



HEALTH SYSTEM REFORM

Health Homes in Medicaid

Designing Consumer-Friendly Health Homes

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

From Families USA • January 2013

Medicaid Health Homes offer states the opportunity and resources to provide coordinated care that can improve the health and well-being of some of their sickest and most vulnerable residents. States have considerable flexibility to identify populations with the greatest need for coordinated care and to design new models of care that address these patients' medical and non-medical needs.

This brief is the second in a series of three pieces that guide advocates as they think about the potential benefits of Health Homes and how they can be designed to most effectively meet patients' needs. It discusses six key decisions that states need to make when setting up Health Homes, and it explains the challenges that state advocates will want to address to ensure that Health Homes improve care.

1. Who gets to enroll in a Health Home?
2. What types of providers can be Health Homes?
3. What standards will providers have to meet to become Health Homes?
4. How will the state define the six Health Home services, and what staff will be needed to provide them?
5. How will health information technology (IT) be used in the Health Home?
6. How will patients be enrolled and engaged in the Health Home?

This piece also includes examples of decisions from the first states to develop Health Homes: Idaho, Iowa, Missouri, New York, North Carolina, Ohio, Oregon, and Rhode Island.

1. Who gets to enroll in a Health Home?

Targeting Based on Condition

The Affordable Care Act lists the following six examples of chronic conditions that can qualify a Medicaid enrollee for a Health Home:

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

States have broad flexibility in deciding which chronic conditions will qualify Medicaid beneficiaries to enroll in a Health Home. Some states have designed Health Homes for enrollees with just one or two of the conditions listed above, while others have targeted people with other conditions. Every Health Home that has been approved by the Centers for Medicare and Medicaid Services (CMS) so far has taken advantage of this flexibility.¹

Health Homes should focus on the state's Medicaid enrollees who will benefit the most from care coordination. Analyzing administrative claims data can help states identify which chronic conditions are associated with high rates of hospital and emergency room admissions. For example, **North Carolina** identified the 10 most common chronic conditions among its Medicaid population, and its Health Home will work with patients who have these conditions, as well as those listed above.²

People with serious mental illnesses or substance use disorders are among those with the most to gain from coordinated care. Mental illness and substance use can make it more difficult to adhere to treatment and to manage chronic conditions. Some medications that are used to address behavioral health problems exacerbate chronic conditions. For example, the antipsychotics used to treat schizophrenia can lead to weight gain and increase a patient's susceptibility to diabetes.³

The traditional separation of behavioral health from other medical care means that providers who treat these conditions rarely work together, and patient health suffers as a result. In addition, non-medical social factors, such as homelessness or isolation, have profound health implications, but they are not usually addressed at all.

As a result of this fragmentation, the rate of chronic illness among those with serious mental illnesses is several times higher than for the general population.⁴ Because people with mental health or substance use disorders would greatly benefit from coordinated

care that integrates medical care, behavioral health care, and social supports, advocates should urge states to develop Health Homes for this population. **Missouri, Ohio, and Rhode Island** have developed Health Homes for people with mental health or substance use disorders, and several other states are working to do so as well.

Targeting Based on Geography

The Affordable Care Act also allows states to design Health Homes for limited geographic areas. This is a good option for states that want to expand coordinated care but that lack the capacity to launch Health Homes statewide. Advocates should encourage Medicaid officials in states that are reluctant to implement Health Homes statewide to develop them first in counties with high levels of need and providers that have the capacity to become Health Homes. The state can later expand Health Homes more broadly if it chooses, and it will still get two years of enhanced matching funds for Health Home services in counties that did not have Health Homes initially.⁵

► Issues for Advocates to Consider

- Who in the state Medicaid population could benefit most from coordinated care?
- Will the option to develop Health Homes for people with a limited number of conditions or in a targeted geographic area help convince the state to pursue this new care model? If the state limits the population or geographic scope of initial Health Homes, what is its plan to expand or develop new Health Homes in the future?

2. What types of providers can be Health Homes?

Once the state has identified who will be eligible for a Health Home, it must decide what types of providers it will allow to become Health Homes. State advocates should think about which providers are best suited to offer the six Health Home services that are listed in the Affordable Care Act:

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

For more information on these six services, see page 11.

What to Look for in a Provider

Few providers already offer all six Health Home services, but some do have the experience and capacity that make them good potential Health Homes. The best Health Home providers will have the following:

- **Existing Care Relationships with the Health Home Population**

Continuity of care is important for all patients, but it is especially critical for those with complex chronic conditions who need ongoing care. States should minimize the disruption caused by the implementation of Health Homes by encouraging providers that already care for patients who would be eligible to become Health Homes. For example, **Missouri**, **Ohio**, and **Rhode Island** have chosen community mental health centers as Health Homes for those with serious mental illnesses.

- **Experience Coordinating Care**

Our current health care system encourages providers to specialize in a particular illness or body system and to treat only that specific aspect of the patient. Coordinated care requires providers to work together as a team to ensure that each patient receives the right treatment. It will be much easier for providers to become Health Homes if they have already made the transition to coordinated care. For example, most states have some form of Patient-Centered Medical Homes (PCMHs), which would have experience providing coordinated care that might make them good Health Homes for people with chronic conditions.

- **Health IT Systems in Place**

The Affordable Care Act strongly encourages states to use health IT to coordinate Health Home care. Adopting electronic health records (EHRs) and other health IT tools can be expensive and time consuming, so states should consider designating providers who already have health IT systems in place as Health Homes. States may want to support providers who are looking to adopt these systems in order to become Health Homes. States should also align their health IT standards for Health Homes with the meaningful use requirements of the Medicaid EHR Incentive Program.⁶ For more information about health IT, see page 14.

- **Strong Relationships with Different Types of Providers**

Each Health Home patient will need care from a range of medical and non-medical providers, and the Health Home is responsible for coordinating that care. To successfully do so, Health Homes must either have a range of providers on staff or be able to refer patients to and exchange information with other providers. These providers should accept new patients and be located close to where the Health Home population lives to ensure that patients can easily see all of their providers.

Although few providers will meet all of these criteria when Health Homes are launched, advocates should encourage states to select providers with the greatest capacity in these areas. Advocates should also push states to specify what additional capabilities these providers will need to develop in order to effectively serve the Health Home population. A timeline for Health Home providers to fill in these gaps should be included in the state plan amendment and in Health Home contracts.

Types of Providers

The early states to develop Health Homes are relying primarily on providers with strong relationships with the Health Home population. These providers include:

■ Safety Net Providers

Many states have designated safety net providers, such as federally qualified health centers (FQHCs) and rural health centers (RHCs), as Health Home providers. Safety net providers may be ideal Health Homes because they already provide care for many Medicaid beneficiaries who would be eligible for Health Homes, they are often located in low-income communities, and they frequently have the cultural and linguistic competence to support the Health Home population.

■ Community Mental Health Centers

Community mental health centers already perform some Health Home functions, including supporting patients' families and connecting vulnerable patients to resources in their community. These providers often have particularly strong relationships with people who have mental illnesses or substance use disorders and who would likely benefit significantly from coordinated care in a Health Home.

Non-Medical Providers as Health Homes

Some non-medical organizations may be good Health Home providers. For example, supportive housing facilities already provide care management, health promotion services, and referrals to community resources for their residents. Lack of stable housing is a significant barrier to health care that can exacerbate chronic conditions, so many people who are eligible for supportive housing would also be eligible for Health Homes. Providing care management that connects residents to primary and behavioral health care services as a part of supportive

housing has successfully improved health status and mental health outcomes, and it has reduced substance use.⁷ Designating supportive housing facilities as Health Homes would build on the strong relationships these facilities already have with Medicaid beneficiaries who would likely be eligible for Health Homes and on their experience with addressing non-medical needs. Selecting these facilities as Health Homes would also enable them to receive Medicaid reimbursement for the care management services they already provide.⁸

Health Homes and Managed Care

Some states may consider designating managed care organizations (MCOs) in Medicaid as Health Homes or having these organizations contract with other providers to offer Health Home services. Managed care organizations already have established provider networks, some experience managing care, and a health IT infrastructure that they use to track patients. However, most of these organizations have the following limitations that would need to be addressed to ensure they could deliver Health Home services effectively:

- **Telephonic Care Management**

Most managed care organizations currently provide care management over the phone rather than in person. Research suggests that care coordination that includes face-to-face interaction between patients and providers is much more effective than care coordination over the phone.⁹ Health Homes should be required to provide in-person care coordination for patients. If managed care organizations contract with providers to deliver Health Home services, face-to-face coordination should be part of the contract.

- **Small Provider Networks**

Some managed care organizations have small networks of providers and restrict the ability of enrollees to receive care from out-of-network providers. Limiting access to specific providers could be particularly harmful to the Health Home population because of the potential for a disruption of care if the network does not include a patient's current physician. Health Homes should be required to maintain networks that meet the diverse needs of the Health Home population.

- **Limited Formularies**

Managed care organizations often have formularies that require higher cost-sharing for non-preferred drugs, which is meant to encourage patients to use less expensive generics. Enrollees who need a non-preferred drug may have to get medical authorization, and they are sometimes required to undergo treatment with a less expensive option to prove that it does not work before the managed care organization will pay for the non-preferred drug. These practices could present a serious barrier to good care, particularly for patients with mental illnesses who are transitioning into a Health Home. Managed care organizations that are selected as Health Homes should be required to either waive cost-sharing for non-preferred drugs when there is medical documentation that the preferred drug does not work for the patient, or they should exclude psychiatric medications from formulary requirements.

■ **Lack of Experience with Behavioral Health and Long-Term Supports and Services**

Many managed care organizations lack experience managing behavioral health care and long-term supports and services because these types of care are often excluded from managed care contracts. If a managed care organization has not included behavioral health and long-term supports and services in the past, it should be required to document the steps it will take to ensure that these types of care will be fully integrated into the Health Home and that the appropriate providers are brought into its network.

It is also critical that existing protections for Medicaid consumers in managed care organizations be extended to include Health Homes. Quality reviews will be needed to ensure that Health Homes do not deny necessary care in an effort to save money. Beneficiaries and their families must know their rights and be able to appeal decisions made by the managed care organization. The same internal and external appeals rights that protect Medicaid beneficiaries in managed care should apply to Health Home services, including Medicaid fair hearing protections. Additionally, Health Home providers that contract with managed care organizations should be able to advocate for beneficiaries against the organizations.

▶ **Issues for Advocates to Consider**

- Which providers have existing care relationships, care coordination experience, health IT systems, and networks to meet the needs of the Health Home population?
- Will the state allow managed care organizations to be Health Homes, or will it contract with other providers to offer Health Home services? If so, what limitations will need to be addressed?

3. What standards will providers have to meet to become Health Homes?

The state will need to establish a set of standards for determining whether providers can become Health Homes. CMS has not provided final guidance on what standards Health Homes should meet, but it did list 11 functions that Health Home providers are required to perform:¹⁰

1. Provide quality-driven, cost-effective, culturally appropriate, and patient- and family-centered Health Home services.
2. Coordinate and provide access to high-quality health care services that are informed by evidence-based guidelines.

3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
4. Coordinate and provide access to mental health and substance abuse services.
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning, or facilitating transfer from a pediatric to an adult system of health care.
6. Coordinate and provide access to chronic disease management, including self-management support for individuals and their families.
7. Coordinate and provide access to individual and family supports, including referrals to community services, social support, and recovery services.
8. Coordinate and provide access to long-term supports and services.
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health care-related needs and services.
10. Demonstrate a capacity to use health IT to link services; facilitate communication among team members and among the health team, the individual, and family caregivers; and provide feedback to practices, as feasible and appropriate.
11. Establish a continuous quality improvement program. Collect and report on data to evaluate the success of increased care coordination and chronic disease management in terms of clinical outcomes, patient experience, and quality of care.

This list does not explain how these functions should be carried out or how a provider's capacity to do so should be evaluated. States need to develop their own ways of evaluating whether a provider is ready to become a Health Home and perform these functions. This can be done through state-specific standards alone or in combination with independent national standards for patient-centered care.

Developing State-Specific Standards

State-specific standards for Health Homes should be based on the needs of the target population, and they should include specific ways to evaluate the systems, protocols, infrastructure, and experience that providers will need to best serve this population.

Advocates should make sure that state standards for provider selection include the following areas that are often overlooked:

■ Behavioral Health

While the degree of focus on behavioral health requirements will vary depending on whether the Health Home is designed specifically for those with serious mental illness and/or substance use disorders, all Health Homes are responsible for integrating and coordinating behavioral health care. In addition to screening for behavioral health problems, Health Homes should follow best practices for integration with behavioral health providers by, for example, using a “warm hand-off” to help the patient connect with the behavioral health provider through an in-person introduction.

■ Support for Non-Medical Needs

Referral to community supports and services is another function that is neglected in most medical home models, and it is a critical component of the Health Home model. Advocates should ask how Health Homes will be required to perform services such as following up on referrals to other community organizations and services.

■ Patient Experience

Health Homes should be required to regularly measure and report patient experience scores and use that feedback to improve how care is delivered. The third brief in this series includes a more detailed discussion of the importance of patient experience measures and different ways to measure patient experience.

Examples of State-Specific Standards

Iowa requires its Health Homes to ensure that each patient has an ongoing relationship with a personal provider and that the patient, the personal provider, and the care team recognize one another as partners in care.

New York requires Health Home providers to guarantee access to a care manager who can provide information and emergency consultation 24 hours a day, seven days a week.

Ohio requires providers to establish partnerships and policies for referrals to and coordination with specialty providers, inpatient facilities, and managed care plans to allow for effective delivery of Health Home services.

Using National Standards

Using independent national standards for patient-centered care in addition to state standards can help states ensure that Health Home providers are qualified, and it can encourage ongoing improvement. Some states require prospective Health Homes to gain a national accreditation or certification, and others require Health Homes to complete patient-centered practice self-assessments.

■ Accreditation or Certification

Several states require their Health Homes to become recognized National Committee for Quality Assurance (NCQA) Patient-Centered Medical Homes (PCMH).¹¹ To meet NCQA PCMH standards,¹² practices have to demonstrate their use of a number of care coordination best practices that align with Health Home goals. NCQA measures how well a provider performs with regard to access, population management, care management, coordination with non-medical supports, tracking referrals and care transitions, quality measurement, and improvement.

NCQA recognition is the only type of national accreditation that has been included in Health Home state plan amendments so far, but other organizations also offer PCMH accreditation or certification, including the Joint Commission,¹³ the Accreditation Association for Ambulatory Health Care,¹⁴ and URAC.¹⁵ There are also accreditations for behavioral health providers who integrate primary care into their practices. **Ohio** requires its behavioral Health Homes to achieve either this primary care integration accreditation or NCQA accreditation.¹⁶ While there is overlap in the capabilities that are measured by each organization, there are also significant differences.¹⁷ Advocates should evaluate each accreditation process and its requirements to determine which one would best protect consumer interests.

■ Self-Assessment

To help providers develop priorities for shifting to a patient-centered focus, states may ask Health Homes to complete PCMH self-assessments that they must submit as part of the application to become a Health Home. For example, the American Academy of Family Physicians offers a free PCMH self-assessment tool that is based on NCQA standards called TransforMED.¹⁸ **Iowa** requires its Health Homes to complete this self-assessment when they sign up to become Health Homes. This type of assessment can help practices identify areas where care can be improved.

Having an outside organization monitor and evaluate how well Health Homes are conducting care coordination can be a valuable consumer protection, but it also carries financial and administrative burdens for providers. States that choose to use national standards should factor the cost of accreditation into Health Home payments. For example, **Idaho** added one dollar per member per month to payments to cover the cost of NCQA accreditation. States

could also provide incentives for providers who pursue higher levels of recognition, such as tiered payments. The third brief in this series discusses tiered payments and other financial incentives for provider transformation.

While accreditations and assessments offer an important source of independent evaluation of provider capacity, they have some limits. The PCMH accreditation standards and assessment tools were not developed with complex patients in mind. As a result, they do not adequately address key areas that are essential for successful Health Homes, such as the integration of behavioral health, support for non-medical needs, and the measurement and improvement of patient experiences. Advocates in states that use national accreditation or self-assessment should make sure the state also has strong state standards for these key areas. Additionally, advocates should work with the organizations that have developed accreditation standards or assessments to modify these tools so that they appropriately evaluate these important areas.

► Issues for Advocates to Consider

- What capacities will providers need to serve the Health Home population?
- What requirements should the state have for the integration of behavioral health, support for non-medical needs, and tracking patient experience?
- Would national certification or accreditation be a helpful supplement to state standards? How will the state support providers in obtaining certification or accreditation?

4. How will the state define the six Health Home services, and what staff will be needed to provide them?

The Affordable Care Act lists six services that Health Homes must provide for their enrollees, but it leaves the task of defining what each service means in practical terms and what types of staff members will be needed to deliver these services to the states.

Defining Health Home Services

The following list describes elements that state advocates should look for in the definition of each service. The recommendations for each service are based on the Health Homes that CMS has already approved and on conversations with state advocates who are involved in Health Home development:

■ Comprehensive Care Management

Comprehensive care management includes identifying individuals who would benefit from a Health Home, assessing patients' medical and non-medical needs, developing patient-centered care plans, and assigning roles in patient care. Patients and/or caregivers should be actively involved in the development of the care plan, which

should reflect the health goals and values of the patient. Because caregivers and family members often have significant care responsibilities, their roles should be included in the care plan as well.

- **Care Coordination**

Care coordination is carried out by a dedicated staff member who helps patients and providers follow the care plan. A care coordinator should help patients set and keep appointments, adhere to medication plans, and communicate with providers and family members. Care coordinators or managers also ensure effective cooperation and communication among providers.

- **Health Promotion**

Health promotion is prevention-focused education and support for the patient and family, and it should be specific to the patient's chronic conditions and risk factors. Possible intervention areas include substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, and increased physical activity. Health promotion should be culturally appropriate and have a strong emphasis on patient empowerment and self-management of chronic conditions. Effective health promotion strategies should be developed in cooperation with the patient, and they should address any barriers that could prevent the patient from successfully managing his or her own health.

- **Comprehensive Transitional Care**

Comprehensive transitional care involves coordination and follow-up among providers, caregivers, and the patient when she leaves an inpatient facility or is transferred. A patient who is moving from a hospital to her home or to a nursing home often has new care needs and new medications and therefore requires follow-up appointments. Without help navigating these changes, many patients end up in the hospital again. To prevent unnecessary readmissions, the patient's care coordinator should be in close contact with the patient and her providers during such transitions. Transitional care should include in-person follow-up with the patient within one week. As part of this visit, providers should review the medications that the patient is taking to make sure they match what was prescribed.

- **Individual and Family Support Services**

Individual and family support services focuses on clear, effective, and culturally and linguistically appropriate communication among providers, the patient, and the patient's family or caregivers. It also connects patients and caregivers with peer supports, including support groups, self-care programs, and peer specialists. Supports should include advocacy and efforts to address barriers to care or health improvements, such as lack of transportation to appointments or difficulty understanding and adhering to medication regimens.

- **Referral to Community and Social Support Services**

Referral to community and social support services helps patients to obtain and maintain the non-medical resources they need to lead healthy lives. Health Homes should refer patients to resources such as long-term services and supports, disability benefits, nutrition assistance, education, housing, and legal services. Such referrals must go beyond handing the patient a list of local service providers—Health Home staff should facilitate connections with other service providers, follow up with the patient, and address barriers to obtaining services.

Patient-centered care engages the patient and her caregivers as active participants in care. The provider's role is to give the patient a thorough explanation of her care options and help her identify what will work best, rather than making decisions for the patient. Patient-centered care recognizes that the effectiveness of treatment, particularly of chronic disease, depends in large part on the patient's self-management of her illnesses. Patient buy-in can dramatically improve the likelihood that treatment will be successful. Patient-centered care also requires a provider to determine what, if any, barriers a patient may encounter when trying to follow through with treatment or improve her health. State advocates should evaluate each service definition by how well it meets these goals of patient-centered care.

Members of the Care Team

Each Health Home patient will need a team to oversee his or her care that includes medical and non-medical Health Home staff, family and caregivers, and the patient. Because no two patients' needs will be the same, there is no one-size-fits-all team. As states develop requirements for what types of providers should be in a Health Home and what the six Health Home services include, advocates should make sure that Health Homes are required to develop teams that are tailored to each individual patient, based on a thorough assessment of her medical and non-medical needs.¹⁹ Key providers that will be a part of most teams include:

- **A Primary Care Provider**

All Health Homes will want to include a primary care provider as a central member of the team. To ease staffing burdens, particularly on Health Homes that are not based in primary care practices, some states are allowing non-physicians, such as nurse practitioners, to be designated as primary care providers.²⁰

- **A Behavioral Health Provider or Consultant**

Patients with multiple chronic illnesses also have higher rates of depression and other mental health problems. All Health Homes, whether or not they are focused on those with serious mental illnesses, should either include a behavioral health provider or have access to a consultant who can give recommendations or referrals for behavioral health needs.

■ **A Dedicated Care Coordinator**

Care coordinators, also known as care managers, are the glue that holds a care team together. Effective care management is time-intensive, involving meetings with providers and patients, home visits, and more. Care coordinators' caseloads must reflect the time and effort required to effectively manage care, particularly for the most complex patients. The optimal ratio of care managers to patients will depend on the needs of the patient population. States are directing Health Homes to use nurses or social workers as care coordinators. States will need to consider how best to train this essential member of the care team. For example, in collaboration with donors and state associations, **New York** has developed the New York Care Coordination Program to train Health Home care managers.²¹

■ **A Pharmacist**

Adverse drug interactions and poor medication adherence are major challenges in controlling chronic illnesses. Having a pharmacist on the Health Home staff, or requiring Health Homes to have a consultative relationship with a pharmacist, is important for preventing medication errors and managing treatment.

▶ **Issues for Advocates to Consider**

- How can the needs of the Health Home population be addressed in each service definition?
- How will the patient's goals, preferences, and priorities be reflected in how each service is delivered?
- How will the patient be engaged in his or her own care and self-management? How will the Health Home assess and address barriers to self-management?
- Does the care plan clearly identify roles for medical and non-medical providers, the care coordinator, the patient, and the patient's caregivers?
- What types of providers will the particular Health Home population need? How will the state ensure that all of the patients' providers and caregivers are part of her care team?

5. How will health IT be used in the Health Home?

A key component of care coordination that runs through all six Health Home services is ensuring that everyone who is involved in a patient's care has the same timely, accurate information about the patient and can communicate easily. Health IT provides powerful tools to facilitate communication and information-sharing, and it is a key part of a successful Health Home. Electronic health records (EHRs) are the most common form of health IT that is used in care coordination, and they can give all providers access to a patient's health history, care plan, medication list, allergies, test results, and current treatments.

Robust health IT systems will benefit Health Homes and their patients in a number of ways:

■ **Easier Care Coordination**

Coordinating care for patients with multiple providers across care settings requires a central source of patient information. All providers should have access to their patients' care plans and notes from other providers about medications, test results, courses of treatment, and the steps being taken to meet the patient's non-medical needs. This can cut down on redundant testing and adverse drug interactions, and it gives each provider a more complete picture of the patient's needs.

■ **Improved Quality of Care**

Health Homes can use a number of tools to help proactively ensure that patients are receiving the care they need. Health IT tools can alert the care manager when each of his diabetic patients needs a hemoglobin A1c test, for example, or they can remind him to make a follow-up home visit to a patient who was recently discharged from the hospital.

■ **More Accessible Provider Tools and Resources**

Health IT can support providers during visits with patients. Tools that are built in to an electronic health records program can aid in the diagnosis, care planning, and treatment of patients with complex conditions. For example, such a tool could alert a physician to a potential interaction among the medicines a patient is currently taking and a new drug the physician is considering prescribing. Lists of community support services could also be made available to the provider during a visit.

■ **Performance and Quality Tracking**

Health Homes are expected to perform well on key quality measures and show ongoing improvement over time. Good electronic records of patients' health care and outcomes allow providers to monitor their progress, identify best practices, and correct problems along the way. The third brief in this series discusses how Health Homes should measure performance and quality in more detail.

■ **Increased Patient Engagement**

Some health IT systems allow patients and their caregivers to view their health records online through a patient portal. For some patients, such portals can support good health self-management by, for example, giving the patient an easy reference guide on when and how to take medications and what each medicine is for. Patient portals can also facilitate email communication between the patient or caregiver and the Health Home, and they can make additional health promotion materials available to the patient.

While health IT systems have great potential to improve care and reduce administrative costs in the long term, they may be expensive and time-consuming to adopt. These costs are particularly burdensome for small providers and solo practices that have trouble finding the time and money to select and implement an electronic health records program.

States should take several steps to help providers adopt the health IT systems that they need to run a successful Health Home. States should align their provider requirements and reporting requirements with the adoption and meaningful use standards of the HITECH Act, and they should encourage providers to pursue the incentive payments that are available for Medicaid providers.²² States should also support small practices by identifying certified electronic health records programs that work well for small practices and meet interoperability standards.²³

Another challenge for Health Homes as they adopt and use health IT is balancing the need for patient information to be private and secure with the importance of sharing information for successful care coordination. State and federal privacy laws restrict the sharing of sensitive patient information regarding mental health, substance use disorders, and HIV status. While these are important consumer protections, the inability to share this information would limit care coordination and the integration of behavioral health into the Health Home. States should support the integration of behavioral health through health IT by providing guidance on issues of privacy and consent that need to be addressed in how behavioral health information is shared.²⁴ Advocates should help states develop guidance that takes a balanced approach to protecting privacy while allowing integration and care coordination in a way that is not overly burdensome on patients or providers.

▶ **Issues for Advocates to Consider**

- What will be the role of health IT in Health Homes? What health IT capacity will Health Homes need to have initially? What is the timeline for adopting and using more advanced forms of health IT?
- How do state requirements for health IT align with meaningful use requirements for Medicaid EHR incentives?
- How will the state support providers in the development of health IT capacity?

6. How will patients be enrolled and engaged in the Health Home?

States must decide how best to enroll eligible patients in Health Homes while ensuring continuity of care and preserving a patient's ability to choose the care that works best for her.

Enrollment

States have taken two approaches to enrolling eligible patients in Health Homes. Health Home enrollment can be active, where potentially eligible individuals sign themselves up, or passive, where the state automatically assigns enrollees to Health Homes. Each option presents challenges that need to be addressed as enrollment procedures are developed. Advocates should support whichever method will ensure that all eligible patients are aware of Health Homes and understand what they are while offering the flexibility for patients to choose the care that best meets their needs.

■ **Active Enrollment (also known as opt-in or voluntary enrollment)**

Active enrollment requires the patient to make an affirmative decision to select and enroll in a Health Home. This method of enrollment helps ensure continuity of care, since patients will usually sign up for a Health Home where they already receive care. A voluntary enrollment process also gives Health Homes an incentive to provide the services that patients want and need, since patients can always “vote with their feet” by leaving the Health Home.

If done poorly, however, active enrollment can lead to low participation among eligible patients, particularly those who don't have ongoing relationships with providers who may need care coordination the most. Advocates should push states that use active enrollment to work with providers and trusted community-based organizations to publicize the Health Home program, educate beneficiaries about their options, and help them select and enroll in a Health Home that works best for them.

■ **Passive Enrollment (also known as opt-out)**

Passive enrollment is a process in which the state automatically assigns eligible individuals to Health Homes, but it gives each beneficiary the option to select another Health Home or to opt out of being in a Health Home altogether. Health Home enrollment becomes the default for eligible Medicaid beneficiaries, leading to higher levels of participation.

If not done properly, passive enrollment can disrupt ongoing courses of treatment or existing patient-provider relationships. Passive enrollment should be paired with a robust assignment process that uses Medicaid claims history to assign each patient to the Health Home where he or she currently receives care. Passive enrollment also needs strong transition protections. If the Health Home to which the beneficiary is

assigned does not include a provider from whom the patient is currently receiving care, the patient must be able to, at a minimum, finish his course of treatment before transitioning to a Health Home. The state should work diligently to bring that provider into the Health Home if possible. In addition to maintaining continuity of care, states using passive enrollment should provide a simple opt-out process for enrollees.

When reviewing a state's Health Home enrollment procedures, advocates should make sure that mandatory enrollment or "lock-in" periods do not restrict patients from switching Health Homes or opting out of being in a Health Home altogether. Mandatory enrollment would allow the state to assign a patient to a Health Home without giving the patient the option to leave. The beneficiary might be able to switch Health Homes, usually once a year during a limited period of time, but she would be required to stay enrolled in the program. Mandatory enrollment poses a serious threat to continuity of care by preventing enrollees from receiving care from their current provider if that provider is not part of the Health Home program and chooses not to participate. No state has decided to use mandatory enrollment. Lock-in periods would also limit a patient's ability to switch Health Homes or leave a Health Home and should be avoided.

Enrollees should be able to switch Health Homes or opt out of the program altogether at any time. Health Homes must not inadvertently create a barrier to obtaining good care by preventing enrollees from identifying the care that works best for them, whether it is inside or outside a Health Home. **Missouri** and **Oregon** both have passive enrollment for their Health Homes, but they allow enrollees to switch Health Homes or opt out of the program at any time.

Outreach

Regardless of the type of enrollment a state chooses, the enrollment process must begin with patient education on what a Health Home is, what services are provided, how it could benefit the patient, and the patient's options to switch or leave a Health Home. States should use a variety of outreach strategies to ensure that as many eligible people as possible learn about Health Homes. Outreach strategies can include:

- **Contacting Beneficiaries**

Many potential Health Home enrollees would appreciate the opportunity to talk to someone about what a Health Home is and how it could affect their care. "High-touch" outreach, including in-person and phone outreach, is particularly effective. A patient's current care providers are best suited to have these conversations. States should require providers that are becoming Health Homes to reach out to patients directly, giving them an opportunity to ask questions.

■ **Informational Mailings**

Prior to enrollment in a Health Home, the patient should receive a clear, easy-to-read description of what a Health Home is and what its benefits are. For example, in its draft state plan amendment, **West Virginia** proposes that notifications to individuals who are automatically enrolled in a Health Home include a description of what the Health Home does; an explanation of the person's ability to choose another Health Home; a list of all Health Homes in the state; information on how to opt out or switch Health Home providers; and an assurance that if the person chooses not to participate in a Health Home, his or her current care will not be jeopardized.²⁵ Information that is sent to those who are assigned to a Health Home must make this opt-out provision clear.

■ **Community Forums**

Community forums can be a helpful way to give caregivers and potentially eligible patients information about what a Health Home is, and it allows them to interact with Health Home staff and to ask questions. Community-based organizations that have strong relationships with people who may be eligible for Health Homes would be ideal hosts for these forums.

Advocates should make sure that states incorporate the needs of people with limited English proficiency, low literacy, and disabilities into their enrollment procedures. Best practices for designing notifications include making sure they are at a 6th grade reading level or lower; translating notifications into all languages that are spoken by either 5 percent of the enrollee population or 500 people, whichever is less; and field testing notifications with the target population.²⁶

Engagement

Health Homes have new roles for not just providers, but for patients as well. Successful Health Home care requires the active participation of the patient and her caregivers. Enlisting patients and their families as members of the care team requires clear communication from the Health Home about the patient's role and responsibilities. Trusted community-based organizations that have strong relationships with the patient population can also play an important role in patient education. For example, the National Alliance on Mental Illness (NAMI) of Ohio is working with the state Department of Mental Health to develop educational materials and training for those who are eligible for Ohio's community behavioral health center Health Homes. NAMI Ohio's local affiliates will use these materials to educate Health Home patients.

► Issues for Advocates to Consider

- Can the patient switch Health Homes or opt out of Health Homes at any time?
- How will eligible patients find out about Health Homes? Who does the Health Home population trust as a source of information?
- How will the state ensure that patients who are eligible for Health Homes can continue to receive the care that works best for them, whether this is in a Health Home or not?

Conclusion

Designing an effective new care model is not easy. It involves asking tough questions about what works and what does not. It also requires rethinking what constitutes high-quality care, who should provide it, and how it should be organized. While there is lots of work to be done to make sure that Health Homes reach their full potential for providing high-quality care for the whole person, the design process is also an exciting opportunity for advocates to be involved in setting up a care model that meets the complex medical and non-medical needs of some of the most vulnerable Americans.

Resources

CMS, *State Medicaid Director Letter Re: Health Homes for Enrollees with Chronic Conditions*, available online at <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf>.

Integrated Care Resource Center, *Medicaid Health Homes Toolkit*, available online at <http://www.integratedcareresourcecenter.com/healthhomes.aspx>.

Endnotes

¹ For a list of the conditions targeted by the first states to develop Health Homes, see the “Health Homes: Summary of Key Details” chart at the end of the first brief in this series, *Health Homes in Medicaid: Challenges and Opportunities for Advocates*, available online at <http://familiesusa2.org/assets/pdfs/health-system-reform/Health-Homes-in-Medicaid.pdf>.

² The North Carolina Health Home state plan amendment is available online at <http://www.ncdhhs.gov/dma/plan/HealthHomeApprovedSPA-Effective10012011.pdf>.

³ Stephen Gough and Robert Peveler, “Diabetes and Its Prevention: Practical Solutions for People with Schizophrenia,” *The British Journal of Psychiatry* 184 (2004): 106-111, available online at <http://bjp.rcpsych.org/content/184/47/s106.full>.

⁴ Joe Parks, Dale Svendsen, Patricia Singer, and Mary Ellen Foti (eds), *Morbidity and Mortality in People with Serious Mental Illness* (Alexandria, VA: National Association of State Mental Health Program Directors, 2006), available online at http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Technical%20Report%20on%20Morbidity%20and%20Mortality%20-%20Final%2011-06.pdf.

⁵ Each new Health Home qualifies for its own two-year enhanced match period. For more information, see Sarah Baggé, *Health Homes in Medicaid: Challenges and Opportunities for Advocates* (Washington: Families USA, November 2012), available online at <http://familiesusa2.org/assets/pdfs/health-system-reform/Health-Homes-in-Medicaid.pdf>.

⁶ The HITECH Act established incentive payments for certain hospitals and individual Medicaid providers who adopt and demonstrate meaningful use of EHRs. Eligible providers can receive up to \$63,750 per year for EHR use. For more information, see <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms/>.

⁷ Michael Nardone, Richard Cho, and Kathy Moses, *Medicaid-Financed Services in Supportive Housing for High-Need Homeless Beneficiaries: The Business Case* (Hamilton, NJ: Center for Health Care Strategies, 2012), available online at http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261378#.UFDxnK604QM.

⁸ Corporation for Supportive Housing, *The Role of Supportive Housing Providers: Creating Health Care Homes for Chronically Ill Residents* (New York: Corporation for Supportive Housing, July 2011), available online at http://www.csh.org/wp-content/uploads/2011/12/Report_HealthHomesOption.pdf.

⁹ Deborah Peikes, Arnold Chen, Jennifer Schore, and Randall Brown, “Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures among Medicare Beneficiaries,” *Journal of the American Medical Association* 301, no. 6 (2009): 603-618, available online at <http://jama.jamanetwork.com/article.aspx?articleid=183370#RESULTS>.

¹⁰ Centers for Medicare and Medicaid Services, *State Medicaid Director Letter Re: Health Homes for Enrollees with Chronic Conditions* (Baltimore: Department of Health and Human Services, Nov. 16, 2010), available online at <http://downloads.cms.gov/cmssgov/archived-downloads/SMDL/downloads/SMD10024.pdf>.

¹¹ Idaho’s Health Homes website indicates that Idaho’s draft state plan amendment includes the requirement that Health Homes reach at least Level 1 NCQA certification by the second year of Health Home participation. Iowa’s state plan amendment indicates that the state will also likely require NCQA accreditation. Missouri is requiring its chronic disease Health Homes to submit an application for NCQA recognition within 18 months of offering Health Home services and to achieve PCMH Level 1 standards.

¹² For more on the NCQA PCMH standards, see <http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx>.

¹³ The Joint Commission offers Primary Care Medical Home Certification. For more information, see <http://www.jointcommission.org/accreditation/pchi.aspx>.

¹⁴ For more information on Medical Home certification by the Accreditation Association for Ambulatory Health Care, see <http://www.aaahc.org/en/accreditation/primary-care-medical-home/>.

¹⁵ Information about URAC’s Patient-Centered Health Care Home certification is available online at <https://www.urac.org/pchch/>.

¹⁶ Ohio’s Health Home state plan amendment is available online at http://www.chcs.org/usr_doc/Medicaid_Model_Data_Lab.pdf.

¹⁷ For a thorough comparison of available PCMH accreditation models, see Rachel A. Burton, Kelly J. Devers, and Robert A. Berenson, *Patient-Centered Medical Home Recognition Tools: A Comparison of Ten Surveys’ Content and Operational Details* (Washington: Urban Institute, 2012) available online at <http://www.urban.org/uploadedpdf/412338-patient-centered-medical-home-rec-tools.pdf>.

¹⁸ For more information about TransformMED, see <http://www.transformed.com/>.

¹⁹ For example, Ohio's state plan amendment developing Health Homes for those with serious mental illnesses requires the Health Home to "establish partnerships and coordinate with other health care resources to address identified client needs, which include, but are not limited to: hospitals, medical service providers, specialists (including OB/GYNs and substance abuse treatment specialists), long-term care service and support providers, managed care plans, and other providers as appropriate to meet beneficiaries needs." The Ohio state plan amendment is available online at http://www.chcs.org/usr_doc/Medicaid_Model_Data_Lab.pdf.

²⁰ For example, Ohio allows not only physicians, but also Certified Nurse Practitioners with a primary care scope of practice, Clinical Nurse Specialists with a primary care scope of practice, and Physician Assistants to fulfill the role of embedded primary clinicians in its behavioral Health Homes. The Ohio state plan amendment is available online at http://www.chcs.org/usr_doc/Medicaid_Model_Data_Lab.pdf.

²¹ For more information, see www.healthhometraining.com.

²² The HITECH Act established incentive payments for certain hospitals and individual Medicaid providers who adopt and demonstrate meaningful use of EHRs. Eligible providers can receive up to \$63,750 per year for EHR use. For more information, see <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms/>.

²³ Interoperability is the ability of health IT systems to exchange information with one another. The electronic health record system at a Health Home and the records systems at local hospitals should be able to securely pass patient information back and forth so that both sets of records remain up-to-date.

²⁴ In a care coordination project for adult Medicaid beneficiaries with serious mental illness and chronic physical conditions, the state agency developed guidance on how to solicit consent for information-sharing from patients and how to protect privacy, allowing for easier integration. Jung Y. Kim, Tricia Collins Higgins, Dominick Esposito, Angela M. Gerolamo, and Mark Flick, *SMI Innovations Project in Pennsylvania: Final Evaluation Report* (Hamilton, NJ: The Center for Health Care Strategies, 2012), available online at http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261431#.UGs6SK6fyQM.

²⁵ West Virginia's draft state plan amendment is available online at <http://www.wvhealthimprovement.org/Initiatives/BMSHealthHomes.aspx>.

²⁶ For more information on guidelines and best practices for plain language, see <http://www.plainlanguage.gov/howto/guidelines/FederalPLGuidelines/FederalPLGuidelines.pdf>. For more information on language access best practices, see Centers for Medicare and Medicaid Services, *Understanding and Using the Toolkit Guidelines for Culturally Appropriate Translation* (Baltimore: Department of Health and Human Services, September 2010), available online at <https://www.cms.gov/Outreach-and-Education/Outreach/WrittenMaterialsToolkit/Downloads/ToolkitPart11.pdf>; Community Catalyst, *Promoting Cultural Awareness and Language Assistance in Health Care* (Boston: Community Catalyst, March 2010), available online at http://www.communitycatalyst.org/doc_store/publications/Promoting_cultural_and_linguistic_competency_March_2010.pdf; and the Federal Interagency Working Group on Limited English Proficiency (LEP) website, available online at <http://www.lep.gov/>.

Acknowledgments

This brief was written by:

Sarah Baggé
Health Policy Analyst
Families USA

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

Michealle Gady, Senior Health Policy Analyst

Kim Bailey, Research Director

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

Dee Mahan, Director, Medicaid Advocacy

Rachel Strohman, Editorial Assistant

Ingrid VanTuinen, Deputy Director of Publications

Tara Bostock, Editor

Nancy Magill, Senior Graphic Designer

Designing Consumer-Friendly Health Homes

© January 2013 by Families USA

*A complete list of Families USA publications is available online at
www.familiesusa.org/resources/publications.*



1201 New York Avenue NW, Suite 1100 ■ Washington, DC 20005

Phone: 202-628-3030 ■ Email: info@familiesusa.org

www.familiesusa.org