CHCS Center for Health Care Strategies, Inc.

Issue Brief

# Implementing Health Homes in a Risk-Based Medicaid Managed Care Delivery System

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JUNE 2011

The Affordable Care Act (ACA) includes a provision on health homes, Section 2703, which allows Medicaid programs the option to reimburse eligible providers for comprehensive care management-related services. This option would create health homes to coordinate and better integrate primary, acute, behavioral health, and long-term services and supports for beneficiaries with complex and chronic conditions. Growing evidence suggests that care management services – particularly when provided at the point of care – not only improve quality but reduce costly and avoidable hospital and skilled nursing facility admissions and emergency room visits. The demonstrated effectiveness of care management models coupled with the availability of enhanced (although time-limited) federal matching dollars makes the health home option particularly attractive to state Medicaid programs.

With some 50 percent of Medicaid beneficiaries enrolled in risk-based managed care today[1] and states enrolling more clinically complex patients into those delivery systems, the health home option may provide an important and cost-effective tool for managed care organizations (MCOs) responsible for the physical, behavioral, and/or long-term care services required by Medicaid beneficiaries with chronic illnesses.

This brief addresses the opportunities for grounding health home programs in risk-based MCOs and the factors states will want to consider in deciding how best to proceed. It details some of the implicit advantages of MCO environments for the development of health homes, as well as some challenges that states may encounter.

**IN BRIEF**

The Affordable Care Act (ACA) gives Medicaid programs the option to create health homes to coordinate and better integrate primary, acute, behavioral health and long-term services and supports for beneficiaries with complex and chronic conditions. States looking to implement a health home strategy within their existing Medicaid managed care infrastructure should consider:

- Which elements of MCO infrastructure offer building blocks for health home programs; and
- What challenges states may face in "nesting" health homes inside Medicaid managed care organizations.

This brief addresses opportunities for grounding health home programs in risk-based managed care organizations (MCOs). It outlines decision points in six critical areas to help states and their health plan partners pursue health homes.

## Overview

Almost 50 percent of Medicaid enrollees are enrolled in risk-based managed care arrangements.[2] MCOs are responsible for various covered services, which may include but are not limited to physical health, behavioral health, and/or long-term care. MCO contract requirements and responsibilities vary widely from state to state; however, MCOs have a common infrastructure and core competencies that could provide critical building blocks for health home programs.

For example:

- **MCOs offer care management services.** Although care management and coordination services are often provided telephonically or online rather than at the point of care, the state or MCO can expand on existing infrastructure and would not have to "start from scratch."
- **MCOs have capacity for data collection and analytics, quality improvement, and reporting.** Health homes are required by the Centers for Medicare & Medicaid Services (CMS) to collect and report on individual-level

This brief was made possible through support from the Robert Wood Johnson Foundation

clinical and experience of care outcomes and population-level quality of care outcomes to assess the performance of increased care coordination and chronic disease management programs. MCOs have patient claims data spanning multiple settings and the analytic resources to calculate these key metrics.

- **MCOs have staff that can outreach to, enroll, and engage Medicaid members, and often link members to primary care providers (PCP).** This one-on-one patient engagement will be vital to enrolling beneficiaries in a health home and achieving quality, utilization, and cost outcomes in health homes.

- **MCOs have invested in quality improvement initiatives**. Some MCOs have invested in medical homes, provider-based HIT, and other activities that are central to the health home model.

- **MCOs often have links to community-based organizations.** Relationships with social service, supportive housing, and other organizations will be a critical component of successful health homes – particularly those serving more complex populations.

- **MCOs have provider networks in place, including hospitals.** Under the health home provision, hospitals that participate under the State Plan or a waiver must establish procedures for referring eligible individuals who seek treatment in the emergency room to designated providers. MCOs are better positioned than individual providers to leverage their relationship with hospitals and facilitate effective patient care transitions after hospital discharge.

Because states have been contracting with MCOs for many years, there is also an existing oversight and regulatory infrastructure in place. Oversight of health homes can be incorporated into existing staff responsibilities -- a key advantage in an era of shrinking state workforces.

Finally, state premium payments to MCOs already include some amount for care management. By vesting health home responsibilities in MCOs, states are able to draw down 90 percent Federal Medical Assistance Percentages (FMAP) – for a limited time – and use those dollars to further expand health homes and enhance quality. That federal match is extremely attractive to states facing severe budget constraints.

While there are many factors that argue for "nesting" health homes inside Medicaid managed care infrastructure, there are challenges as well. For example:

- **Building health homes within a managed care delivery system will still require state resources.** States, already feeling overburdened and understaffed, have serious concerns about re-opening MCO contracts and renegotiating capitation rates.

- **Most care management provided by MCOs occurs telephonically, not at the point of care.** While one-on-one support does exist, MCOs tend to rely more on population management mechanisms. There is growing evidence of the need for greater face-to-face interaction with complex populations and their providers to integrate care across provider settings. MCOs will need – directly or through contracts – to take care management to a more community-based level.

- **Many MCOs have limited experience serving complex patient populations.** Because the majority of Medicaid beneficiaries with complex physical and behavioral health conditions are still in a fee-for-service delivery system, few MCOs have extensive experience serving patients with complex needs. Health home programs could present challenges for MCOs that have not served this population.

## Overview of Health Home Requirements

Section 2703 of the Affordable Care Act (ACA) authorizes 90 percent FMAP for the cost of six health home services for Medicaid beneficiaries with complex and chronic conditions over a two-year period.[3] Intended to enhance coordination of medical and behavioral health services and reduce unnecessary and costly institutionalizations, hospitalizations, and emergency room visits, health homes must provide:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care/follow-up;
- Patient and family support; and
- Referral to community and social support services.

Health home providers are encouraged to use HIT to link these services, where applicable.

Medicaid beneficiaries eligible for health home services include those with: (1) two or more identified chronic conditions; (2) one chronic condition and are at risk for a second; or (3) serious and persistent mental illness. Eligible chronic conditions include mental illness, substance abuse, asthma, diabetes, heart disease, and obesity. Additional chronic conditions can be added at the discretion of the Secretary, so states may include additional conditions in their State Plan Amendment. States may target health home services to certain chronic conditions or geographic locations. Notably, dual eligible beneficiaries may not be excluded.

Providers eligible to serve as health homes include:

- **A designated provider:** May be a physician, clinical/group practice, rural health clinic, community health center, community mental health center, home health agency, pediatrician, OB/GYN, "or any other entity or provider .... determined appropriate by the State and approved by the Secretary."[4]

- **A team of health care professionals:** Includes physicians and other professionals, e.g., a nurse care coordinator, nutritionist, social worker, behavioral health professional, or other professionals deemed appropriate by the state and approved by the Secretary. The team can be freestanding, virtual, hospital-based, a community mental health center, clinical group practice, etc.

- **A health team:** An interdisciplinary and inter-professional team that must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health professionals, chiropractors, licensed complementary and alternative medical practitioners, and physician assistants. The health team has the same definition as the community health team described in Section 3502 of the ACA.

Although MCOs are not identified in the statute, the statute permits the Secretary to approve additional entities or providers that a state deems appropriate. The State Medicaid Director letter from November 2010[5] encourages states to use the health home program to complement medical home initiatives in both Medicaid fee-for-service and managed care.

## Roadmap of Key Decision Points

Medicaid agencies with risk-based managed care systems will want to consider many issues when designing a health home program. The following section details different options for states depending on the existing health care delivery model.

### 1. Target Population

Who is the target population for health homes, and how many of those individuals are enrolled in a risk-based MCO? If the target population is not in managed care, is the state planning to move them into MCOs in the near future?

(a) **The target population is currently enrolled in MCOs.** If a meaningful number of Medicaid beneficiaries with complex chronic conditions are already enrolled in MCOs, the state will want to seriously consider adding health home services to MCO contracts. For eligible beneficiaries, the state will need to be explicit about how health home services will differ from existing care management services. This will require a close look at existing MCO-based programs, identifying existing gaps, and making necessary changes to achieve health home program requirements.

(b) **The target population is not enrolled in MCOs, but will be in the near future.** If high-cost and complex Medicaid beneficiaries are not yet in managed care but the state is planning to move them into risk-based managed care in the near future, the state could embed a health home program within the new managed care program. If the state has an existing complex care management program with care managers serving the targeted population, it may want to require MCOs to contract with those providers as part of its new contract with the state. This would allow the state and MCO to build a stronger health home program more quickly.

### 2. Covered Services

Which of the clinical services (e.g., physical health, behavioral health, etc.) that will be coordinated by the health home does the MCO currently provide to its members? MCOs are contracted to provide a variety of covered services – either comprehensive or limited benefits. Services like behavioral health care, pharmacy and long-term care services are often carved out and either provided fee-for-service or managed by another MCO.

(a) **The contracted MCOs provide comprehensive benefits.** Health homes must support "enhanced integration and coordination of primary, acute, behavioral health, and long-term care services and supports across the lifespan of the chronic illness." MCOs contracted to provide comprehensive benefits – a more integrated model – will be better able to provide more seamless complex care management.

(b) **MCOs do not provide a comprehensive benefit package – key services are carved out and provided by another entity.** If behavioral health, long-term care, or physical health care services are carved out and provided elsewhere, the state will need to take a much more active role in ensuring care coordination, complex care management, care transitions, etc. between the contracted MCOs and the entities providing the carved-out services. The state must leverage its authority to break down barriers and overcome the inertia that exists in a fragmented delivery system. For example, the state can write contracts requiring the MCO to communicate with providers of carved-out services and share data and information. It can also monitor contracts to ensure that care is coordinated, linkages across providers are created, and data and information are shared in a timely and complete manner. The state may want to explore a gain-sharing arrangement between the MCOs and carved-out entities based on a variety of activities – e.g., sharing patient information, identifying and engaging eligible individuals, etc.

### 3. Health Home Services

Which of the required health home services (listed above) are currently provided by MCOs? Are some or all of these services required by state contract with MCOs? Are the services detailed in MCO cost reports?

(a) **Services that the MCO currently provides align with the health home services and requirements.** A state will want to crosswalk the care management services required by the MCO's contract with those actually being provided to members eligible for health home services and with the six required health home services. The state will need to clarify definitions for and expectations related to the health home services.

The crosswalk will identify existing gaps as well as areas of overlap between the MCO's care management services and the required health home services. To the extent that MCOs' care management responsibilities are not explicit in contracts or cost reports, states will have

to work closely with MCOs and actuaries to identify current care management activities and costs.

**(b) Services that the MCO currently offers do not reflect the type, amount, or intensity of services that will be required for health homes.** Historically, MCOs have focused on disease and care management, typically telephonically based and focused on the high-cost utilizers. Health promotion typically occurs through mass mailings or patient reminders to the larger patient population. Interaction between the MCO and providers typically is around prior authorization/utilization management, contracting, patient profiles, and claims payment and billing questions. Some more innovative MCOs give practices feedback on care delivery and provider quality improvement supports.

The opportunity of health homes, however, is to get closer to the individual patient and provider. Growing evidence indicates that face-to-face care management interactions with both the patient and provider at the point of care can improve quality and impact cost. Having health home providers "on the front lines" of care arguably allows them to have clearer communication with the patient. Therefore, states can encourage MCOs to deploy health home providers to the point of care. Care managers can make home visits, accompany patients to appointments, and support patients and families during discharge from the hospital. Community health workers, who may also be part of the health home team, can impact outcomes by working directly and locally within their communities. A face-to-face presence fosters a relationship with the patient and allows trust to grow.

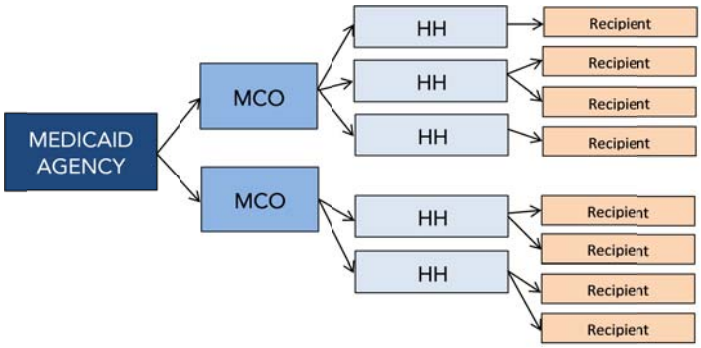
The health home provider should not only manage and coordinate care for the patient, but should ensure that all members of the patient's care team – physical, behavioral, long-term, and social supports – are connected, consulted and informed. Therefore, the state can require that level of integration: for example, the health home team should be "tethered" to the patient's primary care practice or to a community mental health center or nursing home (e.g., discuss the patient, share information, coordinate care plans, etc.), as opposed to merely operating on parallel tracks that never intersect Clinical decisions should not be made in isolation by one part of the health care team, but through consultations with the primary care provider, behavioral health care provider, and other professionals integral to the patient's needs. The health home team should be the glue integrating these providers and services. MCOs should be well positioned for this type of coordination and collaboration.

## 4. Contracting Arrangement for Health Home Structure

What contracting arrangement would the state have with MCOs? What contracting arrangements would the MCOs have with health home providers? There are numerous potential iterations for how health homes might be structured, and a state may adopt different contracting arrangements depending on MCOs' interests, resources, and capabilities. In each model below, the MCO is responsible for the provision of health home services to its eligible members; the difference between the models is the extent to which the MCO provides health home services directly or whether the MCO contracts for some or all of the services.

**(a) The MCO does not have resources internally to directly provide health home services** (Figure A). In this model, the state would contract with the MCO, and the MCO would contract directly with health home providers meeting state-specified standards to provide services.

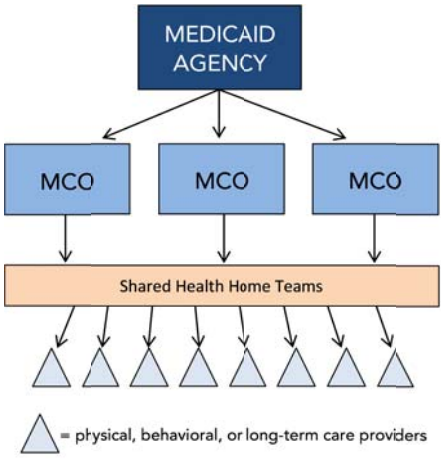
*Figure A.* MCO Contracts with Certified Providers for Health Home Services




Within this model, the state should consider what additional infrastructure support the health home provider might need and whether the MCO can provide that support. For example, some health home providers may not have sufficient HIT infrastructure or data collection/reporting capabilities – typically a core competency of MCOs. Other providers might not have sufficient leverage to achieve hospital participation; MCOs could encourage hospitals to coordinate with designated health home providers when patients visit the ER, for example.

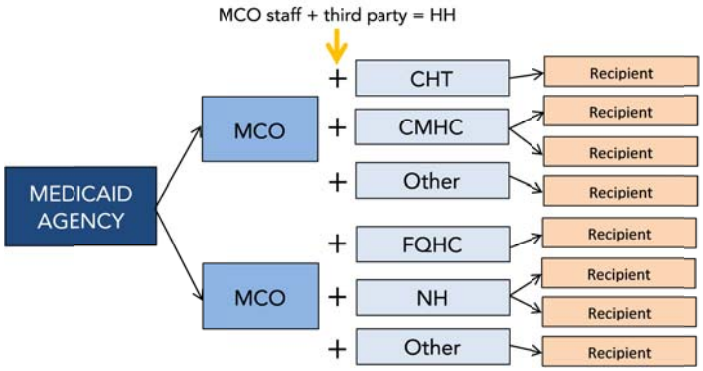
Because states contract with multiple MCOs, it is likely that each MCO will contract with different eligible health home providers. If this is the case, it is feasible that a primary care provider, for example, would be faced with coordinating with multiple health home teams representing different Medicaid patients in the physician's panel. To avoid overwhelming a single PCP with numerous health home teams, a state might consider whether it is feasible to implement a model where one team (e.g., a community health team) is "assigned" to the same PCP or group of PCPs to serve all eligible Medicaid beneficiaries, regardless of the patient's MCO affiliation. This would require greater collaboration by the MCOs and potentially greater oversight by the state in deploying a "shared" health home team to PCPs. Figure B below illustrates this potential approach.

*Figure B.* MCO Provides a Shared Health Home Team Approach




**(b) The MCO adopts a "hybrid" approach (**Figure C). In this model, MCO staff directly provide some health home services while partnering with eligible providers to round out the full set of health home services. For example, if the MCO does not provide health promotion services, it may contract with organizations that do. MCOs using this approach should be cognizant of contracting with too many entities or with entities outside the geographic area, which might necessitate more telephonic outreach.

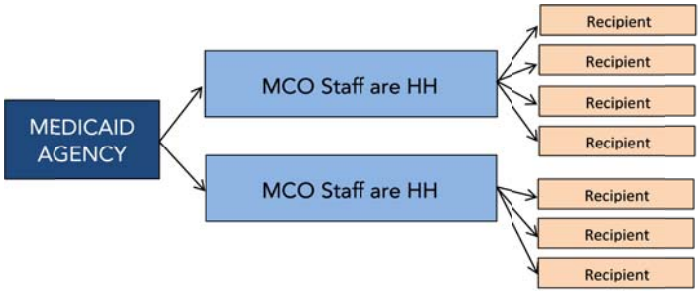
*Figure C.* Hybrid Health Home Approach




This hybrid approach may be particularly valuable for new risk-based managed care programs. In such instances, a care management infrastructure may already exist and be serving parts of the target population. If this is the case, the MCO would benefit from contracting with the existing care management providers. The state may want to identify existing care management building blocks and even require MCOs to include them in a health home provider network.

**(c) The MCO is the health home in its entirety** (Figure D). In this model, the MCO directly delivers the required health home services to eligible members. A variety of factors should be explored when considering whether an MCO is well-positioned to be the health home in its entirety, including (1) investments to date in care management/care coordination/care transitions personnel, including care-coordinator-to-member ratios appropriate to the intensity needs of the population; (2) effectiveness of and innovation around care management services and strategies, particularly at the point of care; (3) investments in primary care and behavioral health care infrastructure (e.g., HIT); (4) a track record of timely, accurate and transparent use of data and reporting; (5) having a network of social and community-based supports and resources; and (6) strong collaboration with PCPs in development of care plans for health home enrollees.

*Figure D.* MCOs Serve as Health Home




As part of this model, the MCO staff would play a very active role delivering health home services, often at the point of care. As such, the MCO would need to have a good working relationship with its provider network, as this model could otherwise be very intrusive for PCPs, behavioral health care and other providers. A state may want to compare current care management practices in operation versus what is specified in the contract when considering this model, in order to determine the efficacy of MCO care management techniques for the health home target populations.

The state would also need to consider whether and how eligible members would have a choice of health home providers. For example, the MCO might have multiple teams or care managers from which a member would choose. If the member already has an established support system outside of the MCO, the MCO will need to consider the potential impact of disconnecting the member from that support.

**(d) Not all MCOs might participate in health home programs.** It is possible that not all MCOs will be capable of or interested in providing health home services. For example, some MCOs may only have a small number of eligible members and may not believe an investment in health homes will have a positive return. In some cases, selective contracting may be necessary; however, states that do so would need to consider additional complexities that selective contracting would create. How will it impact MCO enrollment and membership? Will it create confusion for providers or members? Will it increase member "churn"? Does the state have an appropriate waiver to allow for selective contracting?

## 5. Reimbursement for Health Home Services

How would reimbursement for health home services occur in the context of an MCO? How would funding flow for different contracting arrangements? CMS allows states flexibility to determine service reimbursement. There is little formal guidance for the methods states can use to deliver payments through an MCO; in fact, there is no guidance on how to pay any health home providers. CMS has stated that health home services will be reimbursed at the service rate, as opposed to the administrative rate, after the eight consecutive quarters of 90-10 match have ended. The following health home reimbursement models can occur in a risk-based managed care delivery system.

**(a) If health home services are <u>not</u> provided by a contracted Medicaid MCO and are provided outside of the managed care benefit package, the state will want to evaluate the extent to which the health home will be delivering services previously provided through the MCO and what percentage of the premium dollars covered those services.** The MCO's premium rate would then be reduced by the identified sums. States will want to be cautious in reducing the premium to avoid eliminating payment for related costs and responsibilities that remain with the MCO. For example, care coordination could be duplicative, so costs would be taken out; however, this is not the case for quality management, which would still be included in the capitation rate. In other words, only portions of the capitation rate that account for services duplicative of health home services would need to be removed. A state's actuary should be able to estimate these portions of the capitation payment.

**(b) If health homes are provided by an MCO (i.e., the MCO is the health home <u>in totality</u>), the state would identify dollars in the capitation rate – relevant to care management for members eligible for and enrolled in the health home – in order to get a 90-10 match on those funds.** A state, in partnership with its actuary and MCOs, should consider how to determine the number of eligible members and members actually enrolled – for example, whether the number is an annual average, a point in time, or another approach.

**(c) If health homes are provided <u>in part</u> by the MCO and in part by an external contractor (e.g., MCO staff participate as part of a health home team), the state would identify relevant dollars in the capitation rate and receive the 90-10 match.** The MCO would, in turn, pass through the appropriate reimbursement to health home team members outside of the MCO. The state

would need to confirm that the MCO does not retain a portion of the payment for the administrative purposes of issuing payment, because the money that CMS is matching is only associated with the health home services.

## 6. Quality, Cost and Utilization Outcomes

What metrics will the state use to assess cost savings, quality improvement and patient experience for health home enrollees? How will it gather this information and who will calculate these metrics? What data needs to be fed back to the health home providers to ensure successful care management, coordination and transitions? And what role can MCOs play in these areas?

**(a) Assess current quality, cost and utilization reporting requirements for MCOs and compare with data collection, analysis and reporting requirements for the health home program and health home providers.** Health home providers will be accountable for quality as a condition of payment. A state will want to compare the measures that will be used to evaluate the health home program and the measures the MCOs currently collect, including the timeline for data collection and submission, and the level of granularity (e.g., at the patient level, practice level, health home level, MCO level, program level, etc.), and make sure the requirements are aligned as appropriate.

**(b) Assess the robustness of exchange of data and information sharing across provider settings and delivery systems.** The impact of health homes will likely depend heavily on timely access to information and data and sharing of it with the state, providers, patients and their families. As such, the state should also consider how such information exchange occurs currently, what gaps exist, and what changes need to be made in order to reach the expectations and standards of health home providers. This includes whether and how there is an existing quality, cost and utilization feedback loop for Medicaid providers, particularly those who would be key partners in a health home.

### Questions for Discussion with MCOs

Once states have considered the roles that MCOs might play, it is critical to get their input. States should propose a framework or model and gather insights from MCOs on questions including:

- What additional services would a health home provide – from a member's perspective – beyond what the patient currently receives? From a dual eligible's perspective?
- How would a health home be different from a PCP's perspective? From a behavioral health care provider's perspective? From a community-based organization's perspective?
- How would an MCO link a health home program to existing quality improvement building blocks such as medical home initiatives, quality measurement, pay for performance programs, etc.?
- What impact on cost, utilization, quality, and patient experience would the MCO expect as a result of health home activities?
- What current barriers do MCOs face to reducing avoidable emergency room use and inpatient admissions/readmissions? How could an MCO deliver health home services not only efficiently, but in a way that could help eliminate those barriers?
- Which providers would be health homes, and are they ready to provide services to eligible members?
- How can the health home program be designed to be more patient-centered? More provider-centered?

Once program design strategies and concepts are fleshed out, MCO and provider contracts can be revised to include key requirements such as reimbursement for services, data collection and reporting, and accountability for outcomes in cost, utilization and quality.

## Conclusion

Health homes present a significant opportunity for Medicaid programs to change the way care is delivered to some of the most vulnerable Americans and to curb growing health care costs. Likewise, they also present a transition for MCOs – specifically, an opportunity for them to redefine their role and confirm their value. Innovative and forward-thinking MCOs will recognize and seize the opportunity to position themselves for the future, differentiate themselves from their peers and change care management as we know it.

## Additional Resources

This brief is one in a series of resources that CHCS is developing to support Medicaid stakeholders in developing health home approaches. Future publications will focus on quality measures and outcomes for health homes; MCO contract language for health home programs; and approaches to reimbursement. For more information on Medicaid health homes, as well as additional tools for improving care for beneficiaries with complex needs, visit **www.chcs.org**.

## About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racial and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs.

## Endnotes

[1] MACPAC Report to Congress on Medicaid and CHIP, Table 2 in MAC Stats, March 2011.
[2] MACPAC Report to Congress on Medicaid and CHIP, Table 2 in MAC Stats, March 2011.
[3] For more details about the health home requirements, please refer to Section 2703 of the Affordable Care Act and the November 16, 2010 letter from CMS to State Medicaid Directors. https://www.cms.gov/SMDL/SMD/itemdetail.asp?filterType=none&filterByDID=-9&sortByDID=1&sortOrder=descending&itemID=CMS1241477&intNumPerPage=10.
[4] State Medicaid Director Letter # 10-024, ACA# 12, November 16, 2010, Re: Health Homes for Enrollees with Chronic Conditions
[5] https://www.cms.gov/SMDL/SMD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=descending&itemID=CMS1241477&intNumPerPage=10.