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Developing and Implementing the Section 2703 Health Home State Option: State Strategies to Address Key Issues

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Executive Summary

The rising prevalence of chronic conditions and growing health care costs have placed pressure on policymakers to reform health care delivery systems. Many states are finding that Section 2703 of the Affordable Care Act (ACA), which established the "State Option to Provide Coordinated Care through a Health Home for Individuals with Chronic Conditions," provides an important way to reform health care delivery. The ACA provides funding for a two-year enhanced (90 percent) federal match for health home services for eligible Medicaid enrollees.[1] Statute defines health home services as comprehensive and timely high-quality services provided by a designated provider or a team of providers and specifically include: care management; care coordination; health promotion; transitional care; patient and family support; and referral to community and social support services. To qualify for health home services, eligible Medicaid enrollees must meet one of three requirements: a serious and persistent mental illness, two chronic conditions or one chronic condition and the risk of developing a second.

This paper identifies five particularly salient issues that states are likely to face when developing and implementing a health home state plan amendment (SPA) and illustrates how states with approved SPAs have addressed these issues. This paper draws from the experiences of a 2011-2012 National Academy for State Health Policy (NASHP) Medical Home consortium of 14 leading states supported by The Commonwealth Fund.

I. Coordinating with existing programs. The Centers for Medicare & Medicaid Services (CMS) encourages states to leverage existing programs and infrastructure when developing health home initiatives, and the first four states with approved SPAs are using health homes to improve and spread existing initiatives. It is important to remember that CMS will not reimburse for duplicative services. The risk of duplicative services is of particular concern for Medicaid managed care enrollees that may receive care coordination services from their managed care plan. States with approved SPAs have amended their managed care contracts to establish clear guidelines as to which services are the health home's responsibility and which services are the managed care plan's responsibility. Examples of states coordinating health homes with existing programs include:

- Oregon's health home SPA created the first payment mechanism for the state's Patient-Centered Primary Care Home program, an initiative originating in 2009 legislation.
- Rhode Island amended its managed care contracts and created a set of operational protocols that establish clear guidelines for the plans as to which services are the health home's responsibility.

The ACA also offers health home planning grants, which allow states to draw their non-administrative Federal Medical Assistance Percentage (FMAP) up to $500,000 to design and plan a health home initiative. States are using this to either design health homes that complement current programs or plan an entirely new program.

II. Financing and payment. States have flexibility in designing health home payment methodologies, and there is variation across states; of the six SPAs approved before May 2012:

- Five added a per-member per-month payment in addition to existing fee for service and managed care payments. Two adjust the per-member per-month payment for case mix, geography, or provider medical home level;
- One uses fee-for-service;

- Two pass payments to health home providers through participating managed care plans, and two pay the providers directly; and
- While no approved state plan amendments currently include performance-based payments, the enabling legislation does allow alternative payment methodologies.

To fully leverage the enhanced match, states may want to consider financing or arranging for the financing of practice education and training. The time-limited nature of the enhanced match underscores the importance of upfront and ongoing provider training so that providers understand health home expectations and are capable of providing health home services when the state plan goes into effect. Three states are providing this training through group practice training, also known as learning collaboratives, drawing on a combination of state and private funding sources.

Although the enhanced federal funding for health homes is enticing, the recession has left many states unsure if they will have sufficient state funds to add new services and contribute the 10 percent match. States are also concerned about losing the 90 percent match after two years.

III. Integrating behavioral and physical health. People with severe mental illness have a greater prevalence of physical health conditions than the general population, yet experience greater barriers to the diagnosis and treatment of physical conditions. States are adopting models of care to address this disparity that fall somewhere along the spectrum of integration and collaboration. Missouri's two approved health home SPAs provide examples of each model:

Integrated Care models: Missouri's *primary care* SPA requires the greatest amount of integration among SPAs approved before May 2012. Behavioral health consultants work in primary care settings and screen and evaluate patients for behavioral health conditions, intervene with patients who could benefit from behavioral health intervention, and manage behavioral health needs.

Collaborative Care models: Missouri's *behavioral health* SPA does not require direct co-location of physical health services in community mental health settings. Instead, it relies on primary care physicians participating in the treatment planning, consulting with team psychiatrists, and assisting in coordination with external medical providers.

IV. Sharing health data. Sharing data across the entire health care system will connect providers and better facilitate comprehensive, whole-person care. Ideally, this can be realized through electronic exchange of a common care plan. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) is often identified as a barrier to sharing behavioral health data, but sharing information to coordinate a patient's care is generally permitted with a patient's general consent. However, additional state or federal laws can further limit data sharing. For instance, providers in North Carolina needed an act of the legislature to expand health record sharing laws, easing the burden for providers when sharing confidential patient information "when necessary to coordinate appropriate and effective care, treatment or habilitation of the client."

Federal Confidentiality of Alcohol and Drug Abuse Patient Records regulations can make sharing substance use treatment data particularly difficult. However, New York has developed a single consent form for their health home program that requires enrollees to share all protected data with the health home team, including information from federally-assisted alcohol and drug treatment programs.

Health information technology, including health information exchanges, offers enhanced opportunities for providers to coordinate care across systems. However, adoption rates are low, particularly among small practices and behavioral health providers. Therefore, most states with approved SPAs have yet to require health home providers to adopt their own electronic health records.

V. Evaluating health home programs. The Affordable Care Act mandates two Congressional Reports to determine whether health homes lower costs and improve quality outcomes and patient satisfaction. The core measures for the federal evaluation draw from outcome measures. States have advocated for a mix of process and outcomes measures, preferring claims-based measures. States are wary of requiring providers without electronic medical records to conduct manual chart reviews due to the cost-prohibitive nature of these audits. Some states are providing access to electronic web portals to help health home providers meet data reporting requirements.

Beyond the core set of measures, states have an opportunity to identify state-specific goals and describe how the state will collect outcomes, experience of care, and quality of care data. A vast majority of goal-based outcomes and quality measures across all states are being drawn from claims, encounter and pharmacy data. Sources for patient experience of care measures vary based on the experience of care survey tools that the state uses (e.g., the Consumer Assessment of Healthcare Providers and Systems or Mental Health Statistics Improvement Program surveys).

Summary

The health home state option provides an intriguing opportunity for states to strengthen their primary care system with the federal government financing the majority of the new program costs for the first two years. The five issues described in this paper are not the only issues states will need to address, but they can be among the most difficult to resolve. In addition, states will need to decide which chronic conditions will be included, which providers will be eligible to participate, and whether to use national- or state-developed qualification standards for participation. Federal law and subsequent CMS guidance have given states a great deal of flexibility, and the early adopters have taken a variety of approaches to implement health home programs.

Introduction

The rising prevalence of chronic conditions and growing health care costs have placed pressure on policymakers to reform health care delivery systems designed largely for acute illness care.[5,6] Approximately five percent of the population accounts for nearly half the total health care spending in the United States, and patients with multiple chronic conditions can cost up to seven times as much as patients with only one chronic condition.[7]

Many states are reforming their delivery systems to address costs and quality issues for expensive Medicaid enrollees by pursuing Section 2703 of the Affordable Care Act,[8] which established the "State Option to Provide Coordinated Care through a Health Home for Individuals with Chronic Conditions."[9] (See text box, right) States also see this as an opportunity to better integrate primary care with the behavioral health and long-term care systems, which may advance health equity for vulnerable populations. The Affordable Care Act provides a strong up-front financial incentive for states by providing an eight-quarter enhanced (90 percent) federal match for health home services for eligible Medicaid enrollees. The purpose of this paper is to discuss five issues states pursuing the state health home option found important to address during planning and implementation. This paper will also illustrate how states with approved health home State Plan Amendments (SPAs) have addressed these issues.

What is a Health Home?

Health homes are an extension of the medical home model, which is "an enhanced model of primary care that offers whole-person, comprehensive, ongoing, and coordinated patient and family-centered care."[2] Statute defines health home services as comprehensive and timely high-quality services provided by a provider or team of health care professionals, specifically including the following six services:

1. Comprehensive care management;
2. Care coordination;
3. Health promotion;
4. Comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;
5. Patient and family support (including authorized representatives); and
6. Referral to community and social support services, if relevant.

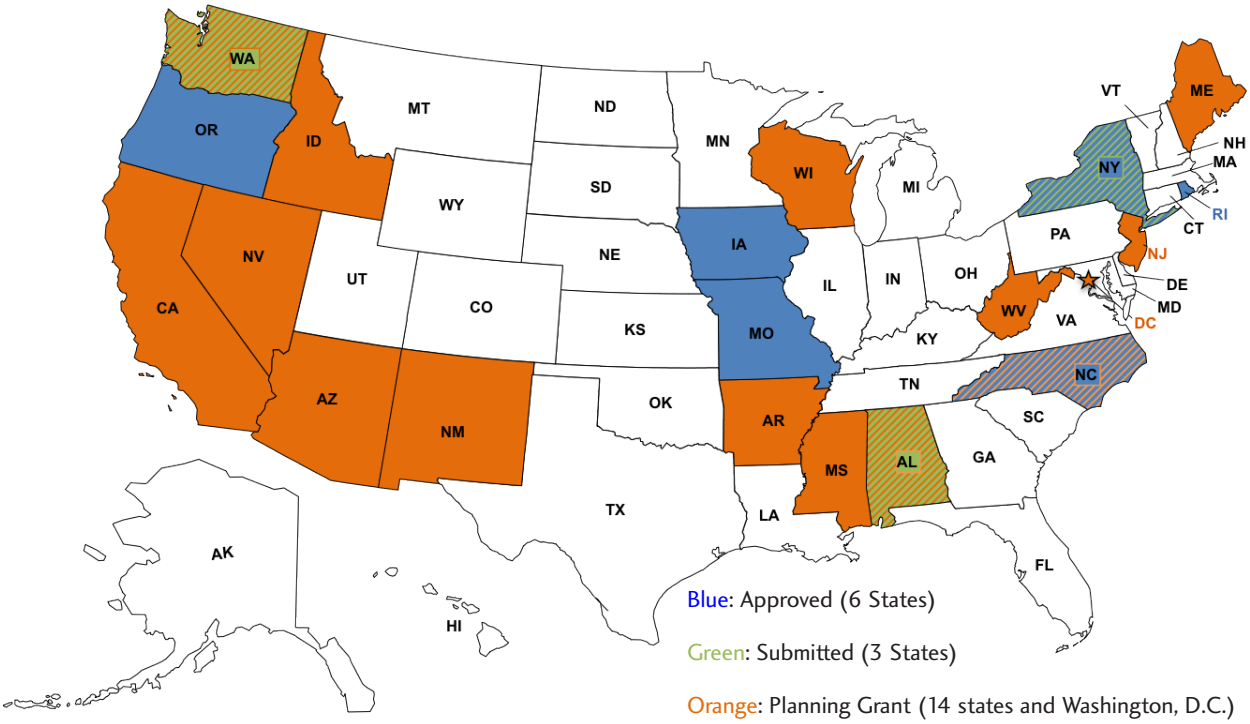
Federal guidance strongly encourages the use of health information technology as feasible and appropriate to link these services.[3]

Eligible individuals include those with: (a) a serious and persistent mental illness; (b) two chronic conditions; or (c) one chronic condition and the risk of developing a second. The statute defines chronic conditions to include mental health conditions, substance abuse disorders, asthma, diabetes, heart disease, and being overweight (as defined by a body mass index BMI of greater than 25), but states can expand the list of eligible chronic conditions subject the approval of the Secretary of Health and Human Services.[4]

A 2011 scan of state Medicaid directors showed that at least 42 states were considering submitting a health home SPA.[10] As of May 1, 2012, the Centers for Medicare & Medicaid Services (CMS) has approved six health home SPAs filed by four states: Missouri (2); Rhode Island (2); New York (1); and Oregon (1).[11] Fourteen states and the District of Columbia have received a federal planning grant,[12] which allows a state to draw their federal medical assistance percentage (FMAP) up to $500,000 for health home planning activities.[13] (See Figure 1)

In 2011-12, The National Academy for State Health Policy (NASHP) supported a consortium of 14 leading states to strengthen, expand, and sustain medical home programs for Medicaid and CHIP enrollees, spon-

Figure 1 - Map of Section 2703 Health Home State Plan Amendment Activity as of June 15, 2012.



sored by The Commonwealth Fund. As part of this consortium—the third since 2007[14]—NASHP led a learning community of six states interested in pursuing the health home option. Through a series of six small group webinars, NASHP worked with Colorado, New Mexico, New York, North Carolina, Oklahoma, and Washington to identify key issues that states will need to address in the planning, development, and implementation of a health home program. These webinars offered states the opportunity to discuss implementation barriers and share potential solutions and lessons learned. Five salient issues identified by the learning community states were:

1. Coordinating with existing programs – building health home services into existing state efforts;
2. Financing and payment – structuring health home payments to cover necessary infrastructure and services while ensuring cost neutrality or savings.
3. Integrating behavioral and physical health – ensuring that patients receive whole-person health home services;
4. Sharing health data – exchanging patient information across the entire health home care team;and
5. Evaluating health home programs – ensuring that measures and methodologies meet state objectives and federal requirements.

Figure 2 - Approved Section 2703 Health Home State Plan Amendments as of May 1, 2012 - Target Population and Eligible Providers

Approved	State	State Plan #	Target Population	Eligible Health Home Providers
10/20/11	**Missouri**	MO-11-0011	Severe Mental Illness/Behavioral Health Conditions	Community Mental Health Centers
11/23/11	**Rhode Island**	RI-11-0006	Children and Youth with Special Health Care Needs	CEDARR Family Centers
11/23/11	**Rhode Island**	RI-11-0007	Severe Mental Illness/Behavioral Health Needs	Community Mental Health Organizations
12/22/11	**Missouri**	MO-11-0015	Chronic Physical Health Conditions	Federally Qualified Health Centers; Rural Health Centers; and Hospital-operated Primary Care Clinics
02/03/12	**New York**	NY-11-0056	Chronic Physical Health Conditions and Serious Mental Illness/Behavioral Health Conditions	Comprehensive Partnerships between Hospitals, Clinics, Primary Care Providers, Medical Homes, Federally Qualified Health Centers, Behavioral Health Providers, and Community Based Organizations
03/13/12	**Oregon**	OR-11-0011	Chronic Physical Health Conditions and Serious Mental Illness/Behavioral Health Conditions	Non-specialty Physicians (OB-GYNs are eligible); Clinics, Group Practices; Federally Qualified Health Centers, Rural Health Clinics, Tribal Clinics, Community Health Centers, Community Mental Health Programs, Select Drug and Alcohol Treatment Programs

Coordinating With Existing Programs

States naturally look for ways to leverage existing programs and infrastructure when starting new initiatives. The federal government recognized this and provided early guidance that encouraged states with existing or planned medical home programs to design their health homes to build on these initiatives.[16] (See text box right.)The health homes state option can also help states finance the launch of entirely new programs; a medical home program is not a prerequisite for health home services. Regardless of where they are in the planning process, states will need to account for care management services that are already being provided to their Medicaid enrollees and design their program to complement these services to avoid duplication.

What is a Medical Home

In 2007, four provider trade organizations (the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association) developed a set of "Joint Principles" that define the care of a patient-centered medical home:

1. **Personal Physician** – Each patient has an ongoing relationship with a personal physician that provides continuous, comprehensive care.
2. **Physician-directed Care** – Personal physicians lead a team of individuals who take collective responsibility for a patient.
3. **Whole-person Orientation** – Personal physicians take responsibility for providing or arranging all of a patient's health needs.
4. **Coordination and/ or Integrated Care** – Care is coordinated or integrated across all elements of the health care system and a patient's community.
5. **Quality and Safety –** Practices advocate for patients to attain optimal, patient-centered outcomes resulting from evidence-based care and decision-making.
6. **Enhanced Access** – Care is available through open scheduling, expanded hours, and new communication options.
7. **Payment** – Reimbursement reflects the added value of medical home services.[15]

Building on Existing State Programs

Health home services enhance patient-centered care. Medical homes or primary care case management programs can provide a strong foundation to add health homes services. Many states are in a good position to do this. In fact, 23 states have provided payment for medical home initiatives in their Medicaid and CHIP programs, independent of a health home SPA.[17] Health homes can augment a medical home initiative or a primary care case management program by improving coordination with other providers such as specialists and hospitals as well as adding services, such as behavioral health or community-based services.

Using a health home SPA to augment existing programs also offers an incentive to build from successful pilots. Each of the first four states with approved SPAs offer examples of how to incorporate health home services within existing programs or pilots:

- New York is phasing in health homes, beginning with a 10-county group that includes the three counties implementing the multi-payer Adirondack Region Medical Home Pilot.[18] Health home teams will develop and implement a single shared care plan for eligible Medicaid enrollees.
- Oregon's health home SPA created the first payment mechanism for the state's Patient-Centered Primary Care Home (PCPCH) program, an initiative originating from 2009 legislation.[19,20]

- Core features of Missouri's behavioral health SPA were influenced by experience from pilots that included a mental health community case management program for Medicaid enrollees with schizophrenia[21] and care integration by co-location of community mental health centers and federally-qualified health centers.[22] These pilots have laid important groundwork allowing the health home teams to effectively coordinate care across the physical and behavioral health systems.
- One of the two Rhode Island SPAs is deeply rooted in the services that the Comprehensive Evaluation Diagnosis Assessment Referral and Re-evaluation (CEDARR) Family Centers have been providing for children and youth with special healthcare needs since 2001.[23] With the approval of the CEDARR health home SPA, certain services once voluntary are now mandatory, such as documented body mass index screening for children six and older and documented depression screening for children twelve and older.

Developing New Programs

Many states are taking advantage of a federal health home planning grant, which allows a state to draw their Federal Medical Assistance Percentage (FMAP) up to $500,000 for health home planning activities. This planning grant opportunity is beneficial for states where the service match is greater than the standard administrative match; Mississippi, Nevada, and the District of Columbia have leveraged this option to launch new programs. To receive the planning grant, states need to submit a brief letter of request outlining the planning activities and an estimated budget.[24] There is not a deadline to apply for a planning grant, so interested states still have an opportunity to submit a letter of request.

Integrating Medicaid-contracted Managed Care Plans

States pursuing the health home option will need to account for the care management services that Medicaid managed care plans provide to potential health home enrollees. CMS will not reimburse for duplicative services, so it is important for states to ensure that health homes services are distinct.[25] States are creating new agreements to meet the requirement that managed care plans work collaboratively with the health home providers and do not duplicate care coordination services. For example, agreements may stipulate that care management services previously provided by plan staff may now be deferred to health home staff and plans are required to notify heath home providers of their patients' admissions to hospitals and emergency departments.

- Rhode Island amended its managed care contracts and created a set of operational protocols that establish clear guidelines for the plans as to which services are the health home's responsibility.[26] These protocols apply to both Rhode Island health home programs.
- New York requires their managed care plans to contract with provider-led health homes to provide health home services for their eligible members.[27]

The promise of enhanced federal funding for health homes is enticing, but states are still feeling the effects of the latest recession, and 30 states expect (or have closed) projected budget shortfalls for FY2013.[28] During a February 2011 environmental scan NASHP prepared for the Assistant Secretary for Planning and Evaluation, states expressed concern that they may not be able to afford paying for any additional services not already covered under Medicaid—even if the state is only paying 10 percent of the cost for the first two years.[29] States participating in the 3rd Consortium have also expressed concern with losing the enhanced match after two years.[30]

As a result, many states have partnered with external stakeholders to help finance the planning and implementation of health home SPAs. California was successful in raising planning grant match funds through the Community Clinics Initiative, a partnership between The California Endowment and The Tides Center.[31]

Infrastructure and Training

That the enhanced health home match is limited to eight quarters underscores the importance of making sure that providers are trained and capable of providing health home services when the state plan amendment goes into effect. To fully leverage the enhanced match, the necessary training (including practice coaching and learning collaboratives) and infrastructure (including staff and, if required, information technology) will need to be in place *before* the enhanced match begins.

However, many small- and medium-sized practices will be challenged to meet health home requirements—their adoption of medical home processes is already low. A 2011 report found that practices of 1-19 physicians adopted an average of just 21.7 percent of the possible medical home processes advocated in the Joint Principles of the Patient-Centered Medical Home.[32] (See text box on page 8) The fact that health homes add criteria beyond what many state medical home initiatives currently require provides a compelling reason to ensure that practices have the tools and the training to take on new responsibilities. Missouri, New York and Oregon are all using learning collaboratives to support continued practice transformation.

Finding a way to pay for infrastructure and training outside of the health home payments will be a challenge for states. Early drafts of Missouri's health home SPAs included a quarterly infrastructure payment to health homes meant to support practice transformation and health home infrastructure costs, but CMS did not approve this payment approach. However, Missouri's approved SPAs built $2.40 into the per-member per-month health home payment to offset the time lost when physicians attend learning collaboratives.[33] Missouri explicitly noted in each approved SPA that state agencies, foundations and providers would collectively pay more than $1.5 million in training and implementation costs not included in the 90 percent enhanced match.

Payment Methodologies

Figure 3 - Approved Section 2703 Health Home State Plan Amendments as of May 1, 2012 – Payment Methodologies

State (SPA)	Methodology	Payments/Range	MCO Payments	Requirements for Payment
Missouri (Behavioral Health)	Monthly Care Management Fee	$78.74 Per-Member Per-Month (PMPM)	Paid directly to the health home	Health home service provided monthly
Missouri (Physical Health)	Monthly Care Management Fee	$58.87 PMPM	Paid directly to the health home	Health home service provided monthly
New York	Monthly Care Management Fee	$75-$390 PMPM, adjusted for geography and case-mix	Paid to MCO, passed through to health home	Health home service provided monthly
Oregon	Monthly Care Management Fee	$10-$24 PMPM, adjusted for medical home tier	Paid to MCO, passed through to health home	Health home service provided quarterly
Rhode Island (CEDARR)	Fee-for-Service	$347, $366 or $397, depending on the service Additional payments of $9.50 or $16.63 per 15-minute for additional services	Paid directly to the health home	Service provided
Rhode Island (Behavioral Health)	Monthly Care Management Fee	$442.21	Paid directly to the health home	Health home service provided monthly

The ACA gives states flexibility in designing health home payment methodologies. Section 2703 explicitly allows states to adjust health home payments to reflect patient complexity and health home capabilities, and the legislation also permits alternative payment methodologies subject to approval.[34] States are using this flexibility to implement a variety of payment models. (See Figure 3)

Monthly Care Management Fees: Of the six state plan amendments approved as of May 2012, five use a per-member per-month payment. There is variation in how the states are taking this approach.

- *Flat payments*: Missouri pays a flat $58.87 per-member per-month payment for enrollees in their primary care clinic SPA and $78.74 per-member per-month payment for enrollees in their community mental health center SPA. Rhode Island also uses a flat monthly case rate for their behavioral health SPA, paying community mental health organizations $442.21 for health home services.
- *Adjusted for risk or geography*: New York adjusts their monthly payments, which range from $75 to $390 per-member per-month, based on geography and patient case-mix.
- *Adjusted for Medical Home tier*: Oregon adjusts their health home payments of $10, $15 or $24 per-member per-month based on the provider reaching one of three tiers using a state-developed qualification standards.

Missouri health homes are not supposed to bill for the per-member per-month payment for enrollees who receive at least one documented health home service in a given month.[35] In contrast, Oregon will con-

tinue to make the health home payment in months where no health home services were provided; however, Oregon requires that health homes provide at least one health home service each quarter for continued payment.

Fee-for-Service: In Rhode Island's CEDARR health home program, Medicaid reimburses CEDARR Family Centers for health home services using a set fee schedule that pre-dates the health home state plan amendment.

Alternative Payments: Alternative payment methodologies under the health home option are allowed. A second SPA submitted by New York, if approved, will set aside a percentage of the state's savings to share among the health homes. New York is asking CMS to include a portion of the federal-share savings as well.[36] Missouri plans to amend their SPAs to include performance-based payments.[37]

Managed Care Payments

States have developed varied approaches to make health home payments for their managed care enrollees. Of the four states with SPAs approved before May 2012, two states are making payments to the managed care plans, and two states pay the providers directly.

- Missouri is making payments directly to the providers for managed care enrollees to avoid the delay of renegotiating managed care contracts or waiting until the next contracting period. The SPA does not change managed care rates.[38]
- Oregon is paying the entire care management fee to the managed care plans and does not require the plans to pass the entire fee onto the providers. However, any money retained by the plans must be approved by the Oregon Division of Medical Assistance Programs and used to carry out functions related to the state's health home program.
- New York is amending their managed care contracts to address the potential payment duplication of managed care capitation and health home payments. A small portion of the New York payment may be retained by managed care plans to support administration of the program. Managed care plans are expected to pay the same rates to contracted health homes as the state, but the amount is prorated proportional to the services provided.

People with severe mental illness have a higher prevalence of physical health conditions than the general population, yet face greater barriers to the diagnosis and treatment of those physical conditions.[39] They also have a mortality rate two to three times that of the general population, resulting in a life expectancy 13-30 years shorter than average; physical illness accounts for nearly 60 percent of the difference.[40] Health homes seek to address this disparity by strengthening the connection between behavioral and physical health to provide care across the entire health system, and according to CMS, "is critical to the achievement of enhanced outcomes."[41]

There are numerous barriers to the successful integration of behavioral and primary health care. Reports issued by the Health Resources and Services Administration (HRSA) and the Agency for Healthcare Quality and Research (AHRQ), identified the following:

- Separation of the health systems: mental health carve-outs and silos;
- Challenges to building interdisciplinary partnerships: differing philosophies and approaches to care between physical and behavioral health providers; and
- Financial barriers: a lack of reimbursement mechanisms for care management services across health systems.[42,43]

States can begin to breakdown the walls and improve partnerships through the adoption of models of integration as discussed below. In addition, health homes can provide the means to address the financial barrier by providing a reimbursement mechanism for care management services across the behavioral and physical sectors, as previously discussed.

Models of Integration

According to the American Academy of Family Physicians, primary care physicians provide the majority of mental health care;[44] in fact, approximately 70 percent of primary care visits are related to behavioral health, which includes mental health and substance abuse issues.[45] Many patients prefer to receive mental health services in a primary care setting.[46] However, many mental health conditions go unrecognized or untreated in that setting,[47] and primary care physicians need resources to serve these patients. Primary care physicians have an especially difficult time referring their patients to high-quality outpatient mental health providers; only one-third of patients who need mental health services actually received them.[48]

States with approved health home programs are attempting to address the behavioral and physical health divide by using collaborative and integrated models of care. A 2010 report supported by The Milbank Memorial Fund provides an apt distinction of the difference: "collaborative care involves behavioral health working *with* primary care; integrated care involves behavioral health working *within and as a part* of primary care."[49] Missouri's two approved health home SPAs provide excellent examples for both:

- *Integrated Care*: Missouri's *primary care* SPA requires the greatest amount of integration among approved SPAs; behavioral health consultants working in primary care settings have specific integrated care tasks, including screening and evaluating patients for behavioral health conditions, intervening with patients who could benefit from behavioral health intervention, and managing behavioral health needs.

- *Collaborative Care*: Missouri's *behavioral health* SPA does not require direct co-location of physical health services; instead, it requires primary care physicians to participate in treatment planning, consult with team psychiatrists, and assist in coordination with external medical providers.

Missouri was able to leverage existing integration efforts, which enabled the state to demand a higher level of integration than other states without similar infrastructure. Many of the state's community mental health centers and federally qualified health centers were already prepared to serve as health homes. Missouri community mental health centers had already woven primary care into their infrastructure (through embedding primary care nurse liaisons and ensuring regular health screening for chronic conditions),[50] and, as previously mentioned, many federally qualified health centers participated in a co-location pilot with community mental health centers.[51]

Most health home care integration requirements fall somewhere on the collaboration-integration spectrum. Oregon's health home SPA strongly encourages co-location of behavioral and physical health services, but there is no expectation beyond direct collaboration and co-management for patients with behavioral health conditions. Similarly, Rhode Island's behavioral health SPA provides a number of examples of how community mental health organizations can ensure health home enrollees receive physical health services (co-location, embedded services, robust referral and follow-up), but the state allows flexibility.

Another approach a state can take is to separate the health home from the direct provision of medical services. Rhode Island's CEDARR Family Centers are in a unique position, because they are independent organizations that are not responsible for providing direct medical services. Instead, CEDARR Family Centers provide evaluation, diagnosis, assessment and referral services. The CEDARR health home SPA enhances care coordination by strengthening referral services between the physical/behavioral health providers, but the health home is not in a position to directly integrate care.

Sharing Health Data

Sharing data across the entire health care system is essential to improving the coordination of care between multiple providers. To meet this objective, states are designing their health home programs to ensure that all providers on the care team have access to a common care plan. Ideally, states will facilitate data sharing through the use of health information technology and exchange.

Addressing Privacy Issues

Effective data sharing across all care team providers reduces data fragmentation and results in more efficient and effective patient care.[52] However, critics of data sharing routinely invoke privacy concerns, especially when the data being shared is mental health, substance abuse, or sexual and reproductive health information. Critics argue that unlawful disclosure can lead to social stigma, discrimination, and—in cases of illicit drug use—criminal prosecution.[53]

Legal protections are in place to prevent the unlawful disclosure of sensitive health information, including the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA created a Privacy Rule that protects identifying health information and introduced stiff penalties for the improper disclosure of protected information.[54] HIPAA is often identified as a barrier to behavioral health data sharing, but sharing information to coordinate a patient's care is permitted under a patient's general consent.[55] However, HIPAA sets a floor, and state law may further restrict the sharing of sensitive health information. States with laws that restrict data sharing beyond federal requirements may look to North Carolina's approach to allow sharing certain health information among the entire care team—which may include both primary care and behavior health providers.

In 2009, North Carolina amended state privacy law for the state's primary care case management program, laying the groundwork for health home providers to share information years later. Prior to 2009, North Carolina state law only allowed the sharing of confidential behavioral health information for care coordination among public facilities and the psychiatric wing of the University of North Carolina Hospitals at Chapel Hill. In 2009 and 2011, the North Carolina legislature expanded health record sharing laws, easing the burden when sharing confidential patient information across all providers "when necessary to coordinate appropriate and effective care, treatment or habilitation of the client."[56,57]

Even in cases where state law mirrors HIPAA, substance use data is further protected by federal regulations and can present a significant barrier to coordinating care for some patients. With very few exceptions, the Confidentiality of Alcohol and Drug Abuse Patient Records regulations—42 CFR Part 2—restricts the sharing of substance use service information tied to federally-assisted programs without a patient's specific and express written informed consent.[58] Some states find that even with a patient's consent under 42 CFR Part 2, the consent may be too narrow to allow the sharing of such data across an entire health home program. New York has attempted to solve this dilemma by developing a single consent form for their health home program that allows all patient data, including federally-assisted alcohol and drug program information, to be exchanged among the health home team.[59] The patient's consent is tied to their ability to participate in the health home program.[60]

Health Information Technology

Health information technology, including health information exchanges, offers enhanced opportunities for providers to coordinate care across systems, but adoption rates present significant challenges for states looking to use these strategies as an important component of their health homes SPA. A 2012 survey

of medical sites conducted by SK&A for the Office of the National Coordinator for Health Information Technology found that the percentage of small practices with electronic health records is between 37 and 55 percent, depending on practice size.[61] Behavioral health providers are even less likely to have electronic health infrastructure.[62]

Figure 4 - Approved Section 2703 Health Home State Plan Amendments as of May 1, 2012 – Health Information Technology (HIT)

State (SPA)	Electronic Record Requirement*	Additional HIT Systems	Support for HIT
Missouri (Behavioral Health)	No	Web-based electronic health record for Medicaid enrollees; electronic registry; customer information outcomes and reporting tool; behavioral pharmacy management system	Single web portal to exchange data among providers and quality outcomes to the state and CMS (in development)
Missouri (Physical Health)	Yes, electronic medical record adoption and use for six months prior to providing health home services	Web-based electronic health record for Medicaid enrollees; electronic registry; data warehouse	Single web portal to exchange data among providers and quality outcomes to the state and CMS (in development)
New York	Yes, electronic health record adoption within 18 months of the program's launch	Health Information Exchange; evidence-based clinical decision-making tool	Medical Home HIT Infrastructure Grant; Regional Health Information Organizations; care management web portal (in development)
Oregon	No	When possible, electronic health records will be used to collect measures	Electronic health record/ health information exchange required for highest reimbursement under state-developed qualification standards
Rhode Island (CEDARR)	No	Electronic case management tool; KIDSNET Child Health Information System	State Health Information Exchange
Rhode Island (Behavioral Health)	No	Providers with an electronic medical record or registry may be required to participate in a pilot to measure the effect of electronic records on care/ outcomes	State Health Information Exchange

* Note: This column applies only for requirements that a practice purchase an electronic medical or health record system. As such, it does not apply to web-based tools or portals available specifically for Medicaid enrollees. The use of "electronic medical record" and "electronic health record" is based on the language found in each approved state plan amendment.

CMS strongly encourages the use of health information technology for all health home providers, but states have flexibility in deciding how to integrate information technology into their health home program. National- and state-based medical home qualification standards often encourage and reward provider

adoption of health information technology. For example, by adopting electronic health records, it is easier for practices to achieve levels II and III in the National Committee for Quality Assurance Patient-Centered Medical Home (Level III is the highest level of recognition),[63] which may be aligned with higher payments. However, electronic health record adoption is not a must-pass element for Level 1, and states have yet to require providers to obtain the highest qualification levels.

As for the specific health information technology health home requirements, states are taking a variety of approaches. (See Figure 4) Notably, not every state has required electronic health record adoption for all health home providers. Of states with SPAs approved before May 2012, Missouri is the only state that requires any of their health homes to have their own electronic medical record system in place prior to participation, and this requirement only applies to the federally qualified health centers, rural health centers, and hospital-based primary care clinics participating under the state's primary care SPA. These large, multi-practitioner sites are more likely to have electronic health records in place.

Unlike their physical health counterparts, electronic medical records are not pre-requisites for Missouri's community mental health centers participating under the state's behavioral health SPA. Community mental health centers are allowed to use CyberAccess[sm], the state's web-based, HIPAA-compliant electronic health record and care coordination tool available to providers for their Medicaid enrollees. This dichotomy—that the state does not require community mental health centers to have their own electronic system in place—reflects the disparity in electronic medical record adoption between the state's physical and behavioral health providers.

Evalution Measures And Methodologies

The Affordable Care Act mandates two Congressional Reports, a 2014 interim report and a 2017 final report and evaluation. These reports will determine the effect of health homes on hospital admissions, emergency room utilization, and admissions to skilled nursing facility admissions. The interim report must also include a survey of states to examine the effects of health homes on: hospital readmission rates; chronic disease management; coordination of care for individuals with chronic conditions; assessment of program implementation; processes and lessons learned; assessment of quality improvements and clinical outcomes; and estimates of cost savings.[64] States may also need evidence to garner legislative support to continue a health home program after the enhanced federal match ends, so states are conducting their own evaluations as well. CMS has developed a core measure set that all participating states will need to collect and report. (See text box)

Although CMS guidance indicated the evaluation would be grounded in outcomes measures,[65] one state participating in the Health Home Learning Community advocated for a mix of process and outcomes measures. States have given numerous reasons why process measures (such as counting care coordination "touches" or the percent of patients receiving body mass index screenings) should be a part of the evaluation.[66] To start, states want to know that health homes are actually providing the core services. Similarly, without this data, it would be difficult to know that it was the health home services and not a combination of health reforms that led to a patient's outcomes—states are not implementing health homes in a vacuum.

All six learning community states also preferred that data reporting include information that could be pulled from claims, as opposed to information that would only be available on a patient's chart or electronic health record. Until most providers adopt electronic medical records, states are wary of requiring providers without electronic medical records to conduct manual chart reviews due to the cost-prohibitive nature of these audits. Most of the health home core measure set can, in fact, be derived from claims, and the measures align with other quality measure improvement initiatives, including Stage 1 meaningful use

CMS Core Measure Set

CMS developed a core set of measures that all states will be required to collect and submit to CMS to meet the requirements of the 2014 and 2017 reports. The core set of measures includes:

1. Percentage of enrollees aged 18-74 with an annual Body Mass Index (BMI) assessment;
2. Rate of Ambulatory Care-Sensitive Condition Admissions for enrollees under the age of 75;
3. Percentage of care transitions for enrollees of all ages with the transmittal of a care transition record within 24 hours of discharge;
4. Percentage of mental health hospitalization discharges for individuals aged six and older where there was follow-up visit within seven days of discharge;
5. All-cause 30-day readmission rate for adults aged 18 and older;
6. Percentage of enrollees aged 18 and older screened for clinical depression and a documented follow-up; and
7. Percentage of adolescents and adults with new substance use episodes who received the initiation or engagement of substance use disorder treatment.

(criteria for using electronic health records to receive Medicare and Medicaid Incentive Program[67] payments) and the adult Medicaid core measure set.[68,69]

State-specific Goals

Health homes SPAs vary considerably across, and even within, states. States have disparate populations, and SPA-specific goals allow a state to focus on measures that may be unique to that state. Beyond the core set of measures, the health home SPA template includes a section for states to develop state-specific goals and describe how the state will collect outcomes, experience of care, and quality of care data to track their goals. The vast majority of goal-based outcomes and quality measures across all states are being drawn from claims, encounter and pharmacy data. Sources for patient experience of care measures vary based on the experience of care survey tools that the state uses (e.g., the Consumer Assessment of Healthcare Providers and Systems or Mental Health Statistics Improvement Program surveys).

In addition to tracking hospital admissions and emergency department use for evaluation purposes, states are including goals to reduce admissions and utilization to serve as a proxy for cost-savings. This is important because states will likely need to make the case to continue the health home program to their legislature after the enhanced federal match ends. States are also using this section of the SPA to track additional process measures to ensure that health homes are providing the necessary services. Examples of states including additional process measures include:

- Oregon measuring improvement in the documentation, tracking and reporting of health risks (tracking practices that maintain health records with BMI and growth charts, with processes to identify patients who would benefit from additional care planning);
- Rhode Island measuring improved care coordination (comparing the number of physician consultation claims with the number of care plans developed or renewed);
- Missouri measuring increases in patient empowerment and self-management (tracking the percentage of patients who log in to their online electronic health record); and
- New York measuring improvements in preventative care services (tracking the number of percentage of patients receiving chlamydia and colorectal cancer screenings).

Conclusion

Health homes are designed to meet three goals: better health; better experience; and lower costs.[71] The health home state option provides an intriguing opportunity for states to promote whole-person care by strengthening the connections between their primary care, behavioral health, and long-term care systems with the federal government financing the majority of the new program costs for the first two years. The eight-quarter clock for the enhanced funding begins once the SPA is effective, so it is imperative that states fully develop their health home program before the SPA is submitted and approved to fully leverage the enhanced match. The five issues described in this paper are not the only issues states will need to confront, but they can be among the most difficult to resolve. Additionally, states will need to decide which chronic conditions will be included, which providers will be eligible to participate, and whether to use national- or state-developed qualification standards for participation. CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA) are working with states to help answer these questions and ease the planning and implementation process, but states should not overlook the resource and value found in the approved state plan amendments.

Federal law and subsequent CMS guidance have given states a great deal of flexibility and the early adopters have taken a variety of approaches to implement health home programs. States are able to craft distinctive programs that reflect the needs and available infrastructure of each state. Examples include building health home services into existing pilots or programs, leveraging existing health information technology, or aligning reporting requirements with current state regulations. The four states profiled in this report (Missouri, New York, Oregon, and Rhode Island) have paved the way for other states planning to pursue the health home option.

Endnotes

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