

Interim Report to Congress
on the Medicaid Health Home
State Plan Option

**As Required by Section 2703 of the Affordable Care Act
From the
Department of Health and Human Services
Office of the Secretary**

Background & Purpose of the Interim Report to Congress

The 111th Congress enacted Section 2703 of the Affordable Care Act (ACA), which added Section 1945 to the Social Security Act (the Act), creating the “State Option to Provide Coordinated Care through a Health Home for Individuals with Chronic Conditions.” The health home state plan option provides an opportunity for states to create a comprehensive person-centered system of care coordination through the delivery of health home services to Medicaid eligible enrollees with chronic conditions.

Pursuant to the Affordable Care Act, the Secretary of Health and Human Services (the Secretary) is required to survey those states that have elected to provide health home services under the Medicaid state plan option and convey the information collected in an Interim Report to Congress. The report is required to describe the nature, extent, and use of the Medicaid health home option, particularly as it relates to the program’s impact on hospital admission rates, chronic disease management, and coordination of care for individuals with chronic conditions. The report must also provide an assessment of program implementation, processes and lessons learned, quality improvements and clinical outcomes, and estimates of cost savings.

In response to the above requirement, this Interim Report describes the commonalities and differences among the health home programs in each of the states that have chosen to implement the program. This report also describes the processes by which states arrived at the decision to pursue a health home state plan amendment and how states built upon initiatives and infrastructure that pre-dated the health home programs. From this information, the report describes challenges and best practices identified by the states in the design and implementation process. The report also presents the results of qualitative research on topics including chronic disease management, coordination of care for individuals with chronic conditions, and assessment of program implementation. The report also addresses enrollment in the health home program by comparing the set of potentially eligible beneficiaries (based on the legislation) for each health home state with those enrolled in each program. Finally, we established baseline hospital admission rates by using inpatient claim discharge data. However, given that health home programs were in early phases of implementation during this evaluation, and claims data were only available for a time period preceding the implementation of health home programs, conclusions cannot be drawn about the program’s impact on admission rates or overall effectiveness.

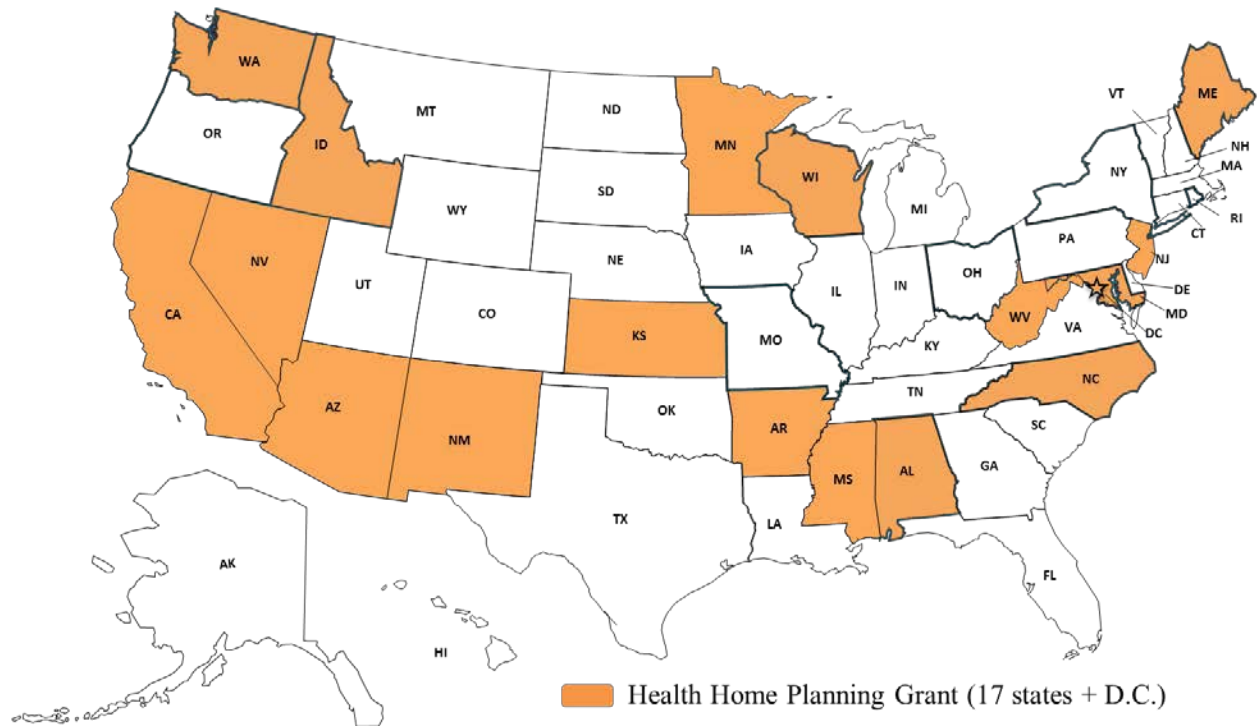
Information for the report was collected through careful review and analysis of 14 health home state plan amendments from 10 states, surveys fielded to state health home program leaders in 8 states and site visits to 6 states. A baseline claims analysis was also conducted using 2010 Medicaid and Statistical

Information System (MSIS) claims data from seven states with approved state plan amendments and where complete 2010 claims data were available for analysis. The claims analysis describes the baseline demographic characteristics, cost, and utilization of beneficiaries who are potentially eligible for a health home program and beneficiaries who were ultimately enrolled in a health home program.

Under the health home state plan benefit, a health home provider delivers a comprehensive system of care by integrating and coordinating all primary, acute, behavioral health (including mental health and substance use) and long term services and supports for individuals with chronic conditions to treat the “whole-person.” As noted in the letter to State Medicaid Directors and State Health Officials on the health home state plan option, the health home provider is responsible for caring not just for an individual’s health condition, but providing linkages to other services and social supports (CMS 2010; <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-13-001.pdf>). The main goals for the health home are to improve health outcomes that will result in lower rates of emergency room use, reduction in hospital admissions and readmissions, reduction in health care costs, create less reliance on long-term care facilities and improve experience of care for Medicaid individuals with chronic conditions.

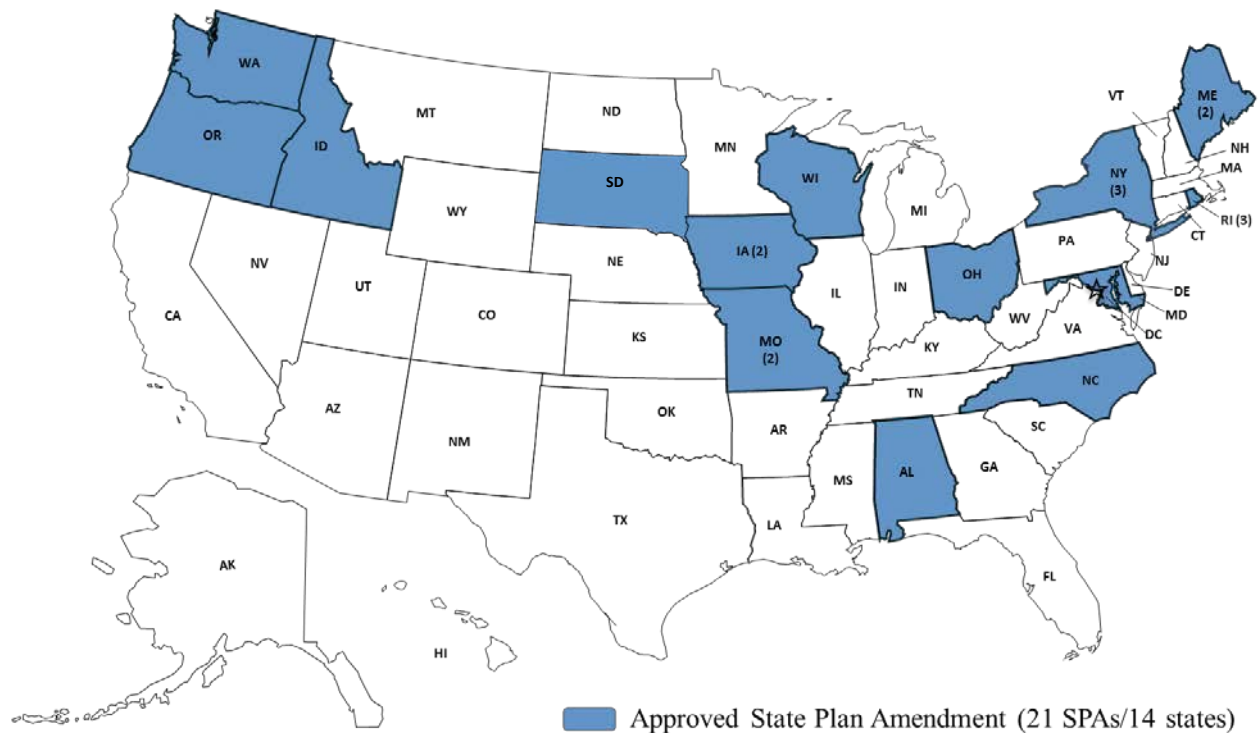
The health home provision authorizes the Secretary of the Department of Health and Human Services to award planning grants to support states in developing and submitting a health home state plan amendment. As of December 31, 2013, 17 states (Alabama, Arkansas, Arizona, California, , Idaho, Kansas, Maine, Maryland, Minnesota, Mississippi, New Jersey, New Mexico, Nevada, North Carolina, Washington, West Virginia, and Wisconsin) and the District of Columbia have been approved for planning grants. As described below, many of these states now have approved health home state plan amendments.

Figure 1. Approved Health Home Planning Grants by State as of December 31, 2013



The provision also offers a significant financial incentive for states to participate in the health home program by providing an eight-quarter enhanced (90 percent) federal match for health home services received by eligible Medicaid enrollees. Many states are interested in the health home model; as of December 31, 2013, the Centers for Medicare & Medicaid Services (CMS) has approved 21 state plan amendments in 14 states: Alabama, Iowa, Idaho, Maine, Maryland, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island, South Dakota, Washington and Wisconsin; one state (Rhode Island) has three state plan amendments, two states (Maine and Missouri,) have two approved state plan amendments and one state (New York) has three. Rhode Island, North Carolina and Oregon had the earliest program effective date of October 1, 2011.

Figure 2. Approved State Plan Amendments by State as of December 31, 2013



Program Design

The health home provision authorized by the Affordable Care Act provides an opportunity to build a person-centered system of care designed to achieve improved outcomes for beneficiaries with chronic conditions and ensure care and value for state Medicaid programs. This provision supports CMS's overarching objective of improving health care through the simultaneous pursuit of three goals: improving the experience of care; improving the health of populations; and reducing per-capita costs of health care (CMS 2010).

CMS Guidance

CMS has provided states flexibility in working with stakeholders to design health home programs that best address the needs of the targeted population consistent with existing patterns of care delivery. On November 16, 2010, CMS released a State Medicaid Directors' Letter (<http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf>) articulating our expectations relative to how the health home program is intended to meet the needs of individuals with chronic illnesses, including those with severe and persistent mental illnesses. The letter provided general guidance clarifying the roles and expectations of a health home program, including guidance on

programmatic design elements such as the eligible population, health home service definitions, provider infrastructure standards, and payment methodologies. These expectations provide a framework for states to consider in developing program designs that provide care and linkages to care that address all of the clinical and non-clinical needs of an individual. In addition, Section 1945 of the Act requires states to seek consultation from SAMHSA (Substance Abuse and Mental Health Services Administration) during the design of their health home programs and prior to submitting their state plan amendments to CMS. CMS and SAMHSA worked collaboratively with each state, providing one-on-one technical assistance and facilitating webinars and learning collaboratives to further assist states in program development.

CMS also eased the process of submitting health home state plan amendments by creating a web-based state plan amendment template. The template is structured to allow states to describe how they will coordinate and provide access to a broad range of services, develop person-centered plans that integrate all needed clinical and non-clinical services, establish a continuous quality improvement program, and promote individual-level quality outcomes, thus promoting a holistic model of care delivery as the basis of the health home model.

In addition, CMS issued a State Medicaid Director's letter in January 2013 (<http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-13-001.pdf>) that recommended eight Health Home Core Quality Measures which will be used to evaluate care across all state health home programs. CMS expects states will report on the health home core set, as well as the specific goals and measures identified by each state. The intent of the two part quality reporting approach is to gain consistency across states while allowing states to use existing quality metrics to measure health home outcomes. These measures will allow CMS, states, and providers to assess progress toward meeting the goals realized via the health home program.

Stakeholder Engagement

Decisions to move forward with a health home program have been made primarily by states' Medicaid offices, often in consultation with various stakeholders. Generally, the health home state plan amendment design and implementation process is built on and strengthened by pre-existing relationships among state Medicaid programs and other state agencies. Often, states convened new or consulted existing advisory councils to assist in designing program elements and implementing program activities. The degree to which various stakeholders were consulted during the design and implementation process varied from state to state.

Target Population

Section 1945(h) of the Social Security Act (the Act) sets forth minimum eligibility criteria for Medicaid individuals with two chronic health conditions, one chronic health condition and the risk of developing a second, or a serious and persistent mental health condition. The statute further defines “chronic conditions” to include (but not be limited to): mental health conditions, substance use disorders, asthma, diabetes, heart disease, and a body mass index of greater than 25. States are also given the option of targeting additional conditions with approval from CMS. Most states to date have complex enrollment algorithms that require conditions to co-occur or be present with certain risk factors in order to qualify an individual for enrollment in their health home program.

State leaders considered multiple factors in selecting their target populations for the health home program. The top five criteria used to select target conditions noted by those states surveyed were:

1. The state’s previous experience with providing specialized care for the population;
2. Relevant evidence or research supporting the inclusion of the target population in the program;
3. Engagement of relevant providers who serve the target population;
4. High per-capita costs;
5. High total costs based on per-capita costs and/or population size.¹

While no single state plan amendment incorporates multiple models, several states developed multiple state plan amendments to allow for the creation of specialized models that address different categories of conditions. A few states submitted and received approval for multiple health home state plan amendments, each focusing on different target populations (i.e., in one state, one state plan amendment targets individuals with a severe and persistent mental illness served by community mental health centers and children with serious emotional disturbances and the second targets individuals with physical chronic conditions served by primary care clinics).

¹ The survey administered to participating states asked them how they selected the target populations for inclusion in their health home program. The fourth (high per-capita costs) and fifth (high total costs based on per-capita costs and/or population size) criteria, although similar, were listed as separate response options. This helps distinguish among states that considered high per-capita costs, but not necessarily the overall size of the target population, from those that emphasized total spending (which could result from a combination of high per-capita costs and population size).

Health Home Operations & Team Composition

The health home services eligible for federal matching percentage as identified in the Affordable Care Act and Section 1945 of the Act are:

1. Comprehensive care management;
2. Care coordination and health promotion;
3. Comprehensive transitional care, including appropriate follow up, from inpatient to other settings;
4. Participant and family support (including authorized representatives);
5. Referral to community and social support services, if relevant; and
6. Use of health IT to link services, as feasible and appropriate (42 USC §1396w-4(h)(4) of the Act).

Additionally, the Health Home State Plan Option identifies three distinct types of permissible health home provider arrangements:

1. Designated providers, e.g., physicians, physician practices, rural health clinics, community mental health clinics, community health centers (42 USC §1396w-(h)(5) of the Act);
2. A team of health care professionals that links to a designated provider, e.g., a group comprised of a physician and other health professionals, including a nurse or a social worker (42 USC §1396w-(h)(6) of the Act); and
3. An interdisciplinary, inter-professional health team, as created by Section 3502 of the Affordable Care Act (42 USC §1396w-(h)(7) of the Act).

While states are required to adhere to the requirements described in Section 1945 of the Act as they relate to health home services, provider infrastructure, provider standards, and reporting requirements, CMS has allowed states the flexibility to administer the program using available resources in a way that supports the states' priorities and goals (42 USC §1396w-4(h)(4) of the Act). As a result, there is significant program-level diversity in the composition of health home teams, individuals' respective roles on the teams, the way that health home services are provided, and how health information technology (health IT) is used.

Although the federal statute includes examples of several different types of care organizations that may qualify as a health home provider, some states have established more restrictive requirements. For instance, two state programs explicitly require that health home providers be primary care provider organizations.

The structure of health home teams also varies across the states. Each state has developed its own requirements for the composition of the health home team and the roles each team member plays in delivering health home services, which are based on the health and psychosocial needs of the state's target populations. At the same time, there is some commonality in terms of team composition, with teams generally including a combination of clinicians, clinical support staff, case management/care coordination staff, clerical/administrative staff, and additional allied health and community health providers. One important difference in team composition is that, in some states, the health home team does not include the participant's primary care provider; e.g., in one state's behavioral health home program, the required primary care physician team member serves as a consultant and not as a provider of health home services. Likewise, in another state's health home program, the primary care provider does not participate on the health home team; the health home team consults with the primary care providers and coordinates, rather than provides the direct care.

Practice Recognition or Certification

In addition to satisfying provider and service requirements in support of care coordination activities, most states require health homes to obtain specific certifications in order to participate in the program. Seven states require participating health home providers to achieve patient-centered medical home recognition through a national organization (e.g., the National Committee for Quality Assurance) or an equivalent state-developed recognition process.

Health Information Technology

Section 2703 of the Affordable Care Act does not mandate the specific technology that health homes must adopt to facilitate the provision of health home services, but the use of health information technology (health IT), as appropriate and feasible, is strongly encouraged. In the absence of federal guidance on health IT for health homes, many states have adopted their own health IT standards for participating providers. Most states require health homes either to use an electronic health record or adopt one within a specific timeframe after becoming a health home. Health homes that are able to transfer electronic health information are expected to do so either through health information exchanges or direct secure messaging. Nine of the ten states surveyed noted that their health home program was either "extremely reliant" or "somewhat reliant" on electronic health records for care coordination, quality measurement, and the achievement of specific quality-improvement objectives.

Patient Enrollment

State approaches to enrollment fall into two major categories: state-driven and provider-driven. Under the state-driven model, claims and encounter data are used to identify beneficiaries who meet the eligibility requirements, and eligible individuals are assigned to participating health homes and notified about their enrollment by either the state or the health home. In these states, beneficiaries are enrolled through an “opt-out” approach, where participants are first notified that they are enrolled in the program, but are given the opportunity to choose not to participate in the program. Under the provider-driven model, participating health homes identify and enroll eligible individuals according to the state’s requirements (after obtaining consent from the enrollee and verifying eligibility with the state).

Payment Methodologies

Most participating states use a per member per month health home fee to pay health homes, with the exception of two state plan amendments. In place of a per member per month payment structure, one program pays a monthly case rate based on a provider’s caseload and staffing costs. The other exception is the state program that provides payments for each of three defined health home service components: Initial Family Intake and Needs Assessment (IFIND), Family Care Plan development (FCP), and Family Care Plan Review (FCPR). Other states tier the monthly health home fee based on patient’s degree of chronic illness, geography, or provider capabilities. One state supplements a per member per month payment with a flat fee for each enrollee once per year.

Baseline Data Analysis

The results of the baseline analysis of cost and utilization of beneficiaries in seven health home states, using 2010 claims data, indicates that states are generally enrolling individuals who have higher rates of health care utilization and higher health care costs when compared to the general Medicaid beneficiary population. In examining a broad group of “targeted” beneficiaries who likely would meet the criteria of health home eligibility as defined in the federal regulation (e.g., those with at least two qualifying chronic conditions and those with one qualifying chronic condition and at risk for a second), those with multiple chronic conditions have significantly higher costs and utilization rates than those who have just one chronic condition. States that prioritize enrollment of those individuals with more complex conditions, are likely to enroll beneficiaries with higher costs and utilization. Given the high costs and utilization of the targeted and enrolled beneficiaries, health home programs have the potential to improve the efficiency of care delivered to this group through improved care coordination and care management services. The impact of the program on cost and utilization will be determined through a longitudinal analysis of health

home enrollees' Medicaid claims that will be conducted as part of a 2017 Independent Health Home Evaluation and Report to Congress.

Key Findings

States Have Leveraged Existing Programs and Care Coordination Infrastructure

Participating states have implemented health home programs that provide comprehensive care coordination and whole-person chronic condition care management to discrete groups of Medicaid beneficiaries with complex health care needs. In doing so, states have designed their health home programs building on existing care coordination programs and infrastructures. They have also implemented new service and provider requirements as needed to better coordinate physical, behavioral, and long-term care. As part of this work, states have made health IT tools available to health home providers and have encouraged their participation in learning collaboratives to support the objectives of the health home program. Health home providers have adopted new strategies for delivering coordinated and integrated care and have adjusted staffing roles to fit the health home model.

States Have Taken Different Approaches to Improve Care Transitions

CMS expects health homes to focus on appropriately transitioning care across the entire care continuum. As a result, all states are requiring health homes to formally establish or strengthen organizational partnerships to ensure bi-directional care coordination across settings during care transitions (e.g., admissions and discharges from hospitals and long-term care facilities). While some states require health homes to enter into contracts or memorandums of agreement with regional hospitals or health systems to formalize transitional care planning, at least one state includes a hospital liaison as part of the health home team.

Although Data Vary, States are Taking Similar Approaches to Measuring Cost Savings

As a condition of state plan amendment approval, states must identify a *methodology* for calculating cost savings resulting from the health home program; they are also required to provide an *estimate* of savings. Chosen methodologies vary and each state has used its own approach to calculate estimated savings. One challenge is that states are not uniformly using or collecting the data to calculate cost savings; e.g., while one state is specifically excluding behavioral health costs, another state's analysis will include behavioral health costs. Furthermore, some states will calculate costs and costs savings for the Medicare-Medicaid eligible population separately from the Medicaid-only population.

Despite these variations, there are common elements across states. States are measuring cost savings primarily in two ways: 1) comparing costs of the cohort of health home enrollees before and after enrollment, and 2) comparing costs of health home enrollees to a control group. Every state is using Medicaid claims and managed care encounter data as the data sources for calculating cost savings, and most states are paying particularly close attention to emergency department and hospital inpatient data. While states are not required to report cost savings annually, most have noted that they will conduct cost analyses at least once per year.

States Expect Reduced Utilization to Sustain Health Home Programs

CMS expects states to continue providing health home services after the enhanced federal match ends, since health homes are authorized via state plan amendments. States report that they plan to continue the programs after the eight-quarter enhanced (90 percent) federal match ends; they believe that the cost savings resulting from improved health status and reduced utilization are expected to, at a minimum, cover the costs of the health home program and anticipate savings in excess of health home costs. Additionally, state health home programs serve to enhance programs that were in place before health home implementation, which makes it unlikely that health home programs will be discontinued after the enhanced federal match is no longer available.

Preliminary Impact of the Health Home Program

Missouri reports that...

Early data from Community Mental Health Center (CMHC) integrated health care home show an annual reduction in hospital admissions (↓12.8%) and emergency room use (↓8.2%). As a result, CMHC health homes are saving the state \$76.33 per member per month in total Medicaid costs and will be expanding enrollment by 25-30% in 2014.

It is difficult to draw conclusions about the preliminary impact of the health home program on the quality of care delivered to and health outcomes of enrollees without conducting a study of enrollees over time and without access to quantitative data to measure these outcomes in a consistent way. Although a baseline analysis of the health home eligible and enrolled population was conducted, conclusions about the impact of the program cannot be derived from these results as they

only provide a description of the population prior to implementation. However, the preliminary impact of the program can be explored by examining qualitative data collected during site visits conducted in states participating in the health home program and speaking with providers and enrollees of health homes. Those states that provide new tools

or facilitate new care infrastructures or staffing models as part of their program appear initially to have a more direct impact on the enrollees. In states where the health home activities as defined by their state plan amendment were closely aligned with a pre-existing program, the impact of the health home program was

New York reports that...

Early data shows that utilization and spending for inpatient services has decreased by approximately 30% for a subset of individuals continuously enrolled in health homes.

harder to isolate. However, all of the enrollees expressed a positive view of the program and recounted a related care experience at their health home provider site. Preliminary impacts of the health home program on enrollees fall into four categories of improvement: 1) patient empowerment, 2) care coordination, 3) access to health care and other community-based services, and 4) care transitions.

Patient Empowerment. Providers and enrollees describe several health home project elements that empower participants by helping them be more proactive and engaged in the management of their conditions. These include creating a care plan for achieving health goals, individualized support from nurse case managers and non-clinical case managers, and patient education programs.

Care Coordination. Health home providers in all states described care coordination as an essential element of the services they provide to enrollees, and there is preliminary evidence that care coordination is being improved. Health home processes such as “morning huddles,” or daily meetings of the health home care teams that occur at the start of each day, help providers to improve and target the care provided to individual enrollees. Health IT tools such as electronic health record systems also play a significant role in improving care coordination processes.

Access to Health Care and Other Community-Based Services. Several health home programs play a key role in helping enrollees obtain referrals for specialist visits, thereby improving access to needed care. In addition to getting access to needed medical services, some health home provider organizations actively work to connect enrollees to other community-based services, including family support workers, home-based care providers, and social services.

Care Transitions. Health home programs in most states, particularly those based in primary care settings, are also designed to help ensure seamless transitions between care settings for enrollees. Although most programs have made significant progress in developing relationships with local hospitals such that they are notified when an enrollee is admitted or discharged, it is unclear whether they have been able to impact transitions in care from other non-hospital settings. As health home programs continue to track and report on quality, outcome, and utilization measures for the population of enrolled health home beneficiaries, the impact of each state plan amendment on health home enrollees can be evaluated.

Operational Challenges

Although each state has created unique health home programs, the states are encountering several common challenges in their design, implementation, and operation. States have reported common operational challenges.

Serving Both Children and Adults

The health home state plan option as defined in Section 2703 of the Affordable Care Act does not allow coverage to be limited to a subcategory of individuals with an eligible chronic condition. Therefore, a health home state plan amendment cannot target by age or be limited to individuals in specific age ranges. States note difficulties in designing a single state plan amendment that targets and adequately serves the needs of both the adult and pediatric populations. States note that many chronic conditions that make up the eligibility criteria for their state plan amendments are not prevalent among children. Additionally, they stress that care delivery to children is unique as it often involves working with and engaging parents and working with other systems including schools, juvenile justice and child welfare agencies. However, while the health home state plan option requires that both adult and pediatric populations be provided with health home services, CMS allows states to align health home program with providers whose programs by their very nature serve the needs of a specific population. In addition, states may target chronic conditions that are more prevalent in particular age groups (e.g., Alzheimer's disease, which would affect primarily older adults). Given this flexibility, states may design their health home provider standards and qualifications to target those providers whose programs serve a particular age group.

Defining a Role for Targeted Case Management Programs

Another challenge noted by states in designing their programs concerns specifying the role of targeted case management in the delivery of health home services. For instance, because one state is transitioning its pre-existing targeted case management program into the state's health home program, it has had to incorporate the various requirements and regulations for that program into the health home initiative. This transition is also a challenge for case managers who must adhere to both sets of rules and regulations until the changeover is complete. Another state has faced challenges in ensuring that, consistent with federal requirements, targeted case management services delivered through their 1915c waiver program do not duplicate care management services provided by health homes. The state's interim solution is that Medicaid beneficiaries cannot be enrolled in both programs. The concern of state leaders and providers is that, since not all health home providers have the resources to offer targeted case management to enrollees, those needing these services could benefit from participating in both programs. Therefore, the

state is exploring a new payment option that may allow health homes to contract with providers of targeted case management services.

Identifying, Engaging, and Enrolling Beneficiaries

The six states also share common challenges as they implement the health home program. Several states have found the process of identifying, conducting outreach to, and enrolling beneficiaries into their health home programs to be challenging. One state has taken a novel approach to enrollment that involves using clinical risk grouping software to analyze claims history and demographic information to identify eligible beneficiaries and prioritize them for enrollment. Although this approach allows the state to identify individuals who could most benefit from a health home, health home providers noted that, at the beginning of the health home program, the lists of eligible health home enrollees provided by the state were often out-of-date and did not always provide up-to-date contact information, making outreach to and enrollment of these individuals very time-consuming and often unsuccessful. In states where outreach and engagement are the responsibility of the health home provider, states may not be reaching all eligible health home enrollees, especially those who do not have an existing relationship with a health home provider. Additionally, for many states, the first contact potential health home enrollees have with the program is a letter from the state or health home notifying them of their enrollment in the program. Most states reported that the enrollment letters describing the health home program caused some initial confusion.

Coordinating with Managed Care Organizations

Coordination between health homes and managed care organizations (MCOs) has been a challenge for a few states. One state noted that, although a relatively small percentage of their eligible participants are enrolled in a MCO, significant contracting delays between health home providers and MCOs early in the process delayed several of the health homes from initiating service delivery. The majority of another state's Medicaid participants are enrolled in Medicaid managed care plans, and a few are commercial MCO members. During the initial stages of implementing the health home program in this state there was limited effective coordination between the health homes and the commercial MCOs for these individuals. Health home providers in another state also noted challenges in ensuring that care coordination activities are not duplicated, but rather coordinated, between health homes and MCOs. To solve this problem, the state developed a formal contingency plan that specifies each organization's responsibilities for coordinating care for health home enrollees, and the state feels that this contingency plan has addressed the initial challenges.

Integrating Health Information Technology

Several states rely on health information technology (health IT) to improve the provision of health home services by facilitating data exchange among providers and to monitor quality improvement and the impact on the health outcomes of program enrollees. Some programs' health IT infrastructures are not fully in place, and this has presented delays in implementing certain aspects of the health home programs. For example, although one state has several operational regional health information organizations, many health home providers and downstream providers lack funding to connect to them and are thus unable to exchange enrollee information. Similarly, another state indicates that its health homes have technical and financial difficulties implementing health IT systems that have functionality consistent with the operations of an efficient health home.

Maintaining a Continuum of Care and Seamless Care Transitions

Several states are finding it difficult to ensure smooth transitions across care settings for health home enrollees. For example, one state was initially having difficulty integrating long-term services and supports (LTSS) into their health home program, but is making efforts to address this by providing health home reports that identify enrollees who are receiving home and community-based services. Health home providers then use the lists to coordinate their services with those provided by home- and community-based service providers for health home enrollees participating in both programs.

Establishing formal relationships with hospitals to ensure that health home providers are notified about health home enrollees' admissions to and discharges from the hospital setting has been a challenge for both the states and health home providers. The community mental health organizations that are part of one state's serious and persistent mental illness health home program often do not receive notifications about health home enrollees who present to emergency departments because many hospitals currently lack an automated admission notifications system.

Administrative Burden of Documenting Services

Providers in several states believe that submitting a claim and attesting to providing services for health home enrollees each month in order to account for per member per month payments is an unnecessary administrative burden. These providers view this type of payment as similar to a capitation payment paid to a MCO and therefore feel that a similar approach should be allowed for the health home program in which Medicaid beneficiaries are also enrolled. These providers also note the expense and time required to customize their existing billing systems in order to file these claims; in general, they prefer a capitated payment model as it avoids this burden. To address these concerns, CMS allows states the flexibility to

require health home service documentation at least once per quarter in order for providers to receive the PMPM payments. CMS also allows states to amend their existing state plan amendments in order to change their health home program payment methodologies. If a state uses a capitated payment arrangement for their health home program, they must adhere to CMS requirements, which require actuarially sound rates and that the state submit amended or new health home provider contracts to CMS.

Lessons Learned

Although the circumstances in which states have been designing and implementing their health home programs are unique and we expect to learn more in the coming years, several common best practices appear to contribute to the success of the health home programs, including:

- Providing strong leadership and a vision that encompasses and engages all stakeholders and entities involved with the program; champions promote adoption of new models of care and put in place administrative supports that will continue to further program goals.
- Leveraging and aligning pre-existing care coordination programs; while the mission of health homes is typically more expansive than traditional care coordination programs, well-developed administrative structures for payment, data collection, and performance measurement can often be used as a foundation.
- Integrating the delivery of behavioral and physical health care to enrollees; co-location of primary care and mental health providers, integration of behavioral and physical health through state requirements for health home staffing, and specific physical and mental health care annual screenings are all ways in which states have advanced integration.
- Establishing priorities for patient enrollment; enrolling patients with the greatest health care needs allows health homes to provide a higher level of care for sicker patients.
- Sharing data among providers involved in enrollee care; health IT can improve the transfer of data among providers to increase care coordination and decrease duplication of services.
- Focusing on enrollee empowerment; approaches adopted by health homes to empower enrollees to take charge of managing their own care are viewed positively by both enrollees and providers.

Conclusion

The resources provided under Section 2703 of the Affordable Care Act allow states to take steps to provide an expanded set of patient-centered, whole-person services for their Medicaid enrollees with multiple chronic illnesses, including behavioral health conditions. During the program's early stages—the primary focus of this Interim Report to Congress—participating states have created several unique programs designed to support care that chronically ill health home enrollees with complex health care needs require. While health home programs have confronted challenges in both their design and implementation, participating states are seeing preliminary successes with patient empowerment, improved care coordination, integration of physical and behavioral health services, care transitions, and access to health care and other community-based services.

The experiences gained from this program will provide valuable insights into how states can continue to employ enhanced care coordination services and health IT to improve enrollees' experiences, improve health outcomes, and lower health care costs. Future evaluation activities will assess the impact of this program over time on outcomes and utilization among the population of enrolled health home beneficiaries, as well as on cost savings in participating states. This national initiative is an important step toward improving health care quality and clinical outcomes for high-cost, high-need patients, while also reducing costs by providing more cost-effective care and improving the experience of care for enrollees themselves.