Medicaid Health Homes
Emerging Models and Implications for Solutions to Chronic Homelessness

Several states have begun implementing the new Medicaid health home benefit created by the Affordable Care Act of 2010 (ACA). As discussed below, this new benefit is a source of funding for care coordination activities that are frequently not covered in Medicaid programs. A health home can help improve behavioral and physical outcomes for vulnerable homeless people, which in turn are proven to reinforce positive housing outcomes. Medicaid payments for health homes can also increase safety net capacity for health care and housing at the community level.

Implementation is in early stages and the impact of this new ACA program in the homeless assistance arena is not yet known. However, advocates for vulnerable people experiencing homelessness have a valuable perspective and can be a constructive voice as home health benefits are created and implemented across the states. As this Alliance policy brief shows, the emerging state models point the way for homeless advocates to engage with Medicaid leaders about integrating supportive housing and health care services. For homeless assistance, key policy considerations include:

- Methods for targeting behavioral health populations;
- Criteria defining the provider types that can be designated a health home;
- Payment strategies to support the intensity of services needed to stabilize people in housing; and
- Enrollment practices that recognize the needs of vulnerable homeless people.

The policy brief offers background on Medicaid health homes, and reviews models that have already been approved by the Centers for Medicare and Medicaid Services (CMS) within the U.S Department of Health and Human Services (HHS). This information can prepare advocates and homeless assistance providers to participate in strategy discussions about integrating health care and supportive housing – in their communities or on a statewide basis.

WHAT IS A HEALTH HOME?

A “health home” is a new Medicaid benefit that some states are adopting as a way to improve the delivery of care to people with high health care needs. The benefit was created by the ACA “to provide enhanced integration and coordination of primary, acute and behavioral health (mental health and substance use), and long-term services and supports for people with chronic illness across their lifespan.”¹ A health home is not a new kind of health care facility or service site. Rather, it functions as a “home base” where various health-related services are coordinated and ongoing person-centered assessments are made.

To offer the benefit to Medicaid enrollees, states must act affirmatively to create health homes in their Medicaid programs. Each state’s health home design must be approved by CMS. Under the ACA, the federal government pays for health home services at a 90 percent match rate for the first two years, after which a given state’s established Medicaid match rate applies. ² For its part, CMS reviews and approves health home proposals under a streamlined system, based on a health home application template. By the end of September 2012, CMS had approved health home designs in 7 states: Iowa, Missouri, New York, North Carolina, Ohio, Oregon and Rhode Island.
Medicaid health homes serve as the center of decision-making by interdisciplinary teams – consisting, for example, of a physician, psychiatrist, nurse, and social worker. Care management activities are reimbursed separately from the discrete health care services provided. The health home role can be assumed within a doctors’ practice, an outpatient clinic, or a behavioral health organization, among other providers. Typically, only patients and clients with a threshold level of health care needs are assigned to a health home.

States can offer (but are not permitted to require) the health home benefit to a high-risk person in Medicaid who meets one of three criteria in federal law, specifically one of the following:

- Having two or more chronic conditions; or
- Having one serious and persistent mental health condition; or
- Having one chronic condition and being at risk of developing a second chronic condition.

States can tailor a health home benefit within these eligibility guides. For instance, a state can limit a health home program to people with serious and persistent mental health conditions.

States are also allowed wide latitude to set the package of services that health homes can provide. In guidance, CMS offered the following examples of services: Comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings; individual and family support; referral to community and social support services, if relevant; and the use of health information technology to link services, as feasible and appropriate.³

**Implications—Medicaid Health Homes**

Health home services, such as care coordination, can be key to supporting people in supportive housing who have experienced chronic homelessness or otherwise need help achieving housing stability. Such individuals tend to have intensive behavioral and physical health needs and may be receiving ongoing treatments from a range of providers. Coordination adds value to their care. Yet advocates often cite gaps in funding for coordination as a barrier to successful housing interventions. The separate Medicaid reimbursement under the health home benefit can also contribute to the bottom line of housing and service providers.

**EMERGING HEALTH HOME MODELS IN MEDICAID**

As Medicaid health home models come on line, features and components relevant to ending chronic homelessness have become apparent. Current models can inform approaches homeless advocates may take now in their states to influence health home designs. The Alliance reviewed state Medicaid plan amendments approved by CMS as of October 1, 2012 (the first year of implementation), with particular attention to target population, provider designations, and payment policies.⁴ These design elements can have significant implications for the goals of supportive housing providers and homeless assistance in a given state.

**POPULATION FOCUS: BEHAVIORAL HEALTH**

All the health home models reviewed focus on at-risk behavioral health populations to varying degrees. For example, Missouri’s plan specifies four distinct groups of enrollees eligible for health home services based on a behavioral health need. The groups range from those with a serious and persistent mental health condition, to those with a “substance use disorder and one other chronic condition (asthma, cardiovascular disease, diabetes, mental illness, development disability, overweight).” For comparison, Rhode Island developed a health home benefit solely for individuals with “one serious mental illness,” with no additional qualifying criteria. Ohio is another example of a
state targeting high-risk behavioral health populations with its Medicaid health home benefit. Other states, such as North Carolina and Iowa, offer health homes to individuals with chronic mental illness co-occurring with chronic physical conditions, but do not specifically target behavioral health populations for health home programs.

**Implications—Behavioral Health Focus**

One of the core advantages of health homes is the ability to integrate behavioral and physical health, while also addressing related problems of housing stability – all within Medicaid. For this reason alone, the implications for supportive housing capacity are significant. Given the prevalence of co-occurring disorders, strategies to address chronic homelessness are best served by health homes that meet the broadest range of behavioral needs. It is important to set eligibility criteria so as not to exclude high-risk homeless groups, e.g., those with primary diagnoses related to substance use. Further, for flexibility to co-locate health home providers within supportive housing, it would be most helpful for health home eligibility to fit clearly the health profiles of people in recovery and with experience of chronic homelessness.

**HEALTH HOME PROVIDER TYPES**

States designate their Medicaid health home providers according to general federal guidance and the additional criteria they may set. Under core federal standards, providers must have integrated medical staff and the ability to organize and supervise interdisciplinary teams. States so far have taken different approaches to defining or limiting the type of provider that can be designated as a Medicaid health home. The Missouri and Rhode Island programs deem their established community mental health centers (CMHCs) to be health home providers for behavioral health populations in their catchment areas. Ohio, which is also focusing on its high-risk behavioral population, includes private non-profit behavioral health agencies in a broader pool of potential health home designees.

Oregon and New York, to compare, are more flexible in defining the types of providers that may serve as Medicaid health homes. This may be because their programs also reach populations with complicated, non-behavioral medical and physical health conditions. In Oregon, the program designates current Medicaid providers such as community health centers and physicians’ practices, in addition to behavioral health organizations that have medical capacity. New York’s design would permit any Medicaid provider to apply for the designation, assuming health home service capacity is demonstrated.

**Implications—Provider Type**

State decisions on health home provider type can have significant implications for homeless assistance and supportive housing capacity. The flexibility in New York’s approach, for example, indicates that housing providers already billing Medicaid are in a position to apply for the designation and be reimbursed for health home services to residents. This type of open model also allows community partnerships to form across safety net silos of housing, health care and social services. The built-in flexibility allows for local collaboration and innovation in housing and serving vulnerable homeless people. Depending on the community, however, a more closed model may also be suited to local plans to end chronic homelessness. In states where behavioral health agencies are strong funders and operators of supportive housing, integrating health homes through those agencies makes strategic sense. As always, the key for homeless coalitions is to advocate for and support local priorities to identify and house the most vulnerable. The added service capacity of health homes in public agencies can inform that strategy.
ENROLLING VULNERABLE PEOPLE IN HEALTH HOMES

To enroll eligible participants, the Medicaid health home models combine administrative “data-mining” methods with more provider-driven enrollment practices. While participation is not mandatory for people in Medicaid who are eligible for health homes, there is a presumption of consent to enroll, with the possibility of “opting out.” Missouri and Rhode Island have similar enrollment models, identifying and auto-enrolling people based on existing Medicaid data on diagnosis and treatment. In contrast, Oregon relies on its community-based providers to identify Medicaid enrollees who meet health home eligibility criteria and follow a process to enroll them electronically. Health home models generally also provide pathways to enrollment when people seek participation on their own, as well as disenrollment/reassignment mechanisms for enrollees to exercise choice.

Implications—Enrollment
Health home enrollment strategies have implications for integrating homeless assistance and supportive housing for the most vulnerable homeless people. Programs relying extensively on analysis of Medicaid user data may fail to “find” eligible people who are homeless or unstable in housing. Even when homeless people can be located, the impersonal nature of auto-enrollment can result in incomplete assessments and failure to build in critical housing-related services. (Health homes, in principle, are meant to remedy this common gap in traditional Medicaid delivery systems.) In contrast, a model that involves providers at the front-end has clear advantages. Frontline clinicians and caseworkers are in better position than data analysts to identify potentially eligible persons who need housing interventions. In addition, community-based providers can help these enrollees navigate to health home providers with housing capacity. A defined role for providers in the enrollment process creates a person-centered framework for this process. At the back end, presumably, states can build controls into their enrollment systems to avoid duplication in health home assignment.

REIMBURSEMENT FOR HEALTH HOME SERVICES

Most states so far have opted to pay health homes on a “per-member-per-month” (PMPM) basis, meaning that Medicaid pays providers a global monthly amount for each health home enrollee they serve. There is some variation in how the amount is set. In Missouri, the state specifies a defined dollar amount. In Oregon, Medicaid pays health home providers with a tiered PMPM methodology that also accounts for the expertise and capacity of the designated provider. Other states have adopted approaches that take into consideration the relative severities of individuals’ conditions in a given health home population (so-called “risk” or “case mix” adjustment). In setting health home rates, states are careful to avoid duplicate payments for services already covered by a state program apart from the health home benefit, e.g., targeted case management or community psychiatric support teams.

Implications—Reimbursement
Approaches to health home reimbursement have clear implications for capacity to address chronic homelessness. People experiencing chronic homelessness tend to have complex behavioral and physical health conditions, such that intensive services are needed to stabilize them in housing, and ongoing supportive services at some level will be required thereafter. Health homes that can be tailored effectively for people in supportive housing are potentially a solution. Whether the amount of Medicaid reimbursement for this function is actually adequate to achieve desired housing and health care outcomes is a critical question for policy analysis as well as safety net planning at the community level. At this early point, nonetheless, the more promising approaches are ones that consider the service needs and appropriate interventions for the most vulnerable people, including service factors for supportive housing.
Endnotes


2 By contrast, the usual Medicaid matching rates for states range from 50 to 73 percent. A list of states’ matching rates (FMAP) can be found on the “State Health Facts” website: http://www.statehealthfacts.org.

3 Centers for Medicare and Medicaid Services, Letter to State Medicaid Directors, November 16, 2010 (SMDL# 10-24).

4 More detailed information about approved Medicaid health homes, including links to available state resources, is available from the Integrated Care Resource Center, http://www.integratedcareresourcecenter.com/.

5 The Assistant Secretary for Planning and Evaluation (ASPE) within HHS published a series of papers identifying and describing a variety of partnership models, analyzing policy and practical considerations of how they are structured in communities. See http://aspe.hhs.gov/./population/pop_detail.cfm?pop=Homeless&&option=1.