

CAPITOL RESEARCH

HEALTH

Health Homes Can Help Improve Care, Save States Money

Health homes are a team-oriented approach, typically implemented out of a physician's office, to meet all of the health care needs of clients with chronic conditions. Also called patient-centered medical homes, the model asks providers to focus on improving care rather than managing costs. It seeks to improve the relationship between doctors and patients. Key components of health homes are:

- Each patient has an ongoing relationship with a personal physician who directs all care. The patient is often seen by other professionals in the physician's office, including nurses, social workers and nutritionists and may be referred outside the office for additional care.
- Each patient's care is coordinated and integrated across all parts of the health care system. The physician's office monitors the quality of care and patient safety for all patients. Patients often have expanded access to care through extended hours and new communication technologies.
- Physicians receive additional payment to support expanded staff and recognize the added value provided to patients.

Under the Patient Protection and Affordable Care Act, section 2703, states are offered the opportunity and funding to widely implement a patient-centered medical home model for Medicaid enrollees. As states continue to adopt the health home model, officials will need to understand the ability of patient-centered medical homes and health homes to create a sustainable and effective health care approach.

Adoption of Medicaid health homes across states varies:¹

- Seventeen states have one or more approved state plan amendments. Three of these states have submitted another state plan amendment to federal Medicaid officials.
- One state, Vermont, has no approved state plan amendment, but has submitted a plan to federal Medicaid officials for approval.
- Twelve states have submitted a health home planning request and have no submitted or approved state plan amendments.



Target Populations

The federal Medicaid program outlines eligibility requirements, but gives states the flexibility to adapt requirements to meet the needs of a target population that could benefit most from this restructured care approach. The federal statute requires enrollees to have at least two chronic conditions, one chronic condition and the potential for developing another chronic condition, or one severe and continuous mental health condition to be eligible. The federal statute defines chronic conditions as disorders related to “mental health, substance abuse, asthma, diabetes, heart disease, and being overweight.”²

Some states expand the definition of chronic disease beyond the federal definition.³

- Alabama does not include being overweight as a chronic disease; however, the state includes the other chronic diseases from the federal statute. Additionally, the state includes cardiovascular disease, chronic obstructive pulmonary disease, sickle cell anemia, cancer, transplants and HIV.
- Maine follows the federal definition with the addition of: use of tobacco, chronic obstructive pulmonary disease, hypertension, hyperlipidemia, developmental disabilities, autism spectrum disorder, acquired brain injury, seizure disorders, cardiac abnormalities and circulatory congenital abnormalities.

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Some states restrict the definition of chronic disease to cover fewer conditions than the federal definition.⁴ For instance, Ohio limits health home access to enrollees with a serious and persistent mental illness.

Provider Teams

The types of providers associated with the Medicaid health homes program vary by state. The federal government provides three main types of provider arrangements—the designated provider, a team of health professionals, or a health team; however, states have the flexibility to make their own decision on provider types.

- Missouri, one of the first states to adopt the health home model, has two state plan amendments. Both amendments have provider teams with a director, nurse care manager and administrative help. The community mental health centers are specifically for behavioral health and have a primary care physician consultant on the team. Primary care centers are for enrollees with physical conditions and include a behavioral health consultant, care coordinator and other clinical employees.
- New York, also one of the first states to adopt the model, determines health home providers through an application process. Providers can become health homes by proving how they will abide by health home guidelines. Examples of approved health homes in New York include hospital networks and community support providers.⁵

Key Research Results

Health homes are relatively new to states. Long-term research on the effectiveness of health

homes for the Medicaid population is not available; however, legislators and policymakers can use research from a similar model, the patient-centered medical home, to begin to understand the impact of collaborated, integrated care. Both medical homes and health homes have a team approach to care and a whole-person view of the patients. The main difference between the models is health homes target patients with chronic conditions who typically have higher medical costs, while patient-centered medical homes serve all populations.⁶

Studies show health outcomes and cost savings vary, but most studies call for more research. A three-year study by the RAND Corporation of 32 primary care practices in the Southeastern Pennsylvania Chronic Care Initiative found:

- The multipayer medical home pilot program did not experience significant decreases in the use or cost of health care. There were also no decreases in emergency department or ambulatory service use.
- Researchers also evaluated 11 health quality indicators, such as eye examinations and breast screening. Only one indicator, the monitoring of kidney disease in diabetics, significantly improved over the three years. The study calls for continued refinement of the medical home model.⁷

A systematic review of patient-centered medical home studies shows some favorable findings; however, it determines most studies done on the effectiveness of patient-centered medical homes were inconclusive. In order to better understand the model, more rigorous studies are needed.⁸ Key findings from the systematic review include:

- The Geriatric Resources for Assessment and Care of Elders program, or GRACE, produced savings

for only one subgroup of the study population: high-risk Medicare enrollees in year three after medical home intervention. Costs for this group decreased by 23 percent, but costs increased for patients who were not high risk, leaving no net gain or loss.⁹

- A study of a program targeting the veteran population—the Veterans Affairs Team-Managed Home-Based Primary Care—found that costs increased by 12 percent in the first year.¹⁰
- A study of an intervention program for adults with a diagnosis of major depression or dysthymia—Improving Mood-Promoting Access to Collaborative Treatment for Late-Life Depression, or IMPACT—was the only one in the systematic review to find rigorous and statistically significant evidence for both improving processes of care and health outcomes.¹¹ The IMPACT study included 1,801 adults with depression and multiple other chronic conditions across five states. IMPACT expanded the provider team by adding a depression care manager and a consulting psychiatrist. In addition, the program included a process to track clinical outcomes and a method to adjust treatments after consultation with the psychiatrist. In one year, patients receiving enhanced care were more likely to have reduced depression, improved quality of life and less pain.¹²
- The IMPACT study found for every \$1 spent on the collaborative care medical home model, \$6.50 could be saved in health care costs. That means if 20 percent of Medicaid enrollees with depression entered a collaborative care health home model, the health care savings would be \$15 billion per year.¹³

The Urban Institute examined health homes in the first four states with the model: Missouri, New York, Oregon and Rhode Island.¹⁴

- Results show the combination of physical and mental health care plus nonclinical support is essential to health homes.
- States report communication is still being improved within and across the sites of care, particularly between providers and hospitals and managed care organizations.
- Other issues include defining provider roles, inadequacy of current electronic health records, and implementation issues such as including children in the model and identifying potential enrollees.

In conclusion, the health homes model has potential for success. The shortcomings of the current Medicaid model are ones that will not disappear without change to the fundamental structure of how care is managed through Medicaid. The preliminary successes seen when the health homes model is implemented are small, yet encouraging, and represent possible cost savings for the Medicaid program, as well as improvement in the continuity of care for Medicaid enrollees.



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REFERENCES

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³State-by-State Health Home State Plan Amendment Matrix: Summary Overview. Centers for Medicare and Medicaid Services. <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-SPA-Matrix-02-14.pdf>

⁴Ibid.

⁵Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Final Annual Report-Base Year. U.S. Department of Health & Human Services. <http://aspe.hhs.gov/daltcp/reports/2012/HHOption.shtml#execsum>

⁶Compare and Contrast: Medicaid Health Homes and Patient Centered Medical Homes."National Council for Community Behavioral Healthcare. http://www.integration.samhsa.gov/integrated-care-models/Medicaid_HH_and_Patient_Centered_Medical_Homes.pdf

⁷Association Between Participation in a Multipayer Medical Home Intervention and Changes in Quality, Utilization, and Costs of Care. The Journal of the American Medical Association. <http://jama.jamanetwork.com/article.aspx?articleid=1832540#joi1400073>

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⁹Ibid.

¹⁰Ibid.

¹¹Ibid.

¹²The Collaborative Care Model: An Approach for Integrating Physical and Mental Care in Medicaid Health Homes. Medicaid.gov Health Home Information Resource Center. <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-IRC-Collaborative-5-13.pdf>

¹³Ibid.

¹⁴Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Final Annual Report-Base Year.



Medicaid State Plan Amendments for Health Homes

State	Status of Health Home Approved State Plan Amendments (SPA), Feb. 2014	Total Number of People Enrolled, July 2013
Alabama	One Approved SPA	67,691
Alaska	No Planning Request or Proposal	
Arizona	Approved Planning Request	
Arkansas	Approved Planning Request	
California	Approved Planning Request	
Colorado	No Planning Request or Proposal	
Connecticut	No Planning Request or Proposal	
D.C.	Approved Planning Request	
Delaware	No Planning Request or Proposal	
Florida	No Planning Request or Proposal	
Georgia	No Planning Request or Proposal	
Hawaii	No Planning Request or Proposal	
Idaho	One Approved SPA	9,158
Illinois	No Planning Request or Proposal	
Indiana	No Planning Request or Proposal	
Iowa	Two Approved SPA's. Third SPA Submitted to CMS.	3,763 (Sept. 2013)
Kansas	Approved Planning Request	
Kentucky	Approved Planning Request	
Louisiana	No Planning Request or Proposal	
Maine	One Approved SPA. Second SPA submitted to CMS.	52,780
Maryland	One Approved SPA	
Massachusetts	No Planning Request or Proposal	
Michigan	No Planning Request or Proposal	
Minnesota	Approved Planning Request	
Mississippi	Approved Planning Request	
Missouri	Two Approved SPA's	34,952 (June 2013)
Montana	No Planning Request or Proposal	
Nebraska	No Planning Request or Proposal	
Nevada	Approved Planning Request	
New Hampshire	No Planning Request or Proposal	
New Jersey	Approved Planning Request	
New Mexico	Approved Planning Request	
New York	Three Approved SPA's	98,739
North Carolina	One Approved SPA	559,839 (June 2013)
North Dakota	No Planning Request or Proposal	
Ohio	One Approved SPA. Second SPA submitted to CMS.	14,594
Oklahoma	No Planning Request or Proposal	
Oregon	One Approved SPA	38,752
Pennsylvania	No Planning Request or Proposal	
Rhode Island	Three Approved SPA's	8,055
South Carolina	No Planning Request or Proposal	
South Dakota	One Approved SPA	
Tennessee	No Planning Request or Proposal	
Texas	No Planning Request or Proposal	
Utah	No Planning Request or Proposal	
Vermont	First SPA submitted to CMS.	
Virginia	No Planning Request or Proposal	
Washington	Two Approved SPA's.	9,545 (Aug 2013)
West Virginia	Approved Planning Request	
Wisconsin	One Approved SPA. Second SPA submitted to CMS.	170 (Aug 2013)
Wyoming	No Planning Request or Proposal	

Source: State Health Home CMS Proposal Status. Centers for Medicare and Medicaid Services.

http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-MAP_v30.pdf