



U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

**EVALUATION OF THE
MEDICAID HEALTH HOME
OPTION FOR BENEFICIARIES
WITH CHRONIC CONDITIONS:
ANNUAL REPORT - YEAR TWO**

June 2014

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ACRONYMS

The following acronyms are mentioned in this report and/or appendices.

ABD	Aged, Blind or Disabled
ACA	Affordable Care Act
ACO	Accountable Care Organization
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
ADMH	Alabama Department of Mental Health
ADPH	Alabama Department of Public Health
AIDS	Acquired Immune Deficiency Syndrome
AMI	Acute Myocardial Infarction
AOD	Alcohol or Other Drug
APCP	Advanced Primary Care Practice
ARCW	AIDS Resource Center of Wisconsin
ASC	Ambulatory Sensitive Condition
ASO	AIDS Service Organization
BCBS	BlueCross Blue Shield
BCBSNC	BCBS of North Carolina
BHCCH	Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
BIPP	Balancing Incentive Payment Program
BMI	Body Mass Index
BPCI	Bundled Payments for Care Improvement Initiative
BPMS	Behavioral Pharmacy Management System
CAD	Coronary Artery Disease
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBHC	Community Behavioral Health Center
CBO	Community-Based Organization
CC4C	Care Coordination for Children
CCC	Connect Care Choice
CCD	Continuity of Care Document
CCIP	Chronic Care Improvement Program
CCNC	Community Care of North Carolina
CCO	Coordinated Care Organization
CCT	Community Care Team
CCTP	Community-based Care Transitions Program
CD4	Cluster of Differentiation Four
CDPHP	Capital District Physicians' Health Plan
CEDARR	Comprehensive Evaluation, Diagnosis, Assessment, Referral, Re- evaluation
CG	CAPHS Clinician and Group survey
CHCS	New York Center for Health Care Strategies
CHF	Congestive Heart Failure

CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Rauthorization Act
CIDP	New York Chronic Illness Demonstration Project
CIMOR	Customer Information Management, Outcomes and Reporting
CMHC	Community Mental Health Center
CMHO	Community Mental Health Organization
CMIS	North Carolina Care Management Information System
CMMI	CMS Center for Medicare and Medicaid Innovation
CMS	HHS Centers for Medicare and Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
COPD	Chronic Obstructive Pulmonary Disease
CPCI	Comprehensive Primary Care Initiative
CPR	Community Psychiatric Rehabilitation
CPRC	Community Psychiatric Rehabilitation Program
CPST	Community Psychiatric Support and Treatment
CRG	Clinical Risk Group
CSHCN	Children with Special Health Care Needs
CSI	Chronic Care Sustainability Initiative
CVD	Cardiovascular Disease
CY	Calendar Year
DHA	Dirigo Health Agency
DHS	Iowa Department of Health Services Rhode Island Department of Human Services Wisconsin Department of Health Services
DM 3700	Disease Management 3700 Project
DMAP	OHA Division of Medical Assistance Programs
DMH	Missouri Department of Mental Health
DOH	New York Department of Health
DTap/DT	Diphtheria, Tetanus and Pertussis Vaccine
DUA	Data Use Agreement
EHR	Electronic Health Record
eMedNY	New York's Medicaid claims processing system
EMR	Electronic Medical Record
EOHHS	Rhode Island Executive Office of Health and Human Services
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
FFS	Fee-For-Service
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FSD	Missouri Family Support Division
FTE	Full-Time Equivalent
GERD	Gastro Esophageal Reflux Disease
HbA1c	Glycated Haemoglobin
HCS	New York Health Commerce System
HEAL NY	Health Care Efficiency and Affordability Law for New Yorkers
HEDIS	Healthcare Effectiveness Data and Information Set
HH	Health Home

HHS	U.S. Department of Health and Human Services
HIE	Health Information Exchange
HIN	Health Information Network
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health Act
HIV	Human Immunodeficiency Virus
IBHP	Idaho Behavioral Health Plan
IDHW	Idaho Department of Health and Welfare
IHDE	Idaho Health Data Exchange
IMD	Institutions of Mental Disease
IME	Iowa Medicaid Enterprise
IMHC	Idaho Medical Home Collaborative
IPV	Polio Vaccine
LDL-C	Low-Density Lipoprotein Cholesterol
LLC	Limited Liability Company
LME	Local Management Entity
LTSS	Long-Term Services and Supports
MAPCP	Multi-payer Advanced Primary Care Practice demonstration
MATS	New York Managed Addiction Treatment Services
MCO	Managed Care Organization
MCP	Managed Care Plan
MFH	Missouri Foundation for Health
MHAS	Ohio Department of Mental Health and Addiction Services
MHCA	Mental Health Consumer Advocates of Rhode Island
MIP	Maximum Incentive Payment
MMC	Maine Medical Center
MMCP	Medicare-Medicaid Coordinated Plan
MMIS	Medicaid Management Information System
MMR	Measles, Mumps and Rubella Vaccine
MOU	Memorandum of Understanding
MPCA	Missouri Primary Care Association
MRT	Medicaid Redesign Team
NAMI	National Alliance on Mental Illness
NC-CCN	North Carolina Community Care Network
NCQA	National Committee for Quality Assurance
NES	Not Elsewhere Classified
NOMs	National Outcome Measures
NOS	Not Otherwise Specified
NQF	National Quality Forum
NYCCP	New York Care Coordination Program
OASAS	New York Office of Alcoholism and Substance Abuse Services
OASIS	Outcome and Assessment Information Set
OB/GYN	Obstetrics/Gynaecology
OHA	Oregon Health Authority

OHITT	New York Office of Health Information Technology Transformation
OHP	Oregon Health Plan
OMH	New York Office of Mental Health
P4P	Pay-For-Performance
PCCM	Primary Care Case Management
PCDCA	Primary Care Development Corporation Assessment
PCM	Pregnancy Care Management
PCMH	Patient-Centered Medical Home
PCMHA	Patient-Centered Medical Home Assessment
PCNA	Patient Care Networks of Alabama
PCP	Primary Care Provider
PCPCH	Patient-Centered Primary Care Home
PDC	Proportion of Days Covered
PDSA	Plan-Do-Study-Act
PHO	Physician Hospital Organization
PMP	Primary Medical Provider
PMPM	Per Member Per Month
PPC	Physician Practice Connections
PPR	New York Potentially Preventable Readmission project
Q-Tool	Alabama's web-based health information exchange
Q4U	Alabama's care management system
QMAF	Quality Measurement and Feedback
Qx	Alabama's data hub
RCC	Regional Coordinating Center
RCO	Regional Care Organization
RFP	Request for Proposal
RHC	Rural Health Clinic
RHIO	Regional Health Information Organization
RHP	Rhody Health Partners
RI-BHOLD	Rhode Island Behavioral Health Online Dataset
RICCMHO	Rhode Island Council of Community Mental Health Organizations
SAMHSA	HHS Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbance
SEP	Single-Entry Point
SHIN-NY	Statewide Health Information Network for New York
SHIP	State Health Care Innovation Plan
SIM	State Innovation Model
SMD	State Medicaid Director
SMI	Serious Mental Illness
SNF	Skilled Nursing Facility
SNMHI	Safety Net Medical Home Initiative
SPA	State Plan Amendment
SPMI	Serious and Persistent Mental Illness
SUD	Substance Use Disorder

T-CHIC	Tri-State Child Health Improvement Consortium
TA	Technical Assistance
TCM	Targeted Case Management
VZV	Varicella-Zoster Virus

EXECUTIVE SUMMARY

This report presents findings from the first two years of the long-term evaluation of Medicaid health homes, a new integrated care model authorized in Social Security Act Section 1945, created in Section 2703 of the Affordable Care Act. The model is designed to target high-need, high-cost beneficiaries with chronic conditions or serious mental illness (SMI). The Urban Institute is conducting the long-term evaluation of this program for the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary of Planning and Evaluation. This evaluation will assess:

- The care models and processes states are using.
- The extent to which health homes result in increased monitoring and care coordination.
- Whether these models result in better care quality; reduced hospital, skilled nursing facility, and emergency department use; and lower costs.

Findings from the evaluation will inform a 2017 Report to Congress.

The Medicaid health home model elevates the importance placed on integrating physical health care with behavioral/mental health care and on linking enrollees to social services and other community supports. States with health home State Plan Amendments (SPAs) approved by the HHS Centers for Medicare and Medicaid Services (CMS) receive eight quarters of 90% federal match for six defined services: comprehensive care management, care coordination and health promotion, comprehensive transitional care, individual and family support services, linkage and referral to community and social support services, and use of health information technology (HIT). States have flexibility with respect to chronic conditions selected, geographic coverage, providers designated, and the payment system for health home services. The minimum eligibility criteria for beneficiaries include a diagnosis of two chronic conditions, one chronic condition and being at risk of a second, or one SMI.

Evaluation Structure, Timeline, and Methods

The long-term evaluation began October 1, 2011, and will continue for five years. This report examines the 13 SPAs in 11 states included in the evaluation. These include two SPAs from both Rhode Island and Missouri, and one SPA each from North Carolina, Oregon, New York, Alabama, Iowa, Ohio, Wisconsin, Idaho, and Maine. For each included SPA, the evaluation team developed background materials on program design and implementation context and conducting site visits. These will provide a qualitative foundation for tracking and interpreting program progress over the eight-

quarter intervention period during which the enhanced federal match is available. Follow-up telephone interviews are being conducted roughly annually after the initial in-person site visits. Quantitative analysis of key outcomes will occur largely in the final two years of the evaluation and will examine utilization and costs for health home participants and comparison groups of beneficiaries.

Profile of State Health Home Initiatives

The health home programs included in the evaluation reflect the substantial flexibility states have in designing their programs, with variation occurring in the designated provider types, the chronic conditions targeted, and how health home services are defined and reimbursed. Most of the 13 SPAs focus on persons with two chronic conditions or one condition and risk for a second chronic condition. States have the ability to define their own qualifying physical and mental/behavioral conditions. Four states included SMI as an independent eligibility criterion. Wisconsin is unique in defining the eligible population as persons with HIV/AIDS served by specialized providers, while Ohio's SPA, and one SPA each in Rhode Island and Missouri focus entirely on persons with serious and persistent mental illness, SMI, serious emotional conditions, or substance abuse who are served by mental health centers. Conversely, North Carolina, Iowa and Missouri's second SPA base eligibility solely on multiple chronic physical conditions. Rhode Island's second program is the only SPA that focuses specifically on younger beneficiaries with special health care needs receiving care from specialized providers known as "Comprehensive Evaluation, Diagnosis, Assessment, Referral, Re-evaluation" (CEDARR) Family Centers. Regardless of whether mental/behavioral conditions are the criterion for eligibility, all health home programs must integrate physical and mental/behavioral health care for all participants.

With one exception, all 11 states are relying on per member per month (PMPM) payment for health home services. The exception to PMPM payments is Rhode Island's CEDARR Family Center-based health homes, which are paid through a mix of fixed service fees and established rates per quarter hour of effort. Several states base their PMPM on staffing needs assumptions (Missouri, Idaho, and Maine). Rhode Island uses a similar methodology based on personnel costs and staffing ratios for its community mental health organizations under the second SPA. The PMPM in Ohio is calculated based on the state's Uniform Cost Report Requirements (licensure and reporting requirements for community mental health centers), which considers staffing costs, indirect costs related to health home service provision and projected caseloads. New York uses regional and case-mix adjusted PMPM payments for health home enrollees and pays providers 80% of the PMPM during the period when they are attempting to enroll eligible beneficiaries. PMPM payments in Oregon are set at three levels based on the extent to which providers meet established criteria for patient-centered primary care homes.

Implementation and Emerging Issues

Our observations during the first two years of the evaluation have yielded a number of insights regarding key program features and early implementation lessons that we will continue to track over the intervention period.

Health Home Models: Broadly speaking, states have designed health homes program that fall into one of three general types: specialty provider-based (Missouri [one SPA], Ohio, Rhode Island [two SPAs], and Wisconsin); medical home-based models (Idaho, Iowa, Missouri [one SPA], and Oregon); or care management networks (Alabama, Maine, New York, and North Carolina). The *specialty provider model* centers on entities that traditionally serve special populations but integrate specialized care with primary care. The *medical home extension* model is based on the patient-centered medical home, but extends to include specialty and other providers beyond the traditional primary care practice. The *care management networks* are networks or coalitions of physical and mental/behavioral health care providers, care coordination entities, social services agencies, and other community organizations overseen by a lead organization or administrative entity.

Flexibility: Health home programs differ in the degree of flexibility afforded to participating providers, particularly in terms of enrollee composition and payment processes. More prescriptive models may entail greater up-front provider investments to meet staffing requirements. In these more prescriptive systems under-enrollment or enrollment discontinuities are problematic for providers if they do not generate sufficient revenue to cover these costs.

Care Integration: Integration of physical health, mental health, and nonclinical support services is crucial to the success of health homes, but is a challenge even in states with more experience with integration. Mental/behavioral health and primary care providers in most states report that paying attention to both physical and mental health issues represents a significant culture change in the approach to patient care.

Children: Incorporating children into the health home model presents some challenges. By and large, the health home model is viewed as more applicable to adults and their providers because of its focus on beneficiaries with chronic conditions less common among children, although the model is being applied broadly to children in some states (Rhode Island and Alabama).

Communication: Modes and patterns of communication are still being developed within and across sites of care, and particularly between health home providers, hospitals, and managed care organizations. The extent to which new patterns of communication and new protocols are needed depends in part on how much of a change from the existing care system the health home program represents. In all programs the lack of widespread and interoperable HIT systems and regulatory restrictions on sharing patient information created barriers to communication at all levels.

Provider Issues and Challenges: Depending on the program, providers are either taking on new roles or becoming a part of a more integrated system. Common issues include possible mismatch between who incurs costs and who benefits from return on investments, the inadequacy of data systems to meet provider needs, and the pace and effects of practice transformation.

HIT Infrastructure and Issues: Providers in all states noted the inadequacy of current electronic health records (EHRs) in supporting care integration, the documentation of nonclinical services, or cross-site communication. The lack of funding to support EHR adoption by mental/behavioral health providers was seen as a significant barrier.

Role of Complementary Programs: All states in this evaluation are building on structures and programs that already exist, are attempting to align their health home programs with other reforms. Participating states have been able to draw on resources and technical assistance made available at both the state and federal level in the last several years to support practice transformation, care coordination, and mental health integration more generally.

The Enhanced Match: In many states, the availability of the enhanced federal Medicaid match rate was cited as an important part of the motivation for implementing health homes. However, several states were already engaged in delivery system transformation and indicated that they would have pursued this model of care regardless of the match.

Overview of Evaluation Design and Challenges

Our research design uses a mixed-methods approach employing both qualitative and quantitative data collection and analysis. We have identified several challenges to the quantitative aspects of the evaluation and potential strategies for addressing them.

- The primary challenge is that the two-year implementation window is a short time over which to realize measurable improvements, as all the participating states noted.
- Implementation of health homes is statewide in nearly all cases and occurring alongside a range of other reforms, making it difficult if not impossible to isolate a health home effect and to identify "uncontaminated" comparison groups.
- The variety in state approaches to health home design and enrollment practices may present opportunities to identify state-specific or program-specific design adaptations to support analyses of changes in utilization and cost, although not necessarily their attribution to health homes.

Coming Year Activities

In the evaluation's third year, we will continue to monitor progress in all the states in our evaluation group. We also will be receiving administrative data from CMS that will allow us to begin developing profiles of the health home-eligible populations in each state. We will continue to work with states to identify suitable comparison groups, obtain identifiers for health home enrollees, and obtain information on quality monitoring measures the states are collecting from health home providers. These activities will support quantitative activities expected to begin in the fourth year of the evaluation and be completed in year 5.

Conclusion

For the most part, states included in this evaluation have used the Medicaid health homes option to augment existing programs, to accelerate implementation of existing policies, as one part of larger system reform efforts, or some combination of these strategies. Even so, implementation appears to be a slow process, at least with respect to the eight-quarter intervention period. Particular issues revealed through the site visits are those relating to the need to improve communication across provider types and settings, as well as the special challenges associated with integrating care. We will continue to observe how progress toward full implementation and system reform differs across these maturing programs, and will document these and other implementation issues that emerge. These findings may inform other states considering health homes about challenges encountered and best practices to address them.

I. INTRODUCTION

This report presents findings from the first two years of the long-term evaluation of Medicaid health homes, a new integrated care model authorized by Social Security Act Section 1945, created in Section 2703 of the Affordable Care Act (ACA).¹ The model is designed to target high-need, high-cost beneficiaries with chronic conditions or serious mental illness (SMI). We introduce the initial group of 11 states implementing the health homes option between its inception in October 2011 and January 2013, describe the programs they have designed and the programmatic and health system context in which they are being implemented, and discuss key themes and issues for implementation.

The long-term evaluation, one of two called for in Section 2703, is being conducted by the Urban Institute for the Department of Health and Human Services (HHS), Office of the Assistant Secretary of Planning and Evaluation. Ultimately, the evaluation will inform a 2017 Report to Congress about the effectiveness of the health home option in reducing hospital admissions, emergency department visits, admissions to skilled nursing facilities (SNFs), and costs. The second evaluation is a survey of states and interim evaluation conducted by a HHS Centers for Medicare and Medicaid Services (CMS) contractor to inform a 2014 Report to Congress.

Overview of the Section 2703 Health Homes Model

The Section 2703 health homes model is closely related to the “patient-centered medical home” (PCMH) model for integrating and coordinating health care, but is distinctive in three primary respects: (1) the focus on persons with specific chronic physical or behavioral conditions; (2) the variety of providers who may deliver health home services; and (3) the elevated importance placed on integration of physical health care with mental/behavioral health care, and on linking enrollees to nonclinical community social and long-term services and supports (LTSS), as well as supports for the enrollee and family. The vision is that the model will ensure coordination and continuity of care across care settings 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.”²

¹ PUBLIC LAW 111-148--MAR. 23, 2010, Title II, Subtitle I--Improving the Quality of Medicaid for Patients and Providers, Section 2703. State option to provide health homes for enrollees with chronic conditions. <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>. Social Security Act, Sec. 1945. [42 U.S.C. 1396w-4] State Option to Provide Coordinated Care Through a Health Home for Individuals with Chronic Conditions http://www.ssa.gov/OP_Home/ssact/title19/1945.htm.

² Mann, Cindy. 2010. “Health Homes for Enrollees with Chronic Conditions.” CMS: State Medicaid Director Letter #10-024, ACA #12.

States can implement health homes by submitting and obtaining CMS approval for a Medicaid State Plan Amendment (SPA) to add health home services as an optional benefit. States with approved health home SPAs receive eight quarters of 90% federal match for specific health home services identified in Section 2703. These include: comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up; individual and family support services, linkage and referral to community and social support services, if relevant; and use of health information technology (HIT), as feasible and appropriate. Consistent with the aim of integrating physical and mental/behavioral health care and supportive services, Section 2703 requires states to consult with the HHS Substance Abuse and Mental Health Services Administration (SAMHSA) in developing their proposals, regardless of whether the eligible population is defined primarily by chronic physical conditions or primarily by mental/behavioral health conditions.

The law allows states latitude in designing their health home programs. States may designate a wide range of providers or groups of providers other than primary care practices as health homes (e.g., community mental health centers [CMHCs], home health agencies), so long as these providers have the required systems and infrastructure in place to provide health home services and meet the qualification standards. Payment methodologies for health homes may include tiered payments for enrollees according to the number or severity of their conditions and for providers based on their capabilities, and states may design methodologies other than capitated per member per month (PMPM) payments, subject to CMS approval.

States also have flexibility in choosing the eligible population. The minimum eligibility criteria are having two chronic conditions, one chronic condition and being at risk of a second, or one serious and persistent mental health condition. Section 2703 specifies a list of eligible chronic conditions (a mental health condition, a substance use disorder, asthma, diabetes, heart disease, or being overweight, to name a few). States may select particular conditions, all of the conditions, or, with CMS approval, other conditions, such as HIV/AIDS. States also may choose to focus on persons with a larger number of conditions or greater severity than the minimum criteria. All SPAs must include a requirement that hospitals serving Medicaid beneficiaries have procedures for referring eligible emergency department patients to health homes, consistent with the aim of reducing avoidable use of hospital services.

Section 2703 allows states to focus on particular geographic areas and to provide services to health home participants that are different in scope, duration, or quantity than those offered to other Medicaid beneficiaries without obtaining a waiver of statewideness or comparability. States are required to offer health home enrollment to all persons meeting the state's eligibility standards who are categorically needy, including children, those who are dually eligible for Medicare and Medicaid, and those receiving services under a Section 1915(c) home and community-based services waiver, and may not use age as an eligibility criterion. States also may choose to include the medically needy and participants in Section 1115 Demonstrations.

Evaluation Aims and Content of Baseline Report

The primary aims of the long-term evaluation are to assess: (1) what models, providers, and processes states are choosing for health homes; (2) the extent to which state health home designs result in increased monitoring and coordination across clinical and nonclinical domains of care; and (3) whether the models result in better quality of care and outcomes, reduced use of hospital, SNF, and emergency departments, and lower costs.

This report focuses primarily on the design, motivations and goals, monitoring measures to be collected, and other basic parameters for each CMS-approved SPA in the 11 states selected for evaluation. Section II discusses the basic evaluation structure, methods, and activities over the first two years of the evaluation. Section III summarizes the health home program(s) in each of the states. Section IV discusses themes and issues for implementation. Section V summarizes the initial evaluation design, challenges for the design presented by the programs states are implementing and the context for their implementation, as well as ways in which our evaluation design may need to be adapted. Section VI briefly concludes and discusses third-year activities.

II. EVALUATION TIMELINE, STRUCTURE, AND METHODS

The long-term evaluation began October 1, 2011 and is scheduled to continue for five subsequent years. The first three years focus on qualitative and quantitative data collection, and the final two years will focus on finalizing the quantitative data analysis plan, conducting quantitative analyses, and preparation of findings for the Secretary's 2017 Report to Congress.

The evaluation is examining the 13 programs in 11 states that had effective dates no later than January 1, 2013, and had been approved by April 30, 2013 (Table 1). The cutoff dates were chosen to increase the likelihood of having claims data to assess outcomes in at least one year of the intervention period, in recognition of substantial lags in the availability of Medicaid data. For each SPA, the intervention period is defined as the eight quarters of enhanced federal match for health home services, beginning with the SPA effective date selected by the submitting state. For quantitative analyses of effects of each program on service use and costs, we also have defined a baseline period for comparison as the eight quarters immediately preceding the program effective date.

Initial evaluation activities for each state included developing background materials summarizing the design and the implementation context of each health home program and conducting site visits. These activities provide a qualitative data foundation for tracking and interpreting program progress and adjustments during the intervention period. Follow-up telephone interviews are being conducted roughly annually after in-person site visits. Quantitative analysis of the key outcomes largely will be confined to the final two years of the evaluation, both because of lags in the availability of Medicare and Medicaid data and to allow time for full implementation of the programs.

Research Questions

We have developed research questions in the domains of structure, process, and outcomes to be addressed by the evaluation and to guide our activities (see Table 2). Questions in the top panel of Table 2 address state choices of target populations and providers, the design of programs, the rationale for the design, and fundamental elements of structure and process. These questions underpin data collection and follow-up for each state. Questions in the lower panel of Table 2 relate to outcomes and relative performance of different providers and models for different target populations, which will be monitored and assessed over the intervention period.

Qualitative Data and Activities

Qualitative data activities in the first two years of the evaluation included the production of detailed memoranda profiling each approved program and the context in which it was being implemented, site visits, and follow-up phone interviews. We developed generic interview protocols based on the research questions (provided in Appendix A) and adapted them as needed to reflect each program.

State Profiles

We developed health home profiles through a systematic process of data collection for each state, drawing on existing reports, background information from state websites and other publicly available sources, and review of each SPA.

The SPAs provide data on the target population; the types of organizations and health care practices that may be health home providers and the qualifications they must meet to participate; state-specific definitions of the six health home services in each program; methodology for monitoring hospital utilization and cost savings from improved chronic care coordination and management; how HIT will be used to improve service delivery and care coordination across care settings; information to be collected from health home providers to monitor hospital admissions, emergency department visits, and SNF admissions, and the frequency of reporting this information.

In the SPAs, states also identify measures for quality monitoring corresponding to each of the required health home services or to specific program goals (e.g., improve health outcomes for persons with chronic conditions, improve diabetes care). For either service-based or goal-based approaches, states are asked to identify measures in the three domains of clinical outcomes, experience of care, and quality of care. CMS ultimately has provided specifications for a “core” set of common measures across all health homes programs.

Based on the information collected, we produced a memorandum for each state included in the evaluation. The memoranda summarize the key structural dimensions of the program, as well as the larger policy and health system context within each state that may have implications for implementation and evaluation. (These memoranda are provided in Appendix B.)

Site Visits and Follow-Up Phone Interviews

We arranged conference calls with contacts in each state to introduce the evaluation team, explain the purpose and aims of the evaluation, answer any questions, and discuss the scope and logistics for site visits, including the types of informants to be interviewed. At a minimum, informants included the state Medicaid Director, the health home program director, a HIT officer, the official leading the state’s evaluation of the initiative, selected participating providers, and patient and provider advocacy groups. During the first year of the evaluation, we completed site visits in the four states which

had programs approved prior to April 30, 2012 (Oregon, Rhode Island, Missouri, and New York). In the second year, we conducted site visits in the remaining seven states with programs approved before April 30, 2013 (North Carolina, Alabama, Iowa, Ohio, Wisconsin, Idaho, and Maine). Following each site visit, we developed high-level observations on major findings and identified key issues to be tracked over the course of the evaluation.

In the second year, we also conducted the first round of follow-up phone calls with key informants in the initial four states. These calls, which will continue annually with all evaluation states, are designed to collect additional data on program implementation, enrollment, and any program changes or mid-course corrections made over time.

Quantitative Data and Activities

Activities related to quantitative data collection and analysis in the first two years of the evaluation included: (1) developing a provisional analysis plan (see Section V); (2) refining the plan as needed, based on what we learned about the design of programs; (3) identifying and requesting the CMS administrative data required to address the primary evaluation questions relating to utilization and costs; (4) developing and executing data use agreements (DUAs) with individual states and beginning to obtain health home participant identifiers, enrollment and disenrollment dates, and algorithms used to select participants and for claims-based quality measures; and (5) beginning to develop analysis files for the baseline period. During the site visits, we identified contacts who were involved in state evaluations and data systems and would be willing to work further with us on data issues, including the identification of potential comparison groups for analyses of health homes effects.

Data for the central quantitative analyses specified in Section 2703 (effects on hospital, emergency department, and SNF use, and on costs) are being obtained on an ongoing basis through a DUA with CMS. The evaluation design calls for examining utilization and costs for health home participants and a comparison group in the eight-quarter baseline period prior to the each program's effective date and the eight quarters of the intervention period. Because states are determining eligibility and participation on a rolling basis and may make adjustments depending on the number of eligibles successfully enrolled, our data request includes beneficiary, claims, and managed care encounter data for all Medicaid enrollees in each state for the full 16 quarters of the baseline and intervention periods, as well as Medicare beneficiary and claims information for dually eligible enrollees.

III. PROFILE OF STATE HEALTH HOME INITIATIVES

In this section, we provide an overview of the 13 health home programs selected for the evaluation, including two each in Rhode Island and Missouri. The programs reflect the substantial flexibility states have in designing their programs, with variation in the designated provider types, the chronic conditions targeted, and how health home services are defined and reimbursed. Most of the 13 programs are available to beneficiaries statewide. The three exceptions are Alabama, Ohio, and Wisconsin, which provide services in targeted geographic areas. Most of the 11 states focus on persons with two chronic conditions, one chronic condition and at-risk for a second, or one serious and persistent mental health condition, but several are defining the eligible population based on only chronic physical conditions, (North Carolina, Iowa, Wisconsin, and Maine), or focusing exclusively on those with SMI (Ohio). Missouri developed separate programs for those with chronic physical conditions and those with SMI. Key design features of each program are shown in Table 3, ordered by SPA effective date. Detailed information is provided in the state memoranda in Appendix B.

North Carolina

North Carolina's health home program is built within its existing statewide care management program, Community Care of North Carolina (CCNC). CCNC is the larger of two primary care case management (PCCM) programs that serve the majority of the state's Medicaid beneficiaries. The second PCCM program--known as Carolina Access--provides a lower intensity of care management than CCNC. The CCNC care management infrastructure is made up of 14 regional networks of providers--including physicians, hospitals, local health departments, and departments of social services. This infrastructure is overseen by a public-private entity called North Carolina Community Care Network, which operates under contract with the state. To be eligible for health home enrollment, beneficiaries must have at least two chronic conditions that fall within one of ten diagnostic categories, or one of eight specific chronic conditions that place the beneficiary at-risk for developing a second chronic condition. Mental illness and developmental disabilities are excluded as qualifying conditions. Beneficiaries with one chronic condition who develop a second pregnancy-related chronic condition also are eligible for health home services. Of the more than 1.2 million Medicaid and North Carolina Health Choice (the state Children's Health Insurance Program [CHIP]) beneficiaries enrolled with a CCNC network, approximately 560,000 were enrolled in the health homes program in July 2013.

Health home services are not distinct from services already provided to CCNC enrollees. Identification and enrollment as a health home beneficiary is an administrative process handled at the state level. The enhanced federal matching rate--

which went into effect in October 2011 and ended September 2013--was used to offset state costs. No health home-related changes were made to the CCNC program or provider payments. For most Medicaid beneficiaries, enrollment with one of the state's PCCM programs is mandatory. New CCNC enrollees must select a primary care provider (PCP) enrolled with that program, and those who require additional care management receive those services through the CCNC network. Each regional network employs care managers who work at either the network or practice level. Care managers perform a number of functions, including home visits, medication reconciliation, care planning and referral coordination, as well as providing technical support for practice transformation. Networks also employ a pharmacist who directs medication management and e-prescribing, and a psychiatrist who directs behavioral health integration efforts. In addition, networks employ quality improvement staff to work with enrolled practices and may obtain their own grant funding for discrete initiatives. CCNC also frequently serves as the coordinating body for pilot initiatives and demonstrations that may later be rolled out statewide, for example, the pregnancy care management (PCM) program. The PCM program promotes healthy mothers and babies by providing care management for high-risk women during pregnancy and for two months after delivery. Risk criteria for receiving pregnancy-related care management services include but are not limited to the history of pre-term birth, chronic conditions that may complicate pregnancy, substance abuse, and missing more than two prenatal appointments.

Providers receive no additional payments for health home enrollees. The payment method for health home enrollees is the same as that paid for other CCNC enrollees. In addition to the base Medicaid fee-for-service (FFS) schedule, CCNC medical homes receive a tiered PMPM payment for each enrolled beneficiary (\$5 for Aged, Blind or Disabled [ABD] beneficiaries; \$2.50 for all others). CCNC networks also receive a tiered PMPM (\$12.85 for the ABD population, \$5.22 for those who qualify through pregnancy, and \$4.33 for all others). A portion of this PMPM is retained by the CCNC central office to support its activities.

CCNC has a well-developed health information exchange (HIE) infrastructure known as the Informatics Center. The Informatics Center uses data from many sources to perform a range of functions and includes several different platforms that CCNC networks and providers can use to manage the health of enrolled Medicaid patients. Current Informatics Center data includes Medicaid claims data, patient record data, laboratory data, and hospital data, which network employees and providers can access through web-based portals. The Informatics Center also produces quarterly reports that are used to identify individuals in need of additional screening and care management services. CCNC conducts regular chart audits using an electronic audit tool, the results of which are made available to both practices and networks.

Oregon

Oregon's health home program was added as a new component within the state's Patient-Centered Primary Care Home (PCPCH) initiative, which was established in 2009. The PCPCH program is a key component of health system transformation in the state, along with the implementation of coordinated care organizations (CCOs), which began during the first year of health homes implementation. These community-based integrated care organizations have a mission similar to that of health homes but without the focus on particular conditions. Health home services were delivered through qualified PCPCHs, which also serve other Medicaid enrollees, government employees, and state education personnel. To qualify for health home services, beneficiaries had to have two or more chronic conditions, one chronic condition and be at risk of developing another, or SMI. The state specified 11 chronic illnesses and nine mental health conditions in the list of qualifying conditions, and based its definition of "at-risk" on guidelines from the U.S. Preventive Services Task Force, the Health Resources and Services Administration Women's Preventive Services, and Bright Futures. Under these criteria, about 118,000 individuals were eligible for health home services, roughly 14% of the Medicaid population. The enhanced federal match rate went into effect in October 2011 and ended in September 2013, after which providers no longer enrolled beneficiaries into the program or received enhanced reimbursement for health home services. During the eight quarters of the health homes program, more than 93,000 individuals were enrolled.

To be recognized as a PCPCH, a provider must demonstrate the ability to meet certain measures and standards. The state assigns providers to one of three tiers based on the number and type of standards met, with Tier 3 reflecting the most advanced level of functioning as a PCPCH. Over the period of the enhanced match, any recognized PCPCH was eligible to apply to provide health home services by submitting an addendum to its PCPCH agreement with the state. Once approved, PCPCHs were eligible to receive a supplemental health home payment (described below) for each qualified patient for whom specific service and documentation requirements were met. These requirements include: (1) providing at least one state-defined core service each quarter; (2) performing panel management at least once per quarter, using data for all patients or for sub-groups of patients for such functions as care management or quality assurance; (3) performing patient engagement and education, and obtaining patient agreement to participate in the health home program; and (4) developing a person-centered health plan. A PCPCH was not required to provide all health home services on site, but no provider could qualify as a PCPCH if they did not offer primary care services on site. Thus, CMHCs were eligible to be health homes only if they also offer primary care on site. All of the health home services were available to any patients enrolled with a PCPCH, but only services for patients identified as health home-eligible were reimbursed at a higher rate.

Providers identified beneficiaries they believed to be eligible for health home services and submitted them to the state for approval, either through the patient's managed care organization (MCO) or directly, for patients not enrolled with an MCO

(about 80% of the state's Medicaid population is enrolled in managed care). Once approved and assigned, the enrollee was informed of their assignment and could then opt-out or select a different provider. Providers were required to update and resubmit health home enrollee lists each quarter, which served as attestation of meeting the quarterly health home service requirements and triggered payment. The state guidelines for achieving PCPCH recognition specified the information that a practice must be able to show in support of its attestation, which was subject to audit.

Payment for health home services provided to health home enrollees was a PMPM amount that varied by the provider's qualification level: Tier 1--\$10 PMPM; Tier 2--\$15 PMPM; and Tier 3--\$24 PMPM. For FFS patients, payments went directly to providers; for MCO-enrolled members, payments were administered by the MCO. Any portion of the payment retained by the MCO was required to be used to carry out health home-related functions and was subject to approval by the state.

Health home providers were encouraged to develop or use their current HIT capacity to perform a range of functions, including electronic health record (EHR) use and data gathering and reporting. Oregon also links certain PCPCH measures to HIT capacity. For example, implementation of an EHR is not required, but providers who have an EHR can earn additional points towards their qualification as a Tier 3 PCPCH. The state also maintains a provider portal and patient panel management system. Use of this system is required as part of the provider's service provision, but it also allows the provider to review data on their patient panel and identify any gaps in care.

Rhode Island

Rhode Island's two health home programs target populations served by existing specialized providers. The first population is persons with SMI served by community mental health organizations (CMHOs), which are overseen by the Department of Behavioral Health, Developmental Disabilities and Hospitals. The second is children and youth with SMI and/or other disabling or chronic physical or developmental conditions served by "Comprehensive Evaluation, Diagnosis, Assessment, Referral, Re-evaluation" (CEDARR) Family Centers, which are overseen by the state Department of Human Services. CEDARR centers provide care exclusively to children and youth with special health care needs, including needs assessment, referral to resources, integration of services provided through different state systems, and a limited number of direct services. An estimated 7,800 enrollees are eligible for health home services statewide, about 5,300 of them through CMHOs. Of this latter population, about 60% are dually eligible. The enhanced federal matching rate went into effect for both state programs in October 2011, and ended in September 2013. During the eight quarters of the enhanced match period, over 9,500 individuals were enrolled in both programs.

CEDARRs and the CMHOs submit lists of potentially eligible clients to Department of Human Services for enrollment into the health home program. To be eligible to receive health home services through a CMHO, an enrollee must have SMI and meet

additional criteria related to their level of impairment. (These criteria are the same as those used to determine eligibility for the state's existing Community Support Services Program, which targets persons with SMI who can be managed outside of institutional settings.) Eligible beneficiaries are auto-assigned to receive health home services based on qualifying conditions and an existing relationship with a CMHO, but may opt-out or change provider. Hospitals also may refer potentially eligible beneficiaries. Beneficiaries may be referred to CEDARR Centers through a number of channels, including PCPs and self-referral. Children and youth receiving care through a CEDARR are eligible for health home services if they have a mental health condition, two chronic conditions, or one chronic condition and the risk of developing another. About 95% of current CEDARR clients meet these diagnostic criteria.

The state has two Medicaid managed care providers, which cover 60% of CEDARR participants and 35% of eligible CMHO participants (through capitated plans known as Rite Care and Rhody Health Partners, respectively). The remaining adult Medicaid population is enrolled in a FFS-based PCCM program called Connect Care Choice. In order to avoid duplication of services, the state-developed operational protocols outlining which care management activities will be conducted by MCOs and which will be conducted by CEDARRs and CMHOs.

The required health home care team for CEDARR includes two members, a licensed clinician and a family service coordinator, who share responsibility for the core health home services but collaborate with other health professionals and CEDARR staff, including the enrollee's PCP. The required team for a CMHO health homes includes at least seven members with behavioral, clinical, or social support expertise.

CMHOs are paid through a PMPM rate reflecting personnel costs and staffing ratios based on estimates of client need. The estimated staff needs for a team serving 200 clients is 11.25 full-time equivalent, or approximately nine staff hours per client per month. CMHOs are required to submit highly detailed encounter data to document services provided. CEDARR centers continue to be paid on a FFS basis. Three existing CEDARR activities--family intake and needs assessment, family care plan development following initial needs assessment, and annual family care plan review--are paid at fixed rates ranging from \$347 to \$397 per enrollee. Two additional services--health needs coordination and therapeutic consultation--are reimbursed at established hourly rates paid per quarter hour of effort and tiered according to the type of professional providing them.

The HIT infrastructure underpinning these two initiatives is built on the existing systems used by CEDARR Family Centers and the two state Medicaid MCOs. Neither group of providers is required to have an EHR, but CMHOs that have an EHR or registry may be required to participate in a pilot study to measure their effect on both care and patient outcomes. CEDARR centers use their existing electronic case management system as well as the KIDSNET Child Health Information System, which provides access to a range of public health and social services information. CEDARR

health homes also offer to enroll all clients into CurrentCare, Rhode Island's electronic HIE.

Missouri

Missouri's health home program builds on the state's relatively long history of behavioral and physical health care integration. The selected populations--beneficiaries with SMI and those with chronic physical conditions--have been the focus of several previous initiatives aimed at integrating physical and behavioral health and coordinating care for patients with multiple chronic conditions. CMHCs are the designated providers for the behavioral health population, while primary care centers--specifically, federally qualified health centers (FQHCs), rural health clinics (RHCs), and hospital-operated primary care clinics--are the designated providers for persons with chronic physical conditions. The qualifying chronic physical conditions are the same in the two SPAs. The primary distinction between the two SPAs is that substance use and mental illness are not qualifying conditions to receive health home services through a primary care center; beneficiaries with these conditions are assigned to a CMHC health home. The Missouri Department of Social Services estimates that about 43,000 Medicaid beneficiaries are eligible statewide, and about 34% of these are dual eligibles. As of March 2014, roughly 35,000 beneficiaries were enrolled in both health home programs. The enhanced federal match period was in effect from January 2012 to December 2013.

Missouri uses a claims-based algorithm to identify eligible persons and auto-assigns them to the relevant type of provider, based on their conditions. Enrollees in both health home-types may opt-out of the program or change providers. Hospitals also may refer unassigned patients to a health home. Though both FFS and managed care enrollees are eligible for health home enrollment, Missouri's managed care program is offered in only certain geographic regions and serves primarily children, youth, and pregnant women. In addition, some CMHCs serve only adult populations. Consequently, managed care enrollees represent a relatively small percentage of health home enrollment (about 10% overall).

The care teams are explicitly defined in both SPAs and similarly structured. Both teams include a director, nurse care manager, and administrative support staff. The CMHC team, however, includes a primary care physician consultant, while the primary care team includes a behavioral health consultant and a care coordinator, as well as additional clinical staff (such a physician or nurse practitioner). The staffing ratio for each of these roles is also defined in the SPA.

Health home services are paid on a PMPM basis, and payment levels are based on staffing needs assumptions. The PMPM payment for services at CMHCs is \$78.74, and the PMPM payment for services delivered at primary care centers is \$58.87. The state originally planned to re-evaluate the PMPM determination annually, but did not adjust payments over the initial two years of the program.

The HIT infrastructure underpinning the initiative is based primarily on the Medicaid HIT infrastructure. Missouri HealthNet maintains a web-based EHR called CyberAccess, which is accessible to all enrolled Medicaid providers, including CMHCs. This system also includes a web-portal called Direct Inform, which allows enrollees to look up information on their care utilization, calculate their cardiac and diabetic risk levels, and develop a personal health plan. The CMHCs also use a tool called ProAct™, which provides medication and care management reports. The ProAct™ tool also produces an Integrated Health Profile that pulls together information from these reports, as well as data on hospital and emergency department use, and other service utilization. ProAct™ is used by health homes to upload metabolic screening data on individuals receiving psychotropic medications, as required since 2010 by the Department of Mental Health.

In addition, Missouri HealthNet maintains an authorization-of-stay tool that requires hospitals to notify Missouri HealthNet within 24 hours of a new Medicaid-financed admission of any Medicaid enrollee, as well as to provide information about diagnosis, condition, and treatment, which triggers a notification email to the health home provider. The system does not yet include Medicare-financed admissions of dually eligible enrollees or emergency department visits that do not result in admission.

New York

New York phased-in its health home program under three separate SPAs, all of which are included in this evaluation. The first SPA covered ten counties with an effective date of January 1, 2012. The second SPA expanded health homes to 12 additional counties, effective April 1, 2012, and the third expanded them to the remaining 39 counties, effective July 1, 2012. The enhanced federal match ended for the first ten counties in December 2013, and will end for the remaining groups of counties in March 2014 and June 2014, respectively. The state is focusing on individuals who have HIV/AIDS and are at risk of developing another chronic condition, those with two or more chronic conditions (including substance abuse or a mental health conditions), and those with SMI. Approximately 158,000 Medicaid beneficiaries statewide are enrolled and about 20% of enrollees are dually eligible for Medicaid and Medicare. The state also plans to implement a second and third wave of health home expansion, with the second wave expanding eligibility to the long-term care population, and the third targeting enrollees with developmental disabilities.

Health home providers are designated through an application process in which a lead health home organization must demonstrate how it will meet health home requirements through its network of partners and affiliated providers. Approved health home providers include hospital networks with affiliated physical health, behavioral health, and community support providers, existing condition-specific Targeted Case Management (TCM) programs, and community-based organizations.

New York State Department of Health identifies and assigns beneficiaries to a health home using a series of algorithms that identify an individual's level of risk and connectivity to the health system. Eligible beneficiaries with a higher level of clinical risk and a lower level of connectivity have higher assignment priority. For FFS enrollees, the state provides candidate "tracking lists" directly to health homes. For managed care enrollees, the state transmits the list to the relevant managed care plan (MCP), which is then responsible for assigning candidates to the health home organization that can best serve their needs. Approximately 65% of eligible health home beneficiaries are enrolled in managed care; the rest are in Medicaid FFS.

Providers receive PMPM payments at two levels: outreach and engagement, and active care management. The active care management group consists of participants who have enrolled in a health home. Beneficiaries in the outreach and engagement group have been assigned to a provider but have not yet agreed to enroll. Services for this group are reimbursed at 80% of the active care management rate for up to three months after a beneficiary is assigned to cover the cost of outreach and engagement. If the beneficiary is not enrolled within that timeframe, a three-month hiatus is required before the outreach and engagement payment can resume. Payment for FFS enrollees goes directly to the health home, while payment for managed care enrollees goes through the plans; MCOs may retain up to 3% of the payment for administrative services. Rates are adjusted by region and case-mix.

Standards for HIT use by health homes are phased-in gradually. Providers must meet a set of initial standards in order to qualify and have 18 months to meet final standards. Final standards require that health homes have interoperable HIT systems and policies that allow for the development and maintenance of the care plan, that they use a certified EHR that complies with the official Statewide Policy Guidance on HIT, that they participate in Regional Health Information Organizations (RHIOs) for the purposes of sharing data, and that they employ clinical decision-making tools where feasible.

Alabama

Alabama offers health home services to beneficiaries who have two chronic conditions, one chronic condition and at-risk for developing another, or SMI. The qualifying chronic conditions include a mental illness, substance use disorder, asthma, diabetes, cardiovascular disease, chronic obstructive pulmonary disease (COPD), cancer, HIV/AIDS, and sickle cell anemia. Persons who have received a transplant within the last five years are also eligible for inclusion. Any beneficiary with one of these targeted conditions is considered to be at-risk for developing another chronic condition.

Services are provided through designated teams of health care providers that include PCPs, behavioral health providers, state-employed case managers, and providers who are part of the Patient Care Networks of Alabama (PCNA). PCNAs, established in 2011, operate as independent, nonprofit entities that contract with the

state and participating Medicaid providers to offer wraparound care management services for eligible beneficiaries enrolled in the state's PCCM program, Patient 1st. Primary responsibility for care management rests with the participant's designated PCP. However, depending on diagnosis, participants may instead receive care management through a state-licensed CMHC, a substance abuse provider, or an Alabama Department of Public Health (ADPH) care manager. Any participant who is unstable but deemed ineligible for care management through a behavioral health or ADPH provider may be referred to the PCNA for care management. Though case management services are available statewide through the Patient 1st program, the PCNA program--and by extension the health homes program--operates in four targeted geographic regions, comprising 21 of the state's 67 counties. Currently, little over 70,000 Medicaid beneficiaries receive health home services through a PCNA.

Enrollment in Patient 1st is mandatory for all Medicaid beneficiaries, with the exception of certain groups of children, members of federally recognized Indian tribes, and individuals who are dually eligible for Medicaid and Medicare. The state identifies health home-eligible individuals through a monthly review of claims data, with an 18-month lookback period. For those with organ transplants, the lookback period is five years. Other providers may also refer patients for enrollment. Once identified, patients are contacted by mail and permitted to choose a primary medical provider (PMP), after which they are enrolled with the PCNA contracted to that practice.

Patient 1st providers receive \$8.50 PMPM for health home beneficiaries, and PCNAs receive \$9.50 PMPM. Rural health centers and FQHCs that participate as PMPs do not qualify for the case management fee because these services are covered under their prospective payment system reimbursement.

Neither Patient 1st PMPs nor PCNAs currently are required to have an EHR or use an electronic Continuity of Care Document to exchange information. However, PCNAs are expected to use and document in a web-based care management tool known as the Realtime Medical Electronic Data Exchange, which provides claims-based data on utilization. Alabama is in the process of implementing a statewide HIE platform known as One Health Record, which will connect providers with state agencies and eventually serve as the primary platform for patient data exchange. A consumer portal is already operational through One Health Record, as is a platform for direct secure messaging between providers who are connected to it.

Iowa

Iowa offers health home services to categorically and medically needy beneficiaries with either two or more chronic conditions, or one chronic condition and at risk of developing another. Qualifying chronic conditions include a mental health condition, a substance use disorder, asthma, diabetes, heart disease, body mass index (BMI) over 25 (or BMI for age over the 85th percentile for children), and hypertension. The definition of at-risk is based on guidelines from the U.S. Preventive Services Task

Force, and includes a diagnosed condition with established chronic co-morbidities, a documented family history of a heritable condition included among the state's qualifying conditions, or environmental exposures known to contribute to those conditions. As of January 2014, 4,396 of the approximately 100,000 health home-eligible beneficiaries were enrolled.

To qualify as a health home, providers must meet state-developed standards, must complete and submit the TransferMED PCMH self-assessment at the time of their enrollment, and are expected to achieve National Committee for Quality Assurance (NCQA) recognition (level unspecified), or another national recognition, within the first year of operation as a health home. Health home practices may include, but are not limited to primary care practices, CMHCs, FQHCs, and RHCs. Designated practices may have multiple sites, provided that these sites are identified as members of a single organization with shared policies and practices, and are supported by a common information technology infrastructure.

Health home enrollment is initiated by providers, who are encouraged to identify and enroll eligible beneficiaries from their existing patient panel. The state may also identify beneficiaries from claims data and notify a health home, but this is intended only to assist providers in identifying and prioritizing patients for enrollment. The provider is still responsible for assessing and enrolling those patients. The assessment, which is based on a state-developed Patient Tier Assignment Tool, is used to assign patients to one of four tiers, with higher tiers corresponding to higher levels of clinical risk.

Payment for health home services is made through a PMPM amount that varies according to a participant's tier (Tier 1--\$12.80; Tier 2--\$25.60; Tier 3--\$51.21; Tier 4--\$76.81). Iowa has also incorporated a pay-for-performance component into their health home program, with incentive payments based on achievement of selected quality and performance benchmarks. These 16 measures are separated into five categories: preventive measures; diabetes/asthma measures; hypertension/systemic antimicrobial measures; mental health measures; and total cost of care. Payments were scheduled to begin in the second year of Iowa's health home program (which started July 2013), but due to ongoing HIT implementation challenges, it remains unclear whether the incentive payment program will be operational within the two-year timeframe of the enhanced match.

Health home providers are required to implement an EHR that includes referral tracking capabilities, and have in place a plan for complying with federal meaningful use requirements. Providers also must employ a population management tool, such as a patient registry, and are encouraged to use email, text messaging, patient web-portals, and other technology where possible to enhance patient access and self-management. Providers are also expected to connect to and participate in the statewide Health Information Network (HIN), which was implemented in 2012.

Ohio

Ohio's health home program is a joint effort between Ohio Medicaid and the Ohio Department of Mental Health and Addiction Services and focuses on adults and children with serious and persistent mental illness (SPMI), SMI, or serious emotional disturbance (SED) served by Community Behavioral Health Centers (CBHCs). Medically needy beneficiaries are excluded from the health homes option. In January 2014, more than 10,000 beneficiaries were enrolled in the health home program.

CBHCs that meet state requirements for integration of physical and behavioral health and other standards relating to their certification, care structures and processes, and relationships with other providers and MCPs are eligible to apply for health homes designation. The health home care team must include a team leader, an embedded primary care clinician, a care manager, and a qualified health home specialist; each health home determines the staffing needed to meet service requirements. Each health home must participate in technical assistance provided by the state, including the Health Homes Learning Community--a learning collaborative established to support health home implementation--and other activities.

Beneficiaries with the specified health home conditions and receiving services at one of the participating CBHCs are engaged and enrolled in the health home program, with a choice to opt-out or enroll with another health home provider. Hospitals, specialty providers, MCOs, or other providers may refer Medicaid beneficiaries to health homes. MCOs are required to establish a partnership with the CBHC health home in their service area and develop procedures for exchanging health information and sharing care management responsibilities. In addition, MCOs are expected to perform ongoing identification, including enrollment assistance, of members who may benefit from health home services and must track which members are receiving these services. MCOs must also participate in transitional care activities with the health home and integrate results from the health homes quality measures into their quality improvement programs.

Payment levels for health home services are based on the state's Uniform Cost Report Requirements, which consider staffing costs, the indirect costs related to health home service provision, and the estimated health home caseload. The monthly case rates cover all health home service components and range from about \$270 to just over \$400 per month. Providers must submit claims to receive payments. Only one claim may be submitted per beneficiary per month.

HIT requirements will be phased-in over two years. Within one year of health home designation, the CBHC must adopt an EHR. Within two years, it must demonstrate that the EHR is used to support all health home services. Furthermore, the CBHC must participate in Ohio's statewide HIE when available. CBHCs will receive quarterly utilization profiles on each health home beneficiary and will be required to use the data in developing appropriate care and coordination plans.

Wisconsin

Wisconsin's health homes program targets individuals with a single chronic condition--HIV/AIDS--who have at least one other diagnosed chronic condition or are at risk of developing another. The at-risk criteria adopted by the state includes individuals who, in addition to being diagnosed with HIV/AIDS, meet clinical benchmarks related to low CD4 cell counts, low BMI, and certain cardiovascular and metabolic risk indicators. The designated provider of health home services are AIDS service organizations (ASOs), which are specialized HIV/AIDS service providers identified under Wisconsin statute. The state has two designated ASOs, the AIDS Network and the AIDS Resource Center of Wisconsin (ARCW). Each organization is responsible for a particular service area; the AIDS Network covers 13 counties in the southern part of the state and operates three clinic sites, and ARCW covers the remaining 59 counties and operates nine sites. Both entities offer a range of medical and social services, including case management, dental care, mental health screening and referral, and prevention services.

Health home eligibility is limited to categorically and medically needy individuals in four noncontiguous counties in the state, three of which are served by ARCW. Though ARCW provides limited services in the fourth county, primary responsibility for coordinating care in that area lies with the AIDS Network, which was not initially qualified as a health home. As a result, initial eligibility for health home enrollment is limited to those who are able to enroll with ARCW in the three designated counties where ARCW has primary responsibility for care coordination. ARCW clinic sites in Brown, Kenosha, and Milwaukee counties offer medical, behavioral health, and social services, as well as preventive services such as sexually transmitted infection screening and needle exchange. Dental clinics are also available on-site in two counties, and the Milwaukee site offers clinical pharmacy services through its on-site pharmacy. Clients requiring services not provided directly at given clinic locations are referred to other providers within the community.

Eligible beneficiaries are auto-enrolled into the health home program. ARCW is required to contact beneficiaries to inform them of the benefits of enrollment and offer them the opportunity to opt-out. By agreeing to participate in the initial assessment and care planning process, the beneficiary consents to enrollment. Beneficiaries who are enrolled in managed care cannot also be enrolled in a health home because of concerns about duplication of services. As of March 2014, ARCW had 188 health home enrollees.

Wisconsin is using two payment methodologies: a PMPM case rate paid to the ASO for providing at least one health home service per month, and a flat fee that covers the initial assessment and development of a care plan for each new enrollee. This latter service can be billed once a year if the care needs of the health home member require another comprehensive assessment and care plan review. Current rates are \$102.95 for the PMPM, and \$359.37 for initial assessment and care plan development.

ASO health homes must have an EHR that is accessible to all care team members and contains health homes enrollee treatment plans. The treatment plan must be updated regularly to reflect services provided. The state requires that providers adopt EHRs that have the capacity to interface with specialty and inpatient care providers, but there is no defined timeline for adoption. It is not made explicit whether this interface will take place through the state's HIE (Wisconsin State Health Information Exchange) or another mechanism. The state HIE is still under development.

Idaho

Idaho offers health home services to categorically needy beneficiaries who have a SMI or SED, have asthma and diabetes, or have either asthma or diabetes and are at-risk one of developing another chronic condition. The identified risk factors include BMI greater than 25, dyslipidemia, tobacco use, hypertension, or diseases of the respiratory system. Medicaid beneficiaries can self-refer or be referred by a provider to a health home. Participating providers are responsible for identifying potentially eligible beneficiaries among their patients. Those confirmed eligible by the state are auto-enrolled, with the right to opt-out.

Idaho's health homes initiative builds on the state's Medicaid PCCM program, Healthy Connections. All Idaho Medicaid beneficiaries are enrolled in some form of managed care, with majority being enrolled in Healthy Connections. Enrollees with disabilities, special health care needs, or who are dually eligible for Medicaid and Medicare are eligible for additional benefits under the Enhanced Plan or the Medicare-Medicaid Coordinated Plan. There are an estimated 30,000 health home-eligible Medicaid beneficiaries in the state, and roughly 9,100 are currently enrolled in the program.

Any Healthy Connections provider who meets state qualifications may serve as a health home, including solo or group practices, RHCs, CMHCs, and home health agencies. The health home provider identifies and leads the care coordination team, which may include other providers as necessary to meet a particular beneficiary's needs. The SPA defines a clear role for a care coordinator in providing care management but does not require a dedicated care coordinator to be part of the health home team, which provides some flexibility for smaller providers. The integration of behavioral health is required and may be achieved through tele-health, co-location of behavioral health professionals within the clinic, or referral to a behavioral health professional. Health home providers must achieve at least Level 1 PCMH NCQA certification by the end of their second year of operation as a health home, as well as meet the 11 health home qualifications required by the state. Health homes are required to conduct two other assessments: the PCMH Assessment, intended to identify strengths and weaknesses in the clinic, and the Primary Care Development Corporation Assessment which is used to map the clinic's progress towards NCQA recognition.

Payment for health home services is made on a PMPM basis. In building the rate, the state assumed that the health homes care team would take on defined roles within the health home, and calculated a rate based on the average salaries and presumed division of labor for each member of the care team. An extra \$1.00 was added to the PMPM to cover the costs of NCQA recognition process. The \$15.50 PMPM is paid to Healthy Connections providers that offer at least 46 hours of clinic access per week to enrollees. Monthly contact with the enrollee is not required in order to receive the PMPM.

Initial HIT standards for participating providers at the time of enrollment include structured information system that will allow providers to use a disease management program for chronically ill enrollees. An EHR is not required, but is encouraged. The final standards require that providers use HIT to: (1) systematically follow-up on tests, services, and referrals; (2) practice population management and identify care gaps; and (3) access and use the Idaho Health Data Exchange, the state HIE. Providers must submit a plan to achieve the final HIT requirement to the state within 24 months of program initiation (or by December 31, 2014) in order to be approved as a Health Home provider, as well as have an electronic disease registry in line with NCQA standards.

Maine

Maine's health home program is being implemented statewide as part of an expansion of the state's pre-existing PCMH pilot. Maine's health home program incorporates care management by regional Community Care Teams (CCTs), which assist practices in managing the needs of high-cost, high-risk patients. As of September 2013, there were approximately 160 designated health homes and ten CCTs. Health home services are offered to categorically and medically needy beneficiaries with two or more chronic conditions, or one chronic condition and the risk of developing another. Qualifying conditions are a mental health condition, substance use disorder, diabetes, heart disease, BMI over 25, tobacco use, COPD, hypertension, hyperlipidemia, developmental disabilities or autism spectrum disorders, cardiac and circulatory congenital abnormalities, acquired brain injury, asthma, and seizure disorders. Beneficiaries with SPMI or SED are currently not eligible to enroll, but the state plans to expand health homes to this population under a separate SPA.

Health home providers are primary care practices that meet the state's established qualifications. They are required to contract with a CCT to provide wraparound clinical care management services for high-risk, high-cost patients within a designated geographic region. Health home practices and CCTs share accountability for reducing avoidable health care costs, with a specific focus on reducing inpatient and emergency department utilization, providing timely post-discharge follow-up, and improving patient outcomes. CCTs are required to establish regular communication and coordination procedures with the health home practices they serve. Each CCT must be led by a CCT manager or director and must include a medical director, responsible for clinical quality improvement efforts, and a clinical leader who directs care management

activities. CCT staff typically includes a mix of nurses, social workers, and other health care professionals. Each CCT must establish a process for identifying a patient's needs and linking them to a lead coordinator whose expertise matches those needs. Both primary care practices and CCTs are required to participate in the PCMH Pilot Learning Collaborative, to have the capacity to share patient data and collect and report quality measures, and to commit to meeting the standards of Maine's multi-payer PCMH Pilot. Practices also must have achieved Level 1 NCQA recognition for PCMH by December 31, 2013.

Eligible beneficiaries are identified through both claims data and provider identification. Eligible beneficiaries who are either enrolled with or who regularly visit a health home practice are notified by the practice of their eligibility and may elect not to participate in the program. Patients are auto-enrolled if they have not opted out within 28 days. The state notifies eligible beneficiaries not enrolled with a health home practice of the benefits of participating and provides a list of health homes in their area. Health home-eligible beneficiaries receiving TCM services may choose to continue in TCM or switch to care management through a health home. Health home enrollees with basic needs receive care management and coordination services through the health home practice, while patients with more complex needs are referred by the health home to a CCT for enhanced care management services. Patients identified as high utilizers (i.e., those with frequent hospital admissions and emergency department visits, and others who are considered priority patients), are eligible for referral to the CCT. Health home practices are encouraged to identify others who would benefit from CCT services, including enrollees who have three or more conditions, are failing to meet treatment goals, are using multiple drugs for their chronic condition(s), or have social service needs that interfere with care. The state estimates that roughly 5% of a practice's patient panel will require CCT services. As of January 2014, almost 43,000 patients were enrolled in the health home program, which is about 30% of the estimated eligible population.

Both health home practices and CCTs receive a separate PMPM payment for the provision of care management services. The PMPM rate paid to the practice is \$12, and is based on estimates of the staffing costs associated with providing health home services not otherwise reimbursable under MaineCare. The CCT payment is described as an "add-on" payment to support care management services for the high-need individuals referred to them, and is set at \$129.50. The state will provide add-on payments for no more than 5% of the total number of health home enrollees associated with a given primary care practice.

Maine requires all health homes to have a fully implemented EHR. Many of the providers are already participating in the MaineCare HIT incentive program and the state's tele-health laws provide incentives for the use of remote monitoring and other technologies. The HIT infrastructure varies across communities. Some CCTs and practices share an EHR, or have negotiated agreements that allow CCTs to use the

practice's EHR. In other cases, the two use the state's HIE, HealthInfoNet (HIN). This exchange connects to more than 80% of Maine hospitals and almost half of primary care practices. HIN includes an enrollee portal, as well as a notification system to alert care managers when an assigned enrollee has visited the emergency department or been admitted to a hospital.

IV. IMPLEMENTATION THEMES AND ISSUES

In this section we report on what we learned during our site visits, including the implementation context, key features across the state programs, and early implementation issues and challenges. Some features reflect the health care landscape prior to implementation and may not be generalizable. Others reflect state choices that may provide lessons for other states and for CMS as it considers health home policies. We will continue to track these issues over the evaluation period, as well as identify new issues as they arise.

Implementation Context

As previously noted, states were granted substantial flexibility in designing their health home programs, resulting in a high degree of diversity among the 13 programs in our evaluation. These baseline differences both reflect and are amplified by the specific context in which the health homes programs have been established. Decisions regarding key health home features depend on a number of factors, including the state's broader policy goals, the existing health system infrastructure, and the other reform initiatives underway in the state. In certain cases, such as in North Carolina and Rhode Island, the state targeted providers who already offered health home-like services, and made little or no substantive changes to their care coordination efforts. In these states, the enhanced match replaced ongoing state expenditures for the eight quarters in which it was available. In other states, health homes are part of a broader transformation of the health care system. Oregon, Idaho, and Maine, for example, incorporated their health home programs into their statewide--and in the case of Idaho and Maine, multi-payer--medical home initiatives. In these states, the enhanced match facilitated ongoing delivery system transformation efforts. Thus, the degree to which health homes represent a new care delivery model varies. All 11 states are building on structures and programs already in place, attempting to align the health home initiative with other reform efforts already underway, or both.

To support health home implementation, some states have taken steps to identify additional resources and coordinate across multiple programs and governmental offices. Their ability to do so depends on the extent to which administrative structures and funding streams are in place. For example, as part of a broader health system transformation process Ohio consolidated its Department of Mental Health and Department of Alcohol and Drug Addiction Services to reduce administrative complexity for its behavioral health programs, including health homes. Similarly, Rhode Island's Section 1115 Global Waiver--in place since 2009--has facilitated the state's attempts to streamline administrative processes and align funding streams between the Medicaid office and the mental health department.

States also have linked health homes with broader HIT transformation processes. In both Alabama and Iowa, providers are expected to connect with and use the statewide HIE, though the timeline for this connection is as yet unspecified. New York and Idaho have made funding and technical assistance available to providers to assist them in either adopting or using HIT. New York provides grants to support EHR adoption through the state's Health Care Efficiency and Affordability Law for New Yorkers Capital Grant Program, while Idaho provides ongoing technical support in using registry data to drive quality improvement.

In addition to these HIT supports, states are leveraging resources and technical assistance made available in the last several years to support practice transformation, care coordination, and mental health integration more generally. Some funding has come directly from the state, as in the case of New York's statewide medical home program and Rhode Island's Chronic Care Sustainability Initiative. Other initiatives have been the fruit of partnerships between the state and private organizations. Missouri partnered closely with its provider associations and the Missouri Foundation for Health to implement a series of reforms to its mental health system, including a pilot care integration program involving collaborations between FQHCs and CMHCs. Some health home providers have also been the recipients of SAMHSA co-location grants and thus have prior experience developing their internal care structures and processes.

The various contextual factors have significant implications for a given state's success in implementing a health homes program and, critically, sustaining it once the enhanced federal match period is over. Many of the state officials and providers we spoke to noted that two years is a short timeframe over which to demonstrate significant impacts on the main outcomes of interest. States and health home providers likely will need to identify additional resources to support the practice transformation and HIT adoption that underpin the health homes programs.

Health Home Models

Though health home models vary widely in their specifics, they can be grouped into one of three general categories: specialty provider models, medical home models, and care management network models (See Figure 1).

CMHCs are the most common specialty provider, designated as the primary health home provider for SPAs, in Rhode Island, Missouri, and Ohio. The second Rhode Island SPA designates CEDARR Centers, which exclusively serve children with special needs, as the primary health home provider, and Wisconsin has designated ASOs. These designations reflect the relatively narrow patient populations targeted under each SPA. Patients with SMI or AIDS, for example, are a relatively small subset of the Medicaid population, but often have care needs that go beyond the services typically provided and managed through PCPs. As a result, they may receive the majority of their services through specialty providers. Tapping providers who already manage the specialized

services may be more appropriate in order to minimize any disruption in established patient-provider relationships.

Oregon, Missouri (through its second SPA), Iowa, and Idaho have adopted a medical home model, most often with primary care practices, FQHCs, or RHCs as the central health home provider. Oregon and Idaho have built their health home programs into their existing medical home initiatives, while Iowa's program was seen as an initial step toward establishing a broader medical home infrastructure. Missouri's primary care health home model places greater emphasis on the integration of behavioral health services into the primary care setting than the other three programs, but like Iowa and Idaho, Missouri requires that providers achieve Level 1 NCQA recognition. Missouri also differs in restricting primary care health home designation to FQHCs, RHCs, and hospital-owned primary care practices, whereas the other three states will designate any provider that meets the established criteria. In all four states, however, state officials view the health home program as a lab for implementing a medical home model that could be applied to any patient requiring enhanced services, rather than as a model only for patient populations defined by the presence of specific conditions. Some of the providers we spoke with echoed this sentiment, and saw no real distinction between health home services and the kind of services that an advanced medical home should be providing.

North Carolina, New York, Alabama and Maine have adopted a model that relies on a care network which collectively provides comprehensive care management. North Carolina's health home program focuses on a subset of beneficiaries served by its longstanding CCNC care management model. Aside from meeting health home reporting requirements, no health home-related changes were made to any aspect of the program. Alabama and Maine drew explicitly on the CCNC example in developing their health home models, although both programs differ from North Carolina and each other in certain respects. Alabama and Maine both utilize regional care coordination teams, and refer high-needs patients out to these teams (the PCNA or the CCTs in Maine). Unlike the CCNC central office, however, neither of these entities provides administrative oversight or payment directly to the regional providers. New York's model is unique, relying on a lead entity that assembles an array of provider partners that collectively are able to provide all health home services. The lead entity oversees administrative responsibilities and distribution of payment. In all four cases, however, the health home is a team of health care professionals and social service partners collaborating across care settings. This approach provides a mechanism through which providers can access coordination and care management services that may not otherwise be available to them, as well as technical assistance or practice transformation resources.

Program Structures and Processes

Health home programs differ in the degree of flexibility afforded to participating providers, particularly in terms of health home team composition and payment processes. Rhode Island, Missouri, Iowa, and Ohio are the most prescriptive; the

composition of the health home team is explicitly defined in the SPA, as are staff roles within each health home. North Carolina, New York, Alabama, Wisconsin and Maine are less prescriptive about the composition of the health home team, although each sets certain minimum requirements. Alabama, for example, requires that PCNAs meet baseline staffing criterion, but allows PCNAs to hire additional staff as necessary. The state also does not specify the staffing mix for a given patients' care team. Oregon and Idaho are the least prescriptive, and do not specify staffing requirements, health home team composition, or team member roles.

A prescriptive model with respect to program structure may entail greater up-front investments in order to meet staffing or administrative requirements, so that under-enrollment or enrollment discontinuities may be problematic for providers. Providers in Missouri initially were facing this problem, with lower enrollment than initially expected. Payment levels had been calculated based on a prescribed staffing ratio, with some providers adding new staff in anticipation of the projected increase in enrollment. The delays in enrolling new patients meant that they were unable to generate the expected amount of health home revenue to cover these costs. Providers in New York and Maine also reported difficulties with under-enrollment. To mitigate issues related to up-front costs, some states elected to phase in requirements over a period of time to allow providers to develop new capacity. Oregon set its PCPCH standards deliberately low in order to encourage practices to become PCPCH and participate as health homes, with the intent of gradually raising those standards over time. Iowa and Idaho require providers to achieve NCQA recognition, but allows them one and two years, respectively, to achieve it.

Regardless of timeline, the payment model is a significant factor in successful implementation of health home structures and processes. With the exception of Rhode Island CEDARRS, health home services in all states are reimbursed through a PMPM rate. (Wisconsin's health home provider also receives a flat fee to cover initial assessment and care plan development, which may be billed annually.) The structure and the level of these PMPM payments differ across programs, and, as a result, have different effects on providers. In Rhode Island, CMHCs 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, in Idaho, the PMPM is paid for each patient attributed to that practice--providers are not required to attest that those patients have received a service in that month. Thus, the difference in administrative burden associated with these two payment mechanisms is substantial. In New York, lead health home agencies can keep no more than 3% of the PMPM for administrative costs (and MCOs can retain an additional 3%). Under-enrollment thus posed a challenge for lead agencies, as the administrative costs of establishing and maintaining multi-provider networks can be significant. The state mitigated this problem somewhat through its tiered payment approach, which allowed providers to receive a reduced PMPM payment during the process of outreach and enrollment.

Eligibility and Enrollment

The range of qualifying conditions targeted for health home eligibility varies significantly, resulting in substantial differences in the size of each state's eligible health home population. In New York, for example, roughly 700,000 Medicaid beneficiaries, 14% of all Medicaid enrollees, are eligible for health home services, while Rhode Island's health home population (under both SPAs) is just under 8,000, 4% of Medicaid enrollees. Regardless of the range of qualifying conditions, providers in several states noted that determining eligibility based on specific conditions inevitably excludes some high-cost, high-need beneficiaries who might benefit from health home services. Furthermore, demand for services may outstrip supply, even in states with relatively small eligible populations. Both Iowa and Idaho's health home programs are statewide, but provider shortages--especially in rural and frontier areas--are an ongoing challenge. Locating providers that would accept new Medicaid patients also has been a challenge for PCNAs in Alabama.

The process for identifying and enrolling potential eligibles also can present challenges. States may opt for a centralized approach, as in Missouri and New York; a dispersed approach, as in Oregon, Rhode Island, Ohio, and Idaho; or some mixture of both. In centralized identification, the state uses enrollment and claims data to identify persons potentially eligible for health home services by the presence of eligible conditions and sometimes other factors, such as level of expenditure (Missouri), or connectivity to the primary care system (New York). In dispersed enrollment, health home providers identify clients who meet the conditions criteria and whom they believe could benefit from health home services. Centralized identification of the eligible population has the benefit of yielding a potentially more complete list of eligible beneficiaries. But Medicaid enrollees, especially those with mental health and/or substance abuse issues, are a difficult population to track. Individual health homes have found it challenging to locate and enroll people identified centrally, because contact information or qualifying conditions may have changed, and enrollees may be wary of such contact. Dispersed identification decreases search costs and time but risks missing eligible individuals who are not well-known to the health home staff, including those with low provider connectivity. Provider-based identification also has the potential to allow cherry-picking of enrollees, although we heard no concerns in that area on our site visits.

Most programs appear to be either planning or already implementing a mixed enrollment system, although there is variation in how responsibility for patient identification is shared between the state and providers. New York, for example, initially adopted an entirely centralized approach, but low enrollment and requests from providers to enroll patients they had identified led the state to implement a community referral process in late 2012. Referrals may now come from the criminal justice system, state-operated psychiatric centers, hospitals, MCPs, designated health homes, case management programs, and other providers. The state continues to develop lists of eligible patients based on a series of algorithms designed to target people with high needs and "low ambulatory connectivity," who are not already being seen regularly by

providers in the community. Lists of eligible patients are sent to the health homes or the MCOs for outreach and enrollment. In Iowa, the state relies primarily on providers to identify health home-eligible patients, but has begun to generate a list of health home-eligible patients to supplement providers' health homes patient panels.

The general expectation appears to be that enrollees will continue to receive health home services unless they become ineligible for Medicaid coverage. (The exceptions are children in the CEDARR health homes program, which eventually age out or may need enhanced care coordination services for only a short time.) All of the health home programs allow for disenrollment, or provide beneficiaries the opportunity to opt-out of the program. However, neither state officials nor providers reported high rates of disenrollment due to patient opt-out. Both state officials and providers expressed concerns, however, about enrollment discontinuities stemming from loss of Medicaid eligibility, particularly among medically needy beneficiaries and others who must "spend-down" income to eligible levels. Such disruptions present challenges for continuity of care and connections to needed services in the community. Health home services may continue, as was reported in Rhode Island, but enrollees may lose access to primary care and medications during coverage hiatuses, unless providers are willing to continue to provide services temporarily without payment. Besides reducing continuity of care, some informants suggested eligibility loss works counter to another fundamental goal of health homes by encouraging use of emergency departments during coverage gaps.

Integration of Care

Integration of mental health, physical health, and nonclinical supports is a key component of the health home concept. States have approached integration in different ways, and there is substantial variation between providers within each state in terms of how the concept of integration is operationalized. Key parameters of differences are staffing size and mix, the systems and processes in place to identify and address patient needs, the mechanism through which patient information is shared, and the degree to which services are co-located versus referred to outside providers. The integration process depends on where each provider started, the needs of the patient population, and the resources available in the community. We heard of large contrasts across providers operating in the same health home program in more than one state. For example, in one state, a large urban organization offering co-located physical and mental health services, substance abuse counseling and treatment, and housing services was implementing an EHR that would allow staff from across the organization to document services accessed in patient care plans. In contrast, a health home practice managed by a solo provider in a comparatively rural area largely provided referrals to external mental health and community support services and was unable to share information electronically with outside entities involved in patients' care.

Issues for integrating mental health care into a primary care-based health home are not symmetric to those for integrating physical health care into a mental health provider-based health home. 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. Regardless of the direction of care integration, however, implementation requires a culture change in the approach to patient care, appropriate training for all care team members, and systems that support open communication and exchange of information. These issues were raised by many of the providers we spoke with and are explored in greater detail below.

Mental health advocates reported that mental health historically has been underfunded and applauded the health home initiative for bringing greater attention and funding to mental health care. They also felt that PCPs have a new incentive to look for mental health issues among their patients because mental health diagnoses can qualify an enrollee for health home services. However, many PCPs we interviewed varied in their ability to address those mental health needs once they were identified. Some providers expressed frustration over the lack of training to manage patients with serious mental health problems, as well as the limited number of external resources available for referrals in their respective communities.

Many participating primary care practices also report struggling to effectively integrate community and other social supports into the practice, although they recognize the importance of such integration and are generally supportive. This type of integration was less of a challenge among CMHCs, which traditionally have paid more attention to nonclinical supports, such as housing and employment, and were more likely to employ social workers and other support staff with knowledge of community resources. One frequently cited advantage of the care management model employed by North Carolina, New York, Alabama and Maine was that it provided an external mechanism for connecting patients to the services they needed, rather than requiring that a PCP invest in additional staff to perform those tasks. The health homes focus on whole-person care also has enhanced attention to nonclinical aspects of care. CMHCs traditionally have paid more attention to nonclinical supports, such as housing, school, and employment, than have primary care practices.

Applicability to Children

Many states are struggling with how to incorporate children into the health home model. In general, the health home model is seen as being more appropriate for adults because of its focus on chronic conditions that are relatively rare among children. The pediatric care model also differs from the adult model in several important respects, including the type and level of support required, the approach to decision-making, and the level of family involvement. The health home model's ability to address the needs of children will depend in part on state decisions regarding the qualifying conditions, designated health home providers, and the quality measures used to measure performance. The CEDARR model in Rhode Island is *de facto* child-focused and specifically tailored to serve a subset of children with special needs. For most of the other participating states, children make up a small share of the health home-eligible population. The relatively small size of the pediatric health home population may be a

barrier to participation for pediatric practices, as health home enrollees would represent a very small share of patients over which to spread the fixed cost of practice transformation.

Nevertheless, providers across these programs felt that the health home model could be adapted to the pediatric population, if the eligibility standards were structured to allow more children to qualify. Some providers also noted that addressing the health needs of children today may be able to reduce the number of adults requiring health home services in the future.

Communication

Communication within the care team and across providers is a fundamental component in achieving the health home model's aims of care integration, management, and coordination. The extent to which new patterns of communication and new protocols are needed depends in part on how much of a change from the existing care system the health home program represents. The change in basic functions and responsibilities is small for Rhode Island's CEDARRs and Wisconsin's ASO, and negligible or nonexistent for North Carolina's CCNC. For other programs having to build new communications processes, the changes are significant and, in some cases, represent a source of ongoing challenges. Barriers to communication include lack of widespread and interoperable information technology systems, different rules covering different types of information sharing (particularly substance abuse, mental health, and HIV/AIDS, which are all prevalent in the target populations), and the competing priorities of the participating entities. Communication is very much a work in progress in most all programs.

Intra-Organization Communication

Communication within care teams, as well as across teams within a health home, supports the integration of mental and physical health and community supports. Common forms of intra-team communication include the patient "huddle," a mini-team meeting of relevant team members before a patient's appointment to discuss his or her health problems and treatment needs, or regular team meetings at varying or fixed intervals. Informants at some sites reported that such intra-organization processes are productive, while other informants said they have been difficult to integrate into the workflow. Some participating health homes did not have the buy-in of all providers within the practice and, as such, coordinating a huddle or regular meeting to discuss health home patients was difficult. Other reported challenges to team communication include EHRs or other patient records that must be modified to support the full range of team input, particularly nonclinical information.

Though intra-organization communication is an important component in team-based care regardless of the health home model, it is particularly critical in the wraparound care model, where members of the health home team must collaborate with

partnering organizations. Among the states that have adopted this model (North Carolina, New York, Alabama, and Maine) a key issue routinely cited by both state officials and providers was the need to establish systematic communication processes that involved both in-person meetings and shared access to patient clinical data. These processes vary substantially in practice. For example, CCNC may "embed" a care manager into a practice that has a large Medicaid population, which facilitates regular and frequent communication. In other practices, care managers interact with providers much less often, and in some cases in an *ad hoc* fashion, which was deemed to be a limiting factor in care coordination. In Maine, care teams meet monthly with partnering practices and, in some cases, have direct access to their EHRs. These communication processes were seen as essential in building trust between the practices that provide most of the care and the external care team staff.

Primary Care and MCOs

Where the health home is not the PCP, as in the specialty provider models adopted in Rhode Island, Missouri and Ohio issues can arise when communication beyond the team or health home is necessary. Education may be required to help the PCPs understand the importance of communicating with the health home and coordinating well with them. Many nonhealth home physicians do not have a clear understanding of what health homes are and what their role in them should be. Thus, training about health homes may need to extend beyond the health home itself, and communication processes may need further development. For many of the health homes we visited, an internal EHR facilitates communication within the health home team, but external communications still require email or fax. The communication issues are different not only among states but also among different health homes within the states, reflecting different existing patterns of care and communication and variable capacity for change.

In states with Medicaid managed care programs, the responsibilities for communication between health homes and MCOs differ. In New York, MCOs are required to assist with identification of eligible beneficiaries, and health homes must report service provision through the MCO, which then reports to the state. In Rhode Island and Ohio, MCOs are to provide care profiles to the health home for their health home enrollees; and in Oregon, they are contractually obligated to encourage practice transformation. In North Carolina and Idaho, behavioral health services are reimbursed on a FFS basis, and health homes are expected to communicate regularly with MCOs responsible for managing the behavioral health needs of their patients.

In each state, the systems and processes that underpin the relationship between MCOs and health homes are still being systematized and fine-tuned. In North Carolina, Ohio and Idaho, for example, health home providers had no prior formal relationships with MCOs and have needed to develop them. Their success in establishing these relationships varies. MCOs share the health home goal of better care coordination and decreased hospital and emergency department use, which may facilitate the relationship-building process. The structures and reporting requirements of the health

home program may not overlap with those of existing MCOs, however, which may create administrative burden for both entities. The competitiveness of the MCO market may have an impact on the level of administrative burden. In New York, the number of MCOs operating in the market varies by region; some health homes must establish relationships with relatively few MCOs, while others must interact with several, each of which may establish separate processes for accessing or reporting patient information.

Hospitals

Transitional care to better manage patients after hospitalization is a critical health home service that can support reductions in avoidable readmissions, but getting timely information from hospitals is seen as a challenge in nearly all states, particularly with regards to emergency department visits. North Carolina and Alabama health home providers reported relatively few problems getting timely information from hospitals, which they attributed to the formal and informal relationships established between hospitals and the regional care management networks in each state. In North Carolina, 56 of the state's 150 hospitals provide twice-daily updates to CCNC on admissions, discharges, and transfers of CCNC-enrolled patients. In Alabama, PCNAs must include a hospital representative on their Board of Directors. In both states, care managers employed by the regional network are either embedded in hospitals or visit them regularly to collect information on admissions or emergency department visits.

In some states, hospitals are directly affiliated with the health home. In New York, health homes include hospitals among their partnering organizations, which facilitates the notification process for patients who are admitted to a partner hospital or visit its emergency department. In Maine, CCTs may be based at a hospital and have access to that hospital's EHR. Hospitals may also own health home practices in some cases, such as the hospital-run clinics in Missouri's primary care health home program. In Oregon, each PCPCH is required to have written agreements with its usual hospital providers on how communications would happen. However, while these formal affiliations and agreements allow for better communication about the services provided within specific hospitals, patients may visit multiple hospitals within a geographic area. In such cases, notification remains challenging.

Many states are attempting to leverage their HIE infrastructure to exchange hospital data, but those systems are still developing. Missouri has an authorization-of-stay tool that requires hospitals to alert the Medicaid agency when any enrollee is admitted for a Medicaid-financed stay. The admission alert triggers an email from the Medicaid agency to the health home. Such alerts are not triggered by emergency department use, however, unless it is associated with a hospital admission. Informants reported that this system also misses even some inpatient hospital use--most glaringly, admissions of dual eligibles, for which Medicare is the first payer. Health home providers in several states (for example, Missouri, Iowa and Ohio) reported that in some cases they learn about an admission weeks or months later, and sometimes only when reported by the health home enrollee. In Rhode Island, MCOs are able to serve as intermediaries between hospitals and health homes.

Some informants reported hospital communication problems specific to the mental health component of the initiative. Mental health providers may have more problems getting access to hospital floors because they often are not credentialed at the hospital. This makes it difficult to provide transitional care and coordination for hospitalized enrollees. In Rhode Island, the CMHOs have had hospital liaisons in the past, and this concept has been reintroduced under health homes.

Medication reconciliation post-discharge is seen as a particular challenge for health homes. Although usually thought of as a hospital quality measure, health home providers recognize the importance of medication reconciliation for care management and good outcomes. Medication reconciliation is a central transitional care goal of the care management networks in North Carolina, Alabama, and Maine. Establishing good post-discharge communication with hospitals is key to meeting this important quality goal.

Most states see hospital communication as an area that needs work. Until real-time/same-day communication is established and is the norm for both inpatient stays and emergency department visits, successful communication will continue to depend on personal relationships with staff in the medical and psychiatric wards and the emergency department, with disruptions associated with personnel turnover.

Provider Issues and Challenges

Depending on the program, providers are either taking on new roles or becoming a part of a more integrated system. Common themes we heard related to who would incur costs and who would benefit from the return on investments, the inadequacy of data systems to meet provider needs, and the pace and effects of practice transformation.

The Role of MCOs

The management of care for high-need, high-cost enrollees could logically be thought of as the responsibility of MCOs. The development of a new entity for care management, paid according to a separate structure, can be seen as usurping the role of the MCO. Health home guidelines require that there not be duplication of payment for services, which requires careful specification of the different roles that health homes and MCOs take in care coordination. The states are approaching this issue in different ways. In New York, MCOs may keep no more than 3% of the health home PMPM unless they provide specific health home services. In Oregon, an MCO had to demonstrate to the state what services it was providing to justify the amount retained. At the time of our visit, only one MCO had been approved to retain a portion of the payment.

The degree to which health homes must interact with MCOs also varies. In Missouri, managed care is limited to children, youth, and pregnant women living in defined geographic areas; few health home enrollees are included. In Wisconsin, health home patients must disenroll from managed care if they choose to enroll in the health home. In Idaho, patients with SPMI who are stable will be managed primarily by health homes, while those in crisis or needing additional support for the mental illness will be managed by the state's behavioral health MCO. North Carolina uses the Four Quadrant Clinical Integration model to determine which entity will take the lead in managing patient care. Although mental illness is explicitly excluded from the list of qualifying health home conditions in North Carolina, health home enrollees who also have high behavioral health needs will be jointly managed by the regional MCO and the health home team.

The different roles and responses of MCOs to health homes reflect to some degree the history and structure of the MCO sector in each state. Even within states, different MCOs have reacted differently. Some have welcomed the clarification of roles of providers and plan, as in the case of the protocols for care coordination developed in Rhode Island. Some are taking advantage of the opportunity to participate in health homes even if, as was the case in Oregon, it means a dilution of their role because health homes are part of a larger system transformation. In other states, such as in North Carolina and Idaho, capitated managed care is a relatively new development. At the time of our visit, the details of how and to what extent MCOs would collaborate with health home providers were still taking shape.

Revenues and Costs

In some states, health home providers expressed concern that although savings will be generated by actions taken by providers those savings will accrue to the Medicaid program. Similarly, there were concerns that hospitals will find some way to recoup any revenue lost from reduced emergency department use or hospitalizations. Some health homes see the practice making the investment in transformation--not all of which is reimbursed by the health home payments--and the return on that investment going elsewhere.

Section 2703 allows states to pay providers for services that previously were not reimbursable under Medicaid, but the effects of participation on provider revenues differs widely across the programs, from mildly negative to strongly positive. In Missouri, providers saw the health home reimbursement as very attractive, as did providers in Ohio and Wisconsin. In New York, most providers will see increased revenues under health homes, with the exception of TCM service providers. Under the state's first SPA, TCM providers would see a gradual reduction in the reimbursement. TCM providers told us that the effect would be mitigated to some extent as their case-mix was also likely to change, and they will have greater flexibility in how the services are provided. However, this change proved difficult to implement, and in November 2013 the state submitted another SPA asking to extend the legacy rate until January 2015. Some informants noted that the lack of funding for infrastructure development was a challenge for lead

health home agencies, especially given that many partnering organizations lacked an EHR.

For a provider with only a few health home-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. Providers in Oregon and Iowa saw an increase in their revenues associated with the health home payment, but also reported that the administrative burden associated with the billing process was substantial, and noted difficulties in adapting their systems to identify and track services automatically.

Data Issues

Complete, timely, and accurate data is important both for health homes services--case management, care coordination, and care transitions--and for program evaluation. Yet, data from other payers, particularly Medicare for the dually eligible, is difficult for health home providers to obtain, leaving a gap in their knowledge of enrollee utilization and needs. The challenge associated with this issue depends on the share of dually eligible beneficiaries in the health home population. In Missouri and New York, for example, dual eligibles represent 34% and 20% of the overall health home-eligible population, respectively. In Rhode Island, 60% of enrollees in CMHO health homes are dual eligibles, and the lack of data on Medicare-financed admissions was noted in both initial and follow-up interviews as a significant problem.

Data on specific services of particular importance to the health home population also need special attention. The rules governing sharing of patient information on substance abuse, mental health, and HIV status require additional patient agreements, and some states have struggled with implementing the necessary consent processes, at least in the initial stages of the health home program. In initial follow-up interviews, Rhode Island reported development of a patient consent process to allow authorized providers to share and access personal health information, including substance abuse treatment, through its HIE, but the process has not yet been approved or implemented. Another issue identified in site visits relates to provider understanding of disclosure regulations. We heard from several providers and state officials that these rules are poorly understood, leading some providers to withhold information unnecessarily.

Providers also have varying levels of experience using patient data to drive quality improvement efforts and perform population management. Many health home providers felt that integrating these processes into a busy clinic, especially when the provider may be receiving a large volume of utilization data or reports from multiple sources, was particularly challenging. In Ohio, for example, CMHCs received six months of historical data from the state as well as from MCOs. To assist providers in incorporating data use into their care routines, states have offered various levels of technical assistance to support meaningful use. In Alabama, the state provided training to PCNA staff through monthly meetings, while the Idaho Medicaid department provided direct practice

coaching, and Ohio sponsored on-line learning collaboratives. Providers in all of these states found this assistance to be extremely helpful.

Practice Transformation

For most providers, practice transformation requires the investment of time, staff and money. Infrastructure costs include developing the HIT systems necessary to support many of the health home services, and training staff in new processes and routines, which may result in temporary productivity losses. For the most part, providers must make these investments well in advance of receiving any additional payment from the initiative. Lack of start-up financing may have been a bar to recruiting practices to be health homes in some cases.

The acuity of this problem varies across the states. For North Carolina's CCNCs, Rhode Island's CEDARRs and Wisconsin's ASO, the problem is minimal. In Oregon, New York, Iowa, and Idaho, where requirements are phased-in, practices may be able to spread out the practice transformation costs. In Oregon, early adopters were predominantly qualified at the highest current level, suggesting that health home participation was most attractive to practices that were already well down the practice transformation road.

In addition to the data analysis training noted above, states have also provided other technical assistance to support practice transformation. Some programs are more general education about the health home concept, while others have a specific focus, such as training for wellness coaches or peer counselors. In some cases, the state has funded training or provided direct technical assistance. In other cases mental health or primary care associations have provided some training for the members through planned peer learning activities or responses to questions from practices.

Oregon, for example, implemented a PCPCH Institute Learning Collaborative as a central resource for PCPCHs, and made additional training available in conjunction with the audits it conducts during monitoring site visits. Missouri, New York, and Iowa also have organized learning collaboratives to help practices understand health homes principles and provide support for practice transformation. These learning collaboratives have been supported by state agencies, provider organizations, and state foundations.

In North Carolina, New York, Alabama, and, Maine, the external care management team is also a source of technical assistance for affiliated PCPs. In North Carolina, for example, CCNC networks employ quality improvement specialists to assist practices in population health management and improvement on quality measures of interest.

Even if training is provided for the health homes free of charge, practices still must invest staff time and sometimes travel costs to participate. Thus, practices must weigh the value of the training against the cost of participation and practice transformation. The health home certification process alone may be expensive, particularly in those states that require health homes to acquire certification from a national organization

such as the NCQA. Providers expressed a preference for training focused less on vision and more on best practices. In-person practice coaching was viewed very positively by practices that received it, as were the opportunities for peer-to-peer sharing.

Almost all health homes are struggling to fully implement the initiative, and several noted the need for a ramp-up period of six or even 12 months. Some informants indicated that greater certainty about the permanence of the model would allow practices to commit to the health home model more fully. Most states expect that some practices will not be able to transform fully over the two-year span of enhanced match. How well practices succeed at transformation depends in part on where they started from, their existing strengths and weaknesses, and leadership at the practice level. As many informants noted, two years is a very short period in which to put in place all of the needed health home components and achieve the necessary culture change.

Health Information Technology

HIT is a critical component of the health home option, and underpins the provision of all six health home services. However, HIT implementation remains an ongoing challenge for both states and providers, regardless of the HIT requirements that states have mandated. EHRs are not yet the norm in many settings, nor are HIEs reliably in place to facilitate communication. Several of the challenges highlighted in the preceding sections--specifically, those related to: (1) communication between providers and across care settings; and (2) data collection and use--are amplified by inadequate HIT systems. In recognition of these and other HIT-related challenges, several states have phased-in their HIT requirements for health home providers, and some have offered technical assistance through learning collaboratives and practice coaching.

Some HIT issues are specific to moving care outside the clinic walls. Often the services provided in the community are not easily documented on current EHRs and may be less adaptable to coding. More generally, EHRs may need to be modified to incorporate health home services, especially nonclinical community support services. Data security is also a concern. Many of the state officials and providers we spoke with noted the regulatory challenges related to sharing health information across care settings. Some argued that the multiple layers of state and federal privacy laws--particularly those related to substance abuse--were a significant barrier to care integration. This was attributed in large part to uncertainty among providers about what information can be shared, and under what circumstances.

Other information technology issues are specific to the effort to integrate mental and physical health care. Behavioral health providers may have higher costs for acquiring information technology infrastructure since they are not eligible for Medicaid or Medicare EHR incentive payments. Even if they were, the structure of a behavioral health visit differs from that of a physical health visit and so the content of an EHR is different, hampering sharing. Many behavioral health providers feel that available EHRs are less well-suited to their practices than to primary care practices. Lack of integration

in the past has meant that often parallel systems have developed. For example, in Missouri, behavioral health providers have access to one data system for pharmacy management and another for routine reporting and outcomes, while PCPs have access to a different system through the local primary care association. The state is in the process of adapting behavioral health outcomes reporting system for primary care health home use.

Practices must also have the necessary infrastructure to communicate within and across sites of care, and staff must be trained in how to use it effectively. A central information technology infrastructure is needed to facilitate communication across sites of care. Central infrastructure can also push data to practices to improve individual care management, as well as patient panel management. Communication through a central site may come with costs, such as connectivity costs associated with a RHIO, which may be hard for some providers to afford or to justify. Though all 11 states have implemented some form of HIE, there is significant variability in terms of the robustness of the data that can be accessed. Even in states with access to relatively well-developed HIT and data infrastructure, such as that developed by North Carolina's CCNC program, practices may struggle to incorporate its use into daily workflow, especially if they are required to use a different system to access information. This problem may be a particular issue in practices with a relatively small Medicaid population.

When a practice transforms, the new models for providing care can be expected to spread to all patients in the practice. As the health home enrollees are a high needs population, some of the care management strategies and procedures may be less applicable to a broader clinic population. Still, many providers say that when they are caring for their patients they do not typically consider what reimbursement might be attached to that person, so changes in how they operate will likely spread to other patients with needs that are similar to health home enrollees. In some cases, such as in Oregon, Idaho, and Maine, this was an explicit policy goal. Health home payments were intended to drive practice-wide changes that would apply to all patients, not just health home enrollees. However, the level and structure of the payments may not cover the costs of those changes, and the spill-over effects of health home implementation may be limited by the size of the Medicaid patient panel. This was a point of concern in Maine. Of the 159 health home practices in the state, roughly 75 were involved in a multi-payer pilot, while the remaining 84 received enhanced payments from Medicaid alone. Some of the key stakeholders we interviewed were concerned that these payments would be insufficient to cover the costs of transformation in those practices.

Some components of the initiatives are not dependent on a complete change of culture at the practice or the system level to have a broader effect. Specifically, improved information technology infrastructure will benefit the whole practice, as will greater electronic connectivity among sites of care.

The Enhanced Match

The enhanced match for health home services is meant to encourage states to take up the optional health home benefit. Most states said that the availability of the enhanced match was an important part of their motivation for implementing health homes, but not necessarily a deciding factor. In North Carolina the match simply offset state costs, with no changes in the ongoing CCNC program. In contrast, in both Alabama and Maine, state officials characterized it as an essential source of implementation support, while in Rhode Island the match allowed Medicaid to continue to fund the CEDARR centers and to extend an integrated model into CMHOs, something the state would have been unable to do in the current budget environment. Similarly, in Missouri, the match allowed progress on integration to continue under budget stringency, and the expectation is that the achieved savings will justify continuation of the program. In Oregon, the match allowed the state to add financial incentives for practices to its plan for primary care delivery system transformation, which was said to have been an important enticement to practice participation in the larger initiative. In New York and Idaho, the match was characterized as an important driver of their reform program. Some states we spoke with said that the enhanced match did not offset additional spending on newly eligible Medicaid beneficiaries and noted that the nominal 90% match was less substantial than face value, given the level of Federal Medical Assistance Percentages, which ranged from 50% to 73% in fiscal year 2013. Several states, however, indicated that irrespective of the match they would have embarked on delivery system transformation because “it is the right thing to do.”

Though the enhanced match was generally viewed as a positive inducement, all state officials and providers we spoke to felt that eight quarters was an insufficient timeframe to achieve and demonstrate meaningful delivery system transformation.

V. OVERVIEW OF EVALUATION DESIGN AND CHALLENGES

Our evaluation design uses a mixed-methods approach employing both qualitative and quantitative data collection and analysis. In this approach, qualitative data collected through program review, site visits, and follow-ups as described above, provide context and rich profiles of programs, insights into the motivations behind state choices, common patterns across programs and states, implementation progress over the intervention period, and provider and participant perspectives. These data also generate information that can be used in quantitative analyses to identify key factors in achieving favorable outcomes.

A key design element of the quantitative component is the use of comparison groups of beneficiaries in analyzing trends and relative gains in the target outcomes for health home enrollees versus comparisons in both the baseline and intervention periods. Analysis of experience in the baseline period serves two purposes. First, it will establish utilization patterns and cost prior to implementation. Second, it will improve our ability to isolate effects associated with health home participation by allowing us to control for common Medicaid program and other factors that may affect both a comparison group and health homes participants before and during the intervention. A pre/post-only design without a comparison is likely to make it more difficult to discern any marginal improvements for health home enrollees over the relatively short intervention period and prevents attribution of changes to the health home model.

Challenges to Quantitative Evaluation

A number of potential challenges for quantitative analysis of the effects of health homes on the key outcomes of hospital, emergency department, and SNF utilization and costs have become clear as we have learned about the specific design of programs, some of which we anticipated in our provisional design. These challenges will make it more difficult to detect changes associated with the health homes model.

An overarching issue is the eight-quarter duration of the intervention period. Under the best of circumstances, two years is a short time over which to realize improvements. Implementation necessarily moves at a slow pace, owing to the transformations in structures, processes, and care culture necessary for the health home model.

A second fundamental issue is that the majority of states are either building marginally on a system that has some components already in place, using health homes as a part of a broader system reform, or both. All of the states are participating or planning to participate in other initiatives. These include the Integrated Care for Dual Eligibles Demonstration and the Financial Alignment Initiative, both of which aim to

support care coordination and integration for duals by allowing states to integrate Medicare and Medicaid financing; the Multi-payer Advanced Primary Care Practice Demonstration; the Children's Health Insurance Program Reauthorization Act (CHIPRA) ten-state CHIP Evaluation; the CHIPRA Quality Demonstration; and the State Innovation Model Test demonstration. Participation in other initiatives implies that practice transformation occurring outside of Section 2703 may contribute to the success of the model but also will make it more difficult to isolate effects attributable to it. At the same time, state participation in other initiatives makes it much more difficult to find “uncontaminated” comparison groups that could help isolate health home effects.

All states except Alabama, Ohio, and Wisconsin have implemented their programs statewide, which eliminates the possibility of using Medicaid enrollees in nonparticipating geographic areas for comparison. In theory, statewide implementation implies that the only “similar” beneficiaries with respect to their condition profile receiving care outside of health homes would be those who refused enrollment or could not be found, which also could mean they would be difficult to find through eligibility algorithms applied to claims data. An additional issue elucidated through our qualitative activities was the potential for biases from differential enrollment practices--centralized selection of an eligible population versus provider referrals. Relative to a consistently applied central eligibility determination process, provider referrals are subject to inter-provider variability and to use of patient-specific factors in referral decisions that we will not be able to observe.

Potential Approaches to Address Challenges

Given the variety in state approaches to health homes, it may be possible to identify state-specific or program-specific design adaptations. We are continuing to work with states toward this end.

Alabama, Ohio, and Wisconsin all have geographically limited programs, so that it may be possible to draw comparison beneficiaries from other geographic areas.

In Rhode Island, enrollment is primarily through provider identification. The number of Medicaid beneficiaries meeting criteria for services through CEDARR Centers is substantially larger than enrollment, so that it may be possible to identify comparison beneficiaries who are not enrolled. The same may be true for CHMO health homes, since initial enrollment was of beneficiaries already receiving services through CMHOs.

In Missouri, the initial selection of health home enrollees was based on a combination of conditions and expenditure patterns over a consistent calendar year, and, to date, provider identification of eligible enrollees contemplated for the future is not in effect. This may allow identification of a similar population based on a different reference period not captured in the initial state identification. The state indicated that only 16% of enrollees fall into the high-expenditures category for more than one year,

so that selection using a different year may be able to generate a comparable but nonoverlapping comparison group.

In New York, enrollment prioritizes eligibility based on condition severity and low connectivity to PCPs, although low connectivity has presented enrollment challenges. In this case, it may be possible to develop a comparison group of those with low connectivity who could not be located but could be tracked in claims data. New York's phased geographic rollout also may provide opportunities for identifying comparison groups by geographic area, phase, and time in program.

In Oregon, Iowa, Ohio, and Idaho, enrollment is through provider recommendation, so that it may be possible to identify similar beneficiaries using nonparticipating providers as comparisons. Maine's enrollment also involves provider recommendation for those already involved with health home providers, but is further complicated by a parallel enrollment process in which the state uses claims analysis to identify eligible persons not served by health home practices and provides them with information about nearby health home providers.

VI. THIRD YEAR ACTIVITIES

In the upcoming year, we will continue to monitor the states selected for the evaluation and conduct follow-up phone interviews with key informants. In addition to working with states on issues relating to comparison groups and identifiers for health home enrollees, we also hope to begin obtaining information from states on quality monitoring measures they are collecting from health home providers. We also hope to receive administrative data through our DUA with CMS that will allow us to begin developing baseline comparative profiles of the health home-eligible populations in each evaluation state.

VII. CONCLUSION

All states included in the long-term evaluation cohort have in common that they have used the Medicaid health homes option to augment existing programs, to accelerate movement down an established pathway toward transforming the state's health care delivery system, or both. The models adopted by these states fall generally into three classes: those relying on specialty providers, those based on the medical home model, and those using comprehensive networks assembled by a lead agency or overseen by an administrative entity. Even that categorization is not hard and fast and may not be enduring, however, in a climate of system reform. For example, during the first year of its health homes implementation, Oregon began implementing a reorganization based on CCOs, community-based integrated care organizations that have a mission similar to that of health homes but without the focus on particular conditions. By the time its health home program ended, the Oregon health system structure was more similar to the network approach taken in North Carolina, New York, Alabama, and Maine.

Our findings over the last year indicate that the issues identified during site visits in the initial four states also are challenges in the final seven states in the evaluation cohort, and that although progress has been made, work remains to be done. Implementation appears to be a slow process that is likely to take longer than the eight-quarter period of enhanced match both for states in the evaluation cohort, as well as for other states choosing to add a health home benefit.

Central issues are those relating to the need to build or improve internal and external communications and systems needed to support the aims of health homes. This was especially true in some states for communications between hospitals and health home providers. This avenue of communication is critical to improving transitional care and to the key health homes aim of reducing inappropriate or unnecessary use of hospital-based care and avoidable readmissions. Integrating behavioral and physical health is an area in which systems integration faces special challenges that differ depending on the direction of integration. Our qualitative analyses so far suggest that both functional aspects of system transformation, such as improving or adapting the HIT infrastructure, and human aspects, such as adapting to new processes and routines and culture change, continue to be a work in progress in all the states studied.

As we continue our evaluation activities over the next year, all of the evaluation cohort will have completed their initial eight quarters. This will allow us to follow-up on the issues identified in this report and find out whether they persist in maturing

programs, as well as begin exploring issues the states may face relating to program sustainability. Documentation of the timeline for full implementation, how it may vary across health home models, and the ways states in the evaluation cohort have addressed implementation challenges may provide important lessons for other states initiating their own health home programs.

FIGURE 1. Health Home Models		
Model Type	State	Description
Specialty Provider	Rhode Island (2 SPAs), Missouri (1 SPA), Ohio, Wisconsin	Centered on entities traditionally serving special populations, but integrating specialized care with primary health care.
Medical Home and Extensions	Oregon, Missouri (1 SPA), Iowa, Idaho	Based on the PCMH, but extended to include specialty and other providers beyond the traditional primary care practice.
Care Management Network	North Carolina, New York, Alabama, Maine	Networks or coalitions of physical and behavioral health care providers, care coordination entities, social services agencies, and other community organizations, overseen by a lead organization or administrative entity.

TABLE 1. Evaluation Cohort States, Programs, and Timeline

State/ Program	Target Population	Designated Providers	Geographic Coverage	Effective Date	Evaluation Period End Date	Approval Date
North Carolina	1 chronic conditions, or 1 chronic condition and at risk of another	CCNC, Medicaid- enrolled PCPs	Statewide	10/1/2011	9/30/2013	5/24/2012
Oregon	2 chronic conditions, 1 chronic condition and at risk of another, SMI	PCPCHs	Statewide	10/1/2011	9/30/2013	3/13/2012
Rhode Island (CEDARR- HHs)	Children with 2 chronic conditions, 1 chronic condition and at risk of another, SMI	CEDARR Family Centers	Statewide	10/11/2011	9/30/2013	11/23/2011
Rhode Island (CMHO-HHs)	SMI	CMHOs	Statewide	10/1/2011	9/30/2013	11/23/2011
Missouri (CMHC-HHs)	SMI, mental health condition or substance use disorder and 1 other chronic condition, or a mental health condition or a substance use disorder and tobacco use	CMHCs	Statewide	1/1/2012	12/31/2013	10/20/2011
Missouri (PCP-HHs)	2 chronic conditions, 1 chronic condition and at risk of another	Primary care practices: FQHCs, RHCs, hospital- operated primary care clinics	Statewide	1/1/2012	12/31/2013	12/23/2011
New York	2 chronic conditions, 1 chronic condition and at risk of another, SMI	Any Medicaid- enrolled provider that meets HH standards	Statewide*	1/1/2012	12/31/2013	2/3/2012
				4/1/2012	3/31/2014	12/5/2012
				7/1/2012	6/30/2014	12/6/2012
Alabama	2 chronic conditions, 1 chronic condition and at risk of another, SMI	PCNA, Medicaid- enrolled PCPs	4 regions comprising 21 counties	7/1/2012	6/30/2014	4/9/2013
Iowa	2 chronic conditions, 1 chronic condition and at risk of another	Any Medicaid- enrolled provider that meets HH standards	Statewide	7/1/2012	6/30/2014	6/8/2012
Ohio	SPMI, SMI, SED	CBHCs	5 counties	10/1/2012	9/30/2014	9/17/2012
Wisconsin	HIV/AIDS and 1 other chronic condition or at risk of another	ASOs	4 counties	10/1/2012	9/30/2014	1/29/2013
Idaho	2 chronic conditions, 1 chronic condition and at risk of another, SMI, SED	Any Medicaid- enrolled PCP that meets HH standards	Statewide	1/1/2013	12/31/2014	11/21/2012
Maine	2 chronic conditions, 1 chronic condition and at risk of another	CCTs, Medicaid- enrolled PCPs	Statewide	1/1/2013	12/31/2014	1/17/2013

* New York's HH program was made statewide under 3 separate SPAs.

TABLE 2. Research Questions for the Long-Term Evaluation

Base Year and Follow-Ups: Implementation
<p>How important was the enhanced match for the decision to initiate health homes?</p> <ul style="list-style-type: none">• For the type of health home undertaken?• What changes, if any, do states anticipate after the enhanced match ends? <p>Which conditions are states targeting, and are they developing specialized models?</p> <ul style="list-style-type: none">• What was the rationale for the conditions/models selected?• What structures and processes have been put in place...<ul style="list-style-type: none">– to introduce or improve care coordination/chronic disease management, including transition coordination?– to encourage/support enrollee participation, beneficiary-centeredness, and self-management of conditions?• What measures are states collecting to assess care improvements?• What experience of care measures are states collecting from providers, beneficiaries, and families? <p>Are states using specialty providers as health home providers?</p> <ul style="list-style-type: none">• If so, what was the impetus for the state?• Are other less specialized types of providers also being used?• What factors did states use in deciding which types of organizations to include as health homes?• Which states are using medical homes as the foundation for health homes?• Are they using medical homes not based in a primary care practice?• What payment structures are states using? <p>How are participating providers integrating behavioral health, primary care, and supportive services?</p> <ul style="list-style-type: none">• What structures have put in place to create these links?• What processes reinforce linkages for providers and beneficiaries?• What is the relationship between health homes and state mental health and long-term services and supports systems?
Assessments Over the Intervention Period
<p>Have care coordination, chronic disease management, patient experience, and clinical outcomes improved for individuals?</p> <ul style="list-style-type: none">• Have patient compliance and adherence improved?• Do improvements differ for different participant groups defined by conditions?• From whose perspective are these outcomes defined and measured (i.e., do providers and beneficiary advocates define and assess them similarly)?• Are beneficiaries and/or caregivers able to participate more effectively in decision-making concerning care?• Is care more beneficiary-centered?• Are beneficiaries better able to self-manage their conditions?• Have health homes improved access to community-based supports? <p>Has the focus on better integrating care for selected populations resulted in cost savings?</p> <ul style="list-style-type: none">• Have the targeted potentially avoidable types of utilization been reduced?• Have reductions resulted in reduced total costs or growth in total costs for these services?• What is the net result for total costs of treating the targeted population? <p>Which types of organizations are better suited to becoming health homes?</p> <ul style="list-style-type: none">• Does “better suited” differ for different target populations?• How do challenges and costs of practice reform and infrastructure differ across different types of organizations (e.g., primary care practices, other providers such as CMHCs and home health agencies, large integrated care organizations, specialty providers, health teams)?• Are there identifiable organizational types that are associated with better quality and cost outcomes? <p>How could pre-existing medical home models be modified to address individuals with multiple chronic conditions and/or SMI?</p> <ul style="list-style-type: none">• Which structures and processes, if any, are missing from existing medical home models?• How well do various payment structures work in bringing about practice transformation?

TABLE 3. Key Features of Programs

State/ Program	Estimated Eligible Population ¹	Eligibility Groups Included ²	Health Home Eligibility Criteria	Qualifying Conditions ³	Enrollment Processes	Payment System	Payment Level
North Carolina	400,000	Categorically and medically needy	2 chronic conditions, 1 chronic condition and at risk of another	<ul style="list-style-type: none"> - Blindness - Congenital anomalies - Alimentary system disease - Mental/cognitive conditions, except mental illness or developmental disabilities - Musculoskeletal conditions - CVD - Pulmonary disease - Endocrine/metabolic disease - Infectious disease - Neurological disorders 	State identification and assignment	PMPM care management fee, paid to network and PCP	PMPM fee based on beneficiary classification: <ul style="list-style-type: none"> - Networks--\$12.85 for ABD; \$5.22 for pregnant patients; \$4.33 for all others. - PCPs--\$5.00 for ABD; \$2.50 for all others.
Oregon	118,000	Categorically needy	2 chronic conditions, 1 chronic condition and at risk of another, SMI	<ul style="list-style-type: none"> - Asthma - Overweight - Cancer - Chronic kidney disease - Chronic respiratory disease - Diabetes - Heart disease - Hepatitis C - HIV/AIDS - Substance abuse disorder - Mental health condition 	Provider identification; state verification	PMPM care management fee	PMPM fee based on provider qualification level: <ul style="list-style-type: none"> - Tier 1--\$10 PMPM - Tier 2--\$15 PMPM - Tier 3--\$24 PMPM
Rhode Island (CEDARR-HHs)	2,500	Categorically and medically needy	2 chronic conditions, 1 chronic condition and at risk of another, SMI	<ul style="list-style-type: none"> - Mental health condition - Asthma - Developmental disability - Diabetes - Down syndrome - Mental retardation - Seizure disorder 	Provider identification; state verification	FFS	Fixed rates of \$347, \$366, or \$397, depending on the service. Additional payments of either \$9.50 or \$16.63 made per quarter hour for 2 other services
Rhode Island (CMHO-HHs)	5,300	Categorically and medically needy	SMI and evidence of need for supports to remain in the community ³	Mental health condition, with a history of intensive psychiatric treatment, no or limited employment, and poor social functioning	Provider identification; state verification	PMPM care management fee	Based on 9 staff hours per client per month

TABLE 3 (continued)

State/ Program	Estimated Eligible Population ¹	Eligibility Groups Included ²	Health Home Eligibility Criteria	Qualifying Conditions ³	Enrollment Processes	Payment System	Payment Level
Missouri (CMHC-HHs)	43,000 (across both categories of HH)	Categorically needy	SMI, mental health condition or substance use disorder and 1 other chronic condition, or a mental health condition or a substance abuse disorder and tobacco use	<ul style="list-style-type: none"> - Substance use disorder - Mental health condition - Asthma - CVD - Developmental disability - BMI over 25 - Diabetes - Tobacco use 	State identification and assignment	PMPM care management fee	\$78.74
Missouri (PCP-HHs)			2 conditions, 1 and at risk of another.	<ul style="list-style-type: none"> - Asthma - CVD - Developmental disability - BMI over 25 - Diabetes - Tobacco use 	State identification and assignment	PMPM care management fee	\$58.87
New York	700,000 (Phases I-III)	Categorically and medically needy	2 chronic conditions, HIV/AIDS, or a serious mental condition	<ul style="list-style-type: none"> - Substance use disorder - Respiratory disease - CVD - Metabolic disease - BMI over 25 - HIV/AIDS - Other chronic conditions 	State identification and assignment	PMPM care management fee	Paid at 2 levels depending on enrollee status, and adjusted for case-mix and geography
Alabama	75,000	Categorically needy	2 chronic conditions, 1 chronic condition and at risk of another, SMI	<ul style="list-style-type: none"> - Mental illness - Substance use disorder - Asthma - Diabetes - Transplant recipients (within last 5 years) - CVD - COPD - Cancer - HIV/AIDS 	State identification and assignment	PMPM care management fee, paid to network (PCNA) and PCP	<ul style="list-style-type: none"> - PCNA--\$9.50 - PCP--\$8.50
Iowa	100,000	Categorically and medically needy	2 chronic conditions, 1 chronic condition and at risk of another	<ul style="list-style-type: none"> - Mental health condition - Substance use disorder - Asthma - Diabetes - Heart disease - BMI over 25 - Hypertension - BMI over 85th percentile for pediatrics 	Provider identification; state verification	PMPM care management fee, plus lump-sum performance-based incentive	<p>PMPM fee varies by patient acuity tiers:</p> <ul style="list-style-type: none"> - Tier 1--\$12.80 - Tier 2--\$25.60 - Tier 3--\$51.21 - Tier 4--\$76.81 <p>Incentive pay based on achievement against 16 measures</p>

TABLE 3 (continued)

State/ Program	Estimated Eligible Population ¹	Eligibility Groups Included ²	Health Home Eligibility Criteria	Qualifying Conditions ³	Enrollment Processes	Payment System	Payment Level
Ohio	14,600	Categorically needy	SPMI, SMI, or SED	Beneficiaries who meet the state definition for SPMI, SMI, or SED	Provider identification; state verification	PMPM care management fee	Site-specific and based on costs; ranges from \$270-\$400 PMPM
Wisconsin	520	Categorically and medically needy	HIV/AIDS and 1 other chronic condition or at risk of another	HIV/AIDS	Provider identification; state verification	PMPM care management fee, plus annual flat fee	– PMPM --\$102.95 – Fee --\$359.00
Idaho	30,000	Categorically needy	2 chronic conditions, 1 chronic condition and at risk of another, SMI, SED	– Mental health condition – Asthma – Diabetes	Provider identification; state verification	PMPM care management fee	\$15.50
Maine	125,000	Categorically and medically needy	2 chronic conditions, 1 chronic condition and at risk of another	– Mental health condition – Substance use disorder – Asthma – Diabetes – Heart disease – BMI over 25 – Tobacco use – COPD – Hypertension – Hyperlipidemia – Developmental disabilities or autism – Seizure disorder – Congenital cardiovascular abnormalities – Other conditions as identified by providers	State and provider identification	PMPM care management fee, paid to CCT and PCP	– CCT --\$129.50 – PCP --\$12.00

1. Data obtained through personal communications with state Medicaid officials.
2. Oregon, Missouri, Alabama, Ohio, and Idaho do not have medically needy programs.
3. See Appendix B for detailed criteria and conditions.

APPENDIX A. HEALTH HOMES SITE VISIT PROTOCOL

I. Introduction (*all interviewees*)

Overview of the purpose of the long-term evaluation:

- Did it “work” (i.e., did it have the intended effect on health outcomes, costs, and health care utilization)?
- If so, what made it work (structure and processes)?
- Is it replicable and scalable?
- What can we learn for other states, other populations?

What we know about the state’s initiative already (verify matrix of components)?

What we need to know going forward (i.e., the purpose of the site visit and of the ongoing evaluation activities). Explain option years, ongoing activities.

- To give context for the findings on outcomes down the road.
- To establish baseline structure and processes.
- To be able to identify mid-course corrections and their effect on eventual outcomes.

Overview of interview questions.

Any questions for us?

II. Design of the Program (*Medicaid director, health home program director, legislators, associated state agency directors, provider health home director, patient advocates*)

Motivation

What was the motivation behind the development of the state’s health home initiative?

- Probe: Role of: the availability of the enhanced federal match, other cost/budget issues, specific stakeholders (providers, advocates, beneficiaries, other), the legislature.

Who were/are the initiative's champions? Who were/are its major detractors?

Specific Design Choices

Why this population?

Why this geographic coverage?

Why these providers?

Context

How does the initiative fit into historical/current context (i.e., does it build on or replicate existing initiatives)?

- If so, have any changes been made to the existing programs/models to meet health home criteria?
 - Probe: Were there any specific structures and processes missing from existing models and needed to meet health home requirements? Beyond health home requirements, were there any other structures or processes added, and, if so, what and why?
- If not, why not?

The Model (plus: director of nursing, care coordination manager)

What are the specific goals of the initiative?

What do you think are the most important features of this model to help meet these goals?

- Probe: Providers, payment method, integration supports, continuity of pre-existing initiatives, community supports, HIT, other.

How are these features supported (financial, technical assistance, capital investment)?

What is the working relationship between health homes and the state mental health and long-term services and supports systems?

Details of initiative's structure and processes to support the following:

- Community supports, care coordination/chronic disease management, transition coordination, condition self-management, patient-centeredness, integration of mental health/behavioral health and physical health services.

III. Enrollment

(health home program director, health home evaluation team, associated state agency directors, patient advocates)

How many of each eligibility group are there in the state? What share of these do you expect to enroll?

How are enrollees notified of eligibility? What outreach activities have been used? Which have been most successful?

How are beneficiaries enrolled (e.g., on-line, auto-enrollment, by providers, at time of eligibility determination, other)? Do beneficiaries have a choice of whether to participate in any health home? If there is auto-enrollment, are these beneficiaries able to opt out of health homes entirely?

What has been beneficiary response to date? Relative to your goals/ expectations is total enrollment low, high, on target? If low, what might be the cause? What steps will you take to increase it? If high, is provider capacity sufficient? If it is insufficient, are you considering expansion? If so, why and how? If not, why not?

What is your experience with continuity of enrollment? What's the drop-out rate? If high, any ideas why? What are the chief causes of discontinuity of enrollment?

- Probe: Medicaid eligibility change, beneficiary dissatisfaction, provider drop-outs, deaths, other.

What policies are in place to minimize cherry-picking of enrollees? Any evidence to date on the extent of this problem, if any?

IVa. Providers

(health home program director, health home evaluation team, associated state agency directors, patient advocates)

Provider Participation

How do providers qualify as health homes?

How does actual provider participation match expected participation? What share of eligible providers are participating?

If low, what might be the cause? Are you considering steps to increase it? If so, what?

- Probe: Qualifications, payment, beneficiaries.

Practice Transformation

What processes are in place to facilitate providers' adoption of health home services and practices?

- Probe: Technical assistance, peer-to-peer efforts such as learning collaboratives, other.

Has provider participation in practice transformation activities and their level of enthusiasm (or resistance) met your expectations?

What has been the progress to date? How is progress measured? What have been the hardest areas to change?

What is your expectation on whether all or most practices will get there (i.e., become functioning health homes)? How long do you think it will take? Have you thought about how you will address failure to achieve progress?

IVb. Providers

(provider health home director, director of nursing, care coordination manager, patient advocates)

Participation (plus control practices)

What factors influenced your decision (*not*) to participate as a health home?

- Probe: How important was the enhanced federal match in your decision to participate? Your current patient panel? Beneficiary advocates?

What changes did you make to qualify as a health home? What support did you get for this effort? What types of support have been most useful? What additional support do you need, if any?

Practice Transformation

What processes are in place to facilitate providers' adoption of health home services and practices? Which of these do you find most useful? What other help, if any, do you think would be useful?

- Probe: Financial support, technical assistance, peer-to-peer/learning collaboratives, other.

What has been your experience to date as a health home? What have been the areas that you have found most challenging? Most rewarding?

- Probe: Staff's ability to meet the new demands; beneficiary response, cooperation of providers outside the health home such as hospitals.

What has been your experience to date with the reporting requirements associated with being a health home? Have the data collection and reporting efforts been of use to your practice in meeting the health home objectives? Do you use the data you collect to assist you in your practice?

Beneficiary Experience

How well do you think that beneficiaries are adapting to the new structure and processes of the health home? What areas do you think they find most difficult? Most beneficial?

How are you assessing beneficiary experience? What has this assessment shown to date? Based on your assessment, have you made or would you recommend any changes in structure or processes?

Payment

Do you feel that the payment system (method and levels) is supportive of the health home services that you are providing? What role did providers play in establishing the method and/or levels for services?

V. Payment System (Medicaid director, health home program director, rate setting team leader)

Why was the specific payment methodology chosen? What other payment systems were considered?

- Probe: Provider input, advocate/beneficiary input, legislature input, consultant recommendation, example from other states/private insurers

What is your assessment to date of effectiveness of payment method at supporting health home services and practice transformation? What do providers say about the method or level, either generally or with respect to specific services? Based on this assessment, are you considering changing either the payment method or level?

VI. Health Information Technology
(Medicaid director, health home program director, data coordinator, Medicaid information technology coordinator, legislators, associated state agency directors, provider health home director)

What is the role of HIT in supporting the initiative? (open-ended)

- Probe: Contribution of HIT to the state's ability to monitor the progress of the initiative? To facilitating care coordination? To integration of mental health and physical health services? To reducing emergency department use and re-hospitalizations? To other health home goals? Which of these would not be possible without HIT?

Was new investment required (on state side, on provider side)? How was it paid for? Was there any associated technical assistance required?

VII. Reporting/Data
(Medicaid director, health home program director, data coordinator, Medicaid information technology coordinator, health home evaluation director, associated state agency directors, provider health home director, advocates)

How were the reporting requirements/data elements/periodicity chosen?

- Probe: Role of national standards, CMS requirements, other.

Are reporting requirements entirely new or do they build on existing systems? Do they represent a big change or just tweaks?

What has been your experience with provider reporting of the required data elements? What assistance have you offered providers?

- Probe: Provider capability, cooperation, adherence.

What is your experience to date of data timeliness, accuracy, and completeness? Are there any notable problem areas? If so, which areas and how are you addressing them?

What data is collected from beneficiaries and their families/caregivers? Have you encountered any problems in collecting this data?

Will the state be willing/able to share with us directly or through CMS the provider-level data providers must report to the state? The data collected from beneficiaries/families?

If so, how long is the lag between service delivery and data availability? What format are these data in?

VIII. Evaluation Design

(Medicaid director, health home program director, health home evaluation director, data coordinator, associated state agency directors, provider health home director, advocates)

Verify our understanding of the evaluation design.

What are the comparison groups and how were they chosen?

- Probe: Are there similar beneficiaries (eligible by chronic condition profile) not currently being served by CMHO or CEDARR, respectively, who will not be auto-enrolled and might be able to serve as a comparison group?

Across what time period(s) will the comparisons be made? If your evaluation calls for comparisons with a pre-initiative period, what period has been designated and where will the data for the pre-period be found?

What methods do you intend to use in comparing beneficiaries and the comparison group(s)?

IX. Wrap-Up

(all interviewees)

Any key things we did not ask about?

Who else should we be talking to?

Periodic follow-up over the next year (and the option years): who should be our point of contact?

We will write-up the notes from this interview. Would you like to have the opportunity to review them?

Thank yous.

**APPENDIX B. MEMORANDA ON PRE-EXISTING
STATE INITIATIVES AND SUMMARY OF
STATE PLAN AMENDMENTS FOR SECTION 2703
MEDICAID HEALTH HOMES**

Separate PDFs are available for each state summary. See the URL list on the next page for URLs.

EVALUATION OF THE MEDICAID HEALTH HOME OPTION FOR BENEFICIARIES WITH CHRONIC CONDITIONS: Annual Report - Year Two

Files Available for This Report

Full Report (including state appendices)

Executive Summary: <http://aspe.hhs.gov/daltcp/reports/2014/HHOption2es.cfm>
HTML: <http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.cfm>
PDF: <http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.pdf>

Alabama appendix only

HTML: <http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.cfm#AL>
PDF: <http://aspe.hhs.gov/daltcp/reports/2014/HHOption2-AL.pdf>

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Maine appendix only

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Rhode Island appendix only

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U.S. Department of Health and Human Services
Office of Disability, Aging and Long-Term Care Policy
Room 424E, H.H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201
FAX: 202-401-7733
Email: webmaster.DALTCP@hhs.gov

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