

Health Homes in Health Care Reform: State Opportunities in the Affordable Care Act

Summary and Overview

The Affordable Care Act¹ offers states the opportunity to temporarily increase their Federal Medical Assistance Percentage, or FMAP, to 90 percent for two years by enrolling individuals with chronic conditions in “health homes.” Health homes expand upon the concept of primary care medical homes that has gained increasing attention over the last decade or more by building “linkages to other community and social supports, and ...enhance(ing) coordination of medical and behavioral health care.”² In order to realize the enhanced FMAP, state Medicaid agencies may need to put in place the following:

- New enrollment procedures and models of reimbursement for health home providers;
- New credentialing processes for paraprofessionals and peers;
- Evidence-based guidelines and recommendations for their implementation;
- Systems for improving coordination and effectiveness of care;
- Enhanced techniques for educating and engaging patients; and
- Methods for handling potential provider shortages.

If states choose to seek the increased FMAP, all of this and more will need to be done within a short time frame and in the context of many other restructuring initiatives in the state’s larger health care system. Policymakers and administrators will want to seek guidance from their peers in other states and from organizations that offer relevant programs throughout the country. This paper details the opportunity available to states and describes more specifically some of the efforts state Medicaid agencies might want to consider. The paper uses recent literature and our experience at OptumHealth to illustrate the types of solutions available today.

Introduction: Health Care Reform Offers States a New Opportunity

The Affordable Care Act (ACA) will require state Medicaid programs, and other state agencies, to change the way they structure, support and deliver health care services. The tasks states will confront, related to both policymaking and implementation, are enormous. The stakes are high because health care constitutes a significant proportion of our economy and of every state budget, and because the decisions will affect many residents of the state through changes in coverage, insurance reforms, and access to and coordination of care.

For example, states will need to create properly functioning insurance exchanges³ and regulate their health insurance markets effectively. With new coverage mandates and eligibility rules, they will also need to develop new eligibility systems to enroll people accurately in subsidized health plans or Medicaid. Medicaid eligibility and enrollment procedures must address categorically needy, medically needy and dual eligible individuals. They will also need to include

those individuals enrolled in home and community-based waivers as well as Section 1115 participants. In addition to enrollment and insurance market reforms, state Medicaid agencies will need to alter their systems to expand capacity (in order to enable new enrollees to access care), reconsider benefit design and improve the care of individuals with chronic illnesses. The National Academy for State Health Policy has identified 10 aspects of federal health care reform that “states must get right if they are to be successful in their implementation.”⁴ These issues range from strategic decisions on insurance exchanges and insurance regulation to expanding capacity and eligibility systems.

One element of ACA that aims to “bend the cost curve,” or reduce the growth in costs, is the emphasis on the expansion of health homes. These are enhanced primary care, home health and behavioral health practices that are designed for individuals with chronic medical and/or behavioral health conditions. The law offers state Medicaid programs an enhanced, 90 percent, Federal Medical Assistance Percentage (i.e., FMAP or “match”) for the first eight quarters of qualified payments for “health home services” to eligible individuals⁵ with chronic conditions. “Health home services” are specifically identified as care management, coordination and support services that supplement the medical and clinical practice (see definitions in the Appendix). The legislation requires a Medicaid state plan amendment to establish the program.

States are permitted to develop “tiered payment” methods for health homes that account for the different levels of provider skills and severity of needs of enrollees. The recent State Medicaid Director’s Letter (SMDL) on health homes indicates that states will have to submit a “comprehensive description of the rate setting policies...,” provide public notice to stakeholders, and work with CMS to ensure that these methods meet all requirements. States should consider payment methods that are designed to help to achieve the goals of the initiative (e.g., reducing hospital readmission rates) and that will help to document the quality measures that will be clarified in future CMS guidance.

This opportunity for states to increase FMAP temporarily for services to eligible individuals with chronic conditions requires that states develop a variety of new policies and procedures. Recognizing the magnitude of the effort required, ACA Section 2703 establishes a program of planning grants to states to support their development of plan amendments. But states’ ability to utilize the 90 percent FMAP option is not contingent on their having received a planning grant. Because of the high prevalence and costs of individuals with behavioral disorders and other chronic conditions, CMS is requiring states to consult with the Substance Abuse and Mental Health Services Agency (SAMHSA) prior to submitting their state plan amendments.⁶ The SMDL lays out a formal process for this consultation.

To implement a health home program, states will want to consider developing: new screening and health home enrollment procedures for eligible individuals; new models of reimbursement for health homes; new credentialing

processes to expand the workforce; evidence-based guidelines and guidance on their implementation; and enhanced techniques for educating and engaging patients. Each state will decide exactly whether and how it is going to implement the health home model within the framework and standards established by the Secretary of Health and Human Services (HHS). This briefing paper suggests some of the techniques states may want to explore, and some of the specific ideas that OptumHealth is currently testing and implementing in the field.

Because the ACA uses new language, as well as new concepts, an Appendix offers background and definitions.

Why Focus on Health Homes?

Nearly half of Americans, about 133 million individuals, experience chronic medical conditions, and about half of those live with multiple conditions.⁷ The Chronic Care Model, published in 1998, attempts to promote change among providers in order to improve care for individuals with chronic conditions. The Model aims to improve outcomes by bringing an “informed, activated patient” together with a “prepared, proactive team.”⁸ Implementation of the Model, whose development was supported by the Robert Wood Johnson Foundation®, has been ongoing over the past decade. Health homes represent a more explicit policy response to the conundrum that 10 percent of patients, most of whom have chronic medical conditions, are responsible for 64 percent of costs to the health care system.⁹ The high costs of care have been attributed to, among other factors: lack of coordination,¹⁰ excessive testing, over-use of emergency rooms and perhaps most importantly a reimbursement system that rewards procedures rather than care.¹¹ The health home concept is intended to respond to all of these problems and to result in care that is patient-centered, comprehensive, coordinated, accessible, and continuously improved, and ultimately ensures that patients receive the right care from the right provider at the right time. If care to this group of people can be improved at reduced cost, it seems likely that it will be possible to “bend the cost curve.”

Because patient-centered medical homes (PCMH), or health homes, are relatively new in practice, and the details of implementation vary, evaluation is challenging. Few evaluations of individual efforts, and fewer comparative evaluations, have been completed. Some preliminary results are promising, however. For example, the Guided Care® program, designed by researchers at the Johns Hopkins Bloomberg School of Public Health with elements similar to those of a medical home, has been subjected to randomized controlled testing, and appears to improve quality of care and reduce health care costs for chronically ill Medicare patients.¹² The Geisinger Health System in Pennsylvania and the North Carolina Medicaid program have also demonstrated cost savings when patients have been enrolled in medical homes where primary care clinicians have received an additional fee to coordinate care

for their patients.¹³ Finally, Group Health Cooperative, which implemented a prototype clinic redesign and compared it to 19 control clinics, found that 21 to 24 months after implementation there were improvements in quality, patients’ experiences and clinician burnout. Patients in the medical home experienced 29 percent fewer emergency visits and six percent fewer hospitalizations.¹⁴

The Patient-Centered Primary Care Collaborative, whose purpose is to “develop and advance the PCMH,”¹⁵ reported that, as of July 2010, 27 PCMH pilots involving multiple stakeholders in 20 states were at various stages of completion. One of these pilots is an effort by United HealthCare Services, Inc. (parent company of OptumHealth) to demonstrate the value of a PCMH primary care practice. Covering about 14,000 members, including individuals enrolled in Medicaid and Medicare, the program involves seven practices and 25 physicians in the Phoenix and Tucson areas. It emphasizes primary disease prevention and improving the quality of care for persons with chronic illnesses, while encouraging members to become more engaged in their own health and wellness. This pilot began in April 2009 and will continue for three years.

The “whole-person” and “person-centered” approaches identified in the ACA and expanded upon in the SMDL emphasize two aspects of the extensive culture change required in the implementation of health homes. With a “whole person” approach, primary care, behavioral health and other health home providers should expand their focus to assess the health, behavioral, social and other needs of patients’ or consumers’ lives. Emphasizing and understanding an individual’s health goals and using principles of shared decision making and self-direction will also be important elements of implementing a “person-centered” practice to improve the experience of care for patients/consumers.

In the health home SMDL, CMS states that they expect that the health home model will lower rates of emergency room use, hospital admissions and readmissions, reduce health care costs, reduce long-term care use and improve the experience of care. Although numerous demonstration and pilot programs are under way, the International Health Policy Survey carried out by The Commonwealth Fund® determined that in 2007 only half of adults in the United States had a medical home.¹⁶ The stakes, and the challenges, for states are significant.

What Will States Want to Do?

To begin, each state will determine whether to develop a health home program, based on savings and revenue projections and other considerations. If a state does decide to proceed, it will want to find the right tools and develop an implementation approach. In the remainder of this paper, we focus on the savings model and tools, techniques and strategies states will want to consider employing.

Develop Savings Models

State Medicaid Directors have to plan several years ahead for the significantly increased enrollment and coverage requirements of Medicaid expansion under health reform. These will take effect in 2014 and have a major impact on many existing state programs.¹⁷ Decisions about implementing health homes, with their federal incentives and improvements in the quality of care, can be a part of the state's long-term strategy, but a health home initiative for individuals with chronic conditions can begin sooner. To accomplish this, states might create a savings model for health homes that describes its investments in time and resources, the impact on existing programs and their anticipated savings. Some of this planning can be funded through the planning grants that will be available for health homes beginning in 2011.

The enhanced 90 percent FMAP rate covers payments to designated providers,¹⁸ teams of professionals and health teams (defined in Section 3502 of the ACA) for health home services to individuals with chronic conditions. The enhanced rate will be effective for the first eight quarters after state plan approval. While the scope of what CMS will allow as payments for health home services needs to be defined further in regulation or other guidance, the law and the SMDL make clear that the enhanced match is only for payments for the health home services and not for medical or other clinical services. Health home services supplement the routine services offered in a primary care setting; they are described in the Appendix. States are not limited to per member per month payments for these services; they can also consider alternative payment methods.¹⁹ The extent of what is included by states in their payments for health home services may make a big difference in the size of the enhanced federal match.²⁰

Should they decide to implement a health home program, states will want to determine whether the extra payments will be efficient, effective and support quality of care,²¹ offsetting other expenditures for acute and specialty care. This will require analyses of current spending for people with chronic conditions as well as assumptions about the ER, hospital and specialty care savings that health homes will create in future years. States with capitated Medicaid managed care contracts will want to review the savings assumptions with their contractors and with CMS. They should assess whether and how federal match procedures will allow claims for health home services in a capitation contract.

The health home program will require a new "enrollment or eligibility" process in each state. Many of the people served may also receive care through existing home and community-based waivers or managed care (1915c) programs. Finally, these individuals are also likely to receive state-funded services from other state agencies, such as those serving people with developmental disabilities and individuals with mental illnesses. To maximize their return, states will need to plan carefully and coordinate the financing of these various efforts.

To help states make these and many other critical financing decisions, OptumHealth offers research and decision support capabilities based both upon our considerable experience working with commercial and Medicaid populations across the country over many years, and upon our ability to leverage the extensive analytic and technical resources of our sister company, Ingenix. This paper provides some additional specific examples of how OptumHealth can assist states in planning for and implementing health homes.

Seek Out or Develop Tools, Techniques and Strategies

If a state does move forward, it may want to make important policy decisions and develop techniques and tools to support the program. The remainder of this paper is devoted to suggesting some of the techniques states may find useful, and some of the specific ideas that are currently being implemented and tested in the field. We have organized them under seven of the key strategic areas that states may want to consider:

- Identify individuals with chronic conditions as early as possible.
- Develop a comprehensive network of health homes, deciding what to measure and how to reward physicians/providers for improving health and avoiding preventable hospitalizations and ER visits.
- Transform current practices by including peers.
- Maximize the effectiveness of services through technology and consultation.
- Coordinate care efficiently.
- Improve physician-patient communication while educating and supporting patients.
- Manage potential provider shortages.

Identify individuals with chronic conditions as early as possible

As quickly as possible after approval of the State Plan Amendment, states will want to identify individuals who are eligible under ACA Section 2703 and enroll them in health homes. They can accomplish this task through screening and health risk assessments as well as by analyzing claims or targeting specific providers. OptumHealth offers a variety of screening tools and health risk assessments, while our sister company, Ingenix, offers extensive analytic and data management support.

- Identification and stratification tools — Using a sophisticated stratification process, these tools are capable of targeting members based on their acuity level and the potential for impact.
- Outreach — It will be necessary not only to identify individuals who are appropriate for enrollment in health homes, but also to reach out and locate them. OptumHealth has current experience on the ground finding Medicaid members who may lack permanent addresses and/or telephones in order to enroll them in programs specifically designed to

meet their needs. For example, our Live Healthy Care Management (LHCM) program staff are charged with locating, meeting and obtaining informed consent from eligible Medicaid fee-for-service members. They use a variety of techniques to locate people, including phone calls, letters, cold call visits and canvassing in the neighborhood.

- Targeting key providers — States might also want to focus their efforts on key medical providers whose practices include large numbers of eligible individuals and offer them incentives to conduct mental health and substance abuse screens of those individuals.

Develop a comprehensive network of health homes

Once eligible individuals with chronic conditions have been identified, the state will want to ensure that they have access to health home services. Ensuring that access will, in turn, require the state to establish processes for approving and providing payments to health homes. Optimally this would include rewarding physicians/providers for improved health outcomes and avoiding preventable hospitalizations and ER visits.

It will be valuable for states to assist primary care, behavioral health and other practices in transforming themselves into health homes; those practices will need continuing support throughout and following the transformation process.²² States will want to ensure that payment methods provide sufficient reimbursement to health homes to cover their added costs in meeting the new qualification standards. States may also consider alternative payment methods to reward provider outcomes. OptumHealth is piloting reimbursement models both within multi-payer pilots and in a single-payer pilot and offers its experience to states in carrying out all of these tasks.

- Establishing standards — Basic health home qualification standards will be established by the Secretary. Most states will probably opt to require practices to achieve a specified level of National Committee for Quality Assurance (NCQA) *Physician Practice Connections*[®] – *Patient-Centered Medical Home (PPC-PCMH)* recognition, rather than developing their own standards. In addition, states will need to monitor approved health homes to ensure that they continue to meet all requirements. OptumHealth has considerable experience in credentialing both traditional and non-traditional staff and in supporting the latter in taking on meaningful roles. We also work extensively with peer-run organizations and encourage their involvement in service networks.²³ This knowledge and experience can offer significant help to states.
- Deciding on an incentive structure — Enhanced reimbursement to providers may include start-up funds, per member per month fees and shared

savings if cost savings are generated. These services are in addition to other routine clinical services. States will make decisions about the level of, and relative emphasis on, each of these.

- OptumHealth has developed a successful reimbursement strategy in the context of our Physician Directed Population Management (PDPM) demonstration program in Arizona that combines fee-for-service and capitation payments with incentives. The PDPM program implemented a risk reduction approach for people with chronic illnesses in three primary care practices with 18 participating providers in Scottsdale, Arizona. Providers monitored 546 continuously enrolled patients with a risk of chronic disease and were paid for outcomes achieved. Using health coaching, pay-for-performance incentives and evidence-based guidelines, the three practices involved in the program increased patient monitoring activities. With this better clinical management, physicians achieved tenfold improvement in patients' basic biometric risk factors including body mass index, blood pressure, cholesterol, A1C and smoking status.²⁴

Transform current practices by including peers

States may want to develop strategies to support primary care physicians and behavioral health clinics in transforming their practices. Primary care physicians and other allied health professionals in the health home are being asked to practice at the “top of their license.” To do this, practices and clinics may choose to develop or affiliate with a health team or recruit and credential non-traditional providers, including peers and care managers.

Consumer- and family-run organizations should be part of the mainstream delivery of services, as a means of enhancing access to recovery and resiliency-oriented services. A key strategy to promote the participation of consumer- and family-run organizations as network providers has been to develop and implement credentialing criteria that guide network participation for peers and paraprofessionals. Criteria have been developed by OptumHealth for the following services: peer bridge, peer counseling, respite, psycho-social rehabilitation and case management.

To support these organizations further, OptumHealth recently published a toolkit and is offering technical assistance to guide consumer- and family-run organizations in how to participate in networks. Appendices to the toolkit offer worksheets explaining the steps necessary for working with managed care companies, including a state-by-state guide to regulatory requirements (e.g., certification requirements and eligible reimbursement codes). OptumHealth has funded five technical assistance trainings around the country, reaching over 500 consumer- and family-run organizations through these trainings and thousands of other organizations through posting of

the materials in the public domain via the OptumHealthSM website at <http://optumhealth.com/PublicSector/PSAboutUs/PSResources/>. With three programs firmly in place today and several in process, our goal is to have over a dozen consumer and family organizations directly contracted as OptumHealth network providers by mid 2011. We currently employ peer and/or family support specialists in New Mexico, New York, Pierce County (Washington) and Kansas:

- In New Mexico, peer and family support specialists are an integral part of each regional care coordination team. Each team includes at least one peer specialist and one family specialist who help members reach their recovery goals. They may share cases with (professional) care coordinators or follow members on their own, under the supervision of the care coordinator supervisor. They also support the creation of community-based support groups in their regions. The average caseload for a full-time specialist is 22 members. In our first year of operations, peer and family specialists established 23 support groups that continue to meet throughout the state.
- OptumHealth partners with the New York Association of Psychiatric Rehabilitation Services (NYAPRS) to provide Peer Bridger services to individuals in Queens diagnosed with substance abuse or mental illness who need to be engaged, or who need support in their recovery. Utilizing a recovery model, the Peer Bridgers help get people with complex medical and behavioral health conditions into treatment as well as helping to support those in active recovery to stay on track. The Chronic Illness Demonstration Project (CIDP) identifies patients who are at risk for recurring high health care costs and multiple hospitalizations and seeks to improve the management and coordination of their care. Peer Bridgers, individuals who are successfully managing their own recovery and have completed the requisite NYAPRS Peer Bridger and certified Peer Wellness Coaching training programs, help individuals bridge the gap between the structure of an inpatient program and the open environment of the community. As a supportive and trusting relationship develops between the consumer and the Peer Bridger through regular contact over a period of time, the Bridger offers a sense of hope, peer mentoring, health literacy education and support, advocacy, and recovery, community and crisis management skill building. This service embraces the recovery model and provides tools for coping with and recovering from a mental illness and/or a substance use disorder.
- Pierce County, Washington, Crisis Response — With a number of partners, OptumHealth is working to transform a traditional facility- and security-driven, crisis response system into a powerful point of entry to recovery for individuals with mental illnesses. The new system offers

a comfortable environment where individuals can relieve their stresses, discover their strengths and talents, and develop new skills leading to increased self-care and wellness. It achieves all this while continuing to respond to the community's need for public safety. Key components include: mobile crisis response with peer support; a "Living Room" model of crisis triage, emphasizing recovery and peer support; and secure beds for both voluntary and involuntary treatment. Recovery Innovations, based in Arizona, has developed the new Crisis Triage/Living Room facility called the Recovery Response Center and a Recovery Support Line answered by peer specialists.

- OptumHealth is also working with the Kansas Health Insurance Association to implement the Stanford Self-Management model,²⁵ which was developed at Stanford University. This program addresses a wide range of chronic illnesses. Workshops are facilitated by two trained leaders, at least one of whom is a non-health professional who has a chronic disease. The course meets once a week for six weeks at a local site such as a hospital, church, senior or community center, library or physician's office. The meetings are highly interactive, focusing on building skills, sharing experiences and offering support. Each group consists of 18 to 22 people with different chronic health problems who attend the workshop together, along with their significant others. Workshops help enrollees learn more effective self-management behaviors (e.g., exercise, stress management, communication with physicians) and improve their self-efficacy (through action planning, active self-monitoring and analysis, and sharing results, for example). The goal is for members to achieve higher levels of self-efficacy so that they can improve their health status and decrease utilization of services.

Maximize the effectiveness of services through technology and consultation

States will want to promulgate evidence-based guidelines, and support their implementation, in health homes, in order to assure that services are meeting patients' needs. OptumHealth supports the effective use of evidence-based guidelines, using continuous analysis to evaluate and help improve outcomes for individuals and for the system as a whole. OptumHealth can help states maximize effectiveness through consultation models, such as the Psychotropic Pharmacy Consultation program and through technology applications such as the OptumHealth eSyncSM platform or Ingenix[®] CareTrackerSM system. The eSync guidelines are integrated into the electronic medical record, making their use more efficient for the physician. The Ingenix CareTracker tool is a cost-effective, web-based practice management and electronic medical record (EMR) option that helps medical practices improve operational efficiency and patient care.

- *OptumHealth eSync Platform* — enables us to synchronize health care management and deliver personal solutions. The eSync tool allows OptumHealth to monitor 100 percent of a population by capturing and synchronizing medical records, lab results, pharmacy data, clinical information, self-reported data, and behavioral, disability and lifestyle data elements. The system proactively identifies and prioritizes opportunities for optimizing the health of the entire population: it identifies gaps in care, wellness and behavioral interventions; generates medication adherence and interaction alerts; and offers opportunities for saving money, accessing preventive care and otherwise enhancing overall health.

The eSync tool includes predictive modeling developed by OptumHealth's sister company, Ingenix. The model highlights opportunities for intervention before a major health event occurs, identifying consumers who are likely to need intensive health care services within 12 to 18 months. Data on diagnosis, care-seeking behavior, prescriptions, hospitalizations, doctor visits and tests ordered, among other factors, are analyzed and refreshed on a monthly basis. Eligibility and membership data also reside on the eSync Platform technology, reducing problems in communication and authorization.

- *Ingenix CareTracker* — OptumHealth's sister company, Ingenix, also has developed the Ingenix CareTracker system which fully automates the primary care practice, from patient registration through EMR and billing. By providing all the capabilities necessary to demonstrate "meaningful use" of health information technology under the American Recovery and Reinvestment Act (ARRA) of 2009, the Ingenix CareTracker system allows practices to qualify for incentives offered by the federal government. Moreover, Ingenix is making a specially designed version of its Ingenix CareTracker system available to Federally Qualified Health Centers (FQHCs). This system delivers tools and technologies to help community health centers as well as other providers better use their limited financial resources, ensure compliance with state and federal regulations, and reduce administrative complexity, so they can focus on caring for patients. OptumHealth BankSM, Member FDIC, offers interest-free loans to support practices, including FQHCs, in implementing the Ingenix CareTracker system.

The Ingenix CareTracker system can manage front-office tasks, clinical records and back-office medical billing. It can also automate patient registration and scheduling; manage e-prescribing;

customize patient notes; submit electronic claims; and manage reimbursements. Integrating all of those tasks into one system — which is accessible only to authorized administrative and clinical staff members — can save valuable resources and achieve smoother day-to-day operations for providers. The system also makes it easier to connect with hospitals, labs and health plans, expediting access to clinical and patient information that can support better health outcomes.

- *Psychotropic Pharmacy Consultation* — Not only are the costs of psychotropic medications rising at an alarming rate, but total health care costs are further increased by the "side effects" of inadequate or inappropriate prescribing of these medications: excessive office and ER visits, hospitalization and poor patient outcomes. OptumHealth's Psychotropic Pharmacy Consultation program leverages industry-leading data analytics and evidence-based medicine to identify opportunities for intervention, increasing the likelihood that psychotropic medications are appropriately prescribed by clinicians and appropriately used by patients. By helping to ensure the right drug is prescribed at the right dose for the right patient at the right time, the program can help to improve clinical outcomes, close gaps in care and reduce costs.

Coordinate care efficiently

A major goal of health home services is to improve the coordination of care for individuals who need a great deal of it. Efficient coordination of care has numerous components, including coordination between primary care clinicians, behavioral health and other specialists and ensuring smooth transitions following inpatient care. Coordination can help prevent unnecessary initial and repeat hospitalizations and significantly improve the patient experience. States will want to encourage and support care coordination efforts to the extent feasible.

- *Finding and engaging people* — Coordinating care for Medicaid members with chronic conditions can sometimes mean reaching out to locate and engage them. Feet-on-the-street as well as in-person coordination are therefore critical elements of the programs that OptumHealth offers. As discussed above, for example, in our Live Healthy Care Management program, staff literally knock on doors in order to find people who are appropriate for enrollment in a chronic illness program.
- *Multidisciplinary team* — Care coordination in a health home generally relies on a set of services provided by a multidisciplinary team. Physicians will require support in developing such teams, in leading them and in ensuring that care is well coordinated within the team. States may choose to create learning collaboratives, webinars or

other kinds of training programs to help practices transform themselves into health homes. Under the provisions of Section 3502 of ACA, HHS will establish a program to provide grants to support the development of “health teams” for health home practices.

- *Care management* — OptumHealth offers support to patients and primary care clinicians through a variety of care management programs, including:
 - Transitional Care Management, to evaluate and coordinate post-hospitalization needs for individuals at risk of being re-hospitalized;
 - General Condition Management, for individuals who have chronic conditions or who need longer-term support; and
 - Complex Care Management, for conditions requiring a more specialized care management approach (for example, transplant, End Stage Renal Disease (ESRD) or Neonatal Intensive Care Unit (NICU)).
 - These programs support coordinated discharge planning and home care services, engage with members for referrals to additional health service programs, and eliminate unnecessary medical services. They minimize gaps in care and control costs, improving the health care experience for patients. For the payer, they are documented to reduce the cost of care for the highest need members.
- Integration of behavioral health care — Because individuals who have behavioral health issues, with or without other chronic conditions, are so important to the ACA health home initiative, many states are likely to focus on that population. Successfully managing the integration of mental health and substance abuse care into the services offered in health homes, as well as the reverse, the integration of physical into behavioral health care, will be critical to the success of those efforts. But such integration is not now common practice, and learning how to achieve it will require significant effort on the part of physicians and their teams as well as mental health and substance abuse providers.²⁶
 - OptumHealth offers tools that can help identify individuals with unmet behavioral health needs and ensure they get the care they need. For example, the LifeSolutions program is a proactive care-coordination program designed to identify and engage high-risk members with chronic medical conditions who also suffer from unrecognized or under-treated co-morbid behavioral health conditions such as depression, anxiety, substance abuse or psychosocial stress. By facilitating appropriate services and overcoming practical and psychosocial barriers to compliance with medical and behavioral treatment, the program can enhance productivity and generate medical cost offset among participants.

Improve physician-patient communication while educating and supporting patients

Another element vital to realizing the promise implicit in health homes is that patients must be actively engaged in improving their own health and care. This engagement requires effort on the part of both the doctor and the patient. In routine health care today, effective communication between patients and their physicians is essential.²⁷ One review completed in 2007 found that good communication between doctors and patients improves not only patient satisfaction but also patient outcomes.²⁸ As one of the authors of this review points out, “We don’t assume that when a pilot and an air traffic controller converse that they have understood each [other] until there is an affirmation of understanding. That acknowledgement is lacking in most patient-physician encounters.”²⁹ Levinson et al. suggest that patients of physicians who are taught patient-centered communication skills will have increased knowledge, make better-informed decisions, increase their adherence to care protocols and improve their self-care. They predict that the longer-term result will be improved health outcomes and quality of life, fewer disparities in care and reduced costs of care.³⁰

- *Reducing inappropriate use of the Emergency Room* — Patient education can make a significant difference regarding the appropriate use of the Emergency Room. The PCMH is expected to offer enhanced access to care by extending its hours and enabling same-day or providing rapid scheduling of appointments. If patients also receive information about the appropriate (and inappropriate) use of the Emergency Room, they can be expected to reduce inappropriate use. The Pierce County, Washington, Recovery Response Center described above, and especially its “living room” program, provides alternative modes of crisis response and peer supports to reduce emergency room use by individuals with behavioral health problems. Two other strategies that OptumHealth offers to reduce inappropriate use of the ER are Emergency Room Decision Support and NurseLineSM services. Both use nurses who are specially trained as coaches.
 - ER Decision Support engages individuals after an ER visit and helps to connect or reconnect them with a primary care provider, offer education on other alternatives and refer the individual to disease management or behavioral health services. Sixty percent of individuals engaged by ER Decision Support say that they would choose a lower level of care instead of the ER in the future.
 - NurseLine offers access to registered nurses 24 hours a day, every day. These nurses help to connect consumers with the most appropriate treatment, provider and medication, and offer guidance on lifestyle and wellness issues. Ninety-seven percent of callers indicate that they follow the nurse’s recommendations and 70 percent, who had intended to visit an ER, did not do so following a NurseLine call.

- *Supporting patient involvement in decision making*— A variety of studies have demonstrated that clients who actively participate in their own care experience a number of benefits, including increased satisfaction and improved functioning.³¹ One major goal of the health home is to offer “patient-centered” care, which includes an effort to provide each individual with as much information as he or she wants. When part of a multidisciplinary team, the physician can share the responsibility for this function with nurses, coaches and/or peers. OptumHealth offers numerous programs geared to individuals with specific conditions, as well as an audio health information library covering more than 1,000 topics.

Manage potential provider shortages

As ACA unfolds and millions of individuals become newly eligible for coverage, the primary care and behavioral health system may be challenged to accommodate them.³² The health home model, by incorporating a multidisciplinary team that includes allied professionals, coaches and peers, and encouraging all members of the team to practice at the top of their licenses, can contribute to solving this problem. UnitedHealthcare and OptumHealth also have developed innovative telehealth programs that bring patients and physicians together in new ways:

- In Colorado, UnitedHealthcare is implementing Connected Care in four rural counties. The Connected Care program combines sophisticated audio and video technology with health resources to connect patients with medical specialists located hundreds of miles away, creating an experience that is remarkably similar to having the doctor in the same room with the patient. The program targets specialties in rural areas that either are not currently available or are available only part time, for example, cardiology, dermatology, pulmonology and diabetes management. In addition, Connected Care enables simultaneous group video consultations with a number of physicians who are in different locations, improving care coordination and reducing the need for additional appointments. Connected Care is being implemented in

conjunction with Centura Health®, the Colorado Rural Health Center and the Colorado Community Health Network. Such telehealth programs can be more widely used to supplement traditional care where reimbursement systems cover the video encounter.

- OptumHealth has developed NowClinicSM Online Care, which allows patients to have a live encounter over the Internet with an appropriate available physician who is credentialed by the UnitedHealthcare® network. The patient need not schedule an appointment. In the NowClinic system: both patient and physician are identified; all physicians are credentialed and are licensed in the state where the patient is initiating the conversation; controlled medications are prohibited; there is a complete audit trail, including a transcript of the conversation; and physicians are able to follow up if necessary. In addition, if the patient chooses, a report can be e-mailed or printed for the patient’s primary care physician. The NowClinic Online model is especially valuable for parents with young children, individuals with disabilities who are homebound and people living in rural areas. The NowClinic service can also be used to provide physician-to-physician consultation, for example, for primary care clinicians who are prescribing psychotropic medications.

Conclusion

Health and medical homes show promise of improving quality of care and outcomes for patients with chronic conditions. The new health care reform legislation presents states with the opportunity to increase their federal Medicaid match rates for two years by enrolling Medicaid eligibles in medical, or health, homes. Planning grants will become available early in 2011, supporting states in the extensive preparation that will be necessary before implementation can take place. OptumHealth can offer state Medicaid programs experience and numerous tools that will support them in both the planning and the implementation efforts that will be required if they are to take meaningful advantage of this opportunity.

About OptumHealth

As one of the nation’s largest health and wellness companies, OptumHealth serves over 5 million Medicaid, Medicare and other public sector beneficiaries. Our services range from integrated programs for statewide Medicaid populations to specialized care management for people in nursing homes and children in foster care. OptumHealth’s comprehensive approach helps to make health care more accessible, effective and recovery-oriented for individuals, while delivering systematic improvements in population health management for states and other payers. We help people live their lives to the fullest.

Appendix: Background on Patient-Centered Medical Home, Planning Grants and Definitions

Development of the Patient-Centered Medical Home (PCMH) Model

In March 2007, four organizations representing primary care physicians (the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association[®]) published “Joint Principles of the Patient-Centered Medical Home (PCMH).”³³ The following year, the American Medical Association adopted the principles as well.³⁴ Although the American Academy of Pediatrics had introduced the concept in 1967, the 2007 statement of principles represented a significant expansion of their original notion. The aim of the PCMH is to replace care that is episodic and initiated due to patient illness with care that is coordinated, continuous and comprehensive. Six of the seven principles outline a system in which:

- Each patient’s care is directed by a personal physician who leads a team that takes collective responsibility for that care;
- The personal physician provides or arranges for all the patient’s health care needs;
- Care is coordinated and integrated across all components of the system;
- Quality and safety are paramount goals;
- Access to care is enhanced; and
- The payment system “appropriately recognizes the added value provided to patients” who have a PCMH.

Also key is the seventh principle, the concept of patient-centeredness: patients actively participate in decision making about their care and providers seek their feedback about quality.

Within one year following the enunciation of the Principles, the NCQA released standards for what it calls *Physician Practice Connections[®] – Patient-Centered Medical Home* (PPC-PCMH). The NCQA program measures nine aspects of care. By 2010, the concept had become sufficiently salient that it was incorporated into ACA. In Section 3502 of the law, PCMHs are defined in essentially the same way as they are in the 2007 Principles.³⁵

Availability of planning grants

Section 2703 of ACA creates a program of planning grants to states to support the development of state plan amendments covering “Coordinated Care through a Health Home for Individuals with Chronic Conditions.”³⁶ The definition of a “health home” is essentially the same as the definition of a “medical home.” The incentives in ACA to expand the use of health homes for people with chronic conditions are seen, in part, as a strategy for implementing elements of the Chronic Care Model³⁷ that Edward H. Wagner developed almost 15 years ago.

Under the law, beginning January 1, 2011, the Secretary may award planning grants to states totaling \$25 million to enable them to develop their plan amendments.³⁸ A state that is awarded a planning grant will contribute an amount equal to the state’s FMAP. Once their amendments are approved and their programs are in place, states will be able, as mentioned above, to receive 90 percent Federal Financial Participation (FFP) for the first eight quarters of qualified medical home expenditures. An independent organization is to evaluate the states that elect this option to determine its effect on reducing hospital admissions, emergency room visits and admissions to skilled nursing facilities. Note that, because regulations in support of Section 2703 have not been promulgated as of this writing, we cannot yet be certain about the specific requirements that will be imposed on states or providers. This paper is intended to identify general issues that states will confront.

State plan amendments must include a requirement for hospitals to establish procedures to refer eligible individuals with chronic conditions who seek or need treatment in hospital emergency departments to “designated providers” (see definitions below).

State plan amendments also must include a methodology for tracking avoidable hospital readmissions and calculating savings; a proposal for the use of health information technology in providing health home services; and improving service delivery and coordination. States must also consult and coordinate with SAMHSA in addressing issues regarding prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Definitions

- A **health home** is defined as a designated provider (see below) or health team selected by an eligible individual to provide health home services. The Secretary is to establish standards for qualification as an eligible health home while the state is to specify in its plan amendment the methodology it will use for determining payment.
- **Health home services** include comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support; referral to community and social support services; and use of health information technology to link services.
- An **eligible individual** is one who is eligible for Medicaid and has at least two chronic conditions or has one chronic condition and is a risk of having a second OR has “one serious and persistent mental health condition.”
- A **chronic condition** is defined to include, but not be limited to, a mental health condition, substance use disorder, asthma, diabetes, heart disease or body mass index over 25.

- A **designated provider** is a physician, group practice, rural clinic, community health center, community mental health center, home health agency or other provider determined by the state and approved by the Secretary to be qualified to be a health home based on evidence of the requisite systems and infrastructure and satisfaction of the qualification standards established by the Secretary.

References

- 1 Full text of the law is available at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf. Accessed July 20, 2010.
- 2 State Medicaid Director Letter (SMDL# 10-024). Center for Medicare and Medicaid Services, November 16, 2010.
- 3 Recognizing the major task states are facing, the Department of Health and Human Services (HHS) announced on July 29, 2010, "the availability of up to \$1 million in grants per state to help states begin work to establish Exchanges and published a request for comment calling for public input as HHS develops standards for the Exchanges." See: <http://www.hhs.gov/news/press/2010pres/07/20100729a.html>. Accessed August 2, 2010.
- 4 Weil A, "State Policymakers' Priorities for Successful Implementation of Health Reform," May 2010. See: http://nashp.org/sites/default/files/policymaker_0.pdf. Accessed July 29, 2010.
- 5 Eligible individuals must either have two chronic conditions, be at risk of a second chronic condition or have one serious and persistent mental health condition (see Appendix).
- 6 State Medicaid Director Letter (SMDL# 10-024). Center for Medicare and Medicaid Services, November 16, 2010, page 11.
- 7 See: http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2. Accessed August 2, 2010.
- 8 Ibid.
- 9 Orszag PR and Emanuel EJ, "Health Care Reform and Cost Control," *The New England Journal of Medicine*, June 16, 2010. Available at <http://healthcarereform.nejm.org/?p=3564&query=TOC>. Accessed July 20, 2010.
- 10 See, for example, "Uncoordinated Care: A Survey of Physician and Patient Experience," a study done by Harris Interactive® for the California HealthCare Foundation in 2007. Available at: <http://www.chcf.org/publications/2007/09/uncoordinated-care-a-survey-of-physician-and-patient-experience#ixzz0uQehTDz6>. Accessed July 20, 2010.
- 11 See McKinsey Global Institute, *Accounting for the Cost of US Health Care: A New Look at Why Americans Spend More*, Executive Summary, December 2008. Available at: http://www.mckinsey.com/mgi/reports/pdfs/healthcare/US_healthcare_Executive_summary.pdf. Accessed July 27, 2010.
- 12 "Guided Care: Better Care for Older People with Chronic Conditions." Available at: <http://www.guidedcare.org/pdf/Guided%20Care%20summary%20and%20results.pdf>. Accessed July 27, 2010.
- 13 Abrams M, "Achieving Person-Centered Primary Care: The Patient-Centered Medical Home," Invited Testimony, Special Senate Committee on Aging Hearing on "Person-Centered Care: Reforming Services and Bringing Older Citizens Back to the Heart of Society," July 23, 2008.
- 14 Reid, RJ et al., "The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers," *Health Affairs*, 29:5 (2010), 835-843.
- 15 See: Patient-Centered Primary Care Collaborative website at <http://www.pccpc.net/pccpc-pilot-projects>. Accessed July 20, 2010.
- 16 See: <http://www.commonwealthfund.org/Content/Charts/Survey/2007-International-Health-Policy-Survey----Toward-Higher-Performance-Health-Systems--Adults-Health-C/A/Adults-with-a-Medical-Home.aspx>. Accessed 8/16/2010. Note that a "medical home" in the survey was defined as "having a regular provider that knows you, is easy to contact and coordinates your care."
- 17 In 2014, states will be required to provide a "benchmark" level of care for individuals, up to 133% of federal poverty level ("newly eligible"). These services will be fully financed by the federal government for the first three years (ACA, Sec.2001(a)(3)(B)). Premium subsidies will cover people up to 400% of poverty level. In many states, this will have a significant impact on current populations covered by section 1115 waivers, children covered by the State Children's Health Insurance Program (SCHIP) and other groups. (Holahan and Dorn, RWJF, June 2010).
- 18 Designated providers are defined in Sec.2703(h)(5) and in the Appendix.
- 19 See Section 2703(h)(4).
- 20 Note also that the 90% FMAP rates for health homes will be considerably more valuable to states with higher incomes, which have lower current FMAP rates. While the base FMAP rate was increased from 50 percent to 56.2 percent for FY 2010, seven states have FMAP rates of at least 80 percent, and nine additional states had rates between 75 and 80 percent (Kaiser Family Foundation, Statehealthfacts.org).

- 21 Payment methods must be consistent with Section 1902(a)(30)(A).
- 22 One approach that states might consider is Massachusetts's recent implementation of a PCMH Initiative. Massachusetts is recruiting primary care practice sites to participate in a PCMH Initiative and is requiring that all participating practices master a set of core competencies; participate in a learning collaborative; create and maintain patient registries to use for tracking, reporting, risk stratification, and analysis of health status and patient need; and participate in an evaluation. See Executive Office of Health and Human Services Request for Responses for Patient-Centered Medical Home Services, amended, July 2010.
- 23 For example, our work in New Mexico or Pierce County, Washington.
- 24 Described in Springrose N and Nelson T, "Engaging Physicians in Risk Factor Reduction," September 21, 2009. Available at: http://www.dmaa.org/theforum09/forum09_presentations/Springrose_Nelson.pdf. Accessed August 5, 2010.
- 25 See: <http://patienteducation.stanford.edu/programs/>. Accessed August 13, 2010.
- 26 See: "Behavioral Health/Primary Care Integration and the Person-Centered Healthcare Home, National Council for Community Behavioral Healthcare," April 2009. Available at <http://www.thenationalcouncil.org/galleries/resources-services%20files/Integration%20and%20Healthcare%20Home.pdf>. Accessed August 3, 2010.
- 27 See, for example: Stewart MA, "Effective physician-patient communication and health outcomes: a review," *Canadian Medical Association Journal*, 152(9): May 1995; 1423-33; and Teutsch C, "Patient Doctor Communication," *Medical Clinics of North America*. 2003 Sep;87(5):1115-45.
- 28 Indiana University (2007, April 10). "Doctor-Patient Communication Has A Real Impact On Health," *ScienceDaily*. Available at: <http://www.sciencedaily.com/releases/2007/04/070409144754.htm>. Accessed August 3, 2010.
- 29 Ibid.
- 30 Levinson W, Lesser CS and Epstein RM, "Developing Physician Communication Skills for Patient-Centered Care," *Health Affairs*, 29: 7 (2010), 1310-1318.
- 31 Adams JR and Drake RE, "Shared Decision-Making and Evidence-Based Practice," 42, 1 (February 2006), 87-105.
- 32 Weil, op. cit., p.3.
- 33 Available at: <http://www.pcpcc.net/node/14>. Accessed August 3, 2010.
- 34 See: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2625832/pdf/0060086.pdf>. Accessed 8/3/2010.
- 35 Op. cit., page 396.
- 36 Ibid., p. 201.
- 37 Wagner EH, et al. "Organizing Care for Patients with Chronic Illness," *Milbank Quarterly*. 1996. 74(4): 511-544.
- 38 Op. cit., pp. 201-205. A state that is awarded a planning grant will contribute an amount equal to the state's FMAP.