patient and a member of her care team is essential, particularly for evaluating the patient's non-medical needs, building rapport, and assessing the suitability of a new care setting after a transition.[18]

- **Strong Communication between Providers**
  All of a patient's medical and non-medical providers need to have access to the patient's information, including the plan of care and a list of medications, and all providers should be notified of hospital and emergency room admissions in a timely fashion. Providers and the care coordinator should meet regularly to review the patient's treatment and care plan to ensure that her care is being delivered successfully.[19]

  *The second brief in this series highlights specific elements that advocates should look for in each of the six service definitions.*

## 3. Enrolling Patients in a Health Home

Continuity of care and freedom of provider choice are important consumer needs, particularly for those with serious medical conditions. Individuals who are eligible for Health Homes should not have their care disrupted or be forced to switch providers as a result of enrollment in a Health Home. States are choosing either active or passive enrollment for Health Homes.

- **Active Enrollment**
  Active enrollment, which requires eligible individuals to sign up, allows the patient to make decisions about where she wants to receive her care. However, active enrollment requires significant outreach to potentially eligible groups, and it runs the risk of not capturing all those who could benefit from Health Home services.

- **Passive Enrollment**
  Passive enrollment, in which states automatically assign eligible individuals to a Health Home, can disrupt care if states are not careful to assign patients to Health Home providers where they already receive services. If a state uses passive enrollment, it should use claims data to assign patients to Health Homes where they are already receiving care. If this is not possible, transition policies must allow the patient to continue any treatment that was in process at the time of enrollment. Patients should always have the option to switch health plans or opt out of having a Health Home.

Mandatory enrollment, which would require enrollment in a Health Home without the ability to opt out, should be avoided. Lock-in periods that prevent enrollees from changing Health Homes or leaving a Health Home for a certain period of time are also a bad idea. Health Homes must not inadvertently create a barrier to obtaining good care by preventing enrollees from identifying the care that works best for them, whether it is inside or outside of a Health Home.

*The second brief in this series takes a closer look at enrollment issues.*

## 4. Holding Providers Accountable for High-Quality Care

Health Homes offer states an opportunity to pay for the quality of care rather than the quantity of care. In time, this approach is expected to lead to a better patient experience, improved health outcomes, and lower costs. States should choose payment methods and quality measures that encourage providers to improve the quality of care, rather than just cutting costs.

- **Payment**
  States can choose to pay for Health Home services by assigning a specific fee for each service, paying providers a monthly per-patient rate, or developing an alternative form of payment. Most of the early states to develop Health Homes give providers a per-member, per-month (PMPM) payment (also known as a capitated payment). Unlike fee-for-service (FFS) payments, which may encourage providers to focus on the services for which they receive the most reimbursement, PMPM payments give providers the flexibility and incentive to focus on the services that will be most helpful, effective, and efficient for each patient. However, it is important that PMPM payments be adequate to cover the additional staff, time, and technology that are needed to successfully provide Health Home services.

  States should also offer providers payment incentives for treating patients with complex health care needs, improving quality, and reducing costs. Becoming a Health Home and making ongoing improvements requires a significant investment of staff time and resources, and Health Homes should have a financial interest in making positive changes and improving quality. Payment incentives can take many forms, including tiered capitated payments (such as making higher monthly payments for patients with three or more chronic conditions), bonus payments (higher payments for providers who exceed certain quality targets), or shared savings opportunities (returning a portion of the state's savings on a patient's care to a Health Home if the state meets quality targets). All incentive payments must be linked to improved patient experience and quality measures.

- **Quality Measures**
  Using sound quality measures will ensure that Health Homes meet the needs of patients. Health Homes must track a number of measures that are required by both CMS and the state. While robust measures of clinical processes and health outcomes are an important part of every Health Home, states tend to focus on these measures and, as a result, neglect equally important measures of patient experience. The Health Home model's emphasis on patient needs, goals, and engagement should be reflected in the measures that are used to evaluate the success of Health Homes.

  *The third brief in this series focuses on Health Home payment models and quality measures.*

## 5. Ensuring the Sustainability of Health Homes over the Long Term

The enhanced Medicaid match provided by the Affordable Care Act is available only for the first two years of any Health Home. This means that, after two years, the state will be reimbursed at its regular Medicaid matching rate for Health Home services. Advocates should encourage states to maximize the enhanced match period using a number of strategies. First, states should provide training and support to providers before they begin operating as a Health Home so that they are ready to offer services on day one. Becoming a Health Home is a significant investment for a provider, usually requiring new staff, health IT improvements, and the adoption of new business processes. States should support this transformation by offering training, learning collaboratives, and other resources, both before and after providers begin offering Health Home services.

States should also look into leveraging other public sources of funding (such as enhanced payments for health IT in the HITECH Act[20]), as well as engaging external stakeholders to assist in the transition to coordinated care. For example, foundations, providers, and state agencies in Missouri provided $1.5 million to fund technical assistance, learning collaboratives, and expert consultation for Health Home implementation. States should also consider working with other payers, both public and private, to explore the possibility of implementing a multi-payer Health Home model.[21]

## Health Homes: Summary of Key Details

| State | Target Condition | Geographic Scope | Provider Type | Payment Model | Enrollment |
|---|---|---|---|---|---|
| Iowa | Mental health condition, substance use disorder, asthma, diabetes, heart disease, BMI over 25, hypertension, BMI over 85th percentile (for pediatric population) | Statewide | Primary care practices, community mental health centers, federally qualified health centers, and rural health clinics | Per-member, per-month, tiered based on acuity; performance payments based on quality in 2013 | Active |
| Missouri (behavioral health) | Serious and persistent mental health condition and/or substance use disorder | Statewide | Community mental health centers | Per-member, per-month ($78.74 per month); eventually plan to incorporate shared savings | Passive |
| Missouri (physical health) | Asthma, diabetes, heart disease, BMI over 25, developmental disabilities | Statewide | Federally qualified health centers, rural health clinics, primary care clinics operated by hospitals | Per-member, per-month ($58.87 per month); eventually plan to incorporate shared savings | Passive |
| New York | Mental health condition, substance use disorder, diabetes, heart disease, BMI over 25, and 3M Clinical Risk Group categories[a] for alcohol and substance abuse, mental health, cardiovascular disease, HIV/AIDS, metabolic disease, and respiratory disease | 10 counties (expanding statewide in 3 phases) | Managed care plans; hospitals; medical, mental, and chemical dependency treatment clinics; primary care practices; Patient-Centered Medical Homes; federally qualified health centers; targeted case management providers; certified home health agencies; and any other Medicaid-enrolled provider who meets standards | Per-member, per-month ($75-$390), adjusted for geography, case mix, and patient functional status | Passive |
| North Carolina | Asthma, diabetes, heart disease, BMI over 25, blindness, chronic cardiovascular disease, chronic pulmonary disease, congenital anomalies, chronic disease of the alimentary system,[b] chronic endocrine and metabolic disease, chronic infectious disease, chronic mental and cognitive conditions (not including mental illness or developmental disability),[c] chronic musculoskeletal conditions, chronic neurological disorders | Statewide | Medical home | Tiered per-member, per-month based on aged, blind, and disabled (ABD) and non-ABD status plus add-on payments to support special care management for people with special health needs | Active |

## Health Homes: Summary of Key Details (cont'd)

| State | Target Condition | Geographic Scope | Provider Type | Payment Model | Enrollment |
|---|---|---|---|---|---|
| Ohio | Serious and persistent mental illness | 5 counties | Community behavioral health centers | Monthly case rate (amount TBD) | Passive |
| Oregon | Mental health condition, substance use disorder, asthma, diabetes, heart disease, BMI over 25, BMI over 85th percentile (for pediatric population), Hepatitis C, HIV/AIDS, chronic kidney disease, chronic respiratory disease, cancer | Statewide | Primary care practices and practices that meet the state's Patient-Centered Primary Care Home criteria | Per-member, per-month based on level of Patient-Centered Primary Care Home recognition | Passive |
| Rhode Island (behavioral health) | Serious and persistent mental illness and eligible for state's community support program | Statewide | Community mental health organizations | Case rate of $442.21 | Passive |
| Rhode Island (CEDARR) | Diagnosis of serious mental illness or serious emotional disturbance, two chronic conditions (mental health condition, asthma, diabetes, developmental disabilities, Down syndrome, mental retardation, or seizure disorder) | Statewide | Comprehensive Evaluation, Diagnosis, Assessment, Referral, and Re-evaluation (CEDARR) Family Center | Fee-for-service, with payment amounts depending on the service and amount of time taken to provide service | Active |

**Table Notes**

[a] 3M categories are groups of conditions and risk factors that predict hospitalization.

[b] The alimentary system is the system of organs that food goes through. It includes organs in the digestive system, except for things like salivary glands, which are involved in digestion but through which food does not pass.

[c] These conditions include autism, attention deficit hyperactivity disorder (ADHD), and traumatic brain injury.

## Conclusion

Fixing what is broken in our health care system will require major changes in the way we engage patients, organize care, pay providers, and measure success. Health Homes offer states an opportunity to move forward with these changes while improving care for some of the sickest and most needy patients. Coordinated care is the right thing for both patients and providers. Patients deserve comprehensive care and coordinated treatments, and providers ought to be paid to address not just the symptoms, but the medical and non-medical causes of chronic illness. Health Homes are an important step toward building a health care system that provides good health outcomes and positive patient experiences at a lower cost.

## Resources

Center for Health Care Strategies, Inc. (CHCS)
http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261269

CMS State Medicaid Director letter outlining requirements for Health Homes
http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf

Commonwealth Fund States in Action
http://www.commonwealthfund.org/Newsletters/States-in-Action/2011/Jan/December-2010-January-2011/Feature/Feature.aspx

Integrated Care Resource Center (ICRC) Health Homes
http://www.integratedcareresourcecenter.com/healthhomes.aspx

National Academy for State Health Policy (NASHP) Medical Homes and Health Homes
http://www.nashp.org/quality-cost-and-health-system-performance/providers-and-services/medical-homes-health-homes

Substance Abuse and Mental Health Services Administration (SAMHSA) Health Homes
http://www.samhsa.gov/healthreform/healthHomes/index.aspx

## Endnotes

[1] Gerard Anderson, *Chronic Care: Making the Case for Ongoing Care* (Princeton: Robert Wood Johnson Foundation, 2010), available online at http://www.rwjf.org/files/research/50968chronic.care.chartbook.pdf.

[2] Accountable Care Organizations are another example of a coordinated care model in the Affordable Care Act. For more information about Accountable Care Organizations (ACOs), see Michealle Gady and Marc Steinberg, *Making the Most of Accountable Care Organizations (ACOs): What Advocates Need to Know* (Washington: Families USA, February 2012), available online at http://familiesusa2.org/assets/pdfs/health-reform/ACO-Basics.pdf.

[3] For other conditions covered by Ohio, Oregon, and other states with Health Homes, see the chart at the end of this brief. More information on the Health Homes that have been approved by CMS so far is available on the website of the Integrated Care Resource Center online at http://www.integratedcareresourcecenter.com/hhstateresources.aspx.

[4] Patient-Centered Medical Homes are a model of enhanced primary care delivery that focuses on patient access and coordinated care. Patient-Centered Medical Homes have received much attention in recent years as a way to improve quality of care and potentially reduce costs. Unlike Health Homes, Patient-Centered Medical Homes are not defined in a law, so there are a wide variety of definitions of a medical home and medical home accreditations. For more on the Patient-Centered Medical Home model, see Robert A. Berenson, Kelly J. Devers, and Rachel A. Burton, *Will the Patient-Centered Medical Home Transform the Delivery of Health Care?* (Washington: Urban Institute, 2011), available online at http://www.urban.org/uploadedpdf/412373-will-patient-centered-medical-home-transform-delivery-health-care.pdf.

[5] While there are examples of Medical Homes that offer these services, the Patient-Centered Medical Home principles do not require them. For more information, see "Joint Principles of the Patient-Centered Medical Home," February 2007, available online at http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home.

[6] Thomas R. Frieden, "Foreword: CDC Health Disparities and Inequalities Report – United States, 2011," *Morbidity and Mortality Weekly Report* 60 (January 14, 2011), available online at http://www.cdc.gov/mmwr/pdf/other/su6001.pdf; National Association of Community Health Centers and The Robert Graham Center, *Access Denied: A Look at America's Medically Disenfranchised* (Washington: National Association of Community Health Centers and The Robert Graham Center, 2007), available online at http://www.graham-center.org/PreBuilt/Access_Denied.pdf.

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[8] Substance Abuse and Mental Health Services Administration, "What Is a Health Home?" *SAMSHA Blog*, December 4, 2010, available online at http://blog.samhsa.gov/2010/12/04/what-is-a-health-home/.

[9] Joe Parks, Dale Svendsen, Patricia Singer, and Mary Ellen Foti (eds), *Morbidity and Mortality in People with Serious Mental Illness* (Alexandria, VA: National Association of State Mental Health Program Directors, 2006), available online at http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Technical%20Report%20on%20Morbidity%20and%20Mortaility%20-%20Final%2011-06.pdf.

[10] Randall Brown, *The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illnesses* (Princeton, NJ: National Coalition on Care Coordination, 2009), available online at http://www.nyam.org/social-work-leadership-institute/docs/N3C-Promise-of-Care-Coordination.pdf.

[11] For a list of states that have received planning grants for Health Homes or that have submitted or approved state plan amendments that is current as of July 2012, see the Integrated Care Resource Center's map, available online at http://www.chcs.org/usr_doc/HHMap_v9.pdf.

[12] CMS can be contacted with questions about Health Homes at healthhomes@cms.hhs.gov.

[13] To contact SAMHSA regarding Health Homes, email health.homes@SAMHSA.hhs.gov.

[14] Charles Townley and Mary Takach, *Developing and Implementing the Section 2703 Health Home State Option: State Strategies to Address Key Issues* (Washington: National Academy for State Health Policy, July 2012), available online at http://www.nashp.org/sites/default/files/health.home_.state_.option.strategies.section.2703.pdf.

[15] Integrated Care Resource Center, *Implications of Health Homes for NCQA Health Plan Accreditation* (Washington: Integrated Care Resource Center, March 2012), available online at http://www.chcs.org/usr_doc/ICRC_NCQA_TA_tool__032312.pdf.

[16] For a brief definition and description of each Health Home service, see *Designing Consumer-Friendly Health Homes*, the second brief in the Health Homes series.

[17] Randall Brown, op. cit.

[18] Ibid.

[19] Eugene Rich, Debra Lipson, Jenna Libersky, and Michael Parchman, *Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions* (Rockville, MD: Agency for Healthcare Research and Quality, January 2012), available online at http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/pcmh_tools___resources_coordinated_care_v2.

[20] The HITECH Act creates incentive payments for individual Medicaid providers and certain hospitals for the adoption of meaningful use of electronic health records. For more information on the program, see http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms/.

[21] For example, Maine is aligning its Health Homes with its existing multi-payer PCMH pilot. While Health Homes will not be limited to providers who are part of the PCMH pilot, practice requirements, learning activities, and reporting requirements are aligned between the two programs to facilitate participation in both. For more information, see the *MaineCare Health Homes Initiative FAQ for Primary Care Providers*, available online at http://www.mainequalitycounts.org/hosp-tools-and-resources/doc_view/539-me-pcmh-pilot-phase-2-expansion-a-mainecare-health-homesfaq03-12.html.

# Acknowledgments

**This brief was written by:**

*Sarah Bagge*
*Health Policy Analyst*
*Families USA*

**The following Families USA staff contributed to the preparation of this report:**

*Michealle Gady, Senior Health Policy Analyst*

*Kim Bailey, Research Director*

*Kathleen Stoll, Deputy Executive Director, Director of Health Policy*

*Dee Mahan, Director, Medicaid Advocacy*

*Rachel Strohman, Editorial Assistant*

*Ingrid VanTuinen, Deputy Director of Publications*

*Nancy Magill, Senior Graphic Designer*

**Health Homes in Medicaid:**
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FamiliesUSA
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1201 New York Avenue NW, Suite 1100 ■ Washington, DC 20005
Phone: 202-628-3030 ■ Email: info@familiesusa.org
www.familiesusa.org