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:

FINAL ANNUAL REPORT - BASE YEAR

December 2012

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Final Annual Report - Base Year

Brenda C. Spillman
Barbara A. Ormond
Elizabeth Richardson

Urban Institute

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ACRONYMS

ACA	Affordable Care Act
ADHD	Attention deficit hyperactivity disorder
AOD	alcohol or other drug
BHCCH	Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
BMI	Body Mass Index
BPMS	Behavioral Pharmacy Management System
CAD	Coronary artery disease
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCC	Connect Care Choice
CCIP	Chronic Care Improvement Program
CCO	Coordinated Care Organization
CDPHP	New York Capital District Physicians' Health Plan
CEDARR	Comprehensive Evaluation, Diagnosis, Assessment, Referral, Re-evaluation
CEDARR-HH	CEDAR-health home
CHCS	Center for Health Care Strategies
CHIP	Children's Health Insurance Program
CHIPRA	Child Health Insurance Program Reconciliation Act
CIDP	New York Chronic Illness Demonstration Project
CIMOR	Customer Information Management, Outcomes and Reporting
CMHC	community mental health center
CMHC-HH	CMHC-health home
CMHO	community mental health organization
CMHO-HH	CMHO-health home
CMMI	CMS Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
CPRC	Community Psychiatric Rehabilitation Program
CPST	Community Psychiatric Support and Treatment
CRG	clinical risk group
CSI	Chronic Care Sustainability Initiative
CVD	cardiovascular disease
DMAP	Oregon Division of Medical Assistance Programs
DMH	Missouri Department of Mental Health
DOH	New York Department of Health
DUA	data use agreement
EHR	electronic health record

EMR	electronic medical record
ER	emergency room
FFS	fee-for-service
FQHC	Federally Qualified Health Center
FSD	Missouri Family Support Division
FTE	full-time equivalent
GERD	gastro esophageal reflux disease
H-MH	hospital-medical home
HCS	Health Commerce System
HEAL NY	Health Care Efficiency and Affordability Law for New Yorkers
HIE	health information exchange
HIT	health information technology
MATS	New York Managed Addiction Treatment Services
MCO	managed care organization
MCP	managed care plan
MFH	Missouri Foundation for Health
MMIS	Medicaid Management Information System
MOU	memorandum of understanding
MPCA	Missouri Primary Care Association
MRT	Medicaid Redesign Team
NCQA	National Committee for Quality Assurance
NYCCP	New York Care Coordination Program
OASAS	New York Office of Alcoholism and Substance Abuse Services
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
PCMH	patient-centered medical home
PCP	primary care provider
PCP-HH	PCP-health home
PCPCC	Patient-Centered Primary Care Collaborative
PCPCH	Patient-Centered Primary Care Home
PDC	proportion of days covered
PMPM	per member per month
PPC-PCMH	Physician Practice Connections--Patient-Centered Medical Home

PPR	potentially preventable readmission
QE	qualified entity
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	Substance Abuse and Mental Health Services Administration
SHIN-NY	Statewide Health Information Network for New York
SMD	State Medicaid Director
SMI	serious mental illness
SNF	skilled nursing facility
SPA	State Plan Amendment
SPMI	serious and persistent mental illness
T-CHIC	Tri-State Child Health Improvement Consortium
TCM	targeted case management
THINC	Taconic Health Information Network and Community

EXECUTIVE SUMMARY

This report presents first-year findings of the long-term evaluation of Medicaid health homes, a new model of care authorized in Section 2703 of the Affordable Care Act for high-need, high-cost beneficiaries with chronic physical conditions or serious mental illness (SMI). The Urban Institute is conducting the long-term evaluation for the U.S. Department of Health and Human Services, Office of the Assistant Secretary of Planning and Evaluation to assess the care models and processes states are using, the extent to which health homes result in increased monitoring and care coordination, and whether these models result in better care quality, reduced hospital, skilled nursing facility, and emergency department use, and lower costs. Findings will inform a 2017 Report to Congress.

Distinct features of Section 2703 health home model include the elevated 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 Centers for Medicare and Medicaid Services (CMS) receive eight quarters of 90% federal match for seven defined services: comprehensive care management, care coordination, 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 are having two chronic conditions, one chronic condition and being at risk of a second, or one serious and persistent mental health condition.

Evaluation Structure, Timeline, and Methods

The long-term evaluation began October 1, 2011, and will continue for five years. This report examines the first four states with approved SPAs--Missouri, Rhode Island, New York, and Oregon. Additional states will be selected for evaluation as their SPAs are approved. For each SPA, initial evaluation activities are developing background materials on program design and implementation context and conducting site visits. These activities 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 will be conducted roughly annually after 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 First-Year State Health Home Initiatives

Health homes in the first four states focus on beneficiaries with SMI, substance abuse, and chronic physical conditions. New York and Oregon have chosen to combine all three populations in single broadly focused SPAs. Health home providers in New York are lead agencies that have assembled comprehensive service networks, while in Oregon they are the patient-centered primary care homes (PCPCHs) that form the foundation of a statewide health system reform. Missouri and Rhode Island each have one SPA focused on people with mental/behavioral health issues and community mental health centers as health home service providers, and a second SPA targeting a different population. Missouri's second SPA focuses on beneficiaries with multiple chronic physical conditions served by federally qualified health centers, rural health clinics, and hospital-operated primary care centers. Rhode Island's second program focuses 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.

With one exception, all four states are relying on per member per month (PMPM) payment for health home services. Missouri bases its PMPM on staffing needs assumptions. Rhode Island uses a similar methodology for its community mental health organizations, based on personnel costs and staffing ratios. 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. Oregon's PMPM payments are set at three levels based on the extent to which providers meet established criteria for PCPCHs. 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.

Implementation and Emerging Issues

Our first year activities have yielded a number of insights regarding key program features and early implementation lessons we will continue to track over the intervention period.

Health home models: The six program models vary in terms of how much flexibility is afforded to participating providers, which is evident across four general areas: provider designation and qualifications (i.e., who can be a health home); structure (i.e., how services are provided, and by what staff); specification of service requirements; and accountability or reporting requirements.

- More prescriptive models (Missouri, Rhode Island) may entail greater up-front provider investments to meet required staffing and make under-enrollment or enrollment discontinuities more of a problem.

- A centralized approach to identifying and assigning potential enrollees to providers (Missouri, New York) may identify eligible beneficiaries more comprehensively but may entail greater costs for locating and recruiting enrollees; provider-based enrollment (Oregon, Rhode Island) may run a greater risk of cherry-picking or missing beneficiaries with low connectivity to the health system.

- 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. In all four states, mental health and primary care providers report that paying attention to both physical and mental health issues represents a culture change in the approach to patient care.

- All four states are struggling with incorporating children into the health home model, which is viewed as more applicable to adults and their providers because of its focus on beneficiaries with chronic conditions, although the extent to which this presents a challenge varies.

Communication: Modes and patterns of communication are still being developed within and across sites of care, and particularly between health home providers and 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 information technology 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 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.

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 federal funding to support EHR adoption by behavioral health providers was seen as a significant barrier.

Role of complementary programs: All four states are building on structures and programs that already exist, are attempting to align their health home programs with other reforms, and 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 all four states, the availability of the enhanced match was cited as an important part of the motivation for implementing health homes.

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.

- Primary challenges are the two-year implementation window, which is a short time over which to realize measurable improvements, and implementation of health homes statewide and alongside a range of other reforms, which makes it difficult 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.

Second Year Activities

In the next year, we will continue to monitor the first four states and begin work with new states, which to date include North Carolina, Iowa, and Ohio. 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.

Conclusion

All states studied in this first year have used the Medicaid Health Homes option to augment existing programs, to accelerate movement down an established pathway, as one part of larger system reform efforts, or all of the above. 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 between provider types and settings, as well as the special challenges associated with integrating care. In the second evaluation year, the four states examined in this report and North Carolina will complete their first intervention year and move well into their second years. This will allow us to observe how progress toward full implementation and system reform may differ across these maturing programs and to document these and other implementation issues for new programs in their first intervention year.

I. INTRODUCTION

This report presents base year findings of the long-term evaluation of Medicaid health homes, a new model of care authorized in Section 2703 of the Affordable Care Act (ACA) that targets high-need, high-cost beneficiaries with chronic conditions or serious mental illness (SMI).[1] We introduce a first group of states implementing the health homes option, describe the programs they have designed and the programmatic and health system context in which they are being implemented, and discuss themes and emerging issues that affect implementation.

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

Overview of the Section 2703 Health Homes Model

Although the Section 2703 health home model is closely related to the "patient-centered medical home" model for integrating and coordinating health care, distinctive features are the elevated importance the health home model places on integration of physical health care with behavioral/mental health care and on linking enrollees to community social services and other long-term services and supports for the enrollee and family. The vision is that the model will ensure coordination and continuity of care across care settings and over time by providing a "cost-effective, longitudinal 'home' to facilitate access to an inter-disciplinary array of medical care, behavioral health care, and community-based social services and supports for both children and adults with chronic conditions."[2]

States implementing health homes do so 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: comprehensive care management; care coordination and health promotion;

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[1] Public Law 111-148--March 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.

[2] Mann, Cindy. 2010. "Health Homes for Enrollees with Chronic Conditions." CMS: SMD Letter #10-024, ACA #12.

comprehensive transitional care; individual and family support services, linkage and referral to community and social support services; and use of health information technology (HIT). Consistent with the aim of integrating physical and mental/behavioral health care and supportive services, Section 2703 requires states to consult with the 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 health/behavioral conditions.

The law allows states considerable flexibility in choosing providers and payment systems. States may designate a wide range of health home providers or groups of providers other than primary care practices (e.g., mental health centers, home health agencies), so long as these providers have the required systems and infrastructure to provide health home services and meet qualification standards. Payment methodologies for health homes may include tiered payments for individuals 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). 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. 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 to 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 chronic condition eligibility standards who are categorically needy, including those who are dually eligible for Medicare and Medicaid and those receiving services under a Section 1915(c) home and community-based services waiver. 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: (a) what models, providers, and processes states are choosing for health homes; (b) the extent to which state health home designs result in increased monitoring and coordination across the

specified clinical and nonclinical domains of care; and (c) whether the models result in better quality of care and outcomes, reduced use of hospital, SNF, and emergency departments, and lower costs.

This first annual data analysis 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 first four states to be selected for evaluation. Section II discusses the basic evaluation structure, methods used, and activities in this base year. Section III summarizes health home program(s) in each of the four states and the context in which they are being implemented. Section IV discusses emerging 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, and ways in which the design may need to be adapted. Section VI briefly concludes and discusses second year activities.

Future annual reports will present similar baseline findings for additional states selected for the evaluation as their SPAs are approved, as well as findings from follow-up analyses of interim progress and outcomes for each health home program. The final report to be produced in the last year of the evaluation will summarize findings on the structure, process, and outcomes of health homes, including analyses of the impacts of health homes on utilization and costs to inform the Secretary's 2017 Report to Congress.

II. EVALUATION STRUCTURE, TIMELINE, AND METHODS

The long-term evaluation began October 1, 2011 and is scheduled to continue for five years. We anticipate evaluating a total of 15-20 programs, depending on the number of SPAs for health homes that are approved in the first three years of the evaluation.[3] Four states and six programs selected in the first year are discussed in this report (see Table 2). Additional states will be selected as their SPAs are approved.

For each SPA, the intervention period is defined as the eight quarters of enhanced federal match for health home services. The intervention period begins 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 effective date.

For each state, initial evaluation activities include developing background materials summarizing the design and the implementation context of each health home program and conducting site visits. These activities will create a qualitative data foundation for tracking and interpreting program progress and adjustments during the intervention period. Follow-up telephone interviews will be 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, primarily because of lags in the availability of Medicare and Medicaid claims and/or encounter data, but also to allow time for full implementation of the health home programs.

Research Questions

Our first task was to develop research questions in the domains of structure, process, and outcomes that will be addressed by the evaluation and will guide our activities (see Table 1). Questions in the top panel of Table 1 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 will guide base year data collection and follow-up for each state. Questions in the lower panel of Table 1 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.

[3] As of the date of this report, seven states had approved SPAs for one or more programs, three additional states had submitted SPAs that were under review, and another 25 were at some stage of planning. Three states with approved SPAs also had additional SPAs under review or being developed.

Qualitative Data and Activities

Qualitative data activities in the base year were the production of detailed memoranda profiling each approved health home program and the context in which it is being implemented, and site visits. In preparation for site visits we developed generic site visit interview protocols based on the research questions (provided in Appendix A). Both the formats developed for these state profiles and the generic protocols will also be used to profile the programs and guide site visits, respectively, for the remaining states selected for evaluation.

State Profiles

Development of health home profiles entails a systematic process of data collection for each state with an approved SPA, drawing on existing reports, background from state websites and other publicly available sources, and review of each approved SPA.

The SPAs provide data on the target population; the types of providers who will be health homes and the qualifications they must meet to participate; definitions of each of the six health home services; methodology for monitoring avoidable hospital readmissions 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, ER visits, and SNF admissions; and the frequency of reporting this information.

In their SPAs, states also identify measures for quality monitoring corresponding either 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. In addition, CMS will specify a "core" set of common measures across all health homes programs. Future annual reports will include assessments based on these performance measures once they begin to be available.

Based on the information collected, we produced a memorandum for each of the first four states covering central structural dimensions of their program(s) and the larger policy and health system context within each state to identify existing or anticipated programs and initiatives that may have implications for implementation and evaluation. (Final memoranda are provided in Appendix B.) Similar memoranda will be produced for all states ultimately included in the evaluation.

Site Visits

We arranged conference calls with contacts in each state to introduce the long-term 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 (SMD), 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. Based on these initial discussions, we tailored the generic protocols to reflect the specifics of the state's program and the role of each person to be interviewed.

We conducted site visits to Rhode Island from May 14-17, Missouri from June 18-22, New York from July 25-27, and Oregon from September 12-14. (Because Rhode Island and Missouri each had two approved health home programs, the site visits to these states involved more informants and thus required additional time.) Following each site visit, we drew on detailed notes to develop high-level observations summarizing the major findings. We also identified key issues to be tracked over the course of the evaluation.

Quantitative Data and Activities

Activities related to quantitative data collection and analysis in the first year of the evaluation were limited to developing a provisional plan for analyses to be conducted (see Section V), refining plans based on what we learned about the design of programs in the first four states, and identifying and requesting the administrative data required to address the primary evaluation questions relating to utilization and costs using consistent methodology across states and programs. 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. These issues include potential comparison groups, identifiers for enrollees, and eligibility algorithms that can be applied to claims data to identify the eligible pool from which enrollees are drawn.

After the first group of states was known, we submitted a data use agreement (DUA) request to CMS for the data needed for our quantitative analyses. The design calls for examining utilization and costs for participants and a comparison group in both 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 enrollees who are dual eligibles. Data collection for the central quantitative analyses specified in Section 2703 (effects on hospital, ER, and SNF use, and costs) will continue past the end of the intervention period because of lags in availability of claims and other administrative data. The DUA will be amended as needed over the course of the evaluation to include additional years of data as they become available and to add data for additional states as their SPAs are approved.

III. PROFILE OF THE FIRST FOUR STATE HEALTH HOME INITIATIVES

The first group of health home programs comprises the six programs in four states that had been approved by CMS by April 1, 2012: two programs each in Missouri and Rhode Island, and one each in New York and Oregon (Table 2). Although all four states are targeting people with SMI, substance abuse, and chronic physical conditions, their approaches differ. New York and Oregon target all three of these populations through one SPA, while Missouri and Rhode Island each have one SPA focused on people with behavioral health issues, and a second SPA targeting a different population. Missouri's second SPA focuses on those with multiple chronic conditions, while Rhode Island's second program focuses on younger beneficiaries with special needs. All four states are implementing their programs statewide, or, in the case of New York, plan to expand statewide over a short time period. Another common element is that this first set of programs reflects the use of health homes to enhance existing programs and providers, or to move further down a path the state already was taking.

This section provides brief summaries of these programs, with key design features shown in Table 3. Detailed information is provided in the state memoranda in Appendix B.

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 chronic physical conditions--have been the target of several previous initiatives aimed at integrating physical and behavioral health and coordinating care for patients with multiple chronic conditions. Community mental health centers (CMHCs) are the designated providers for the behavioral health population, while primary care centers--specifically, federally qualified health centers (FQHCs), rural health clinics, 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 is that substance use and mental illness are not qualifying conditions to receive health home services through a primary care center; such beneficiaries would be 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.

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 fee-for-service (FFS) and

managed care enrollees are eligible for health home enrollment, Missouri's managed care program (MC+) 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. However, the CMHC team 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.

The payment rates for health home services are based upon staffing needs assumptions. Health home services are reimbursed through a PMPM capitation payment. Services at CMHCs will be reimbursed at $78.74, while services delivered at primary care centers will be reimbursed at $58.87. The state plans to adjust these amounts annually and will re-evaluate the PMPM determination method after 18 months.

The HIT infrastructure that underpins the initiative is still being developed, and is based primarily on the existing Medicaid HIT infrastructure. MO HealthNet maintains a web-based electronic health record (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. In addition, MO HealthNet maintains an authorization-of-stay tool that requires hospitals to notify MO 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 ER visits that do not result in admission.

Rhode Island

Rhode Island's two health home programs target two 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, and 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 limited direct services. An estimated 7,000-8,000 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 CEDARRs and the CMHOs submit lists of their clients who are potentially eligible to Department of Health Services, which verifies their eligibility and enrolls them in 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 existing relationship with a CMHO, but may opt out or change provider. Hospitals also may refer eligible beneficiaries in cases where they are identified. Beneficiaries may be referred to CEDARR Centers through a number of channels, including through primary care providers (PCP) 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 between them 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 primary care case management 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 managed care organizations (MCOs) and which will be conducted by CEDARRs and CMHOs.

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

CMHOs will be paid on a PMPM basis, with the 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 will 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--re paid at fixed rates ranging from $347 to $397. 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 will use their existing electronic case management system as well as the Rhode Island KIDSNET Child Health Information System, which provides access to a range of public health and social services information. CEDARR-HHs also will offer to enroll all clients into CurrentCare, Rhode Island's electronic health information exchange (HIE).

New York

New York currently has one health home program with a target population of those who have HIV/AIDS and are at risk of developing another chronic condition, and those with two or more chronic conditions (including substance abuse) and/or SMI in ten counties. The state envisions this program as the first phase in a health home initiative that will be rolled out in three geographically-based phases and will reach statewide coverage over a relatively short time frame, subject to CMS approval. SPAs have been submitted for Phase II, which will cover an additional 12 counties, and Phase III, which will expand health homes to the remaining 39 counties. The expected retroactive effective dates for the latter phases are April 1, 2012, and July 1, 2012, respectively. Ultimately, the state estimates that approximately 700,000 Medicaid beneficiaries will be enrolled statewide in Phases I-III of health home implementation, about 20% of them dual eligibles. The state plans to implement a second and third wave of health home expansion in the next year, with the second wave expanding eligibility to the long-term care population, and the third targeting enrollees with developmental disabilities.

New York does not designate specific providers as health homes. Providers are identified through an application process in which a lead health home organization demonstrates 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.

The 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, which is then responsible for assigning candidates to the lead health home organization that can best serve their needs. A little over 65% of eligible health home beneficiaries are enrolled in managed care; the rest are in Medicaid FFS.

Payment for health home services is made on a PMPM basis at two levels: Outreach and Engagement, and Active Care Management. The active care management group consists of participants who have agreed to enroll in a health home. Beneficiaries in the outreach and engagement group are those who have been assigned to the provider but have not yet consented to enrollment. Services for this group are reimbursed at 80% of the active care management rate. Payment for FFS enrollees goes directly to the health home, while payment for managed care enrollees goes through the plans, which may retain up to 3% of the payment for administrative services. Rates are currently adjusted by region and case-mix.

Standards for HIT use by health homes will be phased in. 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.

Oregon

Oregon's program builds on the state's Patient-Centered Primary Care Home (PCPCH) program, established in 2009. PCPCHs are intended to be a key component of primary care reform in the state and will also serve other populations, including all Medicaid enrollees, government employees, and state education personnel. To be eligible for health home services, enrollees must have SMI, two or more chronic conditions, or one chronic condition and be at risk of developing another. 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 United States Preventive Services Task Force, the Health Resources and Services Administration Women's Preventive Services, and Bright Futures. Under these criteria, about 118,000 people are eligible for health home services.

Health home services are to be delivered through qualified PCPCHs. 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 levels base on the number and type of standards met: Tier 1, Tier 2, or Tier 3, with Tier 3 reflecting the most advanced level of functioning as a PCPCH. Any recognized PCPCH can apply to provide health home services by submitting an addendum to its PCPCH agreement with the state. A recognized PCPCH will receive a health home payment (described below) for each qualified patient for whom specific service and documentation requirements are 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 clients or for sub-groups of clients for such functions as care management or quality assurance; (3) performing patient engagement and education and obtaining

patient agreement; and (4) developing a person-centered health plan. A PCPCH is not required to provide all health home services on site, but no provider can qualify as a PCPCH if they do not offer primary care services on site. Thus, CMHCs are only eligible to be health homes if they also offer primary care. All of these services are available to all patients enrolled with a PCPCH who may need them, but services for patients identified as health home eligible are reimbursed at a higher rate.

Eligible beneficiaries are identified by the providers, who draw up lists of their patients they believe to be qualified and submit them to the state for approval, either through the patient's MCO or directly, if the patient is not enrolled with an MCO. (About 80% of the state's Medicaid population is enrolled in managed care.) Once approved and assigned, the enrollee is informed of their assignment and may then opt out or select a different provider. The provider must update and resubmit this list of patients each quarter. This process serves as attestation of meeting the quarterly health home service requirements and triggers payment. The state guidelines for achieving PCPCH recognition specify the information that a practice should be able to demonstrate in support of its attestation, which is also subject to audit.

Payment for health home services provided to qualified enrollees is made on a PMPM basis that varies by the provider's qualification level: Tier 1 - $10 PMPM; Tier 2 - $15 PMPM; and Tier 3 - $24 PMPM. The state is awaiting CMS approval of a similar payment structure for beneficiaries who are not health home eligible, under which these services would be reimbursed at a lower rate. For FFS patients, payments go directly to providers; for MCO-enrolled members, payments pass through the MCO. Any portion of the payment that is retained by the MCO must be used to carry out health home-related functions and is subject to approval by the state.

Health home providers will be encouraged to develop or use their current HIT capacity to perform a range of functions, including EHR use and data gathering and reporting. Oregon also links certain of its PCPCH measures to HIT capacity. For example, although implementation of an EHR is not required, providers who have an EHR are able to earn additional points towards their qualification as a Tier 3 PCPCH. The state also maintains a provider portal and patient panel management system, run by a contractor. 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.

IV. IMPLEMENTATION AND EMERGING ISSUES

In this section we report what we learned in site visits about key features across the state programs and early implementation. 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. It is important to remember that what we present reflects an early stage of implementation. Findings are organized according to areas that we will track over the intervention period.

Health Home Models

The six programs vary in the degree of flexibility afforded to participating health homes and in what is expected from them. The flexibility is evident in four areas: provider designation and qualifications (i.e., which providers can be a health home and what capabilities they must have or develop); structure (i.e., how health home services are provided, including staffing); service requirements (i.e., specification of services to be provided); and accountability or reporting requirements.

Rhode Island is prescriptive as to structure of the intervention in all four areas, although less so for CMHOs than for CEDARRs. Payment is effectively FFS for designated health home services provided to an identified subset of Medicaid beneficiaries. CEDARR health home services are services that CEDARRs have been providing since their inception with only minor additions. CEDARRs are paid on FFS basis, with fixed payments for initial needs assessment, care plan development, and annual reassessments, and billing by quarter hour for two other professional services at established rates. In contrast, CMHOs are required to submit detailed encounter data supporting service provision to receive PMPM payments, and must provide at least one hour of service, recorded in five minute increments, to each enrollee every month.

Missouri is prescriptive as to the providers that can be health homes and their staffing, although less so than Rhode Island. For both CMHC and PCP PMPM payments are triggered by submission of a list of enrollees and attesting that they have received services. Attestation is made via quarterly reports on each of the required core services.

New York is prescriptive as to provider designation--providers must apply and satisfy state requirements to be recognized as a health home--but accountability is for outcomes (e.g., inpatient and mental health services utilization) rather than for structure or process (i.e., staff involved or services provided). Individual practices can participate in more than one health home. Payment is PMPM for each enrollee for whom at least

one core service was provided and documented in the month. Patient records are subject to audit.

Oregon is prescriptive as to the standards a health home must meet, but any provider that meets the standards can be designated as a health home. Accountability is by attestation to meeting the standards and providing designated core services, with monitoring through random audits. The standards are to be gradually strengthened to include outcome measures.

A prescriptive model with respect to provider qualifications may entail greater up-front investments to meet the required staffing, so that under-enrollment or enrollment discontinuities are more of a problem for providers. For example, providers were facing this problem in Missouri, where PCP-health home enrollment was lower than expected at the time of the site visit. Payment levels had been calculated based on a set staffing ratio, and some providers had added 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 payments to cover these costs.

Enrollment

Identification of potential eligibles can be centralized, as in Missouri and New York, or dispersed, as in Rhode Island and Oregon. In centralized identification, the state uses enrollment and claims data to identify persons potentially eligible for health home services by conditions and sometimes level of expenditure. In dispersed enrollment, health home providers identify clients who meet the conditions criteria and who 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 eligibles. But Medicaid enrollees, especially those with mental health and/or substance abuse issues, are a hard population to track. Individual health homes have found it difficult to locate and enroll people identified centrally, as 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 eligibles who are not well-known to the health home staff and 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 planning eventually for a mixed system.

In Missouri, the state directly auto-enrolls and assigns enrollees to a health home, informing the beneficiary by mail. Assignment is typically to the practice the beneficiary has been using most, since lists are generated from claims data. The state also informs the health home of the assignment. The plan for the long run plan is that providers will identify beneficiaries who become eligible for health home services. In New York, patients are identified by the state based on a series of algorithms designed to target people with high needs who are not already being seen regularly by providers in the community, those with “low ambulatory connectivity.” Lists of eligibles are sent to the health homes or the MCOs for outreach and enrollment. Health homes can also refer

people to the state (or through the MCO, if appropriate) for enrollment, as can “local government units,” although this had not yet happened at the time of the site visit. In Rhode Island and Oregon, health home providers send lists of clients they believe to be eligible to the state for approval.

Some providers report that lists identified centrally do not always match the clients they believe are most in need of health home services. Dispersed provider-based enrollment also may miss good candidates for health home services. CEDARRs report that there are more eligible children than they can handle. They do not conduct outreach but are over-capacity, suggesting that there may be eligible children who are not being served.

The general expectation appears to be that enrollees will remain in the program for the duration of the initiative unless they lose Medicaid eligibility. CMHOs/CMHCs were most likely to express concerns about program discontinuities stemming from loss of eligibility, which present challenges for continuity of care and connections to needed services in the community. On the other hand, in Rhode Island, the expectation was that some CEDARR enrollees could leave the program if their circumstances stabilized. The Missouri program allows for disenrollment, and the New York program has a procedure for returning enrollees to management by their PCP if reassessment indicates that intensive services are no longer needed. In contrast, the Oregon program did not expect anyone to leave the program for reasons other than loss of Medicaid eligibility.

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 a variety of ways. All of these relationships are likely to evolve, and their final form will depend in large part on where each provider started. Our site visits suggest that integration issues differ depending on the provider, and particularly on the direction of the integration, in the case of physical and mental health. 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. Both CMHCs and PCPs in all states report that paying attention to both physical and mental health issues requires a culture change in the approach to patient care.

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 diagnosis can qualify an enrollee for health home services. 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. Many participating primary care health home

practices seem to struggle somewhat with the mechanism for integrating community supports, though they recognize the importance and welcome the availability of funding.

In Rhode Island, each health home program focuses on a specialized type of provider for a defined population. CEDARR family center clientele are children with special health care needs, which may include mental or behavioral health problems. The traditional function of CEDARR centers is needs assessment, referral to other resources, and the integration of services provided through different systems (education, social services, Medicaid, child welfare), so that such linkages are already in place. CEDARR health home staff members are expected to collaborate regularly with the enrollee's PCP and must document annual "outreach" to the primary care physician or MCO. Providers report that the addition of a requirement under health homes for Body Mass Index (BMI) and depression screening has given them an opening to address these issues with both clients and their caregivers. There is greater variation among the participating CMHOs, and the change brought through the health home initiative has been greater. CMHOs have used either co-location (at two sites) or establishing or strengthening referral networks and follow-up to foster care integration. They must submit a list of primary care practices and hospitals with which they expect to establish referral relationships and must have a memorandum of understanding (MOU) with a PCP.

Missouri, with its separate and complementary PCP and CMHC health homes, comes closest to symmetry, with behavioral health consultants located in PCP-health homes and primary care consultants located in CMHC-health homes. However, the two types of consultants have different functions, with behavioral health consultants providing brief treatment, and physician consultants most often providing referrals and team consultation. State-level implementation is highly coordinated; at the provider level, this coordination is still being developed. Some co-located providers are participating in both health home initiatives, which may yield insights into the differences between the two models. Having both types of providers as health homes allows the state to assign enrollees to the health home that most fits the enrollee's primary diagnosis.

In New York, each health home chose how to approach integration, including arrangements with nonclinical community support services. Each health home can choose to partner or otherwise affiliate with the behavioral health providers that best fit its chosen path to integration. For example, in one county, the mental health clinic is developing satellite clinics located at primary care sites, and mental health workers are being trained to look for physical health problems. In another county, mental health providers are full partners in the health home.

In Oregon, the integration of mental health services is a requirement for qualifying as a health home. Although mental health providers may qualify as health homes, they are required to have on-site primary care to do so. Primary care health home service providers are not required to provide on-site behavioral health care, but must develop agreements with external providers of mental health services.

Applicability to Children

All of the states are struggling with incorporating children into the health home model, which is viewed as more applicable to adults and their providers because of its focus on beneficiaries with chronic conditions. The CEDARR model in Rhode Island is *de facto* child-focused although some CEDARR enrollees are no longer children. Missouri is discussing whether children can be well served by a health home model that also serves adults because children have different care needs. The state found that parents and guardians of children opted out of health home enrollment at a higher rate, for example, because they did not want another care manager for their child's asthma. New York is considering developing a child-focused health home SPA to complement its current program. Informants in New York and elsewhere also cited the lower prevalence of the target conditions among children as an issue. Many general pediatric practices may be unwilling to participate because health home enrollees would represent a very small share of patients over which to spread the fixed cost of practice transformation. Potential problems associated with including children seem to be less of a concern in Oregon where health homes are part of a larger system transformation.

Communication

Communication within and across providers is a fundamental component in achieving the health homes model's aims of care integration, management, and coordination. The health home initiative is in its early stages at all sites, and communication patterns are still being developed both within and across sites of care, and particularly with hospitals and MCOs. 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. For example, in Rhode Island, the change in basic functions and responsibilities is relatively small for CEDARRs; for CMHOs the changes are greater. Some CMHO health home providers reported that their previously informal relationships (e.g., between a CMHO and a nearby FQHC) have been strengthened and formalized through MOUs so that health home clients can be flagged in the FQHC's data system. This area is very much a work in progress in all programs.

Intra-organization Communication

Communication within care teams and across teams within health homes supports care coordination and integration of mental and physical health and community supports. Common forms of intra-team communication are 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, alternatively, regular team meetings. Informants at some sites reported that such intra-organization processes are productive, while at other sites informants said they have been difficult to integrate into the work flow. Other reported challenges to team communication include EHRs or other patient

records that must be modified to support such the full range of team input, particularly nonclinical information.

Primary Care and MCOs

Where the health home is not the PCP, issues can arise when communication beyond the team or health home is necessary. Education may be needed to help the PCP understand the importance of communicating with the health home and coordinating well with them. Many nonhealth home physicians are not clear on 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 some health homes--some of Rhode Island's CEDARRs, for example--an internal EHR allows communication within the health home, but external communications still require email or fax. The communication issues are different not only in different states and initiatives but also for different health homes within the states, reflecting different existing patterns of care and communication and different capacity for change.

Responsibilities for communication between health homes and MCOs vary. In New York, MCOs are required to assist with identification of eligibles. In Rhode Island, they 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 New York and Oregon, health homes are required to report service provision through the MCOs, who then transmit the data to the state. These responsibilities are also still being systematized and fine-tuned, a process that will likely be easier than with hospitals since, unlike hospitals, MCOs share the health home goal of better care coordination and decreased hospital and emergency department use.

Hospitals

Transitional care to better manage patients after hospitalization is a critical health home service to support reductions in avoidable readmissions, but getting timely information from hospitals is seen as a challenge in all programs. The size of the challenge varies across the states. New York providers saw hospital cooperation as a smaller problem, perhaps because hospitals were often members of the health home, and the catchment areas for the first phase were chosen in part due to the presence of "forward-thinking" hospitals. In Oregon, each PCPCH must have written agreements with its usual hospital providers on how communication will happen. In some cases hospital communication is indirect. For example, Missouri has an authorization-of-stay tool that requires hospitals to alert the program when any Medicaid enrollee is admitted for a Medicaid-financed stay, which 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 an admission. Informants reported that this system misses even some inpatient hospital use--most glaringly, admissions of dual eligibles, for which Medicare is the first payer. Some Missouri health homes report that they may learn about an admission weeks or months later and sometimes only when reported by the

health home enrollee. MCOs are sometimes able to serve as intermediaries between hospitals and health homes, as is seen in Rhode Island.

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, making it difficult to provide coordination for their enrollees who are admitted. 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 homes recognize the importance of medication reconciliation for care management and good outcomes. Establishing good post-discharge communication with hospitals is key to meeting this important quality goal.

All programs 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, communication will continue to rely on personal relationships with personnel in the medical and psychiatric wards and the emergency department, with disruptions associated with personnel turnover.

Potential for New Silos

Barriers to improved communication among all parties 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 population), and competing priorities of the concerned entities. The nature of the health home itself can create a barrier. Health homes are designed to reduce silos across the health care system, in part by improved communication. But as they have developed, at least in these early days, they may have created silos across types of patients. Because health homes apply only to a subset of patients and therefore often require development of targeted rather than broadly applied communication strategies.

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, 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. The 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 revision of the role of MCOs in different ways. In New York, MCOs can keep no more than 3% of the health home PMPM unless they provide specific health home services. In Oregon, the MCO cannot keep any of the health home payment unless it shows the state what services it is providing to justify the amount withheld. Rhode Island MCOs do not receive any of the health home payment. (In Missouri, managed care is limited to children, youth, and pregnant women in defined geographic areas; few health home enrollees are included.)

The different responses from the MCOs reflect to some degree the history and structure of the MCO sector in the state, and 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 in Oregon, it means a dilution of their role because health homes are part of a larger system transformation.

Distribution of Savings and Effects on Revenues

In each state, at least one and often more than one informant expressed concern that although savings will be generated by actions taken by providers those savings will accrue to the Medicaid program. Similarly, they fear that hospitals will find some way to recoup any savings realized 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 New York, most providers will see increased revenues under health homes.[4] However, rates for practices that had been providing TCM services will be reduced over the life of the initiative. The effect will be mitigated to some extent as their case-mix is also likely to change, and they will have greater flexibility in how the services are provided. In Rhode Island, neither the CEDARRs nor the CMHOs will see a change in their revenue associated with health home enrollees. In Oregon, providers expected additional work

[4] New York has SPA requests under review that would add shared savings to the payment system for the Phase I program being implemented and to Phases II and III.

commensurate with the higher rates for health home enrollees. In Missouri, providers saw the health home reimbursement as very attractive.

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, typically is not available to health home providers, leaving a gap in their knowledge of enrollee utilization and needs.

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. Getting the necessary consent forms in place has proved challenging. Some states are working to “centralize” permissions (e.g., signing up with Rhode Island’s voluntary patient portal, CurrentCare, gives implicit consent for data to be shared with providers). In Oregon, the Department of Health has developed a consent form that health home enrollees sign to give consent for data to be shared with all Medicaid providers; additional service providers, such as for housing or social services, can be added to the list of providers. This issue is still being worked out in all programs at both the provider and the state level.

Practice Transformation

For most providers, practice transformation requires investment of time, staff, and money. Infrastructure costs include investment in developing the HIT necessary to support many of the health home services and in training staff in new processes and routines, which also 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.

The acuity of this problem varies across the states. For CEDARRs, whose care model was very close to the health home, the problem is minimal. In Oregon, where requirements are being phased in and gradually made more rigorous, practices may be able to spread out the practice transformation costs. Early adopters are predominantly qualified at the highest current level, suggesting that health home participation is most attractive to practices that are already well down the practice transformation road.

Training is provided through a variety of mechanisms. Some programs have a specific focus, such as training for wellness coaches or peer counselors, while others seek to impart the health home concept. Mental health or primary care associations have provided some training for their members through planned peer learning activities or responses to questions from practices. The Rhode Island Medicaid agency provides training directly for CMHOs through weekly meetings, although providers do not seem

to consider this as formal training. Rhode Island provided separate training for the CEDARRs at the beginning of the initiative and is developing a training curriculum for new CEDARR staff. Each CEDARR also has its own internal training program. In other states, learning collaboratives are frequently mentioned but their reported effectiveness varied. Missouri's training effort is designed to extend over the life of the initiative with funding from local foundations. New York's learning collaboratives were scheduled for fall 2012. Oregon is developing the PCPCH Institute Learning Collaborative as a central resource for PCPCHs. Additional training is expected to take place in conjunction with the audits that will occur during the state's monitoring site visits. Oregon health homes are expected to help participating practices meet health home standards, and some are designing their own training programs or even providing funding to participating practices for implementation of health home principles.

Although training is provided for the health homes free of charge, practices still must invest staff time and sometime travel costs. Thus, practices must weigh the value of the training against the cost of participation and practice transformation. Providers expressed a preference for training focused less on vision and more on best practices.

Almost all health homes are struggling to fully implement the initiative, and many 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 nearly practices succeed at transformation depends in part on where they started from, their existing strengths and weaknesses, and leadership at the practice level. Oregon's experience with earlier, similar initiatives showed that 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.

HIT Infrastructure and Issues

Use of information technology affects three important health home components--care coordination, use of community services and supports, and integration of behavioral and primary health care. Information technology requirements that health homes must meet vary, and EHRs are not yet the norm nor are HIEs reliably in place to facilitate communication.

Some issues are specific to moving care outside the clinic walls. Saving data to a laptop while providing or supervising community services poses security issues. Often the services provided in the community are not easily documented on current EHRs and may be less adaptable to coding in an EHR. More generally, EHRs may need to be modified to incorporate health home services, especially the nonclinical community support services.

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, where available, will be 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 plans to adapt the 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 (e.g., connectivity costs associated with a RHIO) which may be hard for some providers to afford or to justify.

Rhode Island expects to phase in HIT use over the life of the initiative. The state is developing a data warehouse, but it will have only claims, not clinical data such as test results or BMI. Providers can enroll their patients in CurrentCare, the state's HIE, which is key to promoting patient engagement and patient-centered care. CMHOs must submit a description of each participating provider's information technology and EHR capability and its capacity to use patient registries. CEDARRs will use an existing electronic case management system that supports linkages across medical, human services, and school providers, and Rhode Island's KIDSNET. The hope is that as patients get accustomed to using KIDSNET they will want to start using CurrentCare as well.

Missouri is building on existing infrastructure including a web-based EHR, CyberAccess, that is accessible to all Medicaid providers, and a patient portal, Direct Inform, to promote patient self-management. CyberAccess was seen as a tool for getting people used to sharing information. The existing systems are being revised to include health home metrics. Through the Missouri Primary Care Association, primary care practices also have access to the Quality Improvement Network for reporting quality measures for health homes.

Oregon has contracted with an external vendor to provide a data warehouse that not only allows providers to extract patient information but also pushes data reports to practices for patient panel management. Data lags, however, may limit the usefulness of this portal for care coordination and management at the provider level. Information technology and electronic communication capability requirements at the practice level are phased in across the three Tiers.

New York also recognized that information technology might be a problem for some practices and designed information technology requirements that allowed health homes to gradually build up to full connectivity. Health homes are not required to meet the core information technology requirement until 18 months into the health home period. Before that time, they must establish structures and processes that lay the groundwork for meeting the final standard.

Role of Complementary Programs (Building on What Works)

This first group of health home programs shows the importance of evolution over revolution, building on what exists to further the state's vision for its Medicaid program or to meet other state goals. Though the state programs vary substantially in the particulars, all four states are building on structures and programs that already exist and attempting to align the health home initiative with other reform initiatives already underway. The extent to which each state is able to identify additional resources and coordinate across programs is variable and depends on a range of factors, including the extant administrative structures and funding streams, the political and financial context, and state health system infrastructure.

Some of these complementary initiatives predate passage of the ACA. For example, 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. Oregon built its health home program directly within its existing PCPCH initiative in an effort to align the two programs as much as possible, while Missouri used Health Home funding to advance a reform process that began in 2005. Both Missouri and New York are also proposing to align health homes with their duals demonstration program.

States have taken steps to align Health Homes with broader HIT transformation. Both New York and Rhode Island have made additional funding and technical assistance available to health home providers. In Rhode Island, this funding comes primarily through Beacon Community grants, while New York provides grants through the state's Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY) Capital Grant Program.

States have also been able to use various resources and technical assistance made available in the last several years to support practice transformation, care coordination, and mental health integration more generally. The sources of this funding and technical assistance vary. Some has been made available directly through the state, as in the case of New York's statewide medical home program, or 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--such as the Providence Center in Rhode Island and the Bronx Lebanon Hospital Center in New York--have also been the recipients of SAMHSA co-location grants and thus have prior experience on which to build their internal care structures and processes.

Halo Effects of Health Home Implementation

When a practice transforms, the new models for providing care can be expected to spread to all patients in the practice. Because the health home enrollees are a specific group with high needs, some of the new practices may be less applicable to a broader clinic population. Still, many providers say that when they are caring for patients they do not 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. Such spread may be more complete in practices where the health home enrollees are a larger share of the total client population, such as CMHOs, CEDARRs, and FQHCs.

An example of the potential for the spread of the health home concept can be seen in the nonhealth homes across the country that have incorporated health home concepts into their practices. In several cases, these have served as models for the health home practices. For example, Oregon practices have looked to South Central Alaska clinics, and Missouri practices have looked to the Cherokee Health System in Tennessee. Cherokee offers formal training on care integration for practices that are interested in its model.

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. All of the states said that the availability of the enhanced match was an important part of their motivation for implementing health homes. In Rhode Island, the match allowed Medicaid to continue to fund the CEDARR centers and to extend an integrated model into CMHOs, something they 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; the expectation is that continuation of the program will be justified by the achieved savings. In Oregon, the match allowed the state to add financial incentives to its plan for primary care delivery system transformation, which was said to have been an important enticement to practice participation in that larger initiative. In New York, as well, the match made financial incentives to system change more attractive.

V. OVERVIEW OF EVALUATION DESIGN AND CHALLENGES

For the long-term evaluation our 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 implementation 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 marginal improvements for health home enrollees over the relatively short intervention period.

Challenges to Quantitative Evaluation

As the design of state programs has begun to be known, 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, 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. As noted above, 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 health homes implementation is not occurring in a vacuum. All four 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 these 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 Multipayer Advanced Primary Care Practice Demonstration; the Child Health Insurance Program Reconciliation Act (CHIPRA) ten-state Children's Health Insurance Program (CHIP) Evaluation; and the CHIPRA Quality Demonstration. Participation in these initiatives implies that the considerable 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.

The decision of all four states to implement their programs statewide 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 hard to find through eligibility algorithms applied to claims data. An additional issue elucidated through our qualitative activities over the base year was the potential for biases from differential enrollment practices--centralized selection of an eligible population versus provider referrals. Provider referrals could, in theory, promote cherry-picking of enrollees, but more generally is subject to inter-provider variability, relative to a consistently applied central eligibility determination process.

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 will continue to work with states toward this end.

In Rhode Island, enrollment is primarily through provider identification. The CEDARR Centers are at capacity, and expansion does not appear to be contemplated. Therefore, it may be possible to identify similar beneficiaries who are not enrolled as comparisons. 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.

In Oregon, enrollment is through provider recommendation, so that it may be possible to identify similar beneficiaries using nonparticipating providers as comparisons.

VI. SECOND YEAR ACTIVITIES

In the upcoming year, we will continue to monitor the first four states and begin work with additional states as their SPAs are approved. We also anticipate receiving administrative data through our DUA with CMS that may allow us to develop baseline comparative profiles of the health home eligible populations in each state in our second annual report. In addition to working with states on issues relating to comparison groups and identifiers for health home enrollees, we hope to begin obtaining information from states on quality monitoring measures they are collecting from health home providers.

As of this report, additional states with approved SPAs are North Carolina, Iowa, and Ohio, each with one health home program. North Carolina's program is statewide, focusing on a population with chronic physical conditions, excluding persons with mental illness or developmental disabilities. Like the programs examined in this report, North Carolina's health home option is being incorporated into a longstanding care coordination structure, and, like Rhode Island and Oregon, the state selected an effective date of October 1, 2011, so that it was seven months into its intervention period by the time it was approved in late May 2012. Iowa, which received approval of its SPA in early June 2012 with an effective date of July 1, also is implementing its program statewide and is focusing on persons with selected chronic physical conditions and mental conditions or substance use disorders. Ohio's program was approved in mid-September 2012, effective October 1, and focuses on persons in five counties with serious and persistent mental illness, which the state defines as a SMI in adults and serious emotional disturbance in children.

VII. CONCLUSION

All states studied in this first year of the long-term evaluation have in common that they have used the Medicaid Health Homes option to augment existing programs, to accelerate movement down an established pathway, as one part of larger system reform efforts, or all of the above. Even so, implementation appears to be a slow process, at least with respect to the eight-quarter intervention period, over which the programs are to be evaluated. Particular issues revealed through the site visits are those relating to the need to improve internal and external communications and systems needed to underpin 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 a particular area in which systems integration faces special challenges that differ depending on the direction of integration. In general, our site visits 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, are a work in progress to varying degrees in all the states studied.

In the second year of the evaluation, all of the states examined in this report and North Carolina will complete the first year of their intervention periods and move well into their second years. Thus, we will be able to follow up on the emerging issues identified in this report, observe how progress toward full implementation and system reform may differ across these maturing programs, and document these and other implementation issues for new programs in their first intervention year.

TABLE 1. Research Questions for the Long-Term Evaluation

Base year and follow-ups: Implementation

How important was the enhanced match for the decision to initiate health homes?

- For the type of health home undertaken?
- What changes, if any, do states anticipate after the enhanced match ends?

Which conditions are states targeting, and are they developing specialized models?

- What was the rationale for the conditions/models selected?
- What structures and processes have been put in place…
    - 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?

Are states using specialty providers as health home providers?

- 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?

How are participating providers integrating behavioral health, primary care, and supportive services?

- 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

Have care coordination, chronic disease management, patient experience, and clinical outcomes improved for individuals?

- 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?

Has the focus on better integrating care for selected populations resulted in cost savings?

- 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?

Which types of organizations are better suited to becoming health homes?

- 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?

How could pre-existing medical home models be modified to address individuals with multiple chronic conditions and/or SMI?

- 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 2. First Four Evaluation States, Programs, and Timeline

State/ Program[1]	Target Population	Designated Providers	Geographic Coverage	Approval Date	Effective Date	Evaluation Period End Date
Rhode Island (CEDARR-HHs)	Children, youth with mental illness or other disabling physical or developmental conditions	CEDARR Family Centers	Statewide	11/23/2011	10/1/2011	10/1/2013
Rhode Island (CMHO-HHs)	Mental/behavioral conditions	Community Mental Health Organizations	Statewide	11/23/2011	10/1/2011	10/1/2013
Oregon	Chronic physical conditions	Patient-Centered Primary Care Homes	Statewide	3/13/2012	10/1/2011	10/1/2013
Missouri (CMHC-HHs)	Mental/behavioral conditions	Community Mental Health Centers	Statewide	10/20/2011	1/1/2012	1/1/2014
Missouri (PCP-HHs)	Chronic physical conditions	Primary care practices: FQHCs, RHCs, hospital-operated primary care clinics	Statewide	12/23/2011	1/1/2012	1/1/2014
New York	Chronic mental, physical, or behavioral conditions	Any Medicaid-enrolled provider that meets health home standards	Selected Counties[2]	2/3/2012	1/1/2012	1/1/2014

1. Ordered by effective date.
2. New York intends a geographic rollout statewide. Two other New York SPAs to extend health homes to the remaining counties are under review by CMS.

TABLE 3. Key Features of Programs							
State/ Program	**Estimated Eligible Population**	**Medicaid Eligibility Groups Included[1]**	**Health Home Eligibility Criteria**	**Qualifying Conditions**	**Enrollment Processes**	**Payment System**	**Payment Level**
Rhode Island (CEDARR-HHs)	2,500	Categorically and medically needy.	2 conditions, 1 and at risk of another, SMI.	– 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[2].	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.
Oregon	118,000	Categorically needy.	2 conditions, 1 and at risk of another, SMI.	– Asthma – Overweight – Cancer – Chronic kidney disease – Chronic respiratory disease – Diabetes – Heart disease – Hepatitis C – HIV/AIDS – Substance abuse disorder – Serious Mental Health condition[2]	Provider identification; state verification.	PMPM care management fee plus FFS payments made for direct services under state plan authority.	PMPM fee varies by provider's qualification level: – Tier 1 - $10PMPM – Tier 2 - $15PMPM – Tier 3 - $24PMPM
Missouri (CMHC-HHs)	43,000 (across both categories of Health Home)	Categorically needy.	SMI, a 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.	– Substance use disorder – Mental health condition – Asthma – Cardiovascular disease (CVD) – Developmental disability – BMI over 25 – Diabetes – Tobacco use	State identification and assignment.	PMPM care management fee.	$78.74
Missouri (PCP-HHs)		Categorically needy.	2 conditions, 1 and at risk of another.	– Asthma – CVD – Developmental disability – CMI over 25 – Diabetes – Tobacco use	State identification and assignment.	PMPM care management fee.	$58.87

TABLE 3 (*continued*)							
State/ Program	**Estimated Eligible Population**	**Medicaid Eligibility Groups Included**[1]	**Health Home Eligibility Criteria**	**Qualifying Conditions**	**Enrollment Processes**	**Payment System**	**Payment Level**
New York	700,000 (Phases I-III)	Categorically and medically needy.	2 chronic conditions, HIV/AIDS, or a serious mental condition.	– Substance use disorder – Respiratory disease – CVD – Metabolic disease – BMI over 25 – HIV/AIDS – Other chronic conditions[2]	State identification and assignment.	PMPM care management fee.	Paid at 2 levels depending on enrollee status, and adjusted for case-mix and geography.

1. Missouri and Oregon do not have medically needy programs.
2. 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

MEDICAID HEALTH HOMES IN MISSOURI: REVIEW OF PRE-EXISTING STATE INITIATIVES AND STATE PLAN AMENDMENTS FOR THE STATE'S FIRST SECTION 2703 MEDICAID HEALTH HOMES

Brenda C. Spillman, Barbara A. Ormond and Elizabeth Richardson
The Urban Institute

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Missouri has two approved Medicaid Health Home State Plan Amendments (SPAs), the first targeting beneficiaries with serious mental illness (SMI) or behavioral health conditions, and the second targeting beneficiaries with multiple chronic physical conditions. The former was approved on October 20, 2011, while the latter was approved on December 23, 2001; both SPAs went into effect on January 1, 2012. Community mental health centers (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 the population with multiple chronic physical conditions. (Throughout this memorandum, we denote the initiative targeting persons with behavioral health conditions as the CMHC-HH, and the second targeting beneficiaries with multiple chronic conditions as the primary care provider-health home [PCP-HH].)

Missouri's CMHC catchment system divides the state into 25 geographic areas, each of which is served by at least one, but in some case more than one, CMHC. In total, there are 21 full-service CMHCs--which serve all age ranges and provide psychiatric services, counseling, case management, crisis intervention, and housing support, among other services--and nine affiliate sites--which focus primarily on case management and housing support, and are not required to serve all ages.[1] As of January 2012, the state had selected 18 FQHCs operating 67 clinic sites, six public hospitals operating 22 clinic sites, and one Independent RHC to participate.[2] The Health Home program will be statewide, and the Missouri Department of Social Services estimates that about 43,254 Medicaid beneficiaries are eligible. As of April 2012, 37,720 individuals were enrolled; 17,262 in CMHC-HHs, and 20,458 in PCP-HHs.[3]

Implementation Context

The Missouri Medicaid program (known since 2007 as MO HealthNet) operates both a managed care and a fee-for-service (FFS) program. Participation in Medicaid

managed care is largely a function of geography, though certain eligibility groups are also required to enroll, under the state's 1915(b) waiver.[4] Those who are dually eligible for Medicaid and Medicare, those meeting disability standards for Supplemental Security Income, and those receiving adoption subsidy benefits can choose to receive FFS benefits, enroll in managed care, or disenroll at any time, under the waiver.[5] The state contracts with five managed care organizations (MCOs) (Molina Healthcare, HealthCare USA, Harmony Health Plan, Missouri Care Health Plan, and Blue Advantage Plus of Kansas City) who jointly manage care in the Central, Eastern, and Western regions. These regions are roughly located along the I-70 corridor, which runs east to west and includes the state's major urban areas. Counties to the north and south of this corridor are more rural and sparsely populated; these operate on a FFS basis. (See map.)

The Missouri Health Home initiative is taking place within a broader context of state-sponsored care coordination and integration initiatives, many of which predate the passage of the Affordable Care Act. Though Missouri began implementing targeted care coordination and integration programs for its SMI population in 2003,[6] the major push for reform began in 2005. In that year, the state convened the Missouri Medicaid Reform Commission to develop recommendations for restructuring the entire Medicaid program. Among its many recommendations, the final report endorsed the concept of the medical home for Medicaid recipients, citing the need for better continuity and coordination of care. It also developed several recommendations relating to the integration of behavioral and physical health services.[7] These recommendations for the mental health system were developed in consultation with the state Department of Mental Health (DMH),[8] which subsequently would act as the lead agency on the state's mental health reform efforts. In collaboration with MO HealthNet, the Missouri Coalition of Community Mental Health Centers, and the Missouri Primary Care Association (MPCA), DMH led a series of programs--collectively referred to as DMH Net--which were intended to improve the quality of care for persons with SMI, as well as support the clinical integration of primary and behavioral health care. These initiatives would eventually form the basis of the Health Home initiative.[9]

In 2006, the state received a Transformation Grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to support its reform efforts.[10] The subsequent Comprehensive Plan for Mental Health, which was published in early 2008, underscored the state's commitment to care integration, and specifically cited the efforts of DMH Net as part of the reform plan.[11] In 2007, DMH secured state funding for a pilot care integration program involving collaborations between FQHCs and CMHCs. In this pilot, FQHCs were required to open primary care clinics on site at the partnering CMHC, while CMHCs provided behavioral health consultants to the FQHC's primary health care teams. Of 13 applicants, seven pilot sites were selected. Each received $100,000 for the first six months of 2008, then $200,000 per year for the next three fiscal years. The six sites that were not selected were awarded one-time planning grants of $30,000, to allow them to lay the groundwork for subsequent funding cycles.[8] Technical assistance for these pilot sites was funded by the Missouri Foundation for Health (MFH), which is a grant-making organization focused on

supporting health improvement programs for underserved and uninsured populations. The 13 collaborative sites vary in structure; one CMHC also has FQHC status, while another merged with an FQHC. Other CMHCs contract with FQHCs to provide services to patients.[12]

More broadly, DMH implemented a range of reforms to both the structures and processes in place within the mental health system. The Community Psychiatric Rehabilitation Program (CPRC) established a team approach to care, and focused attention on meeting a broad array of needs (housing, work, recreation, etc.) to support patients with SMI.[13] A range of health information technology (HIT) tools were developed to support that care (e.g., the Behavioral Pharmacy Management Program, Medication Adherence Report, and CyberAccess, which are discussed in further detail below). In 2007, the Missouri Coalition of CMHCs began training case managers to improve care coordination and develop treatment plans that include physical health interventions.[12] Nurse liaisons were also added to CMHC teams to educate behavioral health staff on physical health issues and review patient charts.[9] CMHCs also introduced a number of prevention and wellness services, such as screening for metabolic and cardiovascular conditions, smoking cessation counseling, and nutrition education. More recently, DMH and MO HealthNet collaborated on a two-year disease management project targeted at the 3,700 highest-cost, nondual Medicaid enrollees with SMI and chronic medical conditions. Under this initiative, DMH agreed to contact identified clients, enroll them in the CPR program, and manage their care. The project, known as DM 3700, began in November 2010.[14]

In addition to these reforms to the mental health system, Missouri also introduced a major primary care case management program, which ran from 2007 to 2010. The Chronic Care Improvement Program (CCIP) was aimed at improving quality of care for MO HealthNet clients with chronic conditions, decreasing their complications, reducing the cost of their care, and connecting them with a “health care home.” The program was managed by APS Healthcare, a disease and care management company, and covered all active FFS Medicaid enrollees (roughly 10% of whom are CMHC clients[15]) with a diagnosis of asthma, diabetes, chronic obstructive pulmonary disorder, gastroesophageal reflux disease, cardiovascular disease (CVD), and sickle cell anemia.[3] Under this program, APS conducted outreach and education, telephone support for beneficiaries with questions about medical concerns, and a web-based plan of care that was accessible to any provider with an Internet connection and a password.[16] Providers were paid an incentive to conduct and initial health risk assessment, as well as to develop and use these care plans on a regular basis.[6] As of 2010, CCIP provided additional care management and coordination services to approximately 180,000 patients.[15] Due to budgetary constraints, the program was discontinued in August 2010.

On the private sector side, in 2011 the MFH announced a Request for Applications for a multi-payer patient-centered medical home (PCMH) collaborative project.[17] Though this medical home project is distinct from the Health Homes initiative, the framework for it was developed to resemble Missouri’s Health Home SPA, and the two

initiatives will share in learning collaboratives. The project is funded for two years, and at present includes Anthem Blue Cross. Unlike the Health Homes initiative, it is not statewide--it covers the 84 counties served by the MFH.

Beneficiaries who are enrolled in both Medicare and Medicaid are a significant sub-population of Health Home enrollees (12,230 of the current Health Home beneficiaries are dually enrolled, roughly 29% of the overall population). The state is currently finalizing a proposal to the Centers for Medicare and Medicaid Services (CMS) for a demonstration project that targets the dual eligible population through its Health Home initiative. Under the current draft, the state proposes to share with CMS the Medicare savings that Health Homes generate, which the state will in turn share with providers through a pay-for-performance program.[3] As a part of the demonstration, the state is seeking CMS funding to support three additional staff positions: two analysts to work with Medicare data, and a coordinator who will facilitate integration of the two Health Home programs.

Implications for Missouri Section 2703 Medicaid Health Homes Evaluation

These various pre-existing initiatives have several key implications for both the implementation and evaluation of the health homes demonstration. The state has worked with CMHCs for several years to provide care coordination and disease management services to Medicaid enrollees with multiple chronic conditions and SMI. Thus, CMHC providers and state officials have a substantial base of experience in organizing and providing health home-type services. It will be critical to establish how the enhanced federal match will be used by the state, and to what extent the health home demonstration represents a new kind of service rather than an expansion of an existing initiative. In the latter case, the evaluation may find few changes in structure, process, or outcomes. However, the demonstration may serve as a proof of concept for the health home model, as well as provide valuable insight into the issues and challenges surrounding its implementation.

Given that health home-type services have been provided by some providers for a number of years, while others will be relatively new to the program, it will be necessary to clearly identify and describe the structures and processes that are in place at baseline, and to characterize the changes that providers make to these structures and processes as a consequence of becoming health homes. It will also be necessary to adjust the analysis for both the participants' and providers' time in program. Some of these structures and processes are not yet in place, and the state will likely make adjustments to certain aspects of the program based on feedback from providers and periodic internal review. For example, the delineation between the care coordination activities provided through Health Homes and that provided by MCOs is not yet fully detailed, and the payment system may be altered following the 18-month review planned in the SPA. The relationship between the hospitals and Health Homes--a critical piece of the picture given that admissions, readmissions, and emergency room (ER) use are three of the major outcomes being tracked--is still being formalized in many cases. Though much of Missouri's HIT infrastructure was already in place, the

state is still making changes necessary to implement and support Health Home activities. In addition to the information gathered during the site visit, the Urban Institute team will conduct follow-up calls at regular intervals to discuss the progress of these and other implementation activities.

Population Criteria and Provider Infrastructure

Table 1 summarizes the population criteria for both SPA programs and the designated providers and requirements regarding the minimum composition of the Health Home teams. As noted above, the CMHC-HH SPA targets beneficiaries with behavioral health conditions, including both mental illness and substance use, while the PCP-HH SPA targets those with chronic physical conditions. The qualifying chronic physical conditions are the same in the two SPAs: diabetes, asthma, CVD, obesity (defined as having a Body Mass Index [BMI] over 25), developmental disability, and tobacco use. The primary distinction is that substance use and mental illness are not qualifying conditions to receive Health Home services through a primary care center; such beneficiaries would have their Health Home services managed by a CMHC.

The two types of providers on which Missouri is building its Health Home infrastructure have varying experience with Health Home-type services, and have care teams that reflect the different needs of their respective populations. As Table 2 shows, both teams include a Director, Nurse Care Manager, and administrative support staff. The CMHC-HH team adds a primary care physician consultant, while the PCP-HH team adds a behavioral health consultant and a care coordinator, as well as additional clinical staff (i.e., a physician or nurse practitioner, as well as a licensed nurse or medical assistant). Both SPAs indicate that additional team members may be included, depending on beneficiary needs. These members can include the treating physician (if the participant is enrolled in a CMHC-HH), a dietician/nutritionist, and school personnel, among others.

Table 2 is adapted primarily from the current draft of the state's dual eligible proposal to CMS, which outlines the specific roles and responsibilities of each key care team member. Certain CMHC staff roles will continue unchanged (or largely unchanged), though these individuals will play a role in patient care. Behavioral health clinicians and the CPRC teams will remain unchanged, while Community Support Specialists will receive enhanced training to enable them to serve as health coaches who promote lifestyle changes and preventive care, support participants both in managing their health conditions and accessing primary care.

Service Definitions and Provider Standards

Definitions of health home services are identical for the two SPAs, though the providers who have primary responsibility for managing those services differ slightly. (Table 3 provides the full-service definitions.) Nurse Care Managers play a key role in

all of the defined services across both provider categories, with support from the other team members.

The qualifications for Health Home status are also similar between the two SPAs. All Health Home providers must meet initial and ongoing qualifications in addition to those qualifications that are already required for designation as a CMHCs, FQHCs, RHCs, or hospital-operated primary care clinic. The full list of Health Home qualifications is provided in Table 4. In order to meet these qualifications, both types of Health Home will transform their practices over a two-year period by participating in ongoing training sessions or learning collaborative.[18] These learning collaboratives are funded jointly by MFH, the Greater Kansas City Health Care Foundation, and the Missouri Hospital Association.

Training began in August 2011, and will continue throughout 2012. These training modules focus on three components: understanding and implementing the Health Home initiative as mandated under state law; transforming practice in order to improve care quality and efficiency, as well as meet Health Home accreditation standards; and a care team training module focused on understanding the Healthcare Home model, incorporating "whole-person" strategies into service delivery, understanding and assisting in managing chronic diseases, and working with children and adolescents on their basic health literacy.[2]

Use of Health Information Technology

Missouri's Health Home initiative is supported primarily through the existing Medicaid HIT infrastructure, though the state is building on this infrastructure in several ways that relate to broader statewide initiatives as well as Health Homes, specifically, the state's EHR incentive program, meaningful use compliance, and the development of the health information exchange. MO 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. This feature is intended to facilitate patient self-management and monitoring. In addition, MO HealthNet maintains an initial and concurrent authorization-of-stay tool that requires hospitals to notify MO HealthNet within 24 hours of a new admission of any Medicaid enrollee, as well as to provide information about diagnosis, condition, and treatment.

The state is currently working with its HIT vendor to extend its data transfer capabilities between hospitals and outpatient providers, which would allow Health Home providers to use hospitalization episodes to identify eligible beneficiaries, facilitate the necessary outreach and transfer of care between inpatient and outpatient, and coordinate with the hospital on the discharge process. The state will also encourage Health Home providers to monitor Medicaid eligibility using the Family Support Division (FSD) eligibility website (FSD determines client eligibility for the MO HealthNet program

and database), and will refine the process for notifying Health Home providers of impending eligibility lapses. The state requires all Health Home providers to implement an EHR if they do not already have one, which they will also use for extracting and reporting data.

In addition to these umbrella activities, CMHC-HHs and PCP-HHs will each have provider-specific HIT resources on which to draw. CMHC-HHs will continue to make use of two systems: the Customer Information Management, Outcomes and Reporting (CIMOR) for routine reporting, and ProAct for Care Management Reports. Under the Health Home initiative, the capacity of the CIMOR system will be expanded to enable assignment of enrollees to a CMHC-HH based on enrollee choice and admission for services, and the system will be cross-referenced with the above-mentioned inpatient pre-authorization system to enable concurrent reporting of inpatient authorizations to the appropriate CMHC-HH. The ProAct Care Management Reports include the BPMS, Medication Adherence Report and the Disease Management Report. The BPMS report is used for tracking and reporting on prescribing patterns. The Medication Adherence report alerts to medication adherence concerns. The Disease Management Report provides information on treatment gaps based on diagnosis and EBP. PCP-HHs will have access to the Missouri Quality Improvement Network, which is maintained by the MPCA and will serve as a patient registry as well as a platform for gathering quality measures. The data will be refreshed daily, and will be used to generate reports to support meaningful use requirements, quality improvement, and best practice identification.

Payment Structure and Rates

Both types of health homes will be paid a per member per month (PMPM) capitation rate. The PMPM rate for each enrollee in CMHD-HHs will be $78.74, and the rate for PCP-HHs will be $58.87.

These rates are built up from the assumed staffing ratios for each type of health home personnel. (These are listed above, in the description of the various types of staff that will be involved in the health homes.) In addition to staffing ratios, the input to the PMPM rates included the annual salary (and benefits and overhead) of each type of staffer, which Missouri determined from 2011 surveys of organizations likely to become health homes. For example, if the surveys showed that salary, benefits, and overhead for a given type of staff person came to $60,000 annually, and the assumed staffing ratio was one FTE per 400 patients, then the costs of this type of staff within the total PMPM would be $60,000 divided by 400 divided by 12 months, or $12.50 PMPM.

For both types of health homes, the assumed staffing ratios total to 1-1¼ staff hours (for all types of staff combined) per patient per month. Activities covered by current Medicaid funding streams are not being counted in the planned staffing. PMPM rates reflect only marginal health home-specific staffing requirements.

Missouri plans to adjust the PMPM annually, based on the consumer price index. In addition, the PMPM determination method will be reviewed 18 months after the first PMPM payments "to determine if the PMPM is economically efficient and consistent with quality of care." Consideration will be given at that point to a "tiered rate"--that is, to different PMPM amounts for patients with different characteristics and perhaps to health homes with different characteristics.

Quality Improvement Goals and Measures

Missouri has defined eight overarching quality improvement goals for its Health Homes, each with defined clinical outcome and quality of care measures, summarized in Table 5. The measures are generally similar, with the few differences noted in the table. The only experience of care measure identified is patient satisfaction, which will be obtained from patient surveys, for the goal of empowerment and self-management. Most measures will come from claims, disease registry, medical records, and the web-based health record (CyberAccess).

Evaluation Measures and Methods

The evaluation measures and methodology, as described in the SPAs and reproduced in Table 6, are the essentially the same for CMHC-HHs and PCP-MHs, with the exception of estimated cost savings, discussed below. Four of the evaluation areas --chronic disease management, coordination of care, assessment of program implementation, and processes and lessons learned, and assessment of quality improvements and clinical outcomes--pertain to performance and progress toward health homes goals and rely on a combination of processes, including examination of reports on the goals and quality measures in Table 3, audits of practices, and ongoing assessment and oversight of implementation by a Health Homes Work Group and the Steering Committee of the Missouri Medical Home Collaborative. The clinical outcome and quality measures in Table 5 also will be used to assess improvements over time at the health home practice level and for health home practices as a group, with comparisons to regional and national benchmarks where feasible, although it is noted that such benchmarks will not be available specifically for persons with chronic conditions.

The final two measures specify comparison groups in one or both SPAs, but will need clarification in our discussions with the state. For both CMHC-HHs and PCP-HHs, hospital admission rates will be assessed for beneficiaries with the clinical conditions targeted during the learning collaborative year, and for similar beneficiaries, using combined FFS claims and encounter data for participating health home sites and a control group of nonparticipating sites, not otherwise specified. For CMHC-HHs the comparison beneficiaries will have SMI, two or more chronic conditions, or one chronic condition and at risk for developing a second. Selection criteria are the same for PCP-HHs, except that SMI is omitted. Because the description of the timing of the

assessments for the two groups and the nature of the comparison sites is not clear, we will need to explore the design of this assessment further with the state. Finally, for estimates of cost savings, both SPAs provide details of the computation of savings, but only the CMHC-HH SPA specifies an analysis design, a pre/post analysis of both Health Home providers and a group of comparison practices selected to be as similar as possible to participating practices. Comparison practices will be identified by practice type (e.g., FQHC), geographic region, and number of Medicaid beneficiaries with SMI or two or more chronic conditions. The definition of the pre and post-periods is not given and will need to be explored with the state. We will also have to clarify with the state whether a similar pre/post design is intended for the PCP-HH but was inadvertently omitted.

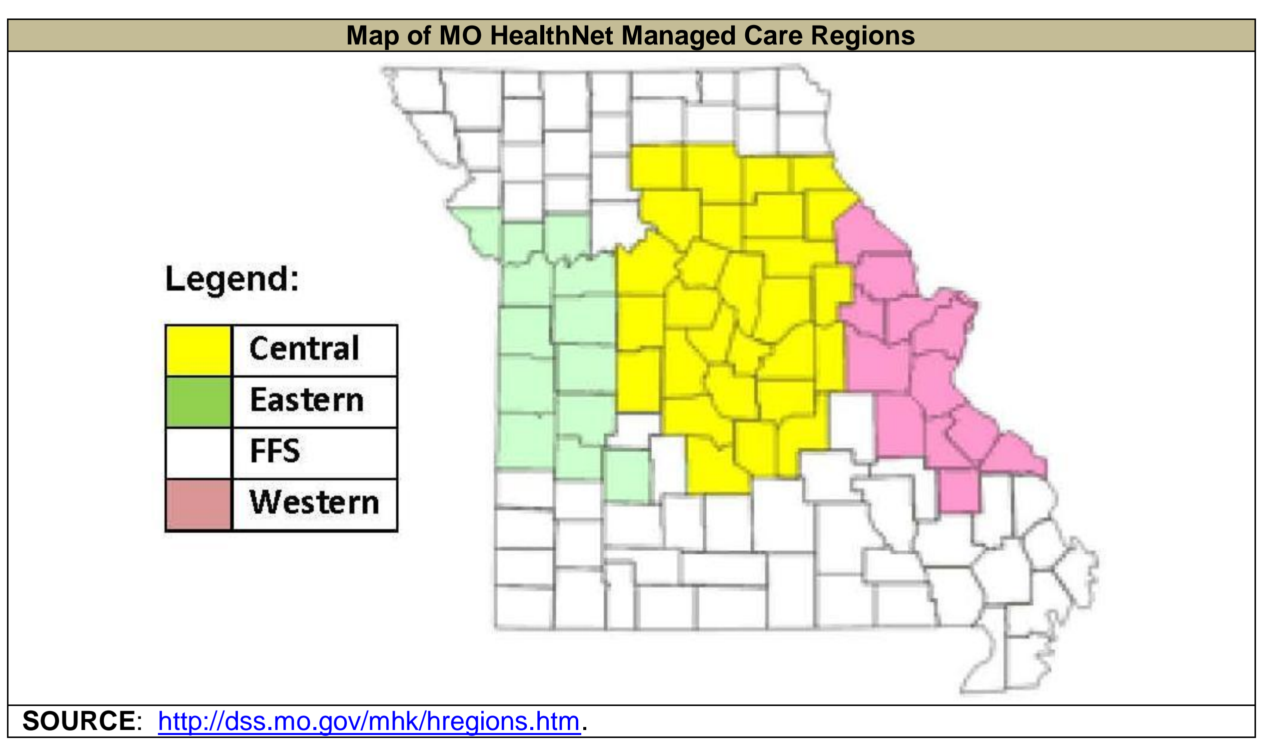
Map of MO HealthNet Managed Care Regions

SOURCE: http://dss.mo.gov/mhk/hregions.htm.

TABLE 1. Target Population and Designated Providers--Missouri		
	SPA 1	**SPA 2**
SPA approval date (Effective date)	10/20/11 (1/1/2012)	12/28/11 (1/1/2012)
Designated provider	CMHCs	PCPs (FQHCs, RHCs, hospital-operated clinics)
Health Home team composition	Required: – Health Home Director – Nurse care manager – Administrative support staff/care coordinator – Primary care physician consultant Optional: – Treating physician or psychiatrist – Mental health case manager – Nutritionist/Dietician – Pharmacist – Peer recovery specialist – School personnel – Others as appropriate	Required: – Health Home Director – Primary care physician or nurse practitioner – Nurse care manager – Administrative support staff/ care coordinator – Licensed nurse or medical assistant – Behavioral health consultant Optional: – Nutritionist – Diabetes educator – School personnel – Others as appropriate
Target population	Beneficiaries must have: – A serious mental health condition (SMI) – SMI or a substance use disorder and another chronic condition, or – SMI or a substance use disorder and tobacco use	Beneficiaries must have: – 2 chronic conditions, or – 1 chronic condition and the risk of developing another
Qualifying chronic conditions	– Asthma – CVD – Developmental disability – BMI over 25 – Substance use disorder (CMHC only) – SMI (CMHC only) – Diabetes* – Tobacco use*	
* Qualifies a person for being at risk of having a second chronic condition.		

TABLE 2. Health Home Staff Roles--Missouri		
Team Member	**Key Roles**	**Staff Ratio**
Health Home Director	– Provides leadership to the implementation and coordination of Health Home activities – Champions practice transformation based on Health Home principles – Develops and maintains relationships with primary and specialty care providers – Monitors performance and leads improvement efforts – Designs and develops prevention and wellness activities	PCPs: 1 full-time equivalent (FTE)/ 2500 enrollees CMHCs: 1 FTE/500 enrollees
Nurse Care Manager	– Develop wellness and prevention initiatives – Facilitate health education groups – Develops the initial treatment plan and health care goals – Consult with Community Support Staff about patient conditions – Liaise with hospital providers on admission/discharge – Provide training on medical issues – Track required assessments and screenings – Assist in implementing core HIT programs and initiatives – Monitor HIT tools and reports for treatment – Medication alerts and hospital admissions/discharges – Monitor and report performance measures and outcomes	1 FTE/250 enrollees
Behavioral Health Consultant (PCPs only)	– Screening/evaluation of individuals for mental health and substance abuse disorders – Brief interventions for individuals with behavioral health problems – Behavioral supports to assist individuals in improving health status and managing chronic illnesses – Meets regularly with the primary care team to plan care and discuss cases, and exchanges appropriate information with team members – Supporting integration with primary care – Conducting treatment interventions and patient education – Providing formal feedback to PCP on behavioral health care issues	1 FTE/750 enrollees
Primary Care Physician Consultant (CMHCs only)	– Participates in treatment planning – Consults with team psychiatrist – Consults regarding specific participant health issues – Assists coordination with external medical providers	1 FTE/500 enrollees
Care Coordinator/ Administrative staff	– Referral tracking – Training and technical assistance – Data management and reporting – Scheduling – Chart audits – Reminding enrollees regarding appointments, filling prescriptions, etc. – Requesting and sending medical records for care coordination	PCPs: 1 FTE/750 enrollees CMHCs: 1 FTE/500 enrollees

TABLE 3. Health Home Service Definitions--Missouri	
Comprehensive care management	– Identification of high-risk individuals and use of client information to determine level of participation in care management services. – Assessment of preliminary service needs. – Treatment plan development, which will include client goals, preferences and optimal clinical outcomes. – Assignment of health team roles and responsibilities. – Development of treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions. – Monitoring of individual and population health status and service use to determine adherence to treatment guidelines. – Development and dissemination of progress reports on outcomes for client satisfaction, health status, service delivery and costs.
Care coordination	Care coordination is the implementation of the individualized treatment plan (with active client involvement) through appropriate linkages, referrals, coordination and follow-up to needed services and supports, including referral and linkages to long-term services and supports. Specific activities include, but are not limited to: appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes and communicating with other providers and clients/family members.
Health promotion	Health promotion minimally consists of: – Providing health education specific to an individual's chronic conditions. – Development of self-management plans with the individual. – Education regarding the importance of immunizations and screenings. – Child physical and emotional development. – Providing support for improving social networks and providing health-promoting lifestyle interventions (e.g., substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, and increasing physical activity). – Assisting clients in participating in treatment plan implementation, and empowering to understand and self-manage chronic conditions.
Comprehensive transitional care	Care coordination services are designed to streamline plans of care, reduce hospital admissions, ease the transition to long-term services and supports, and interrupt patterns of frequent hospital emergency department use. A health team member collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to implement the treatment plan, focusing on increasing clients' ability to manage care and live safely in the community, and shift the use of reactive care and treatment to proactive health promotion and self-management.
Individual and family support services	These services include, but are not limited to advocating for individuals and families, and assisting with obtaining and adhering to prescribed treatments. In addition, health team members are responsible for identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services. A primary focus will be increasing health literacy, and patient ability to self-manage. For individuals with developmental disabilities the health team will refer to and coordinate with the approved developmental disabilities case management entity for services related to habilitation.

TABLE 4. Provider Qualifications by Provider Category--Missouri
Qualifications required for both providers
– Have a substantial percentage of its patients enrolled in Medicaid (at least 25%). – Have strong, engaged, committed leadership (demonstrated through the application process and agreement to participate in learning activities; and that agency leadership have presented the "Paving the Way for Health Care Homes" PowerPoint introduction to Missouri's Health Home Initiative to staff). – Meet state requirements for patient empanelment (i.e., each patient receiving CMHC-HH services must be assigned to a physician). – Provide assurance of enhanced (24/7) patient access to the health team, including the development of telephone or email consultations. – Use MO HealthNet's electronic health record (EHR) to conduct care coordination and prescription monitoring for Medicaid participants. – Utilize an interoperable patient registry to input annual metabolic screening results, track and measure care of individuals, automate care reminders, and produce exception reports for care planning. – Agree to convene internal Health Home team meetings to plan and implement goals and objectives of Health Home practice transformation. – Agree to participate in CMS and state-required evaluation activities. – Agree to develop required reports describing Health Home activities, efforts and progress in implementing Health Home services. – Maintain compliance with all required terms and conditions or face termination as a provider of Health Home services. – Propose a Health Home delivery model that the state determines to have a reasonable likelihood of being cost-effective. – Within 3 months of Health Home service implementation, have developed a contract or memorandum of understanding with regional hospital(s) or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions of Health Home participants and identification of Health Home-eligible individuals seeking emergency department services. – Develop quality improvement plans to address gaps and opportunities for improvement identified during and after the application process. – Demonstrate continuing development of health home functionality at 6 months and 12 months through an assessment process to be applied by the state. – Demonstrate significant improvement on clinical indicators specified by and reported to the state.
Provider qualifications particular to CMHC-HHs
– Routinely use a behavioral pharmacy management system (BPMS) to determine problematic prescribing patterns. – Conduct wellness interventions as indicated based on clients' level of risk. – Complete status reports to document clients' housing, legal, employment status education, custody, etc. – Provide a Health Home that demonstrates overall cost-effectiveness. – Meet National Committee for Quality Assurance (NCQA) Level 1 PCMH requirements OR submit an application for NCQA recognition by month 18 from start of supplemental payments OR meet equivalent recognition standards approved by the state as they are developed.
Provider qualifications particular to PCP-HHs
– Have a formal process for patient input into services provided, quality assurance, access, etc. – Have completed electronic medical record (EMR) implementation and been using the EMR as its primary medical record system. – Attain NCQA 2011 PCMH Level 1 Plus recognition, defined as meeting Level 1 standards, plus the following NCQA 2011 PCMH standards at the specified levels of performance: 3B at 100% and 3C at 75%. Minor deficiencies may be addressed through submission and approval of provider plans of correction. – Meet equivalent recognition standards approved by the state as developed.

TABLE 5. Health Home Goals and Measures--Missouri	
Improve primary health care	Clinical measures: – Ambulatory care-sensitive admissions per 100,000 population under age 75 years. – Preventive/ambulatory care-sensitive ER visits (algorithm, not formally a measure). – Hospital readmissions within 30 days. Quality measures: – Percent of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 3 days of discharge and performed medication reconciliation with input from PCP. – Adherence to prescribed medication for mental condition. (CMHC only)
Improve behavioral health care/Reduce substance abuse	Clinical measures: – Reduced proportion of adults (18 and older) reporting use of illicit drugs (past year for CMHC, past 30 days for PCP). – Reduced proportion of adults reporting excessive drinking of alcohol (past year for CMHC, past 30 days for PCP). Quality measures (PCP only): – Percent patients 18+ years receiving depression screening. – Percent children screened for mental health issues. – Percent members 18+ years screened for substance abuse.
Improve patient empowerment and self-management	Clinical measures: – Patient use of personal EHR (CyberAccess or its successor, or (PCP only) practice EMR patient portal). Experience of care measures: – Satisfaction with services (CMHC: Mental Health Statistics Improvement Program survey; PCP: CAPHS CG 1.0 Adult and Child Primary Care Surveys).
Improve coordination of care	Clinical measures: – Use of CyberAccess PMPM (or its successor) for nonMCO enrollees. Quality measures: – Percent of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 3 days of discharge and performed medication reconciliation with input from primary care physician.
Improve preventive care	Clinical measures: – Percent of patients with documented BMI between 18.5-24.9. – Percent of patients aged 18 years and older with a calculated BMI in the past 6 months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented. (PCP) – Percent of patients 2-17 years who had documented evidence of BMI percentile, counseling for nutrition and physical activity. (PCP) Quality measures: – Percent members receiving metabolic screening in past 12 months. (CMHC) – Percent of children 2 years of age who had 4 DtaP/DT, 3 IPV, a MMR, 3 H influenza type B, 3 hepatitis B, a chicken pox vaccine (VZV) and 4 pneumococcal conjugate vaccines by their 2nd birthday. (PCP)

TABLE 5 (*continued*)	
Improve diabetes care	Clinical measures: – Percent of patients with diabetes (type 1 or 2) who had HbA1c <8.0% (adults ages 18-75 only for CMHC). – Percent of patients 18-75 years old with diabetes (type 1 or 2) who had BP and LDL below certain levels. (PCP) Quality measures: – Adherence to diabetes medication. (PCP) – Percent of members receiving metabolic screening in past 12 months. (CMHC)
Improve asthma care	Clinical measures: – Percent of patients 5-50 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period. Quality measures: – Adherence to prescription medication.
Improve cardiovascular care	Clinical measures: – Percent of patients aged 18 years and older with a diagnosis of hypertension with a blood pressure adequately controlled after 2 office visits. – Percent of patients aged 18+ years diagnosed with coronary artery disease (CAD) with lipid level adequately controlled (LDL<100). Quality measures: – Adherence to CVD and Anti-Hypertensive Meds. – Use of statins by persons with a history of CAD. (CMHC)

TABLE 6. Evaluation Methodology--Missouri	
Hospital admission rates	The state will consolidate data from its FFS Medicaid Management Information System-based claims system and from MCO-generated encounter data for the participating health home sites to assess hospital admission rates, for the participating health home sites and for a control group of nonparticipating sites. The analysis will consider: (a) the experience of beneficiaries with the clinical conditions of focus during the learning collaborative year (expected to grow from year 1 to year 2); and (b) all beneficiaries with SMI, 2 or more chronic conditions, or 1 chronic condition and at risk for a second, drawn from a list of chronic conditions defined by the state.
Chronic disease management	The state will audit each practice. Audits will assess: (a) documented self-management support goal setting with all beneficiaries identified by the practice site as high-risk; (b) practice team clinical telephonic or face-to-face beneficiary follow-up within 2 days after hospitalization discharge; (c) documentation that there is a care manager in place; and (d) that the care manager is operating consistently with the requirements set forth for the practices by the state.
Coordination of care	The state will measure: (a) care manager contact during hospitalization; (b) practice team clinical telephonic or face-to-face beneficiary follow-up within 2 days after hospitalization discharge; (c) active care management of high-risk patients; and (d) behavioral activation of high-risk patients. The measurement methodologies for these 4 measures are described in the preceding section.
Assessment of program implementation	The state will monitor implementation in 2 ways. First, a Health Homes Work Group comprised of Department of Social Services and DMH personnel and provider representatives will meet regularly to track implementation against: (a) a work plan; and (b) against performance indicators to assess implementation status. The meetings will initially occur on a biweekly basis, and then will transition to monthly meetings 6 months into implementation. Second, the 2 departments will join private payers and provider representatives on the Steering Committee of the Missouri Medical Home Collaborative to review monthly practice data submissions and analysis by the MFH, as well as the status of practice transformation activities in conjunction with a MFH-funded learning collaborative and possible practice coaching to be provided to at least some of the participating practices.
Processes and lessons learned	The aforementioned work group, as well as the Steering Committee of the Missouri Medical Home Collaborative will approach the health home transformation process for the participating practices as an ongoing quality improvement exercise. Using a combination of evaluation data, information from the learning collaborative Quality Improvement Advisor who will be reviewing regularly submitted practice narrative and data reports, feedback from any practice coaches, and feedback provided to the Health Homes Work Group and the Collaborative Steering Committee by practice representatives, the state will assess what elements of its practice transformation strategy are working--and which are not. Critical attention will be paid to: (a) critical success factors, some of which have already been identified in the literature; and (b) barriers to practice transformation.

TABLE 6 (***continued***)	
Assessment of quality improvements and clinical outcomes	The state will utilize the quality process and outcome measures described in the prior section to assess quality improvements and clinical outcomes. For registry-based, claims-based and audit-based measures, assessment will occur both at the individual practice level, and at the aggregate level for all participating health homes. For registry and claims-based measures, the state will track change over time to assess whether statistically significant improvement has been achieved. For registry-based measures for which national Medicaid benchmark data is available for Medicaid managed care plans, comparisons will be made to regional and national benchmarks.
Estimates of cost savings	CMHC only: The state will annually perform an assessment of cost savings using a pre/post-period comparison with a control group of Medicaid primary care practices serving clinically similar populations but not participating as Health Homes. Control group practices will be similar to participating practices to the extent that it is feasible to do so. They will be identified by practice type (e.g., FQHC), geographic region, and number of Medicaid beneficiaries with SMI or 2 or more chronic conditions. Savings calculations will be risk-adjusted, truncated claims of high-cost outliers annually exceeding 3 standard deviations of the mean, and will net out the value of supplemental payments made to the participating sites during the 8-quarter period. PCP: Methods for calculating cost savings for inpatient hospital, ER, and skilled nursing facility use, and how those inputs will be used to calculate savings net of Health Home PMPM are illustrated, but no parallel structure is given for a pre/post comparison of costs for participating Health Home practices with those for similar nonparticipating practices, as was provided in the CMHC SPA.

APPENDIX: Pre-existing Initiatives in Missouri				
	Chronic Care Improvement Program (CCIP)	**Missouri Patient-Centered Medical Home Initiative**	**Missouri Primary/ Behavioral Health Care Integration Initiative**	**DM 3700**
Timeline	– CCIP began enrolling participants in November 2006.[1] – Patient management in CCIP began January 2007.[1] – Program ended in August 2010.[2]	– Applications for participating in the Missouri Medical Home Collaborative were released by MFH in the summer of 2011.[3] – The initiative is currently funded for 2 years. – Practices were notified of selection in fall 2011.	– DMH received funding for a pilot integration grant in 2007. – 7 sites were selected in November 2007. – Funding began in 2008, and lasted for 3 years.	– DMH Net implemented DM 3700 in November 2010. – The project is slated to end in 2012.
Geographic area	CCIP began exclusively serving the I-70 corridor, but was expanded to include Northeast, Southeast, and Southwest regions in Missouri.[4]	84 counties served by MFH.	7 pilot sites throughout the state.	Statewide
Sponsors	DMH Net	MFH, Anthem Blue Cross, United	DMH Net	DMH Net
Scope	– As of 2010, approximately 180,000 were enrolled. – Conditions targeted include asthma, diabetes, CAD, congestive heart failure, chronic obstructive pulmonary disease, gastro esophageal reflux disease (GERD), and sickle cell anemia.[4]	– Includes both licensed physicians and other licensed health care professionals. – At least 66% of selected practices must be MO HealthNet providers.[3]	FQHCs and CMHCs partnered on: – Location of an FQHC primary care clinic at CMHC site. – Integration of a behavioral health provider from the CMHC into the FQHC care team. – Adoption of appropriate best and promising practices. – Full documentation of care in an on-site record. – Incorporation of appropriate care management technologies.	Criteria for inclusion in the project include: – $30,000 or greater in combined Medicaid pharmacy and medical costs between June 2009 and May 2010. – A diagnosis of Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, or Major Depression-Recurrent. – Not currently a DMH client.
Goals	– Provide MO HealthNet beneficiaries more coordinated, better quality care. – Help beneficiaries make better health-related choices and more effectively manage their own health needs.[1]	– To improve primary care services to enhance quality of care and patient experience.[3] – To reach underserved and high-risk populations in Missouri. – To spur innovation in achieving better health outcomes and lower clinical costs. – To develop and promote a sustainable, effective health home model.	– To improve clinical care. – To improve collaboration between the behavioral and physical health systems. – To improve access to primary care and behavioral health services and supports.	– To provide care coordination and disease management to identified beneficiaries. – To reduce the cost to the state of providing care and treatment and improve outcomes for enrolled clients.

APPENDIX (*continued*)				
	Chronic Care Improvement Program (CCIP)	**Missouri Patient-Centered Medical Home Initiative**	**Missouri Primary/ Behavioral Health Care Integration Initiative**	**DM 3700**
Payment approach	– FFS, with incentive payments. – Physicians received a $50 payment for completing an initial assessment for CCIP participants, and $25 each month a physician logs onto a CCIP patient's web-based care plan.[5]	– Practices receive PMPM payments for their Medical Home activities. – Practices are also eligible for Shared Savings payments of up to 40% of the savings from reductions in costs related to inpatient acute care and emergency department visits. These savings will be calculated relative to historic costs, with risk and outlier adjustments and all costs related to accident and injury excluded. – An additional PMPM payment is available if practices hire or contract out work for a clinical care manager. – Practices who applied and were accepted to the MO HealthNet Health Home initiative will receive supplemental payments through both programs if selected by MFH.[6]	Sites received grant payments of $100,000 for the first 6 months of 2008, then $200,000 per year for the next 3 fiscal years.	FFS, plus an incentive payment of $24 PMPM paid at the end of the year if providers meet cost reduction goals.[7]
Technical assistance	The 2007 legislation also created the HealthNet Oversight committee to oversee implementation of all aspects of the legislation, including those related to health care homes.	Practices participating in the MFH medical home program will participate in the same learning collaboratives as those in the MO HealthNet health home program.[8]	Technical support for the 7 integration pilot sites was funded through a grant from the MFH.	No information found.
HIT use	Providers have access to MO HealthNet infrastructure, including CyberAccess, the Behavioral Pharmacy Management Program, Disease Management Report, and Medication Adherence Reports.	Participating providers are required to maintain a patient registry, either as part of the practice's EMR or as a free-standing web-based registry.[6]	Providers have access to MO HealthNet infrastructure, including CyberAccess, the Behavioral Pharmacy Management Program, Disease Management Report, and Medication Adherence Reports.	Providers have access to MO HealthNet infrastructure, including CyberAccess, the Behavioral Pharmacy Management Program, Disease Management Report, and Medication Adherence Reports.
Evaluation methods	– The 18-member Advisory Committee contracted with Mercer to conduct an analysis of program outcomes. – Key evaluation measures include cost analyses, clinical outcomes comparisons across groups, and examinations of medical and cost outcome.[7]	– Practices must obtain NCQA PCMH recognition at "Level 1 Plus" by the 18th month following receipt of the first Medical Home payment. – CSI Solutions will perform the formal evaluation, which may include surveys and interviews.	Evaluation components included:[9] – Analysis of both behavioral and physical health performance measures (e.g.; diabetes and hypertension control, behavioral health screening performed). – Staff surveys and interviews. – Consumer surveys. – Financial impact analysis.	The state will collect data on:[7] – ER visits, admissions, readmissions. – Episodes of outpatient care. – Aggregate MPR by drug class. – HEDIS indicators (unspecified). – Total health care utilization for: inpatient, outpatient, pharmacy, CPRC; by behavioral vs. physical.

APPENDIX (*continued*)

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MEDICAID HEALTH HOMES IN NEW YORK: REVIEW OF PRE-EXISTING STATE INITIATIVES AND STATE PLAN AMENDMENTS FOR THE STATE'S FIRST SECTION 2703 MEDICAID HEALTH HOMES

Brenda C. Spillman, Barbara A. Ormond, Elizabeth Richardson and Aaron Chalek
The Urban Institute

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New York currently has one Medicaid Health Home State Plan Amendment (SPA) approved by the Centers for Medicare and Medicaid Services (CMS) on February 2, 2012, with a retroactive effective date of January 1, 2012.[1] The state envisions this program as the first step in a Health Home initiative that will be rolled out in three geographically-based phases and ultimately will cover Medicaid enrollees with chronic physical or behavioral conditions statewide. The currently approved SPA represents Phase I and will cover ten counties. Separate SPAs have been submitted for Phase II, which will cover an additional 12 counties, and Phase III, which will expand Health Homes to the remaining 39 counties. The expected retroactive effective dates for the latter phases are April 1, 2012, and July 1, 2012, respectively.

The current Phase I and planned Phase II and III initiatives cover enrollees in two groups: (1) those who have a serious mental illness (SMI); and (2) those who have two or more chronic conditions (including substance abuse), and those who have HIV/AIDS and are at risk of developing another chronic condition. New York estimates that these two groups covered by Phase I, II, and III SPAs represent about 700,000 of the state's approximately five million Medicaid members. The state also plans to extend statewide coverage to two additional population groups in later SPAs: enrollees with developmental disabilities and enrollees in need of long-term care services. Another 275,000 Medicaid enrollees are estimated to fall into these two groups.

The state identifies Health Home providers through an application process in which a Health Home lead organization demonstrates how it will meet the Health Home requirements through its partners and affiliated providers. Health Home lead organizations have already been designated for Phases I and II and will be designated shortly for Phase III. 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.

The second Health Home wave will expand coverage to the long-term care population. The design of this wave is currently under discussion, but it is expected that

the program will be based on the existing managed long-term care program and a network of nursing home and noninstitutional providers. The third wave will target enrollees with developmental disabilities. Care for this population is currently managed by a TCM program, which is expected to convert to a Health Home in conjunction with implementation of the state's Section 1115 Medicaid Waiver program, People First, currently under development.

Implementation Context

In January 2011, Governor Andrew Cuomo convened a Medicaid Redesign Team (MRT) to assess the Medicaid program overall and develop recommendations for reform, with a focus on quality of care and cost containment and a vision of care management for all. The state's Medicaid program currently has both fee-for-service (FFS) and managed care components. About 70% of all beneficiaries are currently enrolled in managed care, although the share in managed care varies across different eligibility groups. The state has asserted that care for most enrollees is being managed well within a primary care setting but that population groups with increasingly costly and complex medical, behavioral, and long-term health care needs could benefit from additional care management. One of the MRT's 78 approved recommendations was to initiate a statewide Health Home program. A second key recommendation was to extend managed care to all program enrollees.

A wide range of programs similar to Health Homes has informed the development and implementation of the state's initiative. Some are geographically-based initiatives; others are statewide and target enrollees with specific conditions. Many programs are limited to Medicaid enrollees, but a substantial number include other payers as well.

The TCM programs have given the state a decade of experience in comprehensive case management and community support services for particular populations. Three existing case management initiatives will eventually be incorporated into Health Homes. The Office of Mental Health (OMH) has a TCM program that supports people with behavioral or mental health issues. The AIDS/COBRA program provides case management for people who are HIV-positive, and an Office of Alcoholism and Substance Abuse Services (OASAS) Managed Addiction Treatment Services (MATS) program serves enrollees with substance abuse problems.

Some programs, such as the New York Care Coordination Program (NYCCP) and the Chronic Illness Demonstration Projects (CIDPs), are particularly relevant for Health Home implementation, as they both focus on care coordination for patients with mental/behavioral health conditions. The NYCCP is a regional consortium of mental health providers and state and county governments, which over the past decade has developed and implemented a program aimed at coordinating physical and behavioral health care for Medicaid patients.[2] The CIDP initiative began in 2009, when the state-funded six provider groups to provide FFS comprehensive care management for enrollees with both physical and mental health conditions, as well as to address their

social service needs. The state has identified the CIDPs as a direct precursor to the Health Home initiative.[3] One significant lesson from CIDP was that outreach and enrollment costs were much higher than expected. The state found that the complexity and severity of enrollee needs often made it difficult to interest this population in joining a CIDP when they were struggling with other life issues.[4] This experience led to enhanced consideration and provisions for community outreach in the development of health homes, as well as for strong community supports, especially those related to housing and services following hospital discharge. The state's demonstrations and past initiatives have also highlighted the importance of the existing health information technology (HIT) infrastructure and the changes necessary to implement and support Health Home activities.

The state also is engaged in two patient-centered medical home (PCMH) initiatives authorized in the state's 2009 legislative session. The Adirondack Medical Home Demonstration is a five-year regional multi-payer initiative to improve care, expand access, and contain costs in the rural upstate region.[5] Participating payers include Medicare, Medicaid, and the state's civil service system along with several private payers.[6] The pilot was initiated in 2010 and focuses on preventive care and coordination of care for people with chronic conditions. Reimbursement includes a FFS component, a care coordination fee, and performance-based payment for improved patient outcomes. Providers must achieve National Committee for Quality Assurance (NCQA) Physician Practice Connections--Patient-Centered Medical Home (PPC-PCMH) level 2 or 3 status within one year of the beginning of the pilot, and they must report on quality improvements for access of care, coordination and disease management, and hospitalization rates/readmission rates.[7]

The second PCMH initiative, also begun in 2010, is a statewide program for individuals enrolled in Medicaid, Family Health Plus (the state's public health insurance program for adults), or Child Health Plus (the state's Children's Health Insurance Program [CHIP]).[8] Eligible providers include office-based practices, federally qualified health centers (FQHCs), and mental health diagnostic and treatment centers, and may serve both FFS and managed care beneficiaries. As in the Adirondack pilot program, the state adopted NCQA standards for practice certification. The MRT recommended that the PCMH program be expanded to new payers and a broader patient population. The 2011 legislative session authorized the Department of Health (DOH) to establish additional multi-payer medical home initiatives throughout the state. In response, Medicaid submitted a SPA to CMS in June 2011 to test new payment models for qualifying medical home practices, including risk-adjusted global payments and pay-for-performance (P4P).[8]

In August 2011, DOH announced a three-year initiative to improve the quality and coordination of primary care services provided to Medicaid patients by teaching hospitals under a grant from CMS.[9] This initiative had two components: (1) the Hospital-Medical Home project, which will provide financial incentives for the transformation of hospital teaching programs; and (2) the Potentially Preventable Readmissions (PPR) project, which will provide competitive grants to hospitals to

develop strategies to reduce the rate of preventable medical or behavioral health-based readmissions.[9] The agreement includes increased financial support for mental health clinics that serve uninsured patients through grants to diagnostic and treatment centers for services provided to uninsured individuals throughout the state. These programs are authorized to operate through December 31, 2014, and are supported under a Section 1115 waiver called the Partnership Plan.[9]

The Capital District Physicians' Health Plan (CDPHP) Enhanced Primary Care Program pilot is a medical home initiative in the Albany region that is considered a "virtual all-payer" system. It began in 2008 and now encompasses 24 practices, 50,000 members, and nearly 160 network physicians.[10] The CDPHP payment is a capitation model with a bonus incentive based on quality and efficiency.[10] Participating practices receive payments under a risk-adjusted capitation model based on expected levels of care utilization and costs associated with a patient's individual risk profile.[11] The plan keeps "shadow" FFS billing in place. Further, it promised to help doctors if their costs were higher than predicted by the model and to give them the difference if the practice billed less than the model predicted.[11] Data on clinical quality (based on 18 HEDIS measures), cost and efficiency (utilization-based hospital and emergency department rates, population-based metrics, and episode-based medical costs), and patient/provider experience (from surveys) are collected for evaluation.[10]

The Hudson Valley P4P Medical Home Initiative was created under a 2008 grant from DOH to Taconic Health Information Network and Community. It targets adults with chronic conditions in the Mid-Hudson Valley region. The five-year initiative brings IBM, a dominant employer in the region, together with six commercial health plans, who are underwriting the pilot with DOH. This project also bases quality and care coordination benchmarks and incentives on the NCQA level 2 PPC-PCMH standards. The program also seeks to facilitate adoption and use of electronic health records (EHRs) in office practices in the Hudson Valley.[12]

In addition to these state-level initiatives, New York is involved in several CMS projects. It is one of eight states selected to participate in the Medicare Advanced Primary Care Practice demonstration program, and it is also participating in the CMS duals demonstration program.[7] In addition, the Capitol District-Hudson Valley Region of New York has been selected to participate in the CMS's Comprehensive Primary Care Initiative, a multi-payer initiative promoting collaboration between public and private health care payers to strengthen primary care. Medicare will work with these payers and offer bonus payments to primary care doctors who better coordinate care for their patients.[7]

DOH staff has developed a comprehensive Medicaid reform action plan based on the work of the MRT.[13] In particular, the action plan recommends the development of a comprehensive Section 1115 Medicaid waiver to ensure that the state has flexibility to enact all of the reforms proposed by the MRT. This new waiver is designed to allow the state to reinvest in its health care infrastructure in preparation for national health care reform and to work to contain the overall health care cost growth rate.[13] The state

expects to use the 1115 savings to assist Health Homes in attaining long-term sustainability, including help with costs, HIT investment, and recruitment and training of care managers.[14]

The state has also undertaken a numbered series of state-funded initiatives, the Health Care Efficiency and Affordability Law for New Yorkers, known as HEAL NY, to improve its information technology capacity, several of which are relevant for health homes. In particular, HEAL 10 provides financial support to PCMH projects throughout New York to help providers improve care coordination and enhance the continuum of care through HIT linked through the Statewide Health Information Network for New York (SHIN-NY).[15] HEAL 17 builds on this funding for PCMH projects, and HEAL 22 authorizes state funding to support EHR implementation specifically for behavioral health providers.[16,17]

Implications for New York Section 2703 Medicaid Health Homes Evaluation

These various initiatives have several key implications for both the implementation and evaluation of the health homes program. The state has worked with a range of providers over many years to improve care coordination and disease management services to Medicaid enrollees with chronic conditions and SMI, targeted variously to particular conditions, specific geographic areas, and particular providers. Thus, both providers and state officials have a substantial base of experience in organizing and providing health home-type services. It will be critical to establish how the enhanced federal match will be used by the state and to what extent the Health Home initiatives represent a new kind of service rather than an expansion of an existing initiative. The variety of models that are being developed means that the evaluation will need to pay close attention to changes in structure and process across the individual health homes and any differences in outcomes.

Given that some providers have offered services that are similar to health home services for a number of years while other providers will be relatively new to the program, it will be necessary to clearly identify and describe the structures and processes that are in place at baseline and to characterize the changes that providers make to these structures and processes as a consequence of becoming health homes. The state and the participating Health Homes will likely make adjustments to the program based on feedback from providers and periodic internal review, so it will also be necessary to conduct regular follow-ups with key stakeholders over the course of the evaluation.

Population Criteria and Provider Infrastructure[18]

New York's Health Home program both builds on existing provider relationships and encourages development of new provider partnerships. Eligible health home

providers include any type of provider that is enrolled in the Medicaid program and meets the state's designated Health Home requirements. Health homes are empowered to determine the most appropriate composition of the Health Home team for the members it will serve, the state only requires that the team be "multidisciplinary" and led by a dedicated care manager. Health Homes can use teams consisting of medical, mental health and substance abuse treatment providers, social workers, nurses, and other care providers. All members of the team are responsible for reporting to the care manager and for ensuring that care is patient-centered, culturally competent, and linguistically appropriate. Table 1 summarizes the population criteria, the designated providers, and the Health Home team composition requirements.

Enrollee Identification and Assignment[19]

The identification of eligible health home enrollees is based on a set of algorithms and is the same for FFS and managed care enrollees, although the process for assigning eligible enrollees to specific Health Homes differs. DOH identifies the enrollees eligible for health home services using a proprietary clinical risk group (CRG) software and an "intelligent" assignment algorithm that predicts for negative events using claims and encounters. The state uses an Ambulatory Connectivity Measure to help determine enrollees' Health Home assignment priority, with priority given to assigning enrollees with high costs and low ambulatory care connections. The state is also exploring ways to include information on housing and other social services needs and use. Assignment to a particular Health Home is made using a "loyalty" algorithm to match beneficiaries with providers based on their existing relationships with providers. MCPs may use the same assignment algorithm to assign their members to an appropriate Health Home if they so choose, but may also use additional information.

Health Home beneficiaries are categorized into mutually exclusive CRGs using claims data and, when available, additional data. These CRGs can be used to predict the amount and type of health care services that individuals should have used in the past and can be expected to use in the future. CRG-based attribution modeling is being used for group selection, and CRG-based acuity modeling is being used to establish different Health Home payment tiers. The state then assigns enrollees to a specific Health Home based on their level of clinical risk and their current level of connectivity to an outpatient provider. Eligible beneficiaries with a higher level of clinical risk and a lower level of connectivity have higher assignment priority. Health Homes may also accept members that are referred to them from providers or other sources such as local health districts; these are known as community referrals.

Table 2 shows how each of the state Health Home Analytical Products is used in enrollee identification and assignment.

For FFS enrollees, the state provides candidate "tracking lists" to Health Homes electronically via the Health Commerce System (HCS). Lead Health Homes send out welcome letters to these candidates and assign them to individual providers for outreach and engagement, with participant data to be reported to the lead Health Home.

For managed care enrollees, the state provides candidate “tracking lists” to the MCPs for their members via the HCS, based on the same intelligent assignment algorithm, loyalty model, and risk scores as used for FFS members. MCPs are responsible for assigning candidates to the lead Health Home that can best serve their needs. The lead Health Homes receive these member assignments and again assign candidates to individual providers for outreach and engagement. Established case management providers (OMH TCM, MATS, HIV/COBRA TCM, and CIDPs) that choose to convert to Health Homes will determine the most appropriate assignment for each of their members. DOH is designing portals to allow real-time access to beneficiary-level data.

Service Definitions and Provider Standards

There are six core Health Home services (identified in Table 3) that must be provided by designated Health Home providers. Health Homes must provide at least one of the first five core services (use of HIT is excluded for first 18 months as a billable service) per month to receive payment. Service “touches” include face-to-face meetings, mailings, telephone calls, consultation meeting with family, and referrals. Providers must provide written documentation that clearly demonstrates how the core service requirements are being met for each patient.

Health Home provider qualification standards were developed to ensure that Health Homes adhere to the federal Health Home model and state Medicaid standards. Representatives from the DOH Offices of Health Insurance Programs, Office of Health Information Technology Transformation (OHITT), the AIDS Institute, the OASAS, and OMH participated in the development of these standards. Designated Health Homes must be enrolled (or be eligible to be enrolled) in the Medicaid program and they must agree to comply with all of the Health Home requirements. Providers can either directly provide or subcontract for Health Home services but remain responsible for all the Health Home program requirements.

Health homes are required to have dedicated care managers to lead care management and coordination, and the care managers must be involved in all aspects of transitional care management. The Health Home provider standards do not require that any other roles be specifically assigned to particular care team members.

As described in the SPA, Health Home providers must meet six general qualifications:

1. They must be enrolled (or be eligible for enrollment) in the New York State Medicaid program and agree to comply with all Medicaid program requirements.

2. They can either provide services directly, or subcontract for their provision, but they remain responsible for all health home program requirements, including services performed by the subcontractor.

3. Care coordination and integration of heath care services will be provided by an inter-disciplinary team of providers, under the direction of a care manager who is accountable for ensuring access to services and community supports as defined in the enrollee care plan.

4. Hospitals that are part of the health home network must have procedures in place for referring eligible individuals who seeks treatment in a hospital emergency department to a designated health home provider.

5. They must demonstrate their ability to perform the 11 core functions as defined in the CMS State Medicaid Director's Letter of November 2010.

6. They must meet standards for delivery of six core health home services (see Table 3), and they must provide written documentation that clearly demonstrates how the requirements are being met.

In order to guide Health Home providers as they implement the new program, DOH has held a series of teleconferences and webinars; several Health Homes were also awarded a contract from the Department of Labor and DOH to provide workforce retraining for current TCM providers as they transition into their new roles as health home providers.[20] This training will include both web-based and face-to-face training and will be based on curriculum developed by the NYCCP. DOH will also convene a Learning Collaborative for Health Home providers, which will allow providers to share best practices around health home design and implementation.

Use of Health Information Technology

DOH developed standards for HIT use by Health Homes that will be phased in over time. Providers must meet the initial standards on becoming a Health home; final, more comprehensive standards must be met within 18 months. Under the initial standards, qualified Health Homes must have a systematic process to follow referrals and services provided, and must have a health record system to ensure that protected health information and an individual's plan of care is accessible to the Health Home team. 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 the RHIOs for the purposes of sharing data, and that they employ clinical decision-making tools where feasible. (See Table 4 for a full list of the initial and final requirements.)

Health Home providers will be encouraged to use wireless technology as available to improve coordination and management of care and patient adherence to provider recommendations. In order to support providers in their efforts to meet final HIT requirements, New York has made additional funding and learning opportunities available to them through the HEAL NY program and upcoming Learning Collaborative.

OHITT is also working to identify additional opportunities for Health Homes to enhance their HIT capacity.[1]

Payment Structure and Rates

Payment is made on a per member per month (PMPM) basis at two levels: Outreach and Engagement, and Active Care Management. Members in the outreach and engagement group are those who have been assigned to the provider but have not yet engaged in active care management. The active care management group consists of actual Health Home participants.

Health Homes are reimbursed directly by the state for FFS members and through the MCPs for managed care members. MCPs may keep up to 3% of payments for administrative services. TCMs, MATs, and CIDPs bill the state directly for a limited period of time. All monthly payments will be made through eMedNY (the New York State Medicaid program claims processing system).

Health Home providers' payment rates vary based on region and case-mix. Rates are calculated and paid at a member-specific level directly by eMedNY. The state intends to adjust the rates by member functional status once such data is available. Outreach and engagement for Medicaid FFS and managed care members will be paid at 80% of the active care management rate. Once a patient is fully engaged in the program and receiving active care management services, the provider receives full active care management group PMPM rate.

Rate Information and Determination

The Health Home care management rates were calculated based on caseload variation, case management cost, and patient-specific acuity. Caseload variation data was developed based on experience in the TCM programs, CIDPs, and other states' demonstrations related to chronic illness management. Case management cost analysis is based on financial data reported to DOH from existing programs. Patient-specific risk factors were developed using CRG software. DOH is currently developing an additional adjustment for functional status,

Converting TCMs and CIDPs will bill eMedNY directly for their existing caseload at their historical rates. These rates will be phased out over two years for TCMs and over one year for CIDPs, at which time only Health Homes and MCPs will be reimbursed through eMedNY for Health Home services.

Quality Improvement Goals and Measures

The state has identified five quality improvement goals:

- reducing utilization associated with avoidable inpatient stays,
- reducing utilization associated with avoidable emergency room (ER) visits,
- improving outcomes for persons with mental illness and/or substance use disorders,
- improving disease-related care for chronic conditions, and
- improving preventative care.

Table 5 lists each goal with its corresponding measures. Most of the measures are based on HEDIS specifications; two are measures proposed in the Affordable Care Act,[21] and two are specific to New York. Data for these measures are to be drawn entirely from administrative and pharmacy claims.

Evaluation Measures and Methods

Care management metrics are divided into process metrics and outcome (quality) metrics. The state's goal is to have a uniform platform and a standard set of process metrics in place by fall 2012. Outcome metrics will be taken from Medicaid records--enrollment, claims, encounter, and pharmacy data--as well as other state databases that record provisions of substance abuse treatment services. The selected outcome metrics are described in full in Table 6.

The state will work with CMS to develop a patient experience survey that draws from both the Consumer Assessment of Healthcare Providers and Systems survey, and behavioral health-specific items from the Mental Health Statistics Improvement Program. It will work with academic partners to supplement these databases with additional data.

The state proposes a variety of approaches to measuring the impact of Health Homes on selected quality and cost outcomes (hospital admission rates, chronic disease management, assessment of quality improvements and clinical outcomes, and estimates of cost savings). It will analyze historical utilization and cost data, employ statistical matching, and explore the possibility of using propensity score methods by region to identify comparison groups of people with similar demographic, geographic, and medical characteristics as Health Home enrollees. It expects that the phased nature of enrollment will allow identification of variations in outcome measures between enrollees and the eligible but not yet enrolled beneficiaries. Finally, it may look at the differences in outcomes across the designated health homes, adjusting for differences in client characteristics. The state will be working with local academic partners in completing these analyses.

TABLE 1. Target Population and Designated Providers--New York	
SPA approval date (Effective date)	2/3/12 (1/1/12)
Designated provider	Any Medicaid-enrolled provider that meets health home standards; includes managed care plans (MCPs), primary care providers (PCPs), home health agencies, and substance abuse treatment facilities.
Health Home team composition	Required: Multidisciplinary team; led by a dedicated case manager. Optional: Nutritionist/dietician, pharmacist, outreach workers (peer specialist, housing representatives, etc.).
Target population	Beneficiaries must have: – Two chronic conditions – HIV/AIDS – A serious mental condition
Qualifying chronic conditions	Mental health condition – Bipolar Disorder – Conduct, Impulse Control, and Other Disruptive Behavior Disorders – Dementing Disease – Depressive and Other Psychoses – Eating Disorder – Major Personality Disorders – Psychiatric Disease (Except Schizophrenia) – Schizophrenia Substance use disorder – Alcohol Liver Disease – Chronic Alcohol Abuse – Cocaine Abuse – Drug Abuse--Cannabis/NOS/NEC – Substance Abuse – Opioid Abuse – Other Significant Drug Abuse Respiratory disease – Asthma – Chronic obstructive pulmonary disease Cardiovascular disease (CVD) – Advanced Coronary Artery Disease – Cerebrovascular Disease – Congestive Heart Failure – Hypertension – Peripheral Vascular Disease Metabolic disease – Chronic renal failure – Diabetes Body Mass Index (BMI) over 25 HIV/AIDS Other chronic conditions diagnosed in the population.

TABLE 2. Health Home Analytical Products--New York	
CRG-Based Attribution	For Cohort Selection
CRG-Based Acuity	For Payment Tiers
"Intelligent" assignment algorithm	For Assignment Priority
Ambulatory Connectivity Measure	For Assignment Priority
Provider Loyalty Model (connectivity to existing providers)	For Matching to Appropriate Health Home and to Guide Outreach activity

TABLE 3. Health Home Service Definitions--New York	
Comprehensive care management	An individualized patient-centered care plan based on a comprehensive health risk assessment. Care management must be comprehensive, meeting physical, mental health, chemical dependency, and social service needs.
Care coordination and health promotion	The care manager ensures the coordination of services, adherence to treatment recommendations, and generally oversees the needs of the Health Home member. The Health Home provider will promote prevention and wellness by providing resources for prevention and any other services members need.
Comprehensive transitional care	Health Home providers must emphasize the prevention of avoidable readmissions and must ensure proper and timely transitions from one setting to another and follow-up care post-discharge.
Patient and family support services	Individualized care plans must be shared and clear for the patient, family members, or other caregivers to understand. Patient and family preferences must be given appropriate consideration.
Referral to community and social support services	Health Home providers are responsible for identifying and actively managing appropriate referrals, and coordinating with other community and social supports.
Use of HIT to link services, as feasible and appropriate	Health Homes are encouraged to use Regional Health Information Organizations (RHIOs) to access patient data and to maximize the use of HIT in the services they provide and in care coordination. Health Home provider applicants have 18 months from program implementation to submit a plan for achieving compliance with the final Health Home HIT requirements.

TABLE 4. Health Information Technology (HIT) Standards--New York
Initial standards
– Health home provider has structured information systems, policies, procedures and practices to create, document, execute, and update a plan of care for every patient. – Health home provider has a systematic process to follow-up on tests, treatments, services, and referrals which is incorporated into the patient's plan of care. – Health home provider has a health record system which allows the patient's health information and plan of care to be accessible to the inter-disciplinary team of providers and which allows for population management and identification of gaps in care including preventive services. – Health home provider makes use of available HIT and accesses data through the RHIO/qualified entity (QE) to conduct these processes, as feasible.
Final standards
– Health home provider has structured interoperable HIT systems, policies, procedures and practices to support the creation, documentation, execution, and ongoing management of a plan of care for every patient. – Health home provider uses an EHR system that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the patient's health information and plan of care to be accessible to the inter-disciplinary team of providers. If the provider does not currently have such a system, they will provide a plan for when and how they will implement it. – Health home provider will be required to comply with the current and future version of the Statewide Policy Guidance (http://health.ny.gov/technology/statewide_policy_guidance.htm) which includes common information policies, standards and technical approaches governing health information exchange (HIE). – Health home provider commits to joining regional health information networks or qualified HIT entities for data exchange and includes a commitment to share information with all providers participating in a care plan. RHIO/QE provides policy and technical services required for HIE through the SHIN-NY.

TABLE 5. Health Home Goals and Measures--New York	
Reduce utilization associated with avoidable (preventable) inpatient stays	Clinical measure: – *Inpatient utilization*: The rate of utilization of acute inpatient care per 1,000 member months. Data will be reported by age for categories: Medicine, Surgery, Maternity and Total Inpatient.
Reduce utilization associated with avoidable (preventable) ER visits	Clinical measure: – *Ambulatory care (Emergency Department Visits)*: The rate of Emergency Department visits per 1,000 member months. Data will reported by age categories.
Improve Outcomes for persons with Mental Illness and/or Substance Use Disorders	Clinical measures: – *Mental health utilization*: The number and percentage of members receiving the following mental health services during the measurement year for: (1) any service; (2) inpatient; (3) intensive outpatient or partial hospitalization; and (4) outpatient or emergency department. – *Follow up after hospitalization for mental illness*: Percentage of discharges for treatment of selected mental illness disorders who had an outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health provider within 7 days and within 30 days of discharge. In addition, "retention" in services, defined as at least 5 qualifying visits with mental health providers within 90 days of discharge. – *Follow up after hospitalization for alcohol and chemical dependency detoxification*: The percentage of discharges for specified alcohol and chemical dependency conditions that are followed up with visits with chemical treatment and other qualified providers within 7 days and within 30 days and who have ongoing visits within 90 days of the discharges. Quality of Care: – *Antidepressant medication management*: Percentage of members who had a new diagnosis of depression and treated with an antidepressant medication who remained on the antidepressant for acute phase and recovery phase of treatment. – *Follow-up care for children prescribed Attention Deficit Hyperactivity Disorder (ADHD) medication*: Percentage of children newly prescribed ADHD medication that had appropriate follow-up in the initial 30 days and in the continuation and maintenance phase. – *Adherence to antipsychotics for individuals with schizophrenia*: Percentage of patients with a schizophrenia diagnosis who received an antipsychotic medication that had a proportion of days covered (PDC) for antipsychotic medication ≥0.8 during the measurement period. – *Adherence to mood stabilizers for individuals with bipolar I disorder*: Percentage of patients with bipolar I disorder who received a mood stabilizer medication that had a PDC for mood stabilizer medication ≥0.8 during the measurement period.
Improve Disease-Related Care for Chronic Conditions	Quality of Care: – *Use of appropriate medications for people with asthma*: Percentage of members who are identified with persistent asthma and who were appropriately prescribed preferred asthma medication. – *Medication management for people with asthma*: The percentage of members who were identified as having persistent asthma and were dispensed appropriate medications in amounts to cover: (1) at least 50% of their treatment period; and (2) at least 75% of their treatment period. – *Comprehensive diabetes care (HbA1c test and LDL-c test)*: Percentage of members with diabetes who had at least 1 HbA1c test and at least 1 LDL-C test. – *Persistence of beta-blocker treatment after heart attack*: Percentage of members who were hospitalized and discharged alive with a diagnosis of AMI and who received persistent beta-blocker treatment for 6 months after discharge. – *Cholesterol testing for patients with cardiovascular conditions*: Percentage of members who were discharged alive for AMI, CABG or PCI or who have a diagnosis of IVD and who had a least one LDL-C screening. – *Comprehensive care for people living with HIV/AIDS*: Percentage of members living with HIV/AIDS who received: (a) 2 outpatient visits with primary care with 1 visit in the first 6 months and 1 visit in the second 6 months; (b) viral load monitoring; and (c) Syphilis screening for all who 18 and older.

TABLE 5 (*continued*)	
Improve preventive care	Quality of Care: – *Chlamydia screening in women*: Percentage of women who were identified as sexually active and who had at least 1 test for Chlamydia. – *Colorectal cancer screening*: Percentage of members 50+ who had appropriate screening for colorectal cancer.

TABLE 6. Evaluation Metrics--New York	
Hospital admission rates	New York State has been monitoring avoidable hospital readmissions for Medicaid populations since 2009 using 3M software called PPRs. This software has an algorithm for determining whether a readmission is plausibly connected to an initial admission. New York State will calculate PPRs within 30 days of an initial inpatient discharge. New York State will calculate the rate across all conditions and also within condition (i.e., mental health condition, substance use disorder, asthma, diabetes, heart disease, HIV/AIDS, and hypertension). As indicated, New York State will calculate historical avoidable readmission rates for statistically matched comparison group. New York State will also compare avoidable readmission rates across Health Home providers.
Chronic disease management	Data on chronic disease management will be collected in two ways. First, New York State will examine how the Health Homes implement disease management across key chronic illness management functional components of state Health Home qualification criteria. With the aid of state and academic partners, New York State will work with stakeholders to assess the key functional components to include: (1) inclusion of preventive and health promotion services; (2) coordination of care between primary care, specialty providers and community supports; (3) emphasis on collaborative patient decision-making and teaching of disease self-management; (4) structuring of care to ensure ongoing monitoring and follow-up care; (5) facilitation of evidence-based practice; and (6) use of clinical information systems to facilitate tracking of care as well as integration between providers. New York State will modify standardized assessment tools, as well as use qualitative interviews with Health Home administrative staff and providers to determine the implementation of these functional components. Additionally, the patient Experience of Care measure will provide information on self-management support from the health home. Second, New York State will conduct cohort analyses as part of the evaluation focusing on groups at-risk to incur high costs.
Coordination of care	New York State will use claims, encounter, and pharmacy data to collect information on coordination of care. As indicated in the quality measures section of this SPA, New York State will use claims, encounter, and pharmacy data to collect information on post-inpatient discharge continuation of care (e.g., persistent beta-blocker treatment after hospitalization for AMI) or transition to another level of care (e.g., outpatient care following hospitalization for a behavioral health condition). This coordination of care measures will be compared to historical controls, to statistically matched comparison groups, and across Health Home providers. In addition New York State is considering the feasibility of more closely examining provider behavior through medical chart reviews, case record audits, team composition analysis, and key informant interviews. As part of this process, New York State will carefully monitor the use of HIT as a primary modality to support coordination of care.
Assessment of program implementation	As indicated above, Learning Collaboratives will be constituted with a group of providers of Health Homes to identify implementation challenges, as well as potential solutions. Other data related to implementation including responses to the Health Home experiences of care survey and, if feasible, provider audits and surveys, and stakeholder interviews will be collected. All implementation data will be shared with the Health Home Advisory Group (comprised of state, provider, community, and academic members) and a compilation of lessons learned.

TABLE 6 (*continued*)	
Processes and lessons learned	Learning Collaboratives will be constituted with a group of early adopter providers of Health Homes to identify implementation challenges as well as potential solutions. New York State will use the Health Home Advisory Group to monitor, comment, and make recommendations on implementation strategies that are working as well as those that are not. The group will use the Health Home functional components as well as the provider qualification criteria as guides in assessing program processes and outcome success. The Advisory Group will use information gathered through assessments of program implementation as well as from ongoing quality monitoring using administrative data to review program successes and failures.
Assessment of quality improvements and clinical outcomes	New York State has identified an extensive list of quality and outcome measures that will be derived from administrative claims and encounter data. The quality measures are indicators of chronic illness management while the clinical outcome measures are indicators of poor disease management leading to high-cost treatment episodes. Ongoing assessments of these quality measures will be conducted at the levels of Health Home providers, region, and statewide. The endpoint evaluation will be designed as a quasi-experimental longitudinal study where endpoint outcomes will be patient-level indicators of poorly managed care of chronic conditions; indicators of stable engagement in guideline concordant care; and high-cost utilization of services. There are a number of clear indicators of poorly managed care across disorders: emergency department visits, hospital readmissions, poor transition from inpatient to outpatient care, etc. In addition, New York State will attempt to define, where possible, more refined measures that are disease-specific (e.g., repeated detox in substance abuse).
Estimates of cost savings	New York State will work with state and academic partners to devise a sophisticated econometric analysis of the overall Health Home initiative as well as of each vendor. First, New York State will monitor costs savings through by tracking high-cost forms of utilization (e.g., preventable hospitalizations, emergency department use, and detoxification). Utilization of high-cost events will be compared with historical rates, as well as with statistically matched comparison groups as indicated above. Additionally, New York State will compare total costs of care for Health Home enrollees--including all services costs, health home costs and managed capitation--to statistically matched comparisons. The econometric analyses will begin with descriptive statistics and increase in complexity to the minimal level necessary to address the question of cost savings. Analyses will focus on PMPM expenditures of enrollees compared to controls as described in this section’s preamble. For regression analyses that examine changes in cost relative to controls, New York State employs longitudinal nested designs that account for serial correlation within person and within provider and region. Regression analyses will account for prior year costs by type of utilization (e.g., emergency department, inpatient, mental health), clinical complexity (e.g., PPR risk score), regional utilization characteristics, and demographic factors. Parameter estimates for Health Home participants will indicate differences in PMPM relative to controls while controlling for historical utilization patterns, regional practice variation, and individual demographic characteristics.

APPENDIX: Pre-existing Initiatives in New York				
	New York Care Coordination Program	**Chronic Illness Demonstration Project[1,2]**	**Adirondack Medical Home Demonstration[3,4]**	**Statewide PCMH Program[5,6]**
Timeline	– Founded by 6 counties in west and central New York in 2000. – Formed partnership with Beacon Health Strategies (MCO) in 2009. – Awarded contract as Behavioral Health Organization for Western Region in 2011.	– Program authorized in 2007 legislation. – Demonstration project began January 2009. – Contract ended March 29, 2012, and program participants were converted into Health Home members.	– New York legislature authorized the Adirondack Medical Home Demonstration in 2009. – Demonstration begins January 2010. – Participating practices apply for NCQA-certification in February 2011. – Began participating in the Advanced Primary Care Practice demonstration in 2011. – Demonstration will end in 2015.	– New York legislature established a statewide PCMH program for Medicaid, CHIP, and Family Health Plus enrollees in 2009. – Program was expanded to include other payers in 2011. – State submitted a SPA to CMS to test new payment models for medical home practices in 2011.
Geographic area	7 state counties concentrated in west and central New York.	5 state counties and 4 boroughs of New York City.	5-county region in northeast New York.	Statewide
Sponsors	State OMH, county government	New York DOH, Center for Health Care Strategies (CHCS), New York Health Foundation	New York DOH and 7 private payers	New York DOH
Scope	Targeted at all levels of the mental health system.	6 provider organizations covering the areas listed above.	Nearly all PCPs in the region; 5 hospitals, 123 physicians in group and solo practice.	Eligible providers include primary care physicians, nurse practitioners, FQHCs, diagnostic and treatment centers.
Goals	– Build culture of person-centered care and individual empowerment. – Coordination of services delivered by multiple providers. – A rehabilitation and recovery model of services. – Implementation of evidence-based best practices, with outcome-based performance measurement. – Improved information systems.	– Establish inter-disciplinary models of care designed to improve health care quality. – Ensure appropriate use of services. – Improve clinical outcomes. – Reduce the cost of care for Medicaid beneficiaries with medically complex conditions.	– Strengthen regional ability to attract and retain primary care physicians. – Improve quality, access, and outcomes. – Contain costs. – Create a new clinically integrated model that can be replicated in other parts of the state.	– Incentivize the development of PCMHs through enhanced payment to providers who obtain NCQA recognition. – Improve health outcomes through better coordination and integration of patient care.

APPENDIX (*continued*)				
Payment approach	1 initiative involved P4P in 2 counties; providers rewarded for achieving undefined performance targets.	PMPM care management fee, with a risk corridor and shared savings available in 2nd and 3rd year to entities that met performance targets.	FFS, plus a $7 PMPM care management fee.	Enhanced payment for certain evaluation, management, and preventive services, plus a PMPM incentive payment from MCPs for participating enrollees. Rates for both enhanced FFS and the PMPM are tiered by NCQA recognition. Fees range from $5.50-$21.25, and PMPM rates range from $2-$6. Enhanced payment for Level 1 certification will end in December 2012.
Technical assistance	Beacon has provided technical assistance to providers on care management, and various pilot projects have involved training for providers on care integration and person-centered care.	Participating providers took part in learning collaboratives led by DOH and CHCS.	Technical assistance was provided to participating providers in implementing HIT, practice transformation, as well as in establishing the cost basis and rates to be paid to participating practices.	A quality improvement contractor is providing some support to practices in meeting NCQA requirements.
HIT Use	No information found.	Contractors were expected to use or develop HIT capacity to support care management functions.	Practices had to adopt electronic medical records and information exchange capacity, including connection to the RHIO, specialists and hospitals, and 2 data warehouses. 2 grants supported this; 1 from HEAL-10 and 1 from the state medical society.	No information found.
Evaluation methods	Many of the projects have been formally evaluated, with the results published on the program website: http://www.carecoordination.org/results.shtm.	The program is being evaluated by MDRC, and final reports are expected in 2013.[7]	Evaluation will be conducted by the demonstration's governance council.	The state health commissioner is required to report on the program's impact on quality, cost, and other outcomes by December 2012.

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5. New York Department of Health. "Announcing New York Medicaid's Statewide Patient-Centered Medical Home Incentive Program." Medicaid Update, December 2009; 25(16). Available at: http://www.health.ny.gov/health_care/medicaid/program/update/2009/2009-12spec.htm.
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7. MDRC website. Available at: http://www.mdrc.org/project_20_92.html.

Endnotes

1. Unless otherwise noted, information contained in the first two pages of this memo are drawn from one of two sources:

   New York State Medicaid Update. "Introducing Health Homes: Improving Care for Medicaid Recipients with Chronic Conditions". April 2012; 28(4). Available at: http://www.health.ny.gov/health_care/medicaid/program/update/2012/2012-04_pharmsped_edition.htm.

   National Academy for State Health Policy webinar. "Implementing Section 2703 Health Homes: Lessons from Leading States". June 2012. Available at: http://www.nashp.org/webinar/implementing-section-2703-health-homes-lessons-leading-states.

2. New York Care Coordination Program website. Available at: http://www.carecoordination.org/about_the_wnyccp.shtm.

3. National Academy for State Health Policy webinar. "Implementing Section 2703 Health Homes: Lessons from Leading States". June 2012. Available at: http://www.nashp.org/webinar/implementing-section-2703-health-homes-lessons-leading-states.

4. New York Department of Health website. Medicaid Health Home Question and Answer page. Available at: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/questions_and_answers.htm#cidp.

5. Adirondack Region Medical Home Pilot website. Available at: http://www.adkmedicalhome.org/.

6. Private insurers include Blue Shield of Northeastern New York, Capital District Physicians' Health Plan, Empire Blue Cross, Excellus, Fidelis Care, MVP Healthcare, and United Healthcare.

7. National Academy for State Health Policy website. Available at: http://www.nashp.org/med-home-states/new-york.

8. New York State Proposal to Redesign Medicaid. Available at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/descriptions_of_recommendations.pdf.

9. New York State Department of Health website. “New York State Awarded More Than 300 Million from Federal Government to Expand Medicaid Demonstration Programs.” 2011 Press Release. Available at: http://www.health.ny.gov/press/releases/2011/2011-08-05_medicaid_demonstration_programs.htm.

10. Patient-Centered Primary Care Collaborative (PCPCC). “CDPHP Patient-Centered Medical Home Pilot.” Available at: http://www.pcpcc.net/content/cdphp-patient-centered-medical-home-pilot.

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MEDICAID HEALTH HOMES IN OREGON: REVIEW OF PRE-EXISTING STATE INITIATIVES AND STATE PLAN AMENDMENTS FOR THE STATE'S FIRST SECTION 2703 MEDICAID HEALTH HOMES

Brenda C. Spillman, Barbara A. Ormond, Elizabeth Richardson and Aaron Chalek
The Urban Institute

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Oregon's Medicaid State Plan Amendment (SPA) instituting a Section 2703 Health Home benefit was approved by the Centers for Medicare and Medicaid Services (CMS) on March 13, 2012, with a retroactive effective date of October 1, 2011.[1] Oregon's Health Home program builds on the state's Patient-Centered Primary Care Home (PCPCH) program, established in 2009.[2] To be eligible for Health Home services, enrollees must have a serious mental health condition, two or more chronic conditions, or one chronic condition and be at risk of developing another. The state specified 11 chronic illnesses and nine serious mental health conditions in the list of Health Home qualifying conditions. It based its definition of "at-risk" on guidelines from the United States Preventive Services Task Force, the Health Resources and Services Administration Women's Preventive Services, and Bright Futures. (See Table 1 for a full list of qualifying conditions.)

The Health Homes program represents just one component of a larger state effort to transform how medical care is delivered in Oregon. Health Home services, which are aligned with the state's PCPCH Standards, are to be delivered through qualified PCPCHs and are available to a PCPCHs entire patient population. However, the state will provide a supplemental per member per month (PMPM) payment only for those clients identified by the provider as meeting the Health Home eligibility criteria. The state is also working toward providing supplemental payments to PCPCHs for other populations including all Medicaid enrollees, government employees, and state education personnel. The state's goal is to make PCPCH services available to 75% of all Oregonians by 2015.[3] Any recognized PCPCH can apply to become a Health Home through submission of an addendum to its PCPCH agreement with the state, as described below.

PCPCHs (inclusive of their Health Home services) are also a central component of Oregon's health system transformation efforts, particularly through their role in Coordinated Care Organizations (CCOs, described in more detail below). The CCO program was proposed by the Legislature June 2011, and the first CCOs began operations in August 2012. A CCO is a community-based network of health care providers who have agreed to collaborate in the provision of services for people with

Medicaid and/or Medicare coverage. CCOs receive a fixed global payment for mental and physical health care services and, in return, are accountable for the health outcomes of the population they serve.[4] These CCO payments are separate from the Health Home payments, which go to the PCPCHs. The state also plans to integrate oral health care services in the future. The state's hope is that these integrated health care organizations will provide more efficient delivery of and better access to care, strengthen primary care networks while integrating services, and better align incentives to generate substantial savings. CCOs are required to include recognized PCPCHs in their networks of care to the extent possible and to support their member practices in achieving PCPCH recognition.[4] The emphasis on coordinated care, integration of physical and mental health care services, and community linkages is consistent with Health Home goals but, under the state's PCPCH program, they are applied to a broader population.

Oregon's Health Home benefit is managed through the Oregon Health Authority (OHA), which was established in 2009 and is charged with purchasing health insurance for approximately 850,000 Medicaid enrollees, government employees, and state education personnel (representing about one in four people in Oregon).[4] Oregon has approximately 645,000 people enrolled in its Medicaid program [known as the Oregon Health Plan (OHP)], which it has operated under a Medicaid Section 1115 waiver (described below) since 1993.[4,5] The state managed care program covers approximately 80% of OHP beneficiaries. Prior to August 2012 and the formation of CCOs, acute and ambulatory physical health care services were provided by managed care organizations (MCOs), while mental health, chemical dependency, and dental services were carved out and paid for on a capitated basis.[4] Oregon does not have large, national health plans participating in its Medicaid program; most of the MCOs and CCOs are local, community-based nonprofits that serve only publicly insured enrollees; many are physician-owned and run. In some sparsely populated areas, the state contracts directly with providers for primary care case management.

Implementation Context

Oregon has several initiatives underway that have goals that are similar to those of the Health Home benefit or involve the same type of provider. Some of the initiatives have been developed by the state, while others are part of national demonstration projects. These initiatives are seen as complementary and as part of a broad evolution towards a more integrated system of care in the state.

In 2009, the state legislature passed two Bills (HB 2009 and HB 2116) that included provisions to provide health insurance coverage for all children and bring more low-income adults into Medicaid. The HB 2009 legislation also created the OHA and the Oregon Health Policy Board and established the PCPCH Program within the Office for Oregon Health Policy and Research.[6]

As the state began to implement the PCPCH program, many stakeholders felt that the 2008 National Committee for Quality Assurance (NCQA) medical home standards for care coordination did not include a strong enough emphasis on health outcomes and accountability, and so encouraged the state to develop its own. In response, the state convened the Patient-Centered Primary Care Home Standards Advisory Committee and charged it with developing the framework of core attributes, standards, and measures that would be used to define a PCPCH.[7] These standards were released in 2010. (See Appendix B for a list of PCPCH attributes and standards.)

During the 2011 legislative session, the state authorized the creation of the Oregon Integrated and Coordinated Health Care Delivery System, which aimed to move the Medicaid managed care system towards an integrated care management model, and passed legislation to establish CCOs.[4] As noted above, CCOs are community-based networks that are to contract with the state to provide integrated, comprehensive health care, mental health care, and eventually dental care for a defined patient population. CCOs focus on patients with chronic conditions as well as on people with addiction problems and mental illnesses who have traditionally received care through the OHA's Addictions and Mental Health Division.[8] CCOs have flexibility within their budgets to provide services alongside traditional OHP medical benefits with the goal of meeting the "Triple Aim" of better health, better care, and lower costs for the population they serve, but they are required to include PCPCHs within their networks to the extent possible.[6] By making CCOs responsible for the full array of services and paying a fixed global payment, the state hopes these coordinated networks will improve quality outcomes and be more cost-efficient. The state plans a staggered rollout of CCOs; the first wave of eight CCOs launched August 1, 2012, with more expected to start later this year. The state expects CCOs to serve nearly 500,000 Oregonians by September 1, 2012, including virtually all Medicaid enrollees.[2]

Oregon was also one of 15 states that received a grant from CMS to develop a pilot program to better "coordinate care across primary, acute, behavioral health and long-term supports and services for dual eligible individuals."[2] Under the state demonstrations to Integrate Care for Dual Eligible Individuals program, CMS has provided funding and technical assistance to the selected states to develop enhanced patient-centered methods to coordinate the entire continuum of care for dual eligible individuals and to identify delivery system and payment models that can be replicated in other states.[a]

As part of the state's efforts to align payment methods to support its primary care home model, Oregon is participating in the CMS Comprehensive Primary Care Initiative, which will begin in fall 2012. In this multi-payer initiative, Medicare will collaborate with public and private insurers in the selected regions with the goal of strengthening primary care. Participating practices will receive a PMPM care management fee and be given technical assistance to help them better coordinate and manage care. After two years,

[a] The state eventually decided not to move forward with the financial alignment of the duals demonstration.

providers will also have the opportunity to participate in a shared savings model.[9] In Oregon, six health insurance plans and 70 practices were selected to participate.[10]

Oregon is also participating in the Tri-State Child Health Improvement Consortium (T-CHIC), a Child Health Insurance Program Reconciliation Act (CHIPRA) Quality Demonstration Project funded by CMS. T-CHIC is an alliance among the Medicaid/CHIP programs of Alaska, Oregon, and West Virginia, led by Oregon, with the goal of improving children's health care quality. In February 2010, the consortium was awarded approximately $11.5 million over a five-year period ($2.2 million was awarded in the first year). The overarching goal of the CHIPRA quality demonstration is to establish and evaluate a national quality system for children's health care.[11] In Oregon, this demonstration is linked to two additional pediatric medical home practice improvement projects through the Oregon Pediatric Improvement Partnership, which aims to improve children's care through a range of collaborative and educational activities.[12]

Many practices in Oregon have been or are in the process of being recognized as a Patient-Centered Medical Homes (PCMHs) by the NCQA.[6] While the two models share many common concepts, there are a few areas that are not fully aligned. PCMH practices attempting to gain recognition as PCPCHs must contractually attest to being NCQA-certified but must also submit additional information, centered on the contractual attestation of screening strategies for mental health and substance abuse conditions, hospice and palliative care, and quality measurement and patient tracking.[6]

Implications for Oregon Section 2703 Medicaid Health Home Evaluation

These various initiatives have several implications for both implementation and evaluation of the health homes program. The state has envisioned health homes as an integral part of its effort to transform the primary care delivery system across the state for all payors. Other initiatives are key to this overall transformation as well, particularly the development of CCOs and the contractually required encouragement of PCPCHs by the CCOs. The providers of health home services are not designated as "health homes" but rather health home enrollees are identified within the PCPCHs by their receipt of health home services once they meet the qualifying criteria. The state intends for the changes that providers make to care delivery for health home beneficiaries to permeate the PCPCH practice for all patients, but the enhanced payments for health home services currently apply only to identified eligibles. The state's plan is to institute a care coordination payment for other beneficiaries in the future but at a much lower level.

In many practices that have become PCPCHs and are thus eligible to serve health home beneficiaries, practice transformation began before the implementation of the health homes initiative, and providers are charged with identifying health home services recipients. Thus, it will be difficult--and may be impossible--to disentangle a Health Home effect from the effect of ongoing transformation.

Population Criteria and Provider Infrastructure

Oregon is offering Health Home services to categorically needy beneficiaries[b] who have two or more chronic conditions, one chronic condition and are at risk of contracting another, and those with a serious mental illness.[1] (Oregon uses the term "ACA-qualified" for beneficiaries meeting the condition criteria for Health Home eligibility.) Both fee-for-service (FFS) and managed care enrollees are eligible for these services. Table 1 below provides a full list of the population criteria, the designated providers, and the Health Home team composition requirements.

Health Homes are based on the state's PCPCH model, described in further detail below; thus, PCPCH standards are Health Home standards and the two designations will be used interchangeably with respect to providers. Payment for Health Home services, however, is limited to the health home eligible population and this distinction will be maintained. Any designated PCPCH is eligible for a Health Home payment if specific service and documentation requirements are met for each patient.[7] These requirements include: (1) providing at least one Core Service each quarter (described in Table 2); (2) performing panel management at least once per quarter, using data for all clients or for sub-groups of clients for such functions as care management or quality assurance; (3) performing patient engagement and education and obtaining patient agreement; and (4) developing a person-centered health plan.

PCPCH/Health Homes include, but are not limited to, physical and behavioral health care providers, solo practitioners, family and group practices, community mental health centers, drug and alcohol treatment facilities, rural health clinics, federally qualified health centers, and school-based health centers.[1] A PCPCH/Health Home is not required to provide all of the health home services on-site, but it is responsible for coordinating and/or offering those services through partnerships within their community.

All PCPCH-recognized providers wishing to participate in Medicaid and provide health home services must submit an addendum to their Medicaid provider enrollment agreement to the OHA's Division of Medical Assistance Programs (DMAP).[6] This is true for providers serving both FFS and MCO/CCO-enrolled members. PCPCH providers serving MCO/CCO-enrolled members will also have a contract with the MCO/CCO, and the payment arrangement will be negotiated between the MCO/CCO and the provider.[13]

Member Identification and Assignment

Health home eligible beneficiaries will be identified through a referral process managed by DMAP. The process begins with providers, who draw up a list of the patients they believe are eligible from among their FFS and MCO/CCO clients. They then submit the list of FFS patients directly to DMAP and the list of MCO/CCO-enrolled

[b]Oregon does not have a medically needy program.

patients to the appropriate MCO/CCO, which will in turn submit the list to DMAP.[6] DMAP then screens these patients for eligibility and sends a report to each recognized provider or health care entity identifying which of their patients were successfully assigned to their Health Home. This list must be updated and submitted quarterly. DMAP is working with CMS to determine how best to coordinate sending a letter to the qualified Health Home patients notifying them that their provider is now their primary care Health Home. Enrollees will be informed that they may opt out of Health Home coverage or may select a different provider.

Service Definitions and Provider Standards

There are six Core Health Home Services, at least one of which must be provided once per quarter for each patient on a provider's list. (See Table 2 for the service definitions found in the SPA.) These services do not require an office visit and can be performed by any member of the health care team. Health Home services do not require or replace treatment or medical services, and they cannot include services for which a provider is already billing. The provider attests to providing one of these six core services through submitting the quarterly list of health home eligible enrollees, and must document the services provided in each patient's medical record.[6]

Core Attributes and corresponding Standards for Patient-Centered Primary Care Homes

Oregon is basing their provider qualifications on the six attributes of the state's pre-existing PCPCH model, which are cross-walked in the SPA with the core Health Home functions outlined by CMS in the State Medicaid Director's letter of November 2010.[14] These six core PCPCH attributes (Access to Care, Accountability, Comprehensive Whole-Person Care, Continuity, Coordination and Integration, Person- and Family-Centered Care) each have corresponding standards and measures, divided into "Must-Pass Measures" and "Tiers 1-3". These are described in greater detail below.

PCPCH Measures and Tiers

To practice and be recognized as a PCPCH, a provider must demonstrate the ability to meet the guideline PCPCH measures that correspond to each standard. PCPCH measures are divided into ten "Must-Pass" measures and a range of other measures that place the PCPCH practice in one of three Tiers.[6] Must-Pass and Tier 1 measures focus on the basic foundational structures and processes of a PCPCH. Foundational elements should be achievable by most practices, and are not considered to require significant financial expenses. Tier 2 measures reflect intermediate PCPCH functions, demonstrating performance, structural, and process improvements. Tier 3 reflects advanced PCPCH functions, in which the provider demonstrates mature performance improvement capacity, and is accountable for quality. [See Appendix B for a full list of attributes, standards, and measures.]

Except for the ten Must-Pass measures, each measure is assigned a point value corresponding to a tier. Tier 1 measures are worth 5 points, Tier 2 measures are worth 10 points, and Tier 3 measures are worth 15 points. For a practice to be recognized as a PCPCH, it must meet all of the ten Must-Pass measures. Practices must score 30-60 points to qualify as Tier 1, 65-125 for Tier 2, and 130 or more for Tier 3.[6]

Practices demonstrate their current level of practice by contractually attesting to meeting certain of the standards and by submitting data on others. Contractual attestation is contained in the agreement negotiated between a practice and any payer the practice contracts with and is also submitted to the state through a web-based process described in further detail below. (Contractual attestation measures are marked with a "C" in Appendix B.) No other documentation on these measures is required at the time of application, but practices are subject to random audit by the OHA, and all contractual attestation measures must be reported annually for a practice to maintain its PCPCH status.

Six of the PCPCH measures require quantitative data submission (marked with a "D" in Appendix B).[6] These measures will be used by the state to track PCPCH progress and will also be reported to the PCPCHs to help them identify trends in care and identify areas for quality improvement. Recognized PCPCH providers must also submit patient experience of care survey data. Tier 2 and 3 providers are required to use the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools for this purpose.[6]

The OHA has developed a web-based provider portal system where practices can submit all required data to the state. (See health information technology (HIT) section below for more details.) Based on the point system, the OHA will score PCPCHs by combining the contractual attestation information with the quantitative data received. Practices and various plans, insurance carriers, and/or other entities will then be notified of their score.

Use of Health Information Technology

Health Home providers will be encouraged to develop or use their current HIT capacity to perform a range of functions, including:

- gather and report data and group it by subset;
- create and maintain electronic health records (EHRs);
- share clinical information with clients and other providers;
- link to, manage, and track health promotion activities and referrals to community-based or social services; and
- communicate with other providers, family members, and local supports.

Oregon links certain of its provider measures to HIT capacity. For example, although implementation of an electronic medical record (EMR) is not required, those

who have an EMR are able to earn additional points towards their qualification as a Tier 3 PCPCH. The state has indicated that they will encourage providers to implement an EMR that contains at a minimum a problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile chart, and immunization record. Another of the measures for Tier 3 qualification is the ability of a PCPCH to share clinical information electronically in real-time with other providers and care entities.

As noted above, OHA also maintains a provider portal and patient panel management system. This system is run by a contractor, Quality Corporation. Use of this system is required as part of the provider's demonstration of "comprehensive care management", but it also allows the provider to review data on services they have provided to their patient panel, and identify any gaps.

Payment Structure and Rates

Payment for Health Home services is made on a PMPM basis that varies by the provider's qualification level: Tier 1 - $10 PMPM; Tier 2 - $15 PMPM; and Tier 3 - $24 PMPM.[1] For FFS patients, DMAP makes payments directly to PCPCH/Health Home providers; for MCO/CCO-enrolled members, DMAP makes payments to the MCO/CCO, which then make payments to the Health Home. Any portion of the payment that is retained by the MCO/CCO must be used to carry out Health Home-related functions and is subject to approval and oversight by the OHA.[15] Providers are eligible for the PMPM payment if the service and documentation requirements are met for each patient. Submission of the quarterly patient list serves as attestation of meeting the quarterly health home service requirements.

The Health Home must engage in panel management activities at least once quarterly. One team member from each Health Home provider practice must log on to the OHA's provider portal, which can be used as a panel management tool and for tracking quality measures. A Health Home has six months to engage and obtain consent from each eligible patient assigned to their care.[15] Education about PCPCH/Health Home services and benefits can be done in-person, by phone, or by mailing a letter or brochure. (OHA will provide patient brochures to all PCPCH/Health Home providers.) Engagement and member agreement to participate must be active but does not require a patient visit; if a patient declines to participate or the Health Home is unable to get agreement after six months of attempts, the provider should notify DMAP and omit that patient from future patient list submissions.[15]

Quality Improvement Goals and Measures

The state has identified five quality improvement goals, each with defined clinical outcome and quality of care measures:

- reducing the rate of potentially avoidable hospital readmissions;
- decreasing potentially avoidable hospitalizations and increase the ratio of ambulatory care to emergency room (ER) visits;
- improving transitions of care between PCPs and inpatient facilities;
- improving care transitions for people with mental health conditions; and
- improving documentations, tracking, and reporting of health risks and use of preventive services.

The state has also identified two service-based measures, both tied to comprehensive care management. Table 3 below lists each goal with its corresponding measures. Data for these measures will be drawn mostly from administrative data, CAHPS survey data, claims data, and EMRs.

Evaluation Measures and Methods

The state will rely primarily on administrative data, Medicaid management information system (MMIS), provider-reported measures, and patient survey results in their evaluation of the Health Home program. A Learning Collaborative composed of providers and patients will also provide information on program implementation, processes, and lessons learned. For most Health Home measures, beneficiaries who have been enrolled for at least one year will be compared with beneficiaries not enrolled in a Health Home. It is not clear how comparison groups will be identified. Table 4 below excerpts the information provided in the SPA.

TABLE 1. Target Population and Designated Providers--Oregon	
SPA approval date (Effective date)	3/13/12 (10/1/11)
Designated provider	Any Medicaid-enrolled provider that meets the state's PCPCH health home standards; includes FFS providers, managed care plans, primary care providers (PCPs), home health agencies, certified nurse practitioners, clinical group practices, rural community health centers, community mental health facilities, and substance abuse treatment facilities
Health Home team composition	Required: The team is inter-disciplinary and inter-professional Optional: Team of health care professionals includes nonphysician health care professionals, such as a nurse care coordinator, nutritionist, social worker, behavior health professional, or other traditional or nontraditional health care workers. These professionals can operate as free-standing, virtual, or based at any of the clinics/facilities expressed above.
Target population	Beneficiaries must have: – 2 chronic conditions – 1 chronic condition and the risk of developing another – A serious mental condition
Qualifying chronic conditions	Chronic Health conditions – Asthma – Body Mass Index (BMI) over 25 (for adults 20 years or older) – BMI 85 percentile or higher (for patients under age 20) – Cancer – Chronic kidney disease – Chronic respiratory disease – Diabetes – Heart disease – Hepatitis C – HIV/AIDS – Substance Abuse Disorder Serious Mental Health conditions – Alzheimer's – Anorexia Nervosa – Attention Deficit Disorder – Autism – Bipolar Disorder – Dementia – Depression – Post-Traumatic Stress Disorder – Schizophrenia

TABLE 2. Health Home Service Definitions--Oregon	
Comprehensive care management	Providers will be able to identify patients with high-risk environmental or medical factors, including patients with special health care needs, who will benefit from additional care planning. Care management activities include but are not limited to defining and following self-management goals, developing goals for preventive and chronic illness care, developing action plans for exacerbations of chronic illnesses, and end-of-life care planning when appropriate.
Care coordination	Patients will choose and be assigned to a care team, which will develop a care plan based on the needs and desires of the patient with at least the following elements: options for accessing care, information on care planning and care coordination, names of other primary care team members when applicable and information on ways the patient participates in this care coordination. Care coordination functions can include but are not limited to: tracking of ordered tests and result notification, tracking referrals ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and clinicians, and direct collaboration or co-management of patients with specialty mental health, substance abuse, and providers of services and supports to people with developmental disabilities and people receiving long-term care services and supports. Co-location of behavioral health and primary care is strongly encouraged.
Health Promotion	The provider will develop a treatment relationship with the individual, other primary care team members and community providers. The health home provider will promote wellness and prevention by linking the enrollee with resources for smoking cessation, diabetes, asthma, self-help resources and other services based on individual needs and preferences. Health promotion activities will be utilized to promote patient/family education and self-management of the chronic conditions.
Comprehensive transitional care	The provider will have either a written agreement and/or procedures in place with its usual hospital providers, local practitioners, health facilities and community-based services to ensure notification and coordinated, safe transitions, as well as improving the percentage of patients seen or contacted within 1 week of facility discharges.
Individual and family support services	The provider will have processes for patient and family education, health promotion and prevention, self-management supports, and obtaining available nonhealth care community resources, services and supports. The care plan will reflect the client and family/caregiver preferences for education, recovery and self-management. Peer supports, support groups and self-care programs will be utilized to increase the client and caregivers knowledge about the client's individual disease.
Referral to community support services	The provider will demonstrate processes and capacity for referral to community and social support services, such as patient and family education, health promotion and prevention, and self-management support efforts, including available community resources. Care coordination functions will include the use of the care plan to manage such referrals and monitor follow-up as necessary.

TABLE 3. Health Home Goals and Measures--Oregon	
Goal-based measures	
Reduce the rate of potentially avoidable hospital readmissions	Clinical measure: – *Pneumonia (PN)*: Hospital 30-day, all-cause, risk-standardized readmission rate following pneumonia hospitalization.
Decrease potentially avoidable hospitalizations and increase the ratio of ambulatory care to ER visits	Experience of Care measure: – Percentage of adult health plan members who reported how often their doctor and other health provider talked about specific strategies for self-managed illness prevention. Quality of Care measure: – Number of outpatient visits, emergency department visits, ambulatory surgeries/procedures, and observation room stays.
Improve transitions of care between PCPs and inpatient facilities	Experience of Care measure: – Percentage of adult health plan members who reported how often their personal doctor seemed informed and up-to-date about care they got from other doctors or other health provider. Quality of Care measure: – Percentage of patients, regardless of age, discharged from an emergency department setting to ambulatory care or home health care, or their caregiver(s), who received a transition record at the of emergency department discharge.
Improve transitions for people with mental health conditions	Quality of Care measure: – Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge.
Improve documentations, tracking, and reporting of health risks and use of preventative services	Quality of Care measure: – Percentage of members 18-74 years of age who had an outpatient visit and who had their BMI documented during the measurement year or the year prior.
Service-based measures	
Comprehensive care management	Clinical measure: – Percentage of patients, regardless of age, discharged from an emergency department setting to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of emergency department discharge. Quality of Care measure: – Percentage of members who had an outpatient visit and who had their BMI documented during the measurement year or the year prior.

TABLE 4. Evaluation Metrics--Oregon	
Hospital admissions	Using MMIS, Risk-adjusted Prevention Quality Indicators will be compared to nonPCPCH/Health Home members. Assessments will be stratified by risk, tier, and length of enrollment. Propensity scores and difference scores will be used to assess the rates, lengths of stay, and billed charges. Hospital admission evaluation will also be adjusted by the type of hospital (critical access, geographic location, etc.). Data collection will be taken up at baseline, year 2, and 3.
ER visits	Using annual MMIS data, the state will compare ER use that did not result in an admission for noninjury and illness diagnosis for clients who have been enrolled in a Health Home for at least 1 year versus clients not in a Health Home.
Skilled Nursing Facility (SNF) admissions	Using annual MMIS data, the state proposes to compare skilled nursing admissions for clients in a PCPCH/Health Home for at least 1 year versus clients not in a PCPCH/Health Home.
Chronic disease management	Through administrative data, MMIS and submitted quality measures required for PCPCH recognition, a series of national chronic disease-specific measures will be monitored and compared between patients in versus not in a PCPCH/Health Home.
Coordination of care for individuals with chronic conditions	Centered on patient experience of care, administered through CAHPS surveys by the state annually.
Assessment of program implementation	Oregon will use Learning Collaborative models throughout the implementation of PCPCH/Health Homes. A select group of practices and a select group of patients identified as being the highest risk will meet to discuss challenges and opportunities.
Processes and lessons learned	Cites the Learning Collaborative models process--these collaborative meetings will be public and results become a public record so that dissemination of results is easy to access and is transparent.
Assessment of quality improvements and clinical outcomes	Data sources will include administrative data, MMIS, additional quality measures submitted by PCPCH/Health Home providers and contracted MCOs/CCOs.
Estimates of cost savings	The state will use administrative data, MMIS, and will compare members enrolled versus not enrolled in PCPCH/Health Home providers for their primary care. Analysis will focus on looking at care utilization, cost, and cost savings related to inpatient admissions, emergency department visits, diagnostic use, specialty care, pharmacy claims, and emergent and nonemergent transportation.

APPENDIX A: Initial Implementation Measures for Patient-Centered Primary Care Homes--Oregon[1]				
Standard	**Must-Pass**	**Tier 1 5 Points Each**	**Tier 2 10 Points Each**	**Tier 3 15 Points Each**
Core Attribute #1: Access to Care				
In-Person Access	N/A	PCPCH surveys a sample of its population on satisfaction with in-person access to care and reports results. (C)	PCPCH surveys a sample of its population using one of the CAHPS survey tools and reports results on the access to care domain. (C)	PCPCH surveys a sample of its population using 1 of the CAHPS survey tools, reports results on access to care and meets a patient satisfaction benchmark in access to care. (C)
After Hours Access	N/A	PCPCH offers access to in-person care at least 4 hours/week outside traditional business hours. (C)	N/A	N/A
Telephone and Electronic Access	PCPCH provides continuous access to clinical advice by telephone. (C)	N/A	N/A	N/A
Core Attribute #2: Accountability				
Performance and Clinical Quality Improvement	PCPCH tracks 1 quality metric from core or menu set of PCPCH Quality Measures. (C)	N/A	PCPCH tracks and reports to the OHA 2 measures from core set and 1 measure from the menu set of PCPCH Quality Measures. (D)	PCPCH tracks, reports to the OHA and meets benchmark on 2 measures from core set and 1 measure from the menu set of PCPCH Quality Measures. (D)
Core Attribute #3: Comprehensive Whole-Person Care				
Preventive Services	N/A	PCPCH offers or coordinates 90% of recommended preventive services. (C)	N/A	N/A
Medical Services	PCPCH reports that it routinely offers: (1) Acute care for minor illnesses and injuries; (2) Ongoing chronic disease management; (3) Office-based procedures and diagnostic tests; (4) Patient education and self-management. (C)	N/A	N/A	N/A
Mental Health, Substance Abuse, and Developmental Services	PCPCH documents its screening strategy for mental health, substance use, or developmental conditions and documents onsite and local referral resources. (C)	N/A	PCPCH documents direct collaboration or co-management of patients with specialty mental health, substance abuse, or developmental providers. (C)	PCPCH documents actual or virtual co-location with specialty mental health, substance abuse, or developmental providers. (C)
Comprehensive Health Assessment and Intervention	N/A	PCPCH documents comprehensive health assessment and intervention for at least 3 health risk or developmental promotion behaviors. (C)	N/A	N/A

APPENDIX A (*continued*)				
Standard	**Must-Pass**	**Tier 1 5 Points Each**	**Tier 2 10 Points Each**	**Tier 3 15 Points Each**
Core Attribute #4: Continuity				
Personal Clinician Assigned	PCPCH reports the percentage of active patients assigned a personal clinician and/or team. (D)	N/A	N/A	PCPCH meets a benchmark in the percentage of active patients assigned to a personal clinician and/or team. (D)
Personal Clinician Continuity	PCPCH reports the percent of patient visits with assigned clinician/team. (D)	N/A	N/A	PCPCH meets a benchmark in the percent of patient visits with assigned provider. (D)
Organization of Clinical Information	PCPCH maintains a health record for each patient that contains at least the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record. (C)	N/A	N/A	N/A
Clinical Information Exchange	N/A	N/A	N/A	PCPCH shares clinical information electronically in real-time with other providers and care entities (electronic health information exchange). (C)
Specialized Care Setting	PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care. (C)	N/A	N/A	N/A
Core Attribute #5: Coordination and Integration				
Population Data Management	N/A	PCPCH demonstrates the ability to identify, aggregate, and display up-to-date patient data. (C) PCPCH demonstrates the ability to identify, track and proactively manage the care needs of a sub-population of its patients. (C)	N/A	N/A
Electronic Health Record	N/A	N/A	N/A	PCPCH has an EHR and demonstrates meaningful use. (C)
Care Coordination	N/A	PCPCH assigns responsibility for care coordination, tells each patient or family the name of the team member responsible for coordinating his or her care. (C)	PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs. (C)	N/A
Test and Result Tracking	N/A	PCPCH demonstrates tracking of tests ordered by its clinicians and ensures timely and confidential notification to patients, families, and ordering clinicians. (C)	N/A	N/A

APPENDIX A (*continued*)

Standard	Must-Pass	Tier 1 5 Points Each	Tier 2 10 Points Each	Tier 3 15 Points Each
Referral and Specialty Care Coordination	N/A	PCPCH tracks referral orders, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians. (C) PCPCH either manages hospital or SNF care for its patients or demonstrates active involvement and coordination of care in these specialized care settings. (C)	N/A	PCPCH tracks referrals and coordinates care where appropriate for community settings outside the PCH. (C)
Comprehensive Care Planning	N/A	PCPCH demonstrates the ability to identify high-risk patients, who will benefit from additional care planning. PCPCH demonstrates it can provide these patients and families with a written care plan. (C)	N/A	N/A
End-of-Life Planning	PCPCH demonstrates a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services. (C)	N/A	N/A	N/A
Core Attribute #6: Person and Family-Centered Care				
Language/ Cultural Interpretation	PCPCH documents the offer and/or use of providers or telephonic trained interpreters to communicate with patients and families in their language of choice. (C)	N/A	N/A	N/A
Education and Self-Management Support	N/A	PCPCH documents patient and family education, health promotion and prevention, and self-management support efforts, including available community resources. (C)	N/A	N/A
Experience of Care	N/A	PCPCH surveys a sample of its patients and families at least annually on their experience of care. The recommended patient experience of care survey is 1 of the CAHPS survey tools. (C)	PCPCH surveys a sample of its population using 1 of the CAHPS survey tools. (C)	PCPCH surveys a sample of its population using 1 of the CAHPS survey tools and meets benchmarks on the majority of the domains. (C)

1. Table adapted from “Oregon Patient-Centered Primary Care Home Model: Implementation Reference Guide October 2011.” Office for Oregon Health Policy and Research. Available at: http://cms.oregon.gov/OHA/OHPR/HEALTHREFORM/PCPCH/docs/PCPCH_Implementation_Guide_October2011_FINAL.pdf.

(D) = Data report; (C) = Contractual attestation.

APPENDIX B: Pre-existing Initiatives in Oregon				
	Coordinated Care Organizations	**Comprehensive Primary Care Initiative**[1]	**Tri-State Child Health Improvement Consortium (T-CHIC)**	**Demonstration to Integrate Care for Dual Eligibles**[2]
Timeline	– State authorized the creation of CCOs in July 2011.[3] – First wave of CCOs began enrolling beneficiaries in September 2012.	– Practices will begin delivering enhanced services in fall 2012. – Demonstration will run for 4 years.	– Oregon was awarded $11.3 million in February 2010. – Planning was conducted from March-November 2010. – Implementation stage will run from November 2010-March 2015.	– Oregon submitted its proposal to CMS in May 2012. – Pending approval, full implementation will begin January 2014.
Geographic area	Statewide	Statewide	Statewide	Statewide
Sponsors	OHA	CMS/Center for Medicare and Medicaid Innovation (CMMI)	CMS	CMS
Scope	– Eventually will include all Medicaid beneficiaries. – Plans also underway to extend the coordinated care model to state employees. – Standards for the Qualified Health Plans in the state Health Insurance Exchange will include elements of the coordinated care model.	– 70 primary care practices. – 517 providers. – 49,000 Medicare beneficiaries. – 6 payers, including Medicaid and Medicare.	8 pilot sites in Oregon, 3 in Alaska, 10 in West Virginia.[4]	All full-benefit Medicare-Medicaid enrollees, excluding individuals in the Program of All-Inclusive Care for the Elderly (forecasted at 68,000 individuals).
Goals	– Provide and coordinate physical, behavioral, and dental care services. – Reduce health care costs. – Improve care quality through the alignment of financial incentives and integration of care.	Participating practices will:[5] – Provide care management for high-need patients. – Ensure 24/7 accessibility to care. – Provide timely and appropriate preventive care. – Encourage patient and caregiver self-management. – Coordinate care across the care spectrum.	– Develop, implement, and evaluate pediatric quality measures. – Establish pilot EHR projects and health information exchanges. – Pilot different models of care delivery for pediatric patients.	– Coordinate and integrate physical, behavioral, and oral health care for dual eligibles within CCO networks. – Ensure that CCOs coordinate with the long-term care system and share accountability for outcomes.
Payment approach	Global payment.	– Risk-adjusted PMPM care management fee; Medicare beneficiary payment average of $20 for Years 1-2, then $15 for Years 3-4. – Shared savings available to practices in Years 3-4.	Incentives for Learning Collaborative participation vary by state.	– Capitation payment to CCOs for mental, physical, and dental care. – The state is also considering various quality incentive payment models

APPENDIX B (*continued*)				
	Coordinated Care Organizations	**Comprehensive Primary Care Initiative**[1]	**Tri-State Child Health Improvement Consortium (T-CHIC)**	**Demonstration to Integrate Care for Dual Eligibles**[2]
Technical assistance	– With input from CMS, the state will provide technical assistance to CCOs in the development and implementation of a mandated Quality Assurance and Performance Improvement Plan.[6] – Forthcoming Oregon Transformation Center will provide technical assistance and tools to support system transformation.	CMMI will provide resources to participating practices to assist them in practice evolution.	Oregon is convening a series of Learning Collaboratives focused on practice improvement and implementing core quality measures.	No information found.
HIT use	CCOs are required to develop HIT infrastructure that links providers across the continuum of care.	CMMI required that all practices have an EHR or electronic registry, and preference was given to those who had obtained stage 1 meaningful use.[7]	HIT system integration and quality measure reporting through EHRs are major goals of the demonstration.	In addition to general requirements placed on CCOs, the state proposes to implement technology solutions that will permit patient data-sharing between the relevant state agencies, CCOs, and long-term care providers.
Evaluation methods	The state will use independent entities to conduct routine audits of performance against quality metrics, and establish an annual review process for evaluating the appropriateness of those metrics.[8]	CMMI will hire an independent contractor to evaluate the impact of the initiative on health, care experience, and costs.	– CMS has hired an independent contractor to evaluate the entire CHIPRA demonstration, which includes Oregon. – Oregon will also conduct its own evaluation.	The state proposes both ongoing evaluation of CCO and long-term care metrics, as well as a post-implementation evaluation to assess how shared accountability is working, best practices, and lessons learned.

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MEDICAID HEALTH HOMES IN RHODE ISLAND: REVIEW OF PRE-EXISTING STATE INITIATIVES AND STATE PLAN AMENDMENTS FOR THE STATE'S FIRST SECTION 2703 MEDICAID HEALTH HOMES

Brenda C. Spillman, Barbara A. Ormond and Elizabeth Richardson
The Urban Institute

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Rhode Island has two approved State Plan Amendments (SPAs); one for persons with serious and persistent mental illness (SPMI), and one for persons with SPMI and/or other disabling or chronic physical or developmental conditions (this latter group is *de facto* limited to children and youth by virtue of the providers designated in the SPA). Both SPAs were approved on November 23, 2011, and have a retroactive effective date of October 1, 2011. Health Home services under the first SPA will be provided by seven community mental health organizations (CMHOs)--which provide behavioral health services to persons with SPMI, and predominantly serve Medicaid, Medicare, the dually eligible, and the uninsured--and two specialty providers of mental health services, Fellowship Health Resources, Inc., and Riverwood Mental Health Services.[1] The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) oversees CMHOs and the specialty providers. Children and youth will receive services through specialized providers known as CEDARR Family Centers (CEDARR stands for Comprehensive Evaluation, Diagnosis, Assessment, Referral, Re-evaluation). To be eligible for care at CEDARR centers, an individual must be eligible for Medical Assistance, under age 21, a Rhode Island resident, live at home, and have a disabling or chronic condition that is cognitive, physical, developmental and/or psychiatric.[2] The Department of Human Services oversees the four CEDARR centers.

Implementation Context

Rhode Island's two SPAs were developed in the context of several ongoing initiatives aimed at reforming the health system so as to increase care management, develop the medical home model, and integrate care for those who are dually eligible for Medicare and Medicaid, with particular focus on high-cost, high-need populations. The state has characterized the health homes model as an opportunity to improve an existing system of care, develop new payment methodologies to accommodate activities such as community-based care coordination, and provide a consistent system of care for children with special health care needs as they transition to adulthood.[3] An important aspect of Rhode Island's reform is the five-year Global Consumer Choice Compact Waiver approved by the Centers for Medicare and Medicaid Services (CMS)

in early 2009, under which Rhode Island operates its entire Medicaid program. Among other things, the waiver has allowed the state to mandate enrollment in either capitated or fee-for-service (FFS) managed care. The state also is participating in the Multipayer Advanced Primary Care Practice Demonstration, through which CMS provides a monthly care management fee for Medicare enrollees in advanced primary care practices.[4] In addition, the state recently has received a Money Follows the Person grant to support efforts to help institutional residents return to health and supportive care in community settings and is working with CMS to implement models for integrating Medicare and Medicaid services and financing for persons dually eligible for the two programs in capitated or FFS managed care.[5] As part of the integration plan, the state is considering creating a Community Health Care Team to focus on long-term services and supports for FFS participants and incorporating managed long-term services and supports into the service package for managed care participants.

CEDARR Family Centers were selected as Health Home providers based on their experience managing care for children and youth with special health care needs. The centers, established in 2000, currently coordinate care for roughly 2,700 children and youth at any given time. These centers are responsible for assessment of need, referral to resources, and the integration of services provided through different systems (education, Medicaid FFS, Medicaid Managed Care, child welfare), oversight of Medicaid FFS specialized Home and Community-Based Services, and reassessment and adjustment of treatment plans on an annual basis. CEDARR centers also provide direct services, such as home-based therapeutic services, personal assistance services and supports, KidsConnect therapeutic day care, and respite services. About 95% of CEDARR clients meet health home diagnostic criteria.[3]

CMHOs, which were established in 1964 and served about 20,000 persons in 2010, also have experience with care integration. Two of the seven CMHOs designated as Health Home providers received Substance Abuse and Mental Health Services Administration (SAMHSA) primary care/behavioral health integration grants in September 2010.[6] Health Homes will build on this existing infrastructure, which includes community hospital contracts with CMHOs to conduct emergency psychiatric assessments in emergency rooms (ERs), and long-term relationships between some CMHOs and local Federally Qualified Health Centers and primary care practices (e.g., co-location and formal integrated care agreements). CMHO services also include 24-hour crisis intervention and stabilization, medication prescription and management, bio-psychosocial assessment, psychotherapy, counseling, psychiatric evaluation, community psychiatric support and treatment (CPST) specific to substance abuse and supported employment, rehabilitative residence, substance abuse treatment, supported housing/residential services, and two levels of intensive community-based treatment.[7] Basic mental health and substance abuse services are provided through managed care organizations (MCOs) for those enrolled; more extensive services for enrollees with SPMI are available on a FFS basis.[8]

Rhode Island has multiple programs intended to better coordinate and manage care for high-risk populations, including those with disabilities. Under its Section 1115

Global Consumer Choice Compact Waiver, the state has not only continued its efforts to increase access to community-based supports and services and reduce institutional care--a process which was begun in 2006 under a Real Choice Systems Transformation Grant--but has also expanded the scope of its health system reform.[9] As of fall 2009, Rhode Island adults age 21 and older who qualify for Medical Assistance must enroll in either Connect Care Choice (CCC), a FFS-based primary care case management (PCCM) program, or a capitated Medicaid MCO through Rhody Health Partners (RHP), both of which were initiated in 2007.[10] Children with special health care needs living outside of institutional settings (which include the target population for the CEDARR-based health home program) must enroll in a RIte Care managed care plan (MCP).[11] UnitedHealthcare of New England and Neighborhood Health Plan of Rhode Island are the two participating plans for both RIte Care and RHP. In late 2008, the state launched a pilot program known as the Chronic Care Sustainability Initiative (CSI) which is a PCCM program focused on patients who suffer from diabetes, depression, and/or coronary heart disease. In 2011, the program was accepted for participation in the three-year CMS Advanced Primary Care Practice demonstration.[12] These programs are described in greater detail in the table found in the Appendix.

Implications for Rhode Island Section 2703 Medicaid Health Homes Evaluation

The initiatives described above demonstrate that the state has made significant efforts toward expanding care coordination and management in its health system and integrating health services with community support services and in planning additional expansions and models. The health homes initiative provides a vehicle for further system development for two particularly high-need subsets of the Medicaid population. Under the state's Section 1115 Global Waiver both children with special health care needs and adults with disabilities have been required to enroll in managed care for their physical health care--RIte Care MCPs in the case of children and CCC or RHP in the case of adults. Although both CEDARR Family Centers and the SPMI providers have experience with various aspects of health home structures, there appear to be significant differences in the level of development between the CEDARR and SPMI providers and among the designated SPMI providers, and the two SPAs differ significantly in terms of service definition, level of training required, payment structure, and evaluation measures. The range of additional demonstrations and plans for care integration the state is undertaking may have implications for the availability of comparison groups for the evaluation, particularly for adults in the CMHO-HHs. On the one hand, state materials relating to these integration efforts suggest that there are adults with SPMI outside of CMHOs who may be appropriate as comparisons. On the other hand, the progress of these additional care integration efforts may affect the validity of comparisons over time and will need to be monitored over the evaluation period.

Health home-type services have been provided by CEDARR centers for a number of years. Therefore, it will be particularly important to clearly identify and describe the

structures and processes that are in place at baseline, and to characterize the changes that providers make to these structures and processes as a consequence of becoming health homes. It will also be necessary to adjust the analysis for both the participants' and providers' time in program.

The picture is more complex for CMHOs and the two specialty providers because some sites appear to have more experience with care integration and coordination than others. All, however, will require more substantial reorganization and training than the CEDARR centers to meet health home requirements. As in the CEDARR center evaluation, it will be necessary to clearly delineate the existing structure and processes, but it will also be important to document variations between mental health provider sites and how the state is addressing the variations. The baseline site visits will be a critical tool for filling in gaps in our understanding of both provider groups.

Population Criteria and Provider Infrastructure

Table 1 summarizes the population criteria, the designated providers, and requirements regarding the minimum composition of the Health Home team for both health home initiatives. In the rest of the discussion, we denote the initiative targeting persons with SPMI as the CMHO-HH, and the second targeting special needs children and youth as the CEDARR-HH. The CMHO-HH SPA lists additional eligibility criteria aside from diagnostic category that limit those eligible to enroll to a highly impaired subset who have mental or emotional disorders that seriously impair daily functioning, but for whom long-term 24-hour care may be averted.[13] The CEDARR-HH population is also fairly narrowly focused by virtue of the eligibility criteria for receiving CEDARR services. Children and youth 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. The conditions are a mental health condition, asthma, diabetes, Down syndrome, a developmental disability, mental retardation, or a seizure disorder.

CMHOs and CEDARR Family Centers have varying experience with Health Home-type services and have care teams that reflect both the extent to which they are already providing health home-like services and the different needs of their respective beneficiary populations. The required Health Home team for CEDARR-HH includes only two members, a licensed clinician and a family service coordinator who will share responsibility for the core health home services. The required team for CMHO-HH includes at least seven members with behavioral, clinical, or social support expertise. However, the CEDARR-HH SPA states that the Centers employ both licensed health professionals and staff trained to provide Health Home-type services, and that the two-person team is expected to collaborate regularly with the child's primary care provider (PCP).

Service Definitions and Provider Standards

Rhode Island has established both overarching and provider-specific definitions for the six Health Home services. (A full list of these services is provided in Table 5.) Overall, the differences between the provider-specific definitions between the CMHO-HH and the CEDARR-HH reflect the different characteristics and needs of their respective patient populations. Thus, for example, care coordination, transitional care, and referral to support services at CEDARR-HHs would potentially involve school-based services, whereas CMHO-HH services generally would not. Similarly, CMHO-HHs will focus more than CEDARR-HHs on ensuring adequate housing, social integration and functioning, substance abuse treatment, and vocational training. The assignment of service provision within the teams is flexible; although each service is assigned to a provider who will have primary responsibility, many services for both CEDARR-HH enrollees and CMHO-HH enrollees may be performed by various members or combination of members of the Health Home team.

The information provided in the SPAs suggests that practice transformation requirements for the two provider groups will be somewhat different. CEDARR Family Centers already meet established state certification standards, which will serve as the basis for Health Home qualification and will be changed as necessary to meet any additional health home requirements.[14] Additional requirements for Health Home status have been added as an Appendix to the CEDARR Family Center Recognition Standards and include the requirement that Health Homes agree to perform the 11 Health Home functions identified by CMS in the November 16, 2010, State Medicaid Director (SMD) Letter on Section 2703.[15] CEDARR-HHs must also agree to establish a protocol to gather, store, and transmit to the state all required reporting data as part of their quality improvement plan. Additional reporting requirements are listed in Table 2.

The requirements for CMHO-HHs are more extensive. (See Table 2 for a detailed list.) In addition to meeting state licensure requirements for being behavioral health centers, CMHOs must submit a proposal demonstrating how they will structure team composition and member roles to meet Health Home goals, a requirement that is not included for CEDARR teams. CMHOs must also sign a certificate of agreement that outlines their roles and responsibilities as Health Homes and that includes requirements related to care organization, transitional care arrangements with hospitals, progress reports, and state evaluations. CMHOs must also agree to participate in statewide learning activities, which will focus on training providers to perform the 11 Health Home functions identified by CMS in the November 2010 SMD letter. Community support specialists are specifically required to undergo a 17-week training designed to improve their clinical and case management skills.

Use of Health Information Technology

Rhode Island plans to phase-in HIT support to its Health Home providers and, in the interim, will rely on the existing infrastructure used by CEDARR Family Centers and

the state Medicaid MCOs, which cover 60% of CEDARR-HH participants and 35% of eligible CMHO-HH participants. The state is working with the MCOs to develop utilization profiles covering the last 12 months, including the number of ER and urgent care visits, date and diagnosis of most recent ER visit, PCP and number of visits, prescription drug information, and behavioral health utilization. To the extent possible, the state will develop similar profiles from the Medicaid data warehouse and other applicable sources for the remaining FFS individuals. For CMHO-HH participants who are dually eligible for Medicare and Medicaid, the state will work closely with the CMS Center for Medicare and Medicaid Innovation (CMMI) to obtain Medicare utilization and cost data. The state will query CMHO providers about the use of HIT in the delivery of care coordination services and may establish pilot tests of a subset of providers (e.g., those with EHRs and patient registries) to measure changes in health outcomes, experience of care, and quality of care among clients. The Rhode Island Behavioral Health Online Dataset (RI-BHOLD) also is cited as the source for some clinical outcome data, but is not otherwise described in the SPA.

CEDARR-HHs will use an existing electronic case management system, which can support linkages of information from medical and human service providers and school programs, and the Rhode Island KIDSNET Child Health Information System, which provides access to information such as blood lead levels, immunizations, newborn developmental assessment, hearing assessment, WIC participation, and early intervention participation. CEDARR-HHs also will offer to enroll all clients into "CurrentCare," Rhode Island's electronic health information exchange.

Payment Structure

The two types of Health Homes will have very different payment structures. CMHO-HHs will be paid on a monthly case rate basis, with the 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. CMHO-HHs will be required to submit detailed encounter data to the state. After six months, and annually thereafter, the state will consider whether to adjust the case rate or consider alternate payment methodologies, based on analysis of program costs versus services received by recipients.

CEDARR-HHs will be paid on a FFS basis. Three existing CEDARR activities, with established rates, are defined to be the "comprehensive care management" component of a health home. These are initial family intake and needs assessment, family care plan development following initial needs assessment, and annual family care plan review. Fixed rates for each of these three services are in the $350-$400 range. All the other health home services are mapped to two established CEDARR services: health needs coordination and therapeutic consultation. The skill mix associated with each health home service is specified in the SPA. Care coordination, comprehensive transitional care, individual and family support services, and referral to community and social support services are considered to be health needs coordination. Health

promotion is considered to be therapeutic consultation. Payment rates per quarter hour for each type of professional are established hourly rates, and billing will be by quarter hour units of time actually spent on each service. There is no stated plan for revision of the payment system for CEDARR-HHs.

Quality Improvement Goals and Measures

There are five quality improvement goals for CEDARR-HHs and six for CMHO-HHs, summarized in Table 3 below, along with the quality measures that will be used. There is little overlap in either the goals or the measures used, in part because of the very different participant populations for the two types of providers. Both SPAs list "Improved care coordination" as the first goal, but the measures diverge, with CEDARR-HH measures focusing on physician consultations, use of Rhode Island KIDSNET, and communication with MCO PCPs, while those for CMHO-HHs focus on chart documentation of physical and behavioral health needs and post-hospitalization follow-up visits. Other goals are similar in concept, but have very different measures. For example, goals for CEDARR centers include "decrease occurrence of secondary conditions," "decrease emergency department use and preventable admissions," and "improve quality of transitions from inpatient/residential care to community," while CMHO goals include "increase use of preventive services," "reduce preventable emergency department use," and "improve transitions to CMHO care." There are only a few overlaps in measures (e.g., documentation of BMI and depression screening). Both patient groups will be surveyed on their satisfaction with service access and quality.

Data sources also vary, though both evaluations will use claims and encounter data, as well as chart/record review and client surveys. The CEDARR data sources also will include KIDSNET, and CMHO data sources will include the Rhode Island Outcomes Evaluation Instrument, and RI-BHOLD.

Evaluation Measures and Methods

The evaluation measures and methodology described in the CMHO-HH and CEDARR-HH SPAs are reproduced in Table 4 and are different in both content and evaluation methodology for the two provider groups.

The CEDARR-HH evaluation strategy is limited to an entirely pre/post design for all data collected from practices and for cost savings estimates. Based on the detailed information provided for the cost savings estimation, the intent is to consider the "pre" period to be the single quarter preceding the effective date of October 1, 2011 (the 1st quarter of the state's fiscal year 2012), and the "post" period to be the eight subsequent quarters over which the enhanced federal match for health home services is in effect. No comparison group of beneficiaries or practices is specified. Hospital admission rates and length of stay, and the number of emergency department visits and skilled nursing facility admissions will be computed bi-annually.

The CMHO-HH strategy for evaluating chronic disease management, coordination of care, assessment of program implementation, and processes and lessons learned, and assessment of quality improvements and clinical outcomes, does not specify either a pre/post design or a comparison group, apparently relying on change over time after implementation. For hospital admission rates (to be measured per 1,000 member months), both a pre/post analysis of rates for CMHO-HH participants and a comparison with rates for clinically similar individuals not receiving CMHO-HH services are envisioned. It is not made clear whether the intent is to examine rates pre and post for both participants and comparison group, which is the preferred approach. For savings estimations, the state proposes to estimate baseline total costs for Medicare and Medicaid beneficiaries who would have been eligible for CMHO health home services at any time during the 4th quarter of state fiscal 2011 (April-June 2011), presuming they can obtain appropriate Medicare claims data for dual eligible clients. Cost savings will be estimated annually by comparing those baseline estimates with costs for the same beneficiaries one year and two years later. Assessments also will include performance measures, which we interpret as the clinical outcome measures shown in Table 3, and targeted areas of cost in addition to total costs.

TABLE 1. Target Population and Designated Providers--Rhode Island		
	SPA 1	**SPA 2**
SPA approval date (Effective date)	11/23/11 (10/1/11)	11/23/11 (10/1/11)
Designated provider	CMHOs; 2 specialty mental health providers	CEDARR Family Centers
Health Home team composition	Required: – Master's Team Coordinator – Psychiatrist – Registered Nurse – MA Level Clinician – CPST Specialist – CPST Specialist/Hospital liaison – Peer Specialist Optional: – Primary care physician – Pharmacist – Substance abuse specialist – Vocational specialist – Community integration specialist	Required: – Licensed clinician – Family Service Coordinator Optional: – Other medical providers as necessary
Target population and qualifying chronic conditions	Beneficiaries must have serious mental illness, be Medicaid eligible and: 1. Have either undergone psychiatric treatment more intensive than outpatient care more than once, experienced a single episode of continuous, supportive residential care other than hospitalization for at least 2 months, or have impaired role functioning, and 2. Meet at least 2 of the following criteria, on a continuing or intermittent basis for at least 2 years: – If employed, is employed in a sheltered setting, or has markedly limited skills or a poor work history. – Requires public financial assistance for out-of-hospital maintenance and may be unable to procure such assistance without help. – Shows inability to establish or maintain a personal social support system. – Requires help in basic living skills. – Exhibits inappropriate social behavior which results in demand for intervention by the mental health and/or judicial system.	Beneficiaries must have: – 2 chronic conditions – 1 chronic condition and the risk of developing another – SPMI Qualifying chronic conditions include: – Mental health condition – Asthma – Diabetes – Developmental disability – Down syndrome – Mental retardation – Seizure disorder

TABLE 2. Provider Qualifications--Rhode Island
CEDARR qualifications
– Agree to perform the 11 Health Home functions identified by CMS in the November 10th SMD Letter. – Establish a protocol to gather, store and transmit to the state all required reporting data. – Perform yearly outreach to the child's Primary Care Physician and Medicaid MCP (if applicable). – Perform yearly Body Mass Index (BMI) Screening for all children 6 years of age or older. If this is not clinically indicated, reason must be documented. – Perform documented yearly depression screening for all children 12 years of age or older. If this is not clinically indicated, reason must be documented. – Conduct a yearly review of immunizations, screenings and other clinical information contained in the KIDSNET Health Information System.
CMHO qualifications
1. Each CMHO health home provider must sign a certification agreement that outlines CMHO's roles and responsibilities, which will minimally require: – Have psychiatrists/nurse specialists assigned to the health home team, and available 24/7 for all services that address whole-person needs. – Conduct wellness interventions as indicated based on individuals' level of risk. – Agree to participate in any statewide learning sessions that may be implemented for health home providers. – Within 3 months of health home service implementation, have developed a contract or memorandum of understanding with regional hospitals or system(s) to ensure a formalized structure for transitional care planning, as well as maintain a collaboration to identify individuals seeking emergency department services that might benefit from connection with a CMHO health home provider. – Agree to convene internal health home team meetings with all relevant providers to plan and implement practice transformation. – Agree to participate in CMS and state-required evaluation activities. – Agree to develop required reports describing CMHO health home activities, efforts and progress in implementing health home services. – Maintain compliance with all of the terms and conditions as a CMHO health home provider or face termination as a provider of those services. 2. Each CMHO health home must develop and submit to the BHDDH for approval its approach for conducting health home services. Proposals must include: – An overview of the provider's health home approach (e.g., discussion of a care management model, etc.). – A description of the health team, including team member roles and functions. – Local hospitals with which the CMHO health home will establish transitional care agreements. – A description of the health home's processes for integrating physical and behavioral health care, including coordinating care with PCPs. – A list of primary care practices with which the CMHO will develop referral agreements. – An overview of how each of the 6 health home service components will be carried out by the CMHO health home, and, if applicable. – A description of the provider's use of electronic health records (EHRs) or patient registries. – A description of the providers use of health Information technology (HIT) to support care management (e.g., care management software). – A list and description of quality measures currently collected and tracked by the CMHO, and, if applicable. – An overview of embedded or collected primary care services delivered at the CMHO health home provider. Community support professionals will also undergo a 17-week Community Support Professional Certification Training Program funded by BHDDH and administered by the Rhode Island Council of Community Mental Health Organizations (RICCMHO).

TABLE 3. Health Home Goals and Measures--Rhode Island		
Shared goals		
Improve care coordination	*CEDARR:* Clinical outcomes – Percent of Physician Consultation claims to the number of care plans developed and renewed. – Number of hits on the Rhode Island KIDSNET Information system per 1,000 enrollees. – Percent of MCO enrollees with outreach to MCO documented in the CEDARR record. Experience of care – Satisfaction with services, accessibility of services, availability of services. – Percent of Initial Assessment appointment dates offered within 30 days of request. – Percent of Care Plans completed within 30 days of completion of the Initial Assessment. – Percent of Care Plans reviews completed prior to expiration of current care plan. Quality of care – Percent of clients who have adequate or higher level of knowledge of condition. – Percent of clients who indicate having a high level of stress caused by condition(s).	*CMHO:* Clinical outcomes – Percent of patients whose chart includes documentation of physical and behavioral health needs. – Percent of hospital-discharged patients with a follow-up visit within 14 days of hospital discharge. Experience of care – Percent of patients with a regular source of health care. – Percent of patients who had a physical exam in the past 12 months. Quality of care – Percent of hospital-discharged patients contacted by the Health Home team by phone or in person within 2 days of discharge.
CEDARR goals		
Improve Health Outcomes of Children and Youth with Special Health Care Needs	Clinical outcomes – Percent of clients who indicate having adequate or higher level of knowledge of condition. – Number of referrals to community-based resources per member per year. Experience of care – Satisfaction with services, accessibility of services, availability of services. – Percent of community-based service treatment plans reviewed within 30 days of submission to the Health Home. Quality of care – Percent of clients who indicate having a high level of stress caused by condition(s). – Parent/Guardian self-rating of child's ability to take part in age appropriate community and social activities.	

TABLE 3 (*continued*)	
Decrease the occurrence of secondary conditions	<u>Clinical outcomes</u> – Yearly BMI is calculated for all clients 6 years of age and older with documented intervention if <85th percentile. – Yearly Screening for Depression for all clients 12 years of age or above. <u>Experience of care</u> – Satisfaction with services, accessibility of services, availability of services. <u>Quality of care</u> – Reduction of Clients with a BMI >85th percentile. – Clients who screened positive for depression who received further treatment or evaluation.
Decrease Emergency Department and Inpatient Treatment for Ambulatory Sensitive Conditions	<u>Clinical outcomes</u> – Percent of patients with 1 or more emergency department visits for any conditions appearing in a state-defined list of diagnoses that can be treated in a nonemergency department setting. – Percent of patients with 1 or more admissions for any conditions appearing in a state list of diagnoses that can be avoided through preventive care. <u>Experience of care</u> – Satisfaction with care, accessibility of care. <u>Quality of care</u> – Medical follow-up within 7 days of ACS admission. – Medical follow-up within 7 days of ACS emergency department visit.
Improve the quality of Transitions from Inpatient/Residential Care to Community	<u>Clinical outcomes</u> – Percent of discharges for admissions >7 days in length with active participation of Health Home staff. – Percent of discharges for admissions >7 days in length who are contacted by Health Home staff within 7 days of discharge. – Percent of clients re-admitted or utilizing emergency department within 30 days of discharge with same diagnosis as admission. <u>Experience of care</u> – Satisfaction with care, accessibility of care. <u>Quality of care</u> – Percent of clients with nonpsychiatric admissions within 30 days of hospital discharge. – Percent of clients with a psychiatric admission within 30 days of psychiatric hospital discharge.
CMHO goals	
Reduce preventable emergency department visits	<u>Clinical outcomes</u> – Percent of patients with 1 or more emergency department visits for any conditions named in New York University emergency department methodology. – Percent of patients with 1 or more emergency department visits for a mental health condition. <u>Experience of care</u> – Satisfaction with care, accessibility of care. <u>Quality of care</u> – Percent of hospital-discharged patients contacted by the Health Home team by phone or in person within 2 days of discharge.

TABLE 3 (*continued*)	
Increase use of preventive services	<u>Clinical outcomes</u> – Percent of patients who report that they smoke. – Percent of patients who report using illicit substances or abusing alcohol. – Percent of members 18-74 years of age who had an outpatient visit and who had their BMI documented. – Age and gender appropriate use of pap test, mammogram, and colonoscopy, using HEDIS specifications. <u>Experience of care</u> – Percent of patients who are satisfied with their access to outpatient services and with the quality of those services. <u>Quality of care</u> – Percent of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented. – Percent of members with a new episode of alcohol or other drug (AOD) dependence who received initiation or engagement of AOD treatment. – Percent of patients having 1 or more well-visits/physical examination visits in 12 month period. – Percent of smokers counseled and referred for smoking cessation. – Percent of drug/alcohol abusers counseled and referred to drug/alcohol treatment.
Improve management of chronic conditions	<u>Clinical outcomes</u> – Percent of patients with diabetes (type 1 or type 2) who had HbA1c < 8.0%. – Percent of patients identified as having persistent asthma and were appropriately prescribed controller medication. – Percent of patients with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure controlled at <140/90. – Percent of patients diagnosed with coronary artery disease (CAD) with lipid level adequately controlled (LDL<100). <u>Quality of care</u> – Percent of patients who are adherent to prescription medications for asthma and/or COPD. – Percent of patients who are adherent to Meds--cardiovascular disease (CVD) and Anti-Hypertensive Meds. – Percent of patients using a statin medication who have a history of CAD.
Improve Transitions to CMHO Services	<u>Clinical outcomes</u> – Percent of discharges for members 6 years of age and older who were hospitalized for selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge. <u>Experience of care</u> – Percent of patients satisfied with their access to outpatient services and with the quality of those services. <u>Quality of care</u> – Percent of hospital-discharged patients contacted by Health Home team member by phone or in person within 2 days of discharge. – Percent of patients discharged from inpatient facility for whom a transition record was transmitted to Health Home for follow-up care within 24 hours.

TABLE 3 (***continued***)	
Reduce Hospital Readmission	Clinical outcomes – Hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission, per 100,000 under age 75. – Number of acute inpatient stays followed by all-cause readmission within 30 days and the predicted probability of an acute readmission. Experience of care – Satisfaction with care, accessibility of care. Quality of care – Percent of hospital-discharged patients with a follow-up visit to a CMHO or medical provider within 14 days of hospital discharge. – Percent of hospital-discharged patients contacted by Health Home team member by phone or in person within 2 days of discharge.

TABLE 4. Evaluation Methodology--Rhode Island	
Hospital admission rates	<u>CEDARR</u>: Comparison of Claims and Encounter data pre and post-implementation of health homes. <u>CMHO</u>: The state will consolidate data from its Medicaid data warehouse which contains both FFS claims and managed care encounter data, to assess general and psychiatric hospital readmission rates of CMHO health home service users. The state will calculate readmissions per 1,000 member months among CMHO users. The state will track pre/post-hospital readmission rates among health home participants. Rates will also be compared with clinically similar individuals not receiving CMHO health home services.
Chronic disease management	<u>CEDARR</u>: Comparison of Claims and Encounter data pre and post-implementation of health homes. <u>CMHO</u>: For new individuals of CMHO health home services, the state will track hospital referrals and/or hospital liaison encounters as well as track face-to-face follow-up by a health team member within 2 days after hospitalization discharge. The state will also monitor the number of referrals/post-discharge follow-up contacts that resulted in the development of a care plan.
Coordination of care	<u>CEDARR</u>: Comparison of Claims and Encounter data pre and post-implementation of health homes. <u>CMHO</u>: The state will monitor updates to RI-BHOLD to track changes in psychiatric diagnoses, determine individuals' difficulty with Axis N diagnoses (e.g., housing problems, problems with access to health care services) and track individuals' self-reported co-occurring physical health conditions.
Assessment of program implementation	<u>CEDARR</u>: Comparison of Claims and Encounter data pre and post-implementation of health homes. <u>CMHO</u>: The state will monitor implementation through processes developed for regularly occurring meetings of Department of Human Services, BHDDH, RICCMHO, MCOs and PCCMs.
Processes and lessons learned	CEDARR-HH survey to be developed. The state and RICCMHO will develop tools to elicit feedback from CMHOs to understand any operational barriers of implementing CMHO health home services.
Assessment of quality improvements and clinical outcomes	Comparison of quarterly and annual data pre and post-implementation of health homes. The state will utilize quality process and outcome measures described in the prior section to assess quality improvements and clinical outcomes.
Estimates of cost savings	The state will analyze Medicaid and Medicare claims cost and utilization data in order to conduct the cost savings methodology. The state will determine baseline costs of Medicaid and Medicare beneficiaries who would have been eligible for CMHO health home services at any time during the 4th quarter of state fiscal year 2011 (April 2011-June 30, 2011). In order to calculate costs savings and the impact of health home services, the state will perform an annual assessment of baseline costs compared with total Medicaid and Medicare costs of those same CMHO health users 1 year and 2 years following the SPA effective date. The assessment will also include the performance measures enumerated in the Quality Measures section. In addition to looking at overall cost, BHDDH will work with EOHHS to determine specific targeted areas of cost most likely to be impacted by health home implementation for a more detailed analysis. In order to perform both of these operations, the state will require timely and affordable access to Medicare data.

TABLE 5. Health Home Service Definitions--Rhode Island	
Comprehensive care management	
Overarching state definition	Comprehensive care management services are conducted with an individual and involve the identification, development, and implementation care plan that addresses the needs of the whole person. Family/Peer Supports can also be included in the process. The service involves the development of a care plan based on the completion of an assessment. A particular emphasis is the use of the multidisciplinary team including medical personnel who may or may not be directly employed by the provider of the health home. The recipient of comprehensive care management is an individual with complex physical and behavioral health needs.
CEDARR definition	Comprehensive Care Management is provided by CEDARR Health Homes by working with the child and family to: assess current circumstances and presenting issues, identify continuing needs, and identify resources and/or services to assist the child and family to address their needs through the provision of an Initial Family Intake and Needs Determination; develop a Family Care (or Treatment) Plan which will include child specific goals, treatment interventions and meaningful functional outcomes; and regular review and revision of the Family Care Plan to determine efficacy of interventions and emerging needs. Integral to this service is ongoing communication and collaboration between the CEDARR Health Homes Team and the clients Primary Care Physician/Medical Home MCO, Behavioral Health and Institutional/Long-Term Care providers. This service will be performed by the Licensed Clinician with the support of the Family Service Coordinator.
CMHO definition	Comprehensive care management services are conducted with beneficiaries, their families and supporters to develop and implement a whole-person oriented treatment plan and monitor the individual's success in engaging in treatment and supports. Comprehensive care management services are carried out through use of a bio-psychosocial assessment of each individual's physical and psychological status and social functioning. The assessment determines an individual's various needs and expectations, and may be conducted by a psychiatrist, registered nurse or a licensed and/or master's prepared mental health professional. Based on the bio-psychological assessment, a goal-oriented, person-centered care plan is developed, implemented and monitored by a multidisciplinary team in conjunction with the individual served. Comprehensive care management services may be provided by any member of the CMHO health home team; however, Master's Level Health Home Team Coordinators will be the primary practitioners providing comprehensive care management services.
Care coordination	
Overarching state definition	Care coordination is the implementation of the treatment plan developed to guide comprehensive care management in a manner that is flexible and meets the need of the individual receiving services. The goal is to ensure that all services are coordinated across provider settings, which may include medical, social and, when age appropriate, vocational educational services. Services must be coordinated and information must be centralized and readily available to all team members. Changes in any aspect of an individual's health must be noted, shared with the team, and used to change the care plan as necessary. All relevant Information is to be obtained and reviewed by the team.

TABLE 5 (*continued*)	
CEDARR definition	Care Coordination is designed to be delivered in a flexible manner best suited to the family's preferences and to support goals that have been identified. This includes: – Follow-up with family, providers, and others involved in the child's care to ensure the efficient provision of services. – Provide information to families about specific disorders, treatment and provider options, systems of support, services, assistance and legal rights available, and resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, school-based services, etc. – Service delivery oversight and coordination to ensure that services are being delivered in a satisfactory manner. – Assistance in locating and arranging specialty evaluations as needed, in coordination with the child's PCP. This also includes follow-up and ongoing consultation with the evaluator as needed. This service will be performed by the Licensed Clinician or the Family Service Coordinator depending on the exact nature of the activity.
CMHO definition	Care coordination is the implementation of the individualized treatment plan (with active involvement of the individual served) for attainment of the individuals' goals and improvement of chronic conditions. Care managers are responsible for conducting care coordination activities across providers and settings. Care coordination involves case management necessary for individuals to access medical, social, vocational, educational, as well as other individualized supportive services, including, but not limited to: – Assessing support and service needed to ensure the continuing availability of required services. – Assistance in accessing necessary health care, and follow-up care and planning for any recommendations. – Assessment of **housing status** and providing assistance in accessing and maintaining safe and affordable housing. – Conducting outreach to family members and significant others in order to maintain individuals **connection to services, and expand social network**. – Assisting in locating and effectively utilizing all necessary community services in the medical, social, legal and behavioral health care areas and ensuring that all services are coordinated. – Coordinating with other providers to monitor individuals' health status, medical conditions, medications and side effects. Care coordination services may be provided by any member of the CMHO health home team; however, CPST Specialists will be the primary practitioners providing care coordination services.
Health promotion	
Overarching state definition	Health promotion services encourage and support healthy ideas and concepts to motivate individuals to adopt healthy behaviors. The services also enable individuals to self-manage their health.
CEDARR definition	Health Promotion assists children and families in implementing the Family Care Plan and in developing the skills and confidence to independently identify, seek out and access resources that will assist in managing and mitigating the child's condition(s), preventing the development of secondary or other chronic conditions, addressing family and child engagement, promoting optimal physical and behavioral health, and addressing and encouraging activities related to health and wellness. This service will include the provision of health education, information, and resources with an emphasis on resources easily available in the families' community and peer group(s). This service will be performed by the Licensed Clinician.

TABLE 5 (*continued*)	
CMHO definition	Health promotion services encourage and support healthy ideas and concepts to motivate individuals to adopt healthy behaviors. The services also enable individuals to **self-manage their health**. Health promotion services may be provided by any member of the CMHO health home team. Health promotion activities place a strong emphasis on self-direction and skills development for monitoring and management of chronic health conditions. Health promotion assists individuals to take a self-directed approach to health through the provision of health education. Specific health promotion services may include, but are not limited to, providing or coordinating assistance with: – Promoting individuals' health and ensuring that all personal health goals are included in person centered care plans. – Promotion of substance abuse prevention, smoking prevention and cessation, nutritional counseling, obesity reduction, and increased physical activity. – Providing health education to individuals and family members about chronic conditions. – Providing prevention education to individuals and family members about health screening and immunizations. – Providing **self-management** support and development of self-management plans and/or relapse prevention plans so that individuals can attain personal health goals. – Promoting **self-direction** and skill development in the area of independent administering of medication. Health promotion services may be provided by any member of the CMHO health home team; however, Psychiatrists and Nurses will be the primary practitioners providing health promotion services.
Comprehensive transitional care	
Overarching state definition	Comprehensive transitional care services focus on the movement of individuals from any medical/psychiatric inpatient or other out-of-home setting into a community setting, and between different service delivery models. Members of the health team work closely with the individual to transition the individual smoothly back into the community and share information with the discharging organization in order to prevent any gaps in treatment that could result in a readmission.
CEDARR definition	Transitional Care will be provided by the CEDARR Health Homes Team to both existing clients who have been hospitalized or placed in other noncommunity settings as well as newly identified clients who are entering the community. The CEDARR Health Homes Team will collaborate with all parties involved including the facility, primary care physician, Health Plan (if enrolled) and community providers to ensure a smooth discharge into the community and prevent subsequent readmission(s). Transitional Care is not limited to Institutional Transitions but applies to all transitions that will occur throughout the development of the child and includes transition from Early Intervention into **School-based services** and pediatric services to adult services. This service will be performed by the Licensed Clinician with the support of the Family Service Coordinator.

TABLE 5 (*continued*)	
CMHO definition	Comprehensive transitional care services focus on the transition of individuals from any medical, psychiatric, long-term care or other out-of-home setting into a community setting. Designated members of the health home team work closely with the individual to transition the individual smoothly back into the community and share information with the discharging organization in order to prevent any gaps in treatment that could result in a readmission. To facilitate timely and effective transitions from inpatient and long-term settings to the community, all health home providers will maintain collaborative relationships with hospital emergency departments, psychiatric units of local hospitals, long-term care and other applicable settings. In addition, all health home providers will utilize hospital liaisons to assist in the discharge planning of individuals, existing CMHO clients and new referrals, from inpatient settings to CMHOs. Care coordination may also occur when transitioning an individual from a **jail/prison setting** into the community. Hospital liaisons, community support professionals and other designated members of the team may provide transitional care services. The team member collaborates with physicians, nurses, social workers, discharge planners and pharmacists within the hospital setting to ensure that a treatment plan has been developed and works with family members and community providers to ensure that the treatment plan is communicated, adhered to and modified as appropriate. Comprehensive transitional care services may be provided by any member of the CMHO health home team; however, Hospital Liaisons will be the primary practitioners providing comprehensive transitional care services.
Individual and family support services	
Overarching state definition	Individual and family support services assist individuals to accessing services that will reduce barriers to treatment and improve health outcomes. Family involvement may vary based on the age, ability, and needs of each individual. Support services may include advocacy, information, navigation of the treatment system, and the development of self-management skills.
CEDARR definition	The CEDARR Health Homes Team is responsible for providing assistance to the family in accessing and coordinating services. These services include the full range of services that impact on Children with Special Health Care Needs and include, but are not limited to, health, behavioral health, education, substance abuse, **juvenile justice** and social and **family support** services. The CEDARR Health Home Team will actively integrate the full range of services into a comprehensive program of care. At the family's request, the CEDARR Team can play the principal role as organizer, information source, guide, advocate, and facilitator for the family by helping the family to assess strengths and needs, identify treatment goals and services, and navigate agency and system boundaries. This service will be performed by the Licensed Clinician or the Family Service Coordinator depending on the exact nature of the activity.
CMHO definition	Individual and family support services are provided by community support professionals and other members of the health team to reduce barriers to individuals' care coordination, increase skills and engagement and improve health outcomes. Individual and family support services may include, but are not limited to: – Providing assistance in accessing needed **self-help** and peer support services. – Advocacy for individuals and families. – Assisting individuals to identify and develop **social support networks**. – Assistance with **medication** and treatment management and adherence. – Identifying resources that will help individuals and their families reduce barriers to their highest level of health and success. – Connection to peer advocacy groups, wellness centers, NAMI and family psycho-educational programs. Individual and family support services may be provided by any member of the CMHO health home team; however, CPST Specialists will be the primary practitioners providing individual and family support services.

TABLE 5 (*continued*)	
Referral to community and social support services	
Overarching state definition	Referrals to community and socials support services ensure that individuals have access to a myriad of formal and informal resources. Ideally, these resources are easily accessed by the individual in the service system and assists individuals in addressing medical, behavioral, educational, social and community issues.
CEDARR definition	Referral to Community and Social Support Services will be provided by members of the CEDARR Health Homes Team and will include information about formal and informal resources beyond the scope of services covered by Medicaid, such as those which may be available from **other parents, family members, community-based organizations**, service providers, grants, social programs, funding options, school-based services, faith based organizations, etc. Whenever possible, families will be informed of opportunities and supports that are closest to home, that are the least restrictive and that promote integration in the home and community. Members of the CEDARR Health Homes Team will emphasize the use of informal, natural community supports as a primary strategy to assist children and families. This service will be performed by the Licensed Clinician or the Family Service Coordinator depending on the exact nature of the activity.
CMHO definition	Referral to community and social support services provide individuals with referrals to a wide array of support services that will help individuals overcome access or service barriers, increase **self-management** skills and improve overall health. Referral to community and social support involves facilitating access to support and assistance for individuals to address medical, behavioral, educational, and social and community issues that may impact overall health. The types of community and social support services to which individuals will be referred may include, but are not limited to: – PCPs and specialists. – Wellness programs, including smoking cessation, fitness, weight loss programs, yoga. – Specialized support groups (i.e., cancer, diabetes support groups). – Substance treatment links in addition to treatment supporting recovery with links to support groups, recovery coaches, 12-step. – Housing. – Social integration (NAMI support groups, MHCA OASIS, Alive Program (this program and MHCA are Advocacy and Social Centers) and/or Recovery Center). – Assistance with the identification and attainment of other benefits. – Supplemental Nutrition Assistance Program. – Connection with the Office of Rehabilitation Service as well as internal CMHO team to assist person in developing work/education goals and then identifying programs/jobs. – Assisting person in their **social integration** and social skill building. – Faith based organizations. – Access to employment and educational program or training. CPST Specialists will be the primary practitioners providing referrals to community and social support.

APPENDIX: Pre-existing Initiatives in Rhode Island		
	Connect Care Choice (CCC)/Rhody Health Partners (RHP)	**Chronic Care Sustainability Initiative (CSI-RI)**
Timeline	The programs were implemented in September 2007; now include all Medicaid beneficiaries.	Pilot began in October 2008, and the initiative is currently operating as part of the 3-year CMS Multi-payer Advanced Primary Care Demonstration program.
Geographic area covered	Statewide	Statewide
Sponsors	State	Center for Health Care Strategies (CHCS) provided a grant to the Rhode Island Office of the Health Insurance Commissioner for the pilot; the program is now part of the Medicare Advance Primary Care Practice demonstration.
Scope	– Both the CCC and RHP programs serve Rhode Island adults age 21 and older who qualify for Medicaid and are not covered by Medicare or private insurance.[1] – CCC participants enroll in a primary care practice, which provides case management services, and have access to all specialists who accept Medicaid FFS payments.[1] – RHP participants enroll in a capitated managed care health plan, which provides all care, except for a few services (e.g., dental care) that continue to be covered on a FFS basis.[2]	– The medical home multi-payer pilot program in Rhode Island covered 76% of the states' residents who have health insurance at implementation. – The acceptance of the program into the CMS Multi-Payer Advanced Primary Care Initiative added Medicare as a payer and increased eligibility to 98% of insured residents. – The pilot aims to cover Rhode Island residents who suffer from diabetes, depression, and/or coronary heart disease.[3] – Originally began with 5 primary care practices, but in April 2010 an additional 8 sites were included in the pilot. – By October 2010 there were 13 sites, 55 providers, 46,000 lives, and 28 Family Medicine residents were participating in the pilot.[4]
Goals	– The CCC program is intended to improve access to primary care, provide links to social services, enable more coordinated care, and facilitate improvement in self-managed care.[1] – RHP has the goal of improving access to care, the quality of care, and health outcomes while containing costs.[5]	– To align the quality improvement and financial incentives to provide better and more efficient primary care for people who suffer from chronic illnesses. – To prioritize the "whole-person" approach to medicine by more effectively coordinating care and integrating community supports with the beneficiary's personal physician team.[3] – Enhance payment to PCPs so they are able to achieve recognition as medical homes and provide high quality chronic illness care.[3]
Payment approach	<u>CCC</u>: – Participating practices receive monthly care coordination fees, which are adjusted to account for time spent caring for patients with complex health care needs. – Practices that care for moderate to high-risk CCC members and employ a nurse care manager receive an additional $35-40 per member per month (PMPM).[6] <u>RHP</u> – Medicaid contracts with private plans to provide managed health care. – Participating plans are UnitedHealthcare of New England and Neighborhood Health Plan of Rhode Island.[2]	– The payment structure is effectively enhanced FFS, with capitated payment (PMPM) and support for services in kind.[3] – Medicaid MCOs, PCCM, and FFS programs pay $3.00 PMPM, and health plans supply funding for nurse care managers who work at each practice. – Participating practices receive a PMPM care coordination fee, and receive subsidies for hiring on-site nurse care manager.[6] – Purchasers include Care New England and Lifespan, 2 of the largest private sector employers, Rhode Island Medicaid, state employees--health benefits program, Rhode Island Business Group on Health.[3]

APPENDIX (*continued*)		
Technical assistance	No information found	– Training is provided by the Rhode Island Department of Health and Rhode Island Quality Improvement organization, which also has technical experts whom practices may contact for assistance.[7] – Assistance includes on-site practice assistance, statewide learning sessions, mentoring, monthly best practice sharing meetings, nurse care manager training, and sponsorship at national conferences.[7]
HIT use	No information found	Some medical homes are receiving HIT support through the Beacon Community program, as well as ongoing data feedback. It is unclear how many of the pilot sites are receiving this support, however.
Evaluation methods	– Externally funded third-party evaluations will track several key clinical measures focusing on cost, return on investment, quality improvements, and patient/provider satisfaction. – An evaluation of Rhode Island's Global Consumer Choice Compact Waiver included CCC and RHP.[8] – Analyses included a comparison of expenditures for FFS and CCC/RHP programs and changes in medical care service utilization. – The report concludes that managed care programs were cost-effective and improved access to physician services.	– Practices report clinical quality data each quarter, which are shared with other demonstration practices, health insurance providers involved in the pilot, convening organizations, practice transformation consultants, and a stakeholder coalition.[4] – The practices provide clinical quality data related to treatment for diabetes, CAD, and depression, while health plans are reporting inpatient hospitalization and emergency department use to practices.[4] – Claims data will be utilized to assess clinical quality, patient experience, provider experience, cost and quality measures.[7] – Data on provider experience and satisfaction will be collected from interviews and surveys of providers, and patient satisfaction will be measured through a patient experience survey upon the pilot's completion.[4] – Evaluators From the Harvard School of Public Health will collect qualitative data to assess the process of practice transformation, the changes in patient outcomes, and the patient experiences of care.[6]

1. Rhode Island Department of Human Services. "Connect Care Choice Fact Sheet." Available at: http://www.dhs.ri.gov/Portals/0/Uploads/Documents/Public/ConnectCareChoice/ccc_fact_sheet.pdf.
2. Rhode Island Department of Human Services. "Rhody Health Partners Fact Sheet." Available at: http://www.dhs.ri.gov/Portals/0/Uploads/Documents/Public/Rhody%20Health%20Partners/rhp_fact_sheet.pdf.
3. Office of the Health Insurance Commissioner. "CSI Rhode Island: The Chronic Care Sustainability Initiative." Available at: http://www.ohic.ri.gov/documents/Committees/CSI%201st%20annual%20forum/1_Genesis%20of%20the%20RI%20Chronic%20Care%20Sustainability%20Initiative.pdf.
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EVALUATION OF THE MEDICAID HEALTH HOME OPTION FOR BENEFICIARIES WITH CHRONIC CONDITIONS:
Final Annual Report - Base Year

Files Available for This Report

Full Report (including state appendices)
Executive Summary: http://aspe.hhs.gov/daltcp/reports/2012/HHOptiones.shtml
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