



MEDICAID HEALTH HOMES IN MASSACHUSETTS: Recommendation for Policy Reform

EXECUTIVE SUMMARY

The Affordable Care Act (ACA) created the option for states to establish Medicaid Health Homes as part of their Medicaid systems. Medicaid Health Homes are person-centered systems of care that provide coordinated services to individuals coping with chronic conditions. By establishing Medicaid Health Homes, states can realize a number of benefits, including reducing health disparities and controlling health care costs. The holistic, coordinated care provided in Medicaid Health Homes can also be particularly beneficial to patients with conditions such as HIV/AIDS, hepatitis C (“HCV”), and opioid addiction. Thus, as of April 2015, five states have established Medicaid Health Home programs that target persons living with HIV/AIDS, one of which also targets persons living with HCV. Additionally, at least three states have established Medicaid Health Homes that target opioid dependence.

The first section of this document will further describe the Medicaid Health Home option. Section II will then discuss the health and financial benefits of establishing Medicaid Health Homes, with a particular focus on benefits to patients with HIV/AIDS or HCV. Finally, the issue brief will conclude by examining how Massachusetts could enact a state plan amendment (“SPA”) to establish a Medicaid Health Home program.

The Center for Health Law & Policy Innovation provides information and technical assistance on issues related to health reform, public health, and food law. This document should not be considered legal advice. For specific legal questions, consult with an attorney.

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TABLE OF CONTENTS

Executive Summary	Cover
Medicaid Health Homes	2
I. What are Medicaid Health Homes	2
II. Who Is Eligible for Medicaid Health Home Services	2
III. Services	2
IV. Providers	2
Benefits	3
I. Improving Treatment of Persons with Medicaid Who Have Chronic Conditions such as HIV and HCV	3
A. Examples of Benefits	3
B. Benefits Specific to Treating HIV/AIDS and HCV Patients	4
II. Receipt of Additional Federal Funding	4
A. Planning Funds	4
B. Two Years 90% FMAP	5
Implementation: Enacting A State Plan Amendment	5
I. Planning Funds	5
II. State Plan Amendment	5
III. Support for Medicaid Health Homes in Massachusetts	6
Conclusion	7

ABOUT THE AUTHORS

The Center for Health Law and Policy Innovation of Harvard Law School (CHLPI) advocates for legal, regulatory, and policy reforms to improve the health of underserved populations, with a focus on the needs of low-income people living with chronic illnesses. CHLPI works with consumers, advocates, community-based organizations, health and social services professionals, food providers and producers, government officials, and others to expand access to high-quality healthcare and nutritious, affordable food; to reduce health disparities; to develop community advocacy capacity; and to promote more equitable and effective healthcare and food systems. CHLPI is a clinical teaching program of Harvard Law School and mentors students to become skilled, innovative, and thoughtful practitioners as well as leaders in health, public health, and food law and policy.

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MEDICAID HEALTH HOMES

I. WHAT ARE MEDICAID HEALTH HOMES

Medicaid Health Homes are “person-centered” systems of care that provide coordinated services to individuals coping with chronic conditions.¹ Section 2703 of the Affordable Care Act of 2010 (“ACA”), codified at 42 U.S.C. § 1396w-4, “created an optional Medicaid State Plan benefit for states to establish Health Homes.”² Under the statute, Medicaid Health Homes are required to provide certain health care services to eligible persons.³ Notably, Medicaid Health Homes are distinct from Medical Homes.⁴ Health Homes provide coordinated care to individuals with chronic health conditions, while Medical Homes provide overall care to all individuals.⁵

II. WHO IS ELIGIBLE FOR MEDICAID HEALTH HOME SERVICES

States may provide Medicaid Health Home services to Medicaid beneficiaries who: (1) have at least two chronic conditions; (2) have at least one chronic condition and are at risk of having a second chronic condition; or (3) have at least one serious and persistent mental health condition.⁶

Section 2703 lists a number of chronic conditions that can qualify individuals for Medicaid Health Home services. These conditions include: A mental health condition, substance use disorder, asthma, diabetes, heart disease, and being overweight (Body Mass Index over 25).⁷ However, this list is not exhaustive. The Centers for Medicare and Medicaid Services (“CMS”) may also consider additional conditions as chronic conditions for the purposes of Medicaid Health Home eligibility.⁸ Thus, in 2010, CMS issued preliminary guidance which stated that “[a]dditional chronic conditions, such as HIV/AIDS, will be considered for incorporation into health home models.”⁹

States have considerable flexibility when determining which chronic conditions to treat via their Medicaid Health Home programs. A state may elect in its state plan to provide Health Home services to individuals based on all the chronic conditions listed or choose particular chronic conditions.¹⁰ States also have the flexibility to target their Medicaid Health Home services geographically or to “individuals with higher numbers or severity of chronic or mental health conditions.”¹¹

III. SERVICES

According to the statute, Health Homes are to provide comprehensive and timely high-quality services.¹² In particular, Health Homes must provide: (1) comprehensive care management; (2) care coordination and health promotion; (3) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; (4) patient and family support; (5) referral to community and social support services; and (6) use of health information technology to link services.¹³

IV. PROVIDERS

States also have considerable flexibility to determine how providers will administer services within their Health Home programs.¹⁴ There are three types of Medicaid Health Home provider arrangements under the statute.¹⁵ Health Home providers can be (1) a designated provider such as a physician or clinical/group practice; (2) a team of health professionals which may include physicians, nurse care coordinators, etc.; or (3) a health team which must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractics, licensed complementary and alternative practitioners.¹⁶

BENEFITS

There are two primary categories of benefits associated with the implementation of Medicaid Health Homes. First, Health Homes improve treatment of persons who have chronic health conditions. Second, states that implement Health Homes receive the benefit of additional federal funding.

I. IMPROVING TREATMENT OF PERSONS WITH MEDICAID WHO HAVE CHRONIC CONDITIONS SUCH AS HIV AND HCV

By providing person-centered coordinated care, Health Homes can benefit the state by improving care and care coordination, reducing health disparities, improving access to health care and other community based services, integrating physical and behavioral health services, and controlling costs.¹⁷ In addition, Health Homes can better address the needs of Medicaid beneficiaries coping with serious mental illnesses and substance use disorders such as opioid dependence.¹⁸ Thus, several states, including Maryland, Rhode Island, and Vermont, have implemented Medicaid Health Homes for persons with opioid dependence.¹⁹

In order to track the success of Medicaid Health Home programs in improving care, CMS has developed a recommended set of health care core quality measures.²⁰ States are not currently required to use these measures, but will be when official regulations are issued.²¹ The recommended measures include: adult body mass index assessment; ambulatory care – sensitive condition admission; care transition; follow-up after hospitalization for mental illness; plan – all cause readmission; screening for clinical depression and follow-up plan; initiation and engagement of alcohol and other drug dependence treatment; and controlling high blood pressure.²²

A. Examples of Benefits

A number of states that were early adopters of the Medicaid Health Home model have reported positive results. In particular, Iowa, Missouri, and New York have all reported positive impacts derived from their respective Health Home programs.

In 2012, Iowa established its first Medicaid Health Home program targeting people with chronic conditions listed in the statute and hypertension.²³ After 18 months, there is evidence that the existence of Health Homes has improved patient health and satisfaction with care, reduced emergency department use, and reduced overall Medicaid costs associated with treating Health Home eligible patients.²⁴ The average amount of money spent on health care for a Health Home enrollee was 20% less than for non-Health Home individuals with similar conditions.²⁵ Thus, the program resulted in \$11 million in Medicaid cost savings during this period.²⁶

Missouri established two Medicaid Health Home programs in 2012.²⁷ Together, they target people with chronic conditions listed in the statute and developmental disabilities.²⁸ In addition, they define “at risk” criteria as tobacco use and diabetes.²⁹ Early results indicate that the Health Home programs have improved outcomes and reduced costs.³⁰ There has been a decrease in emergency department visits by 6-8%, and ambulatory care-sensitive hospitalizations by 13%.³¹ It is estimated that Missouri’s Health Homes have provided combined cost savings of \$52 per-member-per-month (“PMPM”).³²

Finally, in 2012, New York established a Medicaid Health Home program targeting people with chronic conditions listed in the statute and 3M Clinical Risk Group categories of chronic behavioral and medical conditions.³³ The 3M

Clinical Risk Group categories include: alcohol and substance abuse; mental health; cardiovascular disease; HIV/AIDS; metabolic disease; and respiratory disease.³⁴ Early results for beneficiaries that have been continuously enrolled in the Health Home indicate that the program has improved outcomes and reduced costs.³⁵ There have been increases in primary care visits by 14% and decreases in inpatient utilization and emergency department visits by 23%.³⁶

B. Benefits Specific to Treating HIV/AIDS and HCV Patients

In addition to improving treatment for persons with chronic conditions generally, Health Homes can be particularly beneficial to treating persons with HIV/AIDS or HCV. According to the Kaiser Family Foundation, the Health Home model has been “an important part of HIV care over the course of the HIV epidemic,” and is a key feature of the Ryan White HIV/AIDS program.³⁷ Thus, states can build upon the successes of the Ryan White program by establishing Medicaid Health Homes, thereby expanding access to this key element of care by incorporating it into an entitlement—rather than discretionary—program.

Medicaid Health Homes are also beneficial to treating persons coping with HCV. According to a report by the National Alliance of State and Territorial AIDS Directors, Health Homes have “particular potential to improve viral hepatitis care because of the often multiple needs and coordination among medical and social services providers needed to enable people to adhere to treatment regimens.”³⁸ Generally, “HCV care and treatment often involves coordination among multiple service providers as well as administrative and patient support throughout treatment.”³⁹ Medicaid Health Homes are uniquely well-positioned to meet these treatment needs.

Ultimately, Medicaid Health Homes present an opportunity to provide the essential services for treating persons with HIV or HCV. The Health Home services defined in the statute are precisely the types of services recommended by the Health Resources and Services Administration for “engaging and retaining people with HIV in care, needed to produce good clinical outcomes and manage costs,”⁴⁰ and which often receive only limited coverage in other Medicaid programs.⁴¹ Similarly, Health Homes can provide the holistic care needed for treating HCV patients.⁴² Thus, as of April 8, 2015, one state has implemented a Medicaid Health Home program that targets both HIV and HCV (Oregon), and four states have implemented Medicaid Health Home programs that target HIV but not HCV (Alabama, New York, Washington, Wisconsin).⁴³

II. RECEIPT OF ADDITIONAL FEDERAL FUNDING

The Medicaid Health Home program also provides the benefit of allowing states to take advantage of two additional sources of federal funding: (1) planning funds and (2) funds to assist with the operation of Health Homes.

A. Planning Funds

Upon request, planning funds are available to help state Medicaid agencies in planning Medicaid Health Home programs and developing an SPA.⁴⁴ To request these funds, states should submit a two-page Letter of Request including a description of Health Home planning activities and an estimated budget to CMS.⁴⁵ If approved, CMS will authorize up to \$500,000.⁴⁶ Funding in excess of \$500,000 may be permitted upon review by CMS.⁴⁷ The funding will be provided to the State at its regular medical assistance service match rate.⁴⁸ If during the Health Home planning process the state determines that a Health Home program is not feasible, the state is not required to move forward and submit a SPA.⁴⁹ Additional details regarding planning funds are available on the Medicaid website.⁵⁰

B. Two Years 90% FMAP

For the first eight fiscal quarters an SPA is in effect, the state will also receive an enhanced Federal Medical Assistance Percentage (“FMAP”) of 90%.⁵¹ Regular Medicaid FMAP rates will apply thereafter.⁵² The enhanced FMAP rates apply only to Health Home core services listed in Section 2703 and do not apply to other underlying Medicaid services provided to beneficiaries enrolled in Health Homes.⁵³ States may receive more than one period of enhanced match, but they are only allowed to claim the enhanced match for a total of eight quarters for one beneficiary.⁵⁴

IMPLEMENTATION: ENACTING A STATE PLAN AMENDMENT

I. PLANNING FUNDS

The first step in implementing a Medicaid Health Home program in Massachusetts would be to request funds from CMS to support Health Home planning activities. As mentioned above, up to \$500,000 in planning funds are available to assist state Medicaid agencies in planning Medicaid Health Home programs and developing an SPA.⁵⁵ Although only the Massachusetts Medicaid agency, MassHealth, can request the planning funds, other stakeholders and Massachusetts policymakers can assist the agency by providing it with feedback and consultation regarding the request.

To request planning funds MassHealth should submit a Letter of Request of no more than two pages to CMS.⁵⁶ The letter should describe Health Home planning activities and include an estimated budget request.⁵⁷ Appropriate Health Home planning activities include: (1) “hiring of personnel or contractors to determine feasibility and develop the [H]ealth [H]ome program;” (2) “initiatives to obtain consumer and provider feedback;” (3) “training and consultation related to designing components of any provisions of the SPA”; (4) “development of systems for reporting and other infrastructure building tasks;” and (5) travel to accomplish the activities described.⁵⁸

If the request is approved, CMS will authorize up to \$500,000 for MassHealth to pursue planning activities and to develop an SPA for the Medicaid Health Home program.⁵⁹ MassHealth may also request further funds, but must provide additional justification in that case.⁶⁰ The approved planning activities and expenditures supporting the activities must be reported on a separate expenditure line on the Medicaid quarterly expense report (CMS-64).⁶¹

II. STATE PLAN AMENDMENT

In order to establish a Medicaid Health Home program, MassHealth must submit an SPA to CMS for approval.⁶² In Massachusetts, changes to the state’s Medicaid program through a SPA do not require legislative approval.⁶³ In other words, MassHealth can simply move forward with the SPA if it chooses to do so.

To develop the SPA, MassHealth should start with the Medicaid Health Home SPA Template available on the Medicaid website.⁶⁴ The key design factors to consider include: (1) target population and conditions covered; (2) geographic area covered; (3) provider model; (4) enrollment model; and (5) payment model.⁶⁵

Specifying the target population and conditions covered will determine who will be eligible for the Health Home program established by the SPA. States can decide if the target population consists of people with two or more chronic conditions, one chronic condition and at risk of developing another, or one serious mental illness.⁶⁶ As discussed above, options for conditions to be covered include all of the chronic conditions that are listed in the

statute.⁶⁷ There is also an option to add additional chronic conditions that are not listed in the statute that will be covered, and in this case, HIV/AIDS and HCV should be added.⁶⁸

Currently only one state, Oregon, includes both HIV/AIDS and HCV as covered chronic conditions in their Health Home program.⁶⁹ Other than the addition of a few covered chronic conditions, Oregon's target population and conditions covered definition is otherwise consistent with the definition in the statute.⁷⁰ Four other states, Alabama, New York, Washington, and Wisconsin, include HIV/AIDS as a covered chronic condition but not HCV.⁷¹ Other than adding new chronic conditions to be covered, Alabama and New York SPAs follow the target population and conditions covered definition in the statute.⁷² By contrast, Washington and Wisconsin have used the flexibility in the statute to create more targeted programs that focus on a subset of the possible target population and covered conditions listed in the statute.⁷³

Deciding which geographic areas to cover is an important design consideration as well. Health Home programs can target certain cities or regions, or the entire state.⁷⁴ Of the five states with programs covering HIV/AIDS, only Oregon's is state-wide.⁷⁵ Alabama, Washington, and Wisconsin target specific regions within their states.⁷⁶ Interestingly, New York has implemented a three-phase plan in which each phase covers new regions.⁷⁷

The third design consideration is to decide on the provider model and provider criteria. As described above, states can choose from the following three provider models: (1) designated providers; (2) teams of health care professionals; and (3) health teams.⁷⁸ In addition to choosing the applicable model(s), the SPA will have to include provider standards such as minimum qualifications to be a provider.⁷⁹ New York, Washington, and Wisconsin's Health Home programs use the designated provider model; Alabama uses the team of health care professionals model; and Oregon uses both the designated provider and the team of health care professionals models.⁸⁰ Regardless of the model chosen, states should work to ensure that the Health Home is composed of a wide variety of care providers that can provide comprehensive whole-person care for each patient. States should also consider how they might integrate providers into the Health Home team that can help patients to address the social determinants of health such as housing and nutrition.

The enrollment design consideration allows states to decide how individuals will be assigned to Health Homes. Individuals can either opt-in to a Health Home, or they can be automatically enrolled and have the option to opt-out.⁸¹ Alabama has a voluntary, opt-in program, while New York, Oregon, Washington, and Wisconsin have automatic enrollment with opt-out programs.⁸² When making this decision, the state should consider how enrollees typically react to these options. For example, an opt-out program may encourage enrollment as it does not require proactive decision-making on the part of the enrollee.

The final important design consideration is the payment model. The payment model can be fee-for-service, flat-fee, or some other model.⁸³ States can also decide whether payments are tiered based on factors such as the severity of a patient's condition.⁸⁴ Alabama has a per-member-per-month (PMPM) and fee-for-service (FFS) model.⁸⁵ Wisconsin has a PMPM model.⁸⁶ New York's program is on a PMPM model that is adjusted based on factors such as region and case mix.⁸⁷ Oregon also has a PMPM model and is tiered based on provider functions.⁸⁸ Finally, Washington's program has a tiered FFS model, PMPM model, and incentive payment model.⁸⁹

III. SUPPORT FOR MEDICAID HEALTH HOMES IN MASSACHUSETTS

There are indications that research has been undertaken and plans are already underway for the creation of Health Homes in the state. First, in March of 2012, the Center for Health Law and Economics at the University of Massachusetts Medical School published a document titled, *Service Inventory of Managed Care Entities to*

*Support Development of a Health Homes State Plan Amendment.*⁹⁰ The purpose of the document was to gather information to support a Health Homes SPA application to CMS.⁹¹ Second, according to a recent report by the Kaiser Family Foundation, Massachusetts has plans to establish Health Homes in 2015.⁹² Finally, a CMS document outlining Health Home proposal statuses across the nation as of April 2013 indicates that Massachusetts had a draft Health Home SPA under CMS review.⁹³

Massachusetts policymakers, such as the Massachusetts Department of Public Health (MDPH), should work with MassHealth to explore the current plans for Medicaid Health Homes in Massachusetts and encourage the integration of public health goals into those plans as they develop. In particular, MDPH and MassHealth should consider how the Medicaid Health Home model could be used to encourage improved care for individuals living with HIV/AIDS, HCV, and opioid addiction. Policymakers should also make sure that other stakeholders interested in the treatment of these conditions are involved in the planning of the Medicaid Health Homes.

CONCLUSION

By establishing the Medicaid Health Home option, the ACA provided states with a powerful new tool for delivering more coordinated, focused care to individuals coping with chronic disease. Early reports indicate that Medicaid Health Home programs are successfully improving care while cutting costs. Massachusetts policymakers should therefore consider the possibility of developing a Medicaid Health Home program to address the complex needs of individuals living with HIV/AIDS, HCV, and/or opioid addiction.

ENDNOTES

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- ⁶ 42 U.S.C. § 1396w-4(h)(1) (2010).
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- ¹² 42 U.S.C. § 1396w-4(h)(4)(A) (2010).
- ¹³ 42 U.S.C. § 1396w-4(h)(4)(B) (2010).
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- ²⁴ See *Iowa Medicaid Medical Health Home*, The University of Iowa Public Policy Center, 9-10 (Mar. 2015), available at http://ppc.uiowa.edu/sites/default/files/hh_4-way_report.pdf.
- ²⁵ See *Iowa Medicaid Medical Health Home*, The University of Iowa Public Policy Center, 9 (Mar. 2015), available at http://ppc.uiowa.edu/sites/default/files/hh_4-way_report.pdf.
- ²⁶ See *Iowa Medicaid Medical Health Home*, The University of Iowa Public Policy Center, 9 (Mar. 2015), available at http://ppc.uiowa.edu/sites/default/files/hh_4-way_report.pdf.
- ²⁷ See *State-by-State Health Home State Plan Amendment Matrix: Summary Overview*, Centers for Medicare and Medicaid Services, 3 (Mar. 2014), available at <http://www.medicare.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/hh-spa-at-a-glance-3-19-14.pdf>.
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- ⁴⁵ Request Health Home Planning Funds, MEDICAID.GOV, <http://www.medicare.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/request-health-home-planning-funds.html> (last visited Apr. 15, 2015).
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⁶⁸ See *Health Home SPA Template*, Centers for Medicare and Medicaid Services, 2, available at <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/health-homes-spa-template-2/14.pdf>.

⁶⁹ See *State-by-State Health Home State Plan Amendment Matrix: Summary Overview*, Centers for Medicare and Medicaid Services, 4 (Mar. 2014), available at <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/hh-spa-at-a-glance-3-19-14.pdf>.

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