Table of Contents

State/Territory Name: District of Columbia

State Plan Amendment (SPA) #: 15-0005

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

Region III/Division of Medicaid and Children's Health Operations

SWIFT #062520154007

SEP 04 2015

Claudia Schlosberg, J.D.
Senior Deputy Director/State Medicaid Director
Department of Health Care Finance
441 4th Street, N.W., Suite 900 South
Washington, D.C. 20001

RE: DC SPA #15-005

Dear Ms. Schlosberg:

The Centers for Medicare & Medicaid Services (CMS), Philadelphia Regional Office, has completed its review of The District of Columbia State Plan Amendment (SPA) Transmittal Number 15-005, Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions. This SPA implements Health Homes as authorized under Section 2703 of the Patient Protection and Affordable Care Act. Individuals eligible to receive Health Home services include those with Serious Mental Illness (SMI) who are enrolled in risk based managed care. The District defines SMI to include diagnosable mental, behavioral, or emotional disorder, including those of biological etiology, as defined in D.C. Code §7-1131.02 (1f) and (24). This SPA was submitted to improve the integration of physical and behavioral health care within the District of Columbia.

This SPA is approved September 2, 2015, with an effective date of January 1, 2016. Enclosed is a copy of the approved pages for incorporation into the District of Columbia State plan.

In accordance with the statutory provisions at Section 1945 (c)(1) of the Social Security Act, for payments made to health home providers under this amendment, during the first eight fiscal quarters that the SPA is in effect, January 1, 2016 through December 31, 2018, the federal medical assistance percentage (FMAP) rate applicable to such payments shall be equal to 90 percent. The FMAP rate for payments made to health home providers will return to the state's published FMAP rate on January 1, 2019. The Form CMS-64 has a designated category of service Line 43 for States to report health home services expenditures for enrollees with chronic conditions.

Please share with your staff my appreciation for their time and effort throughout this process. If you have any questions regarding the State Plan Amendment, please contact Alice Robinson Penn at 215-861-4261 or by email at Alice.RobinsonPenn@cms.hhs.gov.

Sincerely,

[redacted]

Francis McCullough
Associate Regional Administrator

Enclosures

cc: M. Diane Fields, DHCF
D. Hasan, DHCF

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER: 15-005	2. STATE District of Columbia
	3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act	
TO: Regional Administrator Centers for Medicare & Medicaid Services Department of Health and Human Services	4. PROPOSED EFFECTIVE DATE January 1, 2016	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION Section 2703 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148) 42 CFR 447.205 1945 of the Social Security Act [42 U.S.C. 1396w-4]	7. FEDERAL BUDGET IMPACT a. FFY 16 $ 7,070,000 b. FFY 17 $ 9,700,000
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT The State Plan Amendment (SPA) for the Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions, also known as the Health Homes SPA, will be submitted to CMS via the Medicaid Model Data Lab (MMDL).	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)* The State Plan Amendment (SPA) for the Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions, also known as the Health Homes SPA, will be submitted to CMS via the Medicaid Model Data Lab (MMDL).

10. SUBJECT OF AMENDMENT:
Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

11. GOVERNOR'S REVIEW *(Check One)*
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER: B21-0157

[redacted]	16. RETURN TO
13. TYPED NAME Claudia Schlosberg, JD	Claudia Schlosberg, J.D. State Medicaid Director Department of Health Care Finance 441 4th St. N.W., Suite 900 South Washington, DC 20001
14. TITLE State Medicaid Director	
15. DATE SUBMITTED August 25, 2015	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED June 19, 2015	18. DATE APPROVED SEP 02 2015
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL January 1, 2016	20. SIGNATURE OF REGIONAL OFFICIAL [redacted]
21. TYPED NAME Francis McCullough	22. TITLE Associate Regional Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **15-005**	2. STATE District of Columbia
	3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act	
TO: Regional Administrator Centers for Medicare & Medicaid Services Department of Health and Human Services	4. PROPOSED EFFECTIVE DATE January 1, 2016	

5. TYPE OF PLAN MATERIAL *(Check One)*:

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☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER: B21-0157

[redacted]	16. RETURN TO
13. TYPED NAME Claudia Schlosberg, JD	Claudia Schlosberg, J.D. State Medicaid Director Department of Health Care Finance 441 4th St. N.W., Suite 900 South Washington, DC 20001
14. TITLE State Medicaid Director	
15. DATE SUBMITTED August 25, 2015	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED	18. DATE APPROVED

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL	20. SIGNATURE OF REGIONAL OFFICIAL
21. TYPED NAME	22. TITLE

Health Home State Plan Amendment

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Transmittal Number: DC-15-0005 Supersedes Transmittal Number: Proposed Effective Date: Jan 1, 2016 Approval Date: Attachment 3.1-H Page Number:

Submission Summary

Transmittal Number:
Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

DC-15-0005

Supersedes Transmittal Number:
Please enter the Supersedes Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

☑ **The State elects to implement the Health Homes State Plan option under Section 1945 of the Social Security Act.**

Name of Health Homes Program:

Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

State Information

State/Territory name:	**Dist. of Columbia**
Medicaid agency:	District of Columbia (DC) Department of Health Care Finance

Authorized Submitter and Key Contacts

The authorized submitter contact for this submission package.

Name:	Claudia Schlosberg
Title:	DC Department of Health Care Finance, State Medicaid Director
Telephone number:	(202) 442-9075
Email:	claudia.schlosberg@dc.gov

The primary contact for this submission package.

Name:	Dena Hasan

Title:	District of Columbia Department of Health Care Finance, Lead Project Manager
Telephone number:	(202) 535-2178
Email:	dena.hasan@dc.gov

The secondary contact for this submission package.

Name:	Shelly Ten Napel
Title:	DC Department of Health Care Finance, Director, Health Care Reform & Innovat
Telephone number:	(202) 442-9090
Email:	shelly.tennapel@dc.gov

The tertiary contact for this submission package.

Name:	Oscar Morgan
Title:	DC Department of Behavioral Health Services, Director, Adult Services
Telephone number:	(202) 673-7067
Email:	oscar.morgan@dc.gov

Proposed Effective Date

01/01/2016 (mm/dd/yyyy)

Executive Summary

Summary description including goals and objectives:
The District of Columbia's (DC) Departments of Health Care Finance and Behavioral Health partnered to develop the DC's Health Home (HH) state plan benefit for individuals with serious and persistent mental health illness (SMI). The goals of DC's HH program for individuals with SMI are aligned with those of CMS and are to improve the integration of physical and behavioral health care; lower rates of hospital ED use; reduce avoidable hospital admissions and re-admissions; reduce healthcare costs; improve the experience of care, quality of life and consumer satisfaction; and improve health outcomes. Under DC's approach, the HH is the central point for coordinating patient-centered and population-focused care for both behavioral health and other medical services. To leverage already established relationships between the SMI population and community mental health providers, Core Services Agencies (CSAs) will deliver the HH benefit. HH services are built upon an existing service under the DC's Mental Health Rehabilitation Services (MHRS) Medicaid state plan benefit, called Community Support Services (CSS), which are rehabilitation and recovery supports that underpin the other services included within the MHRS benefit. The HH program will add primary care focused individuals to the existing teams within the CSAs to achieve an interdisciplinary team approach that integrates behavioral, primary and acute health services. An individual can only be enrolled in one HH at a time, and cannot be both enrolled in the HH program and Assertive Community Treatment, nor in the HH program and receive case management services under the Elderly Persons with Disabilities (EPD) Waiver. While enrolled in a HH, an individual can concurrently receive all MHRS with the exception of CSS. Communication and collaboration within HHs and with external health care partners is supported by DBH's web-based medical record and billing system (iCAMS).

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2016	$ 7070000.00
Second Year	2017	$ 9700000.00

Federal Statute/Regulation Citation

Section 2703 of the Patient Protection and Affordable Care Act of 2010 (Pub.L.111.148); 42 CFR 447.205; 1945 of the Social Security A

Governor's Office Review

- ○ **No comment.**
- ○ **Comments received.**
  Describe:
- ○ **No response within 45 days.**
- ◉ **Other.**
  Describe:
  The District of Columbia does not have a Governor. In lieu of a Governor, The Council of the District of Columbia must approve each Medicaid State Plan Amendment (SPA) for submission to the US Centers for Medicare and Medicaid Services. The Council's approval of this SPA is included in the District of Columbia's Fiscal Year 2016 Budget Support Act of Fiscal Year 2015 (B21-0157).

Transmittal Number: DC-15-0005 Supersedes Transmittal Number: Proposed Effective Date: Jan 1, 2016 Approval Date:

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Attachment 3.1-H Page Number:

Submission - Public Notice

Indicate whether public notice was solicited with respect to this submission.

- ○ **Public notice was not required and comment was not solicited**
- ○ **Public notice was not required, but comment was solicited**
- ◉ **Public notice was required, and comment was solicited**

Indicate how public notice was solicited:

- ☐ **Newspaper Announcement**
- ☑ **Publication in State's administrative record, in accordance with the administrative procedures requirements.**

Date of Publication:

06/13/2014 (mm/dd/yyyy)

☐ **Email to Electronic Mailing List or Similar Mechanism.**

Date of Email or other electronic notification:

(mm/dd/yyyy)

Description:

☑ **Website Notice**

Select the type of website:

☑ Website of the State Medicaid Agency or Responsible Agency

Date of Posting:

06/13/2014 (mm/dd/yyyy)

Website URL:

http://dhcf.dc.gov

☐ Website for State Regulations

Date of Posting:

(mm/dd/yyyy)

Website URL:

☐ Other

☑ **Public Hearing or Meeting**

Date	Time	Location
Jun 24, 2015	1:30 - 3:00 pm	DC Department of Health Care Finance 441 4th Street, NW Washington, DC 20002

☐ **Other method**

Indicate the key issues raised during the public notice period:(This information is optional)

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service Delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Transmittal Number: DC-15-0005 Supersedes Transmittal Number: Proposed Effective Date: Jan 1, 2016 Approval Date:

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Submission - Tribal Input

☐ **One or more Indian health programs or Urban Indian Organizations furnish health care services in this State.**

☐ **This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**

☐ **The State has solicited advice from Tribal governments prior to submission of this State Plan Amendment.**

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner:

☐ **Indian Tribes**

☐ **Indian Health Programs**

☐ **Urban Indian Organization**

Indicate the key issues raised in Indian consultative activities:

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Transmittal Number: DC-15-0005 Supersedes Transmittal Number: Proposed Effective Date: Jan 1, 2016 Approval Date:

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Attachment 3.1-H Page Number:

Submission - SAMHSA Consultation

☑ **The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.**

Date of Consultation	
Date of consultation: 04/30/2015 (mm/dd/yyyy)	

Transmittal Number: DC-15-0005 Supersedes Transmittal Number: Proposed Effective Date: Jan 1, 2016 Approval Date:
Attachment 3.1-H Page Number:

Health Homes Population Criteria and Enrollment

Population Criteria

The State elects to offer Health Homes services to individuals with:

☐ **Two or more chronic conditions**

Specify the conditions included:

☐ **Mental Health Condition**
☐ **Substance Abuse Disorder**
☐ **Asthma**
☐ **Diabetes**
☐ **Heart Disease**
☐ **BMI over 25**

Other Chronic Conditions	

☐ **One chronic condition and the risk of developing another**

Specify the conditions included:

☐ **Mental Health Condition**
☐ **Substance Abuse Disorder**
☐ **Asthma**
☐ **Diabetes**
☐ **Heart Disease**
☐ **BMI over 25**

Other Chronic Conditions	

Specify the criteria for at risk of developing another chronic condition:

☑ **One or more serious and persistent mental health condition**

Specify the criteria for a serious and persistent mental health condition:
Criteria for a serious and persistent mental health condition are defined in D.C. Code § 7-1131.02 (1f) and (24). Individuals eligible for HH services have a diagnosable mental, behavioral, or emotional disorder (including those of biological etiology) which substantially impairs the mental health of the person or is of sufficient duration to meet diagnostic criteria specified within the DSM-IV or its ICD-9-CM equivalent (and subsequent revisions) with the exception of DSM-IV "V" codes, substance abuse disorders, intellectual disabilities and other developmental disorders, or seizure disorders, unless those exceptions co-occur with another diagnosable mental illness.

Geographic Limitations

☑ **Health Homes services will be available statewide**

Describe statewide geographical phase in/expansion. This should include dates and corresponding geographical areas that bring the program statewide.

If no, specify the geographic limitations:

○ **By county**

Specify which counties:

○ **By region**

Specify which regions and the make-up of each region:

○ **By city/municipality**

Specify which cities/municipalities:

○ **Other geographic area**

Describe the area(s):

Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the State will use to enroll eligible Medicaid individuals into a Health Home:

◉ **Opt-In to Health Homes provider**

Describe the process used:
DBH will use an 'Opt-In' method to enroll eligible Medicaid individuals into HHs. DC will leverage existing relationships between CSAs and individuals with severe and persistent mental illness (SMI), and designate CSAs, that meet DC's criteria, as HHs. CSAs deliver the majority of community-based mental health services to Medicaid individuals with SMI. The enrollment process is as follows: 1) DC will assign eligible individuals to HHs based on the individual's health status and historical CSA service utilization found in Medicaid claims data; 2) DBH will send a letter to individuals to provide notification of HH eligibility, the individual's assigned HH; and the process for choosing another HH if desired; 3) the HH will engage each individual assigned to them to obtain consent to be enrolled in the HH and begin to deliver HH services. Individuals with no recent MHRS claims will be attributed to a HH based on the current distribution of SMI individuals to CSAs. Individuals who elect not to receive HH services may do so without jeopardizing their access to other medically necessary services, such as MHRS. Individuals who opt-out will be permitted to receive HH services in the future as long as they continue to meet HH eligibility requirements. Individuals new to Medicaid or newly diagnosed with an SMI will be eligible for this benefit. A protocol for informing new consumers of their eligibility for HH services and their options of service providers is described in the DC Municipal Regulations (DCMR).

○ **Automatic Assignment with Opt-Out of Health Homes provider**

Describe the process used:

☐ **The State provides assurance that it will clearly communicate the opt-out option to all individuals assigned to a Health Home under an opt-out process and submit to CMS a copy of any letter or other communication used to inform such individuals of their right to choose.**

○ **Other**

Describe:

- [x] **The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**
- [x] **The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**
- [x] **The State provides assurance that hospitals participating under the State Plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.**
- [x] **The State provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each Health Homes enrollee will be claimed. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.**
- [x] **The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

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Attachment 3.1-H Page Number:

Health Homes Providers

Types of Health Homes Providers

- [x] **Designated Providers**

Indicate the Health Homes Designated Providers the State includes in its program and the provider qualifications and standards:

- [ ] **Physicians**

Describe the Provider Qualifications and Standards:

- [ ] **Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards:

- [ ] **Rural Health Clinics**

Describe the Provider Qualifications and Standards:

☐ **Community Health Centers**

Describe the Provider Qualifications and Standards:

☑ **Community Mental Health Centers**

Describe the Provider Qualifications and Standards:

Designated providers of HH services for individuals with SMI shall be CSAs identified by DC to meet the standards of a HH. CSA qualifications are listed in 22-A DCMR § 3400 et seq. In order to meet the HH standards, CSAs must be adequately staffed by teams of health care professionals that, at a minimum, are capable of providing specific functions to meet HH standards. Each of these functions, as well as the particular qualifications/ credentials required of the individuals responsible for these roles, includes: 1) Health Home Director- Master's level education in a health-related field; 2) Primary Care Liaison- nurse practitioner or physician; 3) Nurse Care Manager- nurse with an advanced practice license or a registered nurse with experience in one or more areas of practice relevant to integrated chronic disease care management (i.e. adult health, family nurse practitioner, advanced primary care, other chronic disease specialties); and 4) Care Coordinator- Bachelor of Arts with training in a health care, human service field or equivalent experience. All clinicians must meet the requirements of Health Occupations and Revisions Act of 1985, and subsequent amendments thereto, and implementing regulations.

The ratio for each required HH staff member to HH enrollee is listed in the DCMR, and serves as the foundation for the HH team. HHs are encouraged to add additional roles to HH teams that reflect the needs of their empaneled members (e.g. pharmacist; dietician).

HHs must document all services delivered and information received from external health care providers in iCAMS.

☐ **Home Health Agencies**

Describe the Provider Qualifications and Standards:

☐ **Other providers that have been determined by the State and approved by the Secretary to be qualified as a health home provider:**

☐ **Case Management Agencies**

Describe the Provider Qualifications and Standards:

☐ **Community/Behavioral Health Agencies**

Describe the Provider Qualifications and Standards:

☐ **Federally Qualified Health Centers (FQHC)**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Teams of Health Care Professionals**

Indicate the composition of the Health Homes Teams of Health Care Professionals the State includes in its program. For each type of provider indicate the required qualifications and standards:

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Nurse Care Coordinators**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Professionals**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Health Teams**

Indicate the composition of the Health Homes Health Team providers the State includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards:

☐ **Medical Specialists**

Describe the Provider Qualifications and Standards:

☐ **Nurses**

Describe the Provider Qualifications and Standards:

☐ **Pharmacists**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Dieticians**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Specialists**

Describe the Provider Qualifications and Standards:

☐ **Doctors of Chiropractic**

Describe the Provider Qualifications and Standards:

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Describe the Provider Qualifications and Standards:

☐ **Physicians' Assistants**

Describe the Provider Qualifications and Standards:

Supports for Health Homes Providers

Describe the methods by which the State will support providers of Health Homes services in addressing the following components:

1. **Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services,**
2. **Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines,**
3. **Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders,**
4. **Coordinate and provide access to mental health and substance abuse services,**
5. **Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care,**
6. **Coordinate and provide access to chronic disease management, including self-management support to individuals and their families,**
7. **Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services,**
8. **Coordinate and provide access to long-term care supports and services,**
9. **Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services:**

10. **Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate:**
11. **Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.**

Description:

The HH program is a partnership between DHCF, DBH and providers. DC is committed to providing ongoing technical assistance, training, IT (i.e. iCAMS; CRISP) and data support, care management guides and other assistance necessary to help HHs succeed. To support the launch of the program, DC will provide training to support HHs' development and implementation of electronic information infrastructure, culturally appropriate HH care plans, policies and practices, and ability to conduct data analytics and financial modeling. Post program launch, DC will support HH's continuous quality improvement by fostering shared learning, information sharing and joint problem solving. Ongoing DC-sponsored educational opportunities, coaching, and collaborative learning programs will support the provision of evidence-based, timely, high-quality HH services that are whole-person focused and that integrate medical and behavioral health, community supports and social services. DC will communicate externally to other agencies, providers, and community stakeholders to facilitate HH referrals and the collaborative engagement of those entities with HHs. HHs will have access to real-time hospital and ER use alerts of their enrolled individuals through CRISP, and further support via a coordinated HH care plan embedded in iCAMS. The HH care plan expands upon data gathered via the MHRS treatment planning process outlined in 22-A DCMR § 3407, to include primary, acute and long term health care information to achieve an individualized, comprehensive approach for health care treatment and self-management. It will also serve as a source of information for monitoring and evaluation purposes. DC will maintain a close working relationship with HHs to monitor program implementation, respond to learning needs that emerge, and establish HH performance monitoring activities to ensure HHs' services meet DC's and CMS' individualized and population-focused standards.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.

Designated providers of HH services to individuals with SMI will be CSAs identified by DC to meet the standards of a HH. Through DC's initial engagement efforts with CSAs, DBH will consider its analysis of HH eligible individuals and their existing relationships with CSAs, then solicit interest from as many CSAs that are interested and capable of meeting requirements to serve as HHs. HHs are responsible for developing working relationships and partnership agreements, as appropriate, with primary care and community based service providers to order to deliver HH services to enrolled individuals. On an ongoing basis, DBH will work collaboratively with DHCF to facilitate relationships between HHs and Medicaid primary care, long term care, acute care and other community and social services providers in order to coordinate services.

iCAMS is the platform HHs will use to capture, track and claim services provided to enrolled HH individuals. iCAMS may be populated with information generated via interfaces to entities such as: 1) DC's FQHCs; 2) local hospitals, by leveraging the Encounter Notification Service within the CRISP HIE; 3) DC's MMIS from which periodic feeds of Medicaid claims and encounter data will be generated and uploaded into iCAMS; and 4) other administrative systems such as the DC Access System (DCAS), the DC's integrated eligibility determination system.

Provider Standards

The State's minimum requirements and expectations for Health Homes providers are as follows:

HHs will operate under a "whole-person" approach to care within a culture of continuous quality improvement that looks at an individual's full array of clinical and non-clinical health care needs and services and social needs and services. HHs will deliberately organize culturally appropriate, person-centered care activities and share information among all the participants concerned with a person's care to achieve safer, more effective care and improved health outcomes.

At a minimum, HHs must:

- have current certification as a MHRS CSA in accordance with 22-A DCMR § 3400;
- be enrolled as a DC Medicaid provider for the delivery of mental health rehabilitation services;
- not have any current or pending exclusions, suspensions or debarment for any federal or DC healthcare program; and
- be willing and able to enter all data into DBH's data management system, iCAMS. Using health information technology (i.e. iCAMS) will enable HHs to link services; facilitate communication among HH team members, and between the HH team and the individual and family caregivers; and provide feedback to practices, as feasible and appropriate. iCAMS will also support a continuous quality improvement program, and enable DC and HHs to collect and report on data that will facilitate the District's evaluation of process and outcome measures at the individual and population level.

Additionally, CSA's must meet the following HH certification standards to be certified as a HH:

1. Each CSA seeking designation as a HH must participate in a readiness assessment to determine its ability to meet HH service

delivery standards. These standards require that a HH is:
a. adequately staffed by core teams of health care professionals that represent the following functions: Health Home Director, Primary Care Liaison, and Nurse Care Manager. HHs may add additional staff to HH teams (e.g. pharmacist; dietician) to meet enrollees' needs or request a different team configuration that still meets program objectives. HHs must submit reports to DC indicating full- or part-time employee status of HH team members and vacancies, with an improvement plan in place to address deficiencies in core HH team member vacancies; and
b. able to perform each of the functional requirements, as well as document the processes used to perform these functions:
• Provide quality-driven, cost-effective, culturally appropriate, and person-and family-centered HH services,
• Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines,
• Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders,
• Coordinate and provide access to mental health and substance abuse services,
• Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participations in discharge planning and facilitation transfer from a pediatric to an adult system of health care,
• Coordinate and provide access to chronic disease management, including self-management support to individuals and their families,
• Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services,
• Coordinate and provide access to long-term care supports and services, and
• Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services; and
• Establish a continuous quality improvement program.

2. Each CSA seeking designation as a HH must agree to document HH services delivered in DBH's electronic health record, iCAMS; and use iCAMS to create and execute a person-centered care plan for each enrolled individual based on HH assessments, hospital data and information gathered from the individual's other external health care providers. DBH will monitor the services documented in iCAMS for HH reimbursement, program monitoring and HH performance evaluation purposes.

3. Each CSA seeking designation as a HH must complete the DC-sponsored Health Home Learning Community Curriculum created to foster HHs professional competency and best practice development related to person-centered planning, chronic disease self-management, and other topics; continuous quality improvement tasks; monitoring and performance reporting; and CMS and DC-required evaluations.

4. Each CSA seeking designation as a HH must directly provide, or subcontract for the provision of, HH services. The HH remains responsible for all HH program requirements, including services performed by the subcontractor.

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Health Homes Service Delivery Systems

Identify the service delivery system(s) that will be used for individuals receiving Health Homes services:

☑ **Fee for Service**
☐ **PCCM**

○ **PCCMs will not be a designated provider or part of a team of health care professionals. The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments.**

○ **The PCCMs will be a designated provider or part of a team of health care professionals.**

The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Requirements for the PCCM participating in a Health Homes as a designated provider or part of a team of health care professionals will be different from those of a regular PCCM.**

If yes, describe how requirements will be different:

☑ **Risk Based Managed Care**

◉ **The Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals. Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be affected:**

☐ **The current capitation rate will be reduced.**

☑ **The State will impose additional contract requirements on the plans for Health Homes enrollees.**

Provide a summary of the contract language for the additional requirements:
The population of Medicaid individuals eligible to receive HH services includes individuals with SMI enrolled in risk based managed care. DHCF administers the District's Medicaid managed care program, and after competitive procurement, contracts with licensed HMOs to be Medicaid Managed Care Organizations (MCOs).

Modifications to the current Medicaid MCO contracts will be executed to ensure MCOs and the downstream HHs included within their MCO provider networks truly collaborate in primary care and behavioral health service integration. MCOs will be expected to leverage relationships between the HH and their MCO-enrolled individuals in meeting their contractual population-based service coordination mandates. For individuals enrolled in both a HH and an MCO, the HH and MCO will establish a formal agreement that sets the communication frequency and protocol for: 1) identifying individuals receiving services from both entities; 2) developing a joint care plan for each shared individual, and clear division of labor for executing the care plan, that is reflected in each entity's respective care plan for each shared person; 3) outlines types of HH services delivered or that will be delivered to the shared individuals; 4) flagging each other on new information necessary for coordinating services, such as failure to pick up medication, recent housing status, new community-based supports, and others. This agreement will specify the point of contact for each entity. MCOs are expected to refer eligible individuals to an appropriate HH, and the HH should partner with the MCOs, where appropriate, to ensure individuals receive timely access to needed health services.

At a set frequency stated in the DCMR and Medicaid MCO contracts, DHCF will forward a report to each MCO that: 1) lists enrollees eligible for HH program, and of this list, individuals currently empaneled with a HH; and 2) lists of DBH-certified HHs.

☐ **Other**

Describe:

○ **The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.**

Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Homes services.

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

The State intends to include the Health Homes payments in the Health Plan capitation rate.

○ **Yes**

☐ **The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:**

- **Any program changes based on the inclusion of Health Homes services in the health plan benefits**
- **Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)**
- **Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)**
- **Any risk adjustments made by plan that may be different than overall risk adjustments**
- **How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM**

☐ **The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services.**

☐ **The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found.**

○ **No**

Indicate which payment methodology the State will use to pay its plans:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Other Service Delivery System:**

Describe if the providers in this other delivery system will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers:

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

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Health Homes Payment Methodologies

The State's Health Homes payment methodology will contain the following features:

☑ **Fee for Service**

☑ **Fee for Service Rates based on:**

☑ **Severity of each individual's chronic conditions**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

DC will use two per member per month (PMPM) rates to reimburse for HH services. Costs and utilization patterns in FY 2013 Medicaid claims data were used to stratify the SMI population into two acuity groups: High and Low. The High Acuity group includes those with at least one high-cost condition (i.e. cancer; coronary artery disease; diabetes; peripheral vascular disease; congestive heart failure; cirrhosis; HIV; lung disease; multiple sclerosis; quadriplegia; seizure disorders; rheumatoid arthritis), plus an inpatient hospital admission within the FY; or individuals with no high-cost condition and either two non-psychiatric hospital admissions or one psychiatric hospital admission within the FY. The rest of the SMI population is in the Low Acuity group.

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Other: Describe below.**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee-for-service rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

☑ **Per Member, Per Month Rates**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

DC will use two per member per month (PMPM) rates to reimburse for HH services. Costs and utilization patterns in FY 2013 Medicaid claims data were used to stratify the SMI population into two acuity groups: High and Low. The High Acuity group includes those with at least one high-cost condition (i.e. cancer; coronary artery disease; diabetes; peripheral vascular disease; congestive heart failure; cirrhosis; HIV; lung disease; multiple sclerosis; quadriplegia; seizure disorders; rheumatoid arthritis), plus an inpatient hospital admission within the FY; or individuals with no high-cost condition and either two non-psychiatric hospital admissions or one psychiatric hospital admission within the FY. The rest of the SMI population is in the Low Acuity group.

Aligned to 42 U.S.C. §1396(a)(30), the two resulting rates are based on the HH staffing model and average expected service intensity for those receiving HH services based on their placement in either the High or Low Acuity group. The rates calculation includes: 1) costs of new staff required on the HH team, plus the 2) expected average monthly CSS service levels, based on current utilization, as well as the additional HH services needed to integrate behavioral and physical health needs. A higher rate for High Acuity individuals reflects their higher expected need for services.

DC will review the HH rates annually and re-base as necessary. Criteria for revising the rates may include changes in salary indexes for required HH staff, relevant operational expenses not captured in the rate prior to implementation, and other factors. DC will collect financial statements from each HH to assess the impact of the HH program on each HH's financial health. Except for the salary inflation adjustments, criteria used to update the re-base the rates must be a significant industry wide trend that is captured in HHs submitted cost reports or validated by independently available data sources.

An individual can only be enrolled in one HH at a time, and only one HH per month will receive payment for delivering HH

services to an individual.

To receive a monthly payment for High Acuity individuals, HHs must provide and document in iCAMS at least two comprehensive care management (CCM) services (comprised of assessment/screening; care plan development; care plan review; or transition care) and at least two other HH encounters, at least one being face-to-face, with no duration requirement. Low Acuity individuals must receive at least one CCM service and one other HH service, with no face-to-face requirement, documented in iCAMS.

HHs will submit claims to DBH, who will then audit each claim against information on the delivered HH services documented in iCAMS by the HH. Documentation in iCAMS must align to the HH services required for the monthly High Acuity or Low Acuity payment. If DBH approves the claim for payment, DBH forwards the claim, along with the approved High Acuity or Low Acuity HH rate to DHCF to process for payment.

DHCF's HH rate was set as of June 11, 2015, and is effective for HH services provided on or after January 1, 2016. All rates are published on the agency's website at https://www.dc-medicaid.com/dcwebportal/home.

☐ **Incentive payment reimbursement**

Provide a comprehensive description of incentive payment policies that the State will use to reimburse in addition to the unit base rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the incentives that will be reimbursed through the methodology, how the supplemental incentive payments are tied to the base rate activities, the criteria used to determine a provider's eligibility to receive the payment, the methodology used to determine the incentive payment amounts, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

☐ **PCCM Managed Care (description included in Service Delivery section)**

☐ **Risk Based Managed Care (description included in Service Delivery section)**

☐ **Alternative models of payment, other than Fee for Service or PM/PM payments (describe below)**

☐ **Tiered Rates based on:**

☐ **Severity of each individual's chronic conditions**

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Rate only reimbursement**

Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your

description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.
HH service payments will not result in any duplication of payment or services between Medicaid programs, services, or benefits (i.e. managed care, other delivery systems including waivers, any future HH state plan benefits, and other state plan services).

DC has two 1915(c) waivers; only one, the Elderly and Persons with Disabilities (EPD) waiver provides Medicaid-reimbursable case management services. The EPD waiver includes a number of services (e.g. Personal Care Aide; Assisted Living; Homemaker), and case management is the only mandated service for EPD beneficiaries. EPD case management services are delivered by EPD case managers, who will be paid a PMPM rate to develop and execute a person-centered care plan for individuals enrolled in the EPD waiver program. This care plan directs the use of EPD waiver services and other resources provided in the community setting. Other functions provided by EPD case managers include assessments to determine unmet needs related to waiver services, submission of requests for the authorization of waiver services, care coordination and monitoring service provisions. Thus, to avoid duplicative efforts and payments, individuals may not receive both HH services and case management services through the EPD waiver. HHs will provide case management services for individuals enrolled in the EPD waiver. In order to meet requirements listed in 42 C.F.R. §§ 441.301(c)(1)(vi), 441.730(b), HHs that deliver services to individuals enrolled in the EPD waiver must meet DHCF's EPD provider enrollment requirements.

HH services will add to, and not duplicate, the clinical care coordination services provided under the Adult Substance Abuse Rehabilitative Services Medicaid State Plan benefit, where clinical coordinators focus on ways to ensure care plans include services that address an individual's substance use disorder. HHs will partner with DC Medicaid MCOs, where the roles and responsibilities for each party are clearly defined, and guided by the DCMR and MCO contracts, in order to avoid duplicative efforts, and to ensure timely communication, care transition planning, use of evidence-based referrals, and follow-up consultations with appropriate health service providers. HHs will include the MCO, as appropriate, when creating or updating the HH care plan. The HHs and MCOs will be expected to develop protocols for sharing information on care planning and patient care. HHs will identify any gaps in service need for HH enrolled individuals' regardless of the programs the individuals receive services through. DC does not provide coverage for targeted case management services under 1915(g).

In addition to offering guidance to providers regarding these restrictions, DC may periodically examine Medicaid beneficiary MMIS files to ensure that individuals enrolled in the HH program are not receiving similar services through other Medicaid-funded programs.

☑ **The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule**

☑ **The State provides assurance that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.**

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Submission - Categories of Individuals and Populations Provided Health Homes Services

The State will make Health Homes services available to the following categories of Medicaid participants:

☑ **Categorically Needy eligibility groups**

Health Homes Services (1 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive Care Management

Definition:
Comprehensive care management (CCM) services address stages of health and disease to maximize current functionality and prevent individuals from developing additional chronic conditions and complications. As part of CCM, the Nurse Care Manager will conduct a comprehensive needs assessment to determine the risks and whole-person service needs of individuals for HH team assignment, and lead the HH team through the collection of behavioral, primary, acute and long-term care information from health and social service providers [e.g. from existing MHRS Diagnostic Assessments and individual service plans; physical assessments from PCPs; hospital discharge planners; etc.] to create a person-centered HH care plan for every enrolled individual. HHs will use a strengths-based approach in developing the HH care plan that identifies the positive attributes of the individual, which includes assessing his/her strengths and preferences health and social services, and end of life planning. Each HH team will update the care plan for each empaneled individual at set intervals (as detailed in the DCMR) and following an unplanned inpatient stay. The HH team will monitor individual's health status and progress toward goals in the care plan documenting changes and adjusting the plan as needed. The HH care plan is created and updated in iCAMS, along with documented activities completed to create and maintain the HH care plan. In addition, HHs use aggregated data to determine levels of consumer engagement, progress toward CCM goals, and adherence to or variance from treatment guidelines. Based on this analysis, HHs will prioritize outreach, reminders and notifications to certain individuals. HHs systematically review and report quality metrics, assessment results, and service utilization in order to evaluate health status, service delivery, and consumer satisfaction. Activities of this HH component are driven by protocols developed by the Nurse Care Manager or Primary Care Liaison.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
iCAMS will provide integrated patient profiling and risk assessment, charting, care management and administrative functionality for managing service authorizations, payments and reports. All HHs will use iCAMS. This system will allow HHs to report and review individual's intake, assessment results, assigned HH team, integrated HH care plans, clinical baselines and data related to chronic conditions, as well as HH services provided, such as referrals made and health promotion activities completed. iCAMS has functionality to stratify populations based on certain risk factors and to aggregate data from external sources (e.g., ambulatory electronic medical records used by federally qualified health centers [FQHCs] and other primary care providers, hospital information systems, MCOs and health information exchanges). The system will also assist in the development of HH care plans, facilitate provider empanelment, determine and assign tasks to HH team members, and create disease management protocols and generate reports.

Additionally, HHs are expected to use data from CRISP, or other HIE services as directed by DC, to receive hospital event alerts (e.g. emergency department visits; hospital admissions, transfers and discharges) that will help HHs create a person-centered HH care plan.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Community Mental Health Centers

Description

Designated providers of HH services for individuals with SMI shall be CSAs identified by DC to meet the standards of a HH. CSA qualifications are listed in 22-A DCMR § 3400 et seq. In order to meet the HH standards, CSAs must be adequately staffed by teams of health care professionals that, at a minimum, are capable of providing specific functions to meet HH standards. Each of these functions, as well as the particular qualifications/ credentials required of the individuals responsible for these roles, includes: 1) Health Home Director- Master's level education in a health-related field; 2) Primary Care Liaison- nurse practitioner or physician; 3) Nurse Care Manager- nurse with an advanced practice license or a registered nurse with experience in one or more areas of practice relevant to integrated chronic disease care management (i.e. adult health, family nurse practitioner, advanced primary care, other chronic disease specialties); and 4) Care Coordinator- Bachelor of Arts with training in a health care, human service field or equivalent experience. All clinicians must meet the requirements of Health Occupations and Revisions Act of 1985, and subsequent amendments thereto, and implementing regulations.

The ratio for each required HH staff member to HH enrollee is listed in the DCMR, and serves as the foundation for the HH team. HHs are encouraged to add additional roles to HH teams that reflect the needs of their empaneled members (e.g. pharmacist; dietician).

HHs must document all services delivered and information received from external health care providers in iCAMS.

Care Coordination

Definition:
Care coordination is the implementation of the HH care plan through appropriate linkages, referrals, coordination and follow-up to needed services and support. Care coordination may involve:
a. appointment scheduling and providing telephonic reminders of appointments;
b. telephonic outreach and follow-up to individuals who do not require face-to-face contact;
c. ensuring that all regular screenings are conducted through coordination with the primary care or other appropriate providers;
d. assisting with medication reconciliation;
e. assisting with arrangements such as transportation, directions and completion of durable medical equipment requests;
f. obtaining missing records and consultation reports;
g. participating in hospital and emergency department transition care; and
h. documentation in iCAMS.

HHs will have partnerships with DC Medicaid MCOs, primary care, specialists, and behavioral health providers, as well as community based organizations. Within these partnerships, the roles and responsibilities for each party will be clearly defined, and guided by the DCMR, in order to avoid duplicative efforts, and to ensure timely communication, use of evidence-based referrals, and follow-up consultations. HHs will ensure that screenings appropriate for specific chronic conditions are conducted through coordination with the primary care or other appropriate providers.

Care coordination services may be provided by any member of the Health Home team, but are driven by protocols and guidelines developed by the RN Care Manager or Primary Care Liaison, in collaboration with the consumer's mental health and substance use disorder (SUD) practitioners.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
HHs will use iCAMS report and review referrals made to outside providers, social and community resources and individual and family supports. Through this system, HHs will have access to each individual's historical service utilization which will allow better tracking of individual's needs, services received, and the identification of opportunities for improved care coordination.

To enable critical information exchange, all HHs will utilize CRISP, or other HIE services as directed by DC, to receive hospital event alerts (e.g. emergency department visits; hospital admissions, transfers and discharges) and both generate and receive continuity of care information.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Community Mental Health Centers

Description
Designated providers of HH services for individuals with SMI shall be CSAs identified by DC to meet the standards of a HH. CSA qualifications are listed in 22-A DCMR § 3400 et seq. In order to meet the HH standards, CSAs must be adequately staffed by teams of health care professionals that, at a minimum, are capable of providing specific functions to meet HH standards. Each of these functions, as well as the particular qualifications/ credentials required of the individuals responsible for these roles, includes: 1) Health Home Director- Master's level education in a health-related field; 2) Primary Care Liaison- nurse practitioner or physician; 3) Nurse Care Manager- nurse with an advanced practice license or a registered nurse with experience in one or more areas of practice relevant to integrated chronic disease care management (i.e. adult health, family nurse practitioner, advanced primary care, other chronic disease specialties); and 4) Care Coordinator- Bachelor of Arts with training in a health care, human service field or equivalent experience. All clinicians must meet the requirements of Health Occupations and Revisions Act of 1985, and subsequent amendments thereto, and implementing regulations.

The ratio for each required HH staff member to HH enrollee is listed in the DCMR, and serves as the foundation for the HH team. HHs are encouraged to add additional roles to HH teams that reflect the needs of their empaneled members (e.g. pharmacist; dietician).

HHs must document all services delivered and information received from external health care providers in iCAMS.

Health Promotion

Definition:
Health Promotion services involve the provision of health education to the individual (and family member/significant other when appropriate) specific to his/her chronic illness or needs as identified in his/her HH care plan. This service includes assistance with medication reconciliation and provides assistance for the individual to develop a self-management plan, self-monitoring and management skills and promotion of a healthy lifestyle and wellness (e.g. substance abuse prevention; smoking prevention and cessation; nutrition counseling; increasing physical activity; etc.). Health promotion also involves connecting the individual with peer/recovery supports including self-help/self-management and advocacy groups, providing support for improving an individual's social network, and educating the individual about accessing care in appropriate settings. HH team members will document the results of health promotion activities (e.g. individuals requesting additional nutrition counseling; individuals selecting a date to quit smoking; successful linkage with a community-based support group) in the individual's care plan, and ensure health promotion activities align with the individual's stated health and social goals.

Each HH will use data to identify and prioritize particular areas of need with regard to health promotion; research best-practice interventions; implement the activities in group and individual settings; evaluate the effectiveness of the interventions, and modify them accordingly.

Health promotion services may be provided by any member of the Health Home team, but are driven by protocols and guidelines developed by the RN Care Manager or Primary Care Liaison, in collaboration with the provider's mental health and substance use disorder (SUD) practitioners.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
All HHs will use iCAMS to document, review, and report health promotion services delivered to each individual. Additionally, clinical data such as height, weight and BMI will be recorded and reported in iCAMS.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Community Mental Health Center

Description

Designated providers of HH services for individuals with SMI shall be CSAs identified by DC to meet the standards of a HH. CSA qualifications are listed in 22-A DCMR § 3400 et seq. In order to meet the HH standards, CSAs must be adequately staffed by teams of health care professionals that, at a minimum, are capable of providing specific functions to meet HH standards. Each of these functions, as well as the particular qualifications/ credentials required of the individuals responsible for these roles, includes: 1) Health Home Director- Master's level education in a health-related field; 2) Primary Care Liaison- nurse practitioner or physician; 3) Nurse Care Manager- nurse with an advanced practice license or a registered nurse with experience in one or more areas of practice relevant to integrated chronic disease care management (i.e. adult health, family nurse practitioner, advanced primary care, other chronic disease specialties); and 4) Care Coordinator- Bachelor of Arts with training in a health care, human service field or equivalent experience. All clinicians must meet the requirements of Health Occupations and Revisions Act of 1985, and subsequent amendments thereto, and implementing regulations.

The ratio for each required HH staff member to HH enrollee is listed in the DCMR, and serves as the foundation for the HH team. HHs are encouraged to add additional roles to HH teams that reflect the needs of their empaneled members (e.g. pharmacist; dietician).

HHs must document all services delivered and information received from external health care providers in iCAMS.

Health Homes Services (2 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

Definition:
Comprehensive transitional care includes the HHs efforts to reduce hospital emergency department and inpatient admissions, readmissions and length of stay through planned and coordinated transitions between health care providers and settings. HHs will increase individual's and family members' ability to manage care and live safely in the community, shifting the use of reactive or emergency care and treatment to proactive health promotion and self-management. HHs will automatically receive notifications of emergency room visits, admissions, discharges and transfers (ADT) from hospitals as part of HHs' enrollment in CRISP, and will outreach to the hospitals individuals related to these notifications to ensure appropriate follow-up care after transitions. HHs will conduct in-person outreach when the individual is still in the hospital or call the individual within 48 hours of discharge. They will schedule visits for individuals with a primary care provider and/or specialist within one week of discharge. HHs will have a clear protocol for responding to ADT alerts from hospitals or any other inpatient facility to facilitate collaboration in treatment, discharge, and safe transitional care. As part of consumer contacts during transitions, the HH will: a) review the discharge summary and instructions; b) perform medication reconciliation; c) ensure that follow-up appointments and tests are scheduled and coordinated; d) assess the patient's risk status for readmission to the hospital or other failure to obtain appropriate, community-based care; and e) arrange for follow-up care management, if indicated on the discharge plan. This HH component is provided primarily by the RN Care Manager and Care Coordinator.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
To enable critical information exchange, all HHs will enroll with CRISP, or other HIE services as directed by DC, to receive hospital event alerts (e.g. emergency department visits; hospital admissions, transfers and discharges) and both

generate and receive continuity of care information. MCOs also receive hospital alerts through CRISP. To the extent that hospitals, MCOs and other inpatient settings have care transition programs, HHs are expected to coordinate with hospital discharge planners to prevent duplication of services and to ensure that all essential functions of an effective care transition have been performed.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name
Community Mental Health Centers

Description
Designated providers of HH services for individuals with SMI shall be CSAs identified by DC to meet the standards of a HH. CSA qualifications are listed in 22-A DCMR § 3400 et seq. In order to meet the HH standards, CSAs must be adequately staffed by teams of health care professionals that, at a minimum, are capable of providing specific functions to meet HH standards. Each of these functions, as well as the particular qualifications/ credentials required of the individuals responsible for these roles, includes: 1) Health Home Director- Master's level education in a health-related field; 2) Primary Care Liaison- nurse practitioner or physician; 3) Nurse Care Manager- nurse with an advanced practice license or a registered nurse with experience in one or more areas of practice relevant to integrated chronic disease care management (i.e. adult health, family nurse practitioner, advanced primary care, other chronic disease specialties); and 4) Care Coordinator- Bachelor of Arts with training in a health care, human service field or equivalent experience. All clinicians must meet the requirements of Health Occupations and Revisions Act of 1985, and subsequent amendments thereto, and implementing regulations.

The ratio for each required HH staff member to HH enrollee is listed in the DCMR, and serves as the foundation for the HH team. HHs are encouraged to add additional roles to HH teams that reflect the needs of their empaneled members (e.g. pharmacist; dietician).

HHs must document all services delivered and information received from external health care providers in iCAMS.

Individual and family support, which includes authorized representatives

Definition:
Individual and family support services include all the ways a HH supports the individual and their support team (including family and authorized representatives) in meeting their range of psychosocial needs and accessing resources (e.g. medical transportation; language interpretation; appropriate literacy materials; and other benefits to which they may be eligible or need). The services provide for continuity in relationships between the individual/family with their physician and other health service providers and can include communicating on the individual and family's behalf. These services also educate the individual in self-management of their chronic condition; provide opportunities for the family to participate in assessment and care treatment plan development; and ensure that HH services are delivered in a manner that is culturally and linguistically appropriate. Additionally, these services include referrals to support services that are available in the individual's community and assist with the establishment of and connection to "natural supports." They promote personal independence; assist and support the consumer in stressor situations; empower the consumer to improve their own environment; include the individual's family in the quality improvement process including surveys to capture their experience with HH services; and allow individuals/families access to electronic health record information or other clinical information. Where appropriate, the HH will see the whole family as the client, developing family support materials and services, including creating family support groups.

This HH component is provided by any member of the HH team, but will be primarily conducted by the Care Coordinator, in line with the individual's care plan, and driven by protocols and guidelines developed by the RN Care Manager or Primary Care Liaison.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
All HHs will use iCAMS, to document, review, and report family support services delivered to each individual.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Community Mental Health Centers

Description

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The ratio for each required HH staff member to HH enrollee is listed in the DCMR, and serves as the foundation for the HH team. HHs are encouraged to add additional roles to HH teams that reflect the needs of their empaneled members (e.g. pharmacist; dietician).

HHs must document all services delivered and information received from external health care providers in iCAMS.

Referral to community and social support services, if relevant

Definition:

Referral to community and social support services provide individuals with referrals to a wide array of support services that will help them overcome access or service barriers, increase self-management skills, and achieve overall health. Referral to community and social support involves facilitating access to support and assistance for individuals to address medical, behavioral, educational, social and community issues that may impact overall health. The types of community and social support services to which individuals will be referred may include, but are not limited to: a) wellness programs, including smoking cessation, fitness, weight loss programs; b) specialized support groups (e.g. cancer; diabetes support groups; etc.); c) substance treatment, support groups, recovery coaches, and 12-step programs; d) housing resources; e) social integration; f) financial assistance such as TANF or Social Security; g) Supplemental Nutrition Assistance Program; h) employment and educational program or training; i) legal assistance resources; and j) faith-based organizations. HHs will assist in coordinating the services listed above and following up with individuals after services have been received. The HH will develop and monitor cooperative agreements with community and social support agencies in order to establish collaboration, follow-up, and reporting standards and provide training and technical assistance as needed regarding the special needs of the population.

This HH component is provided by any member of the HH team, but will be primarily conducted by the Care Coordinator, in line with the individual's care plan, and driven by protocols and guidelines developed by the RN Care Manager or Primary Care Liaison.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.

All HHs use iCAMS to document, report and review referrals to community-based resources.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

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Description

☑ **Other (specify):**

Name
Community Mental Health Centers

Description
Designated providers of HH services for individuals with SMI shall be CSAs identified by DC to meet the standards of a HH. CSA qualifications are listed in 22-A DCMR § 3400 et seq. In order to meet the HH standards, CSAs must be adequately staffed by teams of health care professionals that, at a minimum, are capable of providing specific functions to meet HH standards. Each of these functions, as well as the particular qualifications/ credentials required of the individuals responsible for these roles, includes: 1) Health Home Director- Master's level education in a health-related field; 2) Primary Care Liaison- nurse practitioner or physician; 3) Nurse Care Manager- nurse with an advanced practice license or a registered nurse with experience in one or more areas of practice relevant to integrated chronic disease care management (i.e. adult health, family nurse practitioner, advanced primary care, other chronic disease specialties); and 4) Care Coordinator- Bachelor of Arts with training in a health care, human service field or equivalent experience. All clinicians must meet the requirements of Health Occupations and Revisions Act of 1985, and subsequent amendments thereto, and implementing regulations.

The ratio for each required HH staff member to HH enrollee is listed in the DCMR, and serves as the foundation for the HH team. HHs are encouraged to add additional roles to HH teams that reflect the needs of their empaneled members (e.g. pharmacist; dietician).

HHs must document all services delivered and information received from external health care providers in iCAMS.

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:
The HH receives a list of eligible individuals already being served by that CSA and makes plans for team member(s) to inform and enroll individuals during a planned or newly scheduled visit. Information is provided to inform choice about enrolling into the HH program (i.e. assignment to a HH team, HH services are free, enrollment is optional, not enrolling does not impact current services). After consent and enrollment, the HH gathers health information from individuals' service providers (e.g. MCOs; PCP; etc.), conducts health risk screens (e.g. depression; substance abuse; etc.), and a comprehensive health assessment is completed. Results are entered into iCAMS. The Nurse Care Manager (NCM) and individual review/discuss assessment results, health goals and health care priorities. The individual and multi-disciplinary HH team agrees upon and document a comprehensive HH care plan that addresses wellness and self-management goals for physical and behavioral health conditions and the HH team delivers HH services (all services/encounters are documented in iCAMS). The HH team works with an individual's PCP via protocols for disease management and/or accompanying an individual to visits; steps are taken to link an individual with a PCP if necessary. Daily, the HH team reviews hospital ADT feeds to determine if any individuals used the ER or were admitted to the hospital. Weekly, the HH team uses huddles to monitor individuals progress and plan accordingly for interventions/interactions. Monthly, the NCM reviews updated registries and care plan statuses for all individuals on the HH team's panel and targets planned services accordingly, identifying emerging issues warranting changes and follow-up (e.g. re-assessment, revised/increased levels of activity). Issues flagged include medication management, care compliance, outlier lab values, and progress controlling BMI levels, tobacco use, and metabolic screening values. HH care plans are updated at least every 180 days.

☑ **Medically Needy eligibility groups**

◉ **All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.**

○ **Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.**

○ **All Medically Needy receive the same services.**

○ **There is more than one benefit structure for Medically Needy eligibility groups.**

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Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:
In line with the technical specifications for the core HH measures, DC will collect all-cause 30 day readmissions for all individuals enrolled in the HH program. DC will use claims data from DHCF.

Data are reported in the following categories:
- Denominator: Count of Index Hospital Stays (IHS)
- Numerator: Count of 30-Day Readmissions
- Average Adjusted Probability of Readmission (rate).

DHCF will calculate and report this measure for two age groups: age 18 to 64 and 65 and older. The measure will include all paid, suspended, pending, and denied claims.

While claims data will be an important source of information related to hospital admissions and readmissions, the time lag of this data is not ideal for real time management of patient care. For that reason, a connection to CRISP will be made available through iCAMS to provide real-time admissions, discharge and transfer feeds from participating hospitals. Through CRISP, real-time notifications of the majority of hospital admissions can be available to HH teams.

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.
DC will use historical claims and encounter data from fiscal years 13 through 15 to establish a baseline and expected trend on medical spending for the eligible HH population. DC will then compare expected trend with actual spending. The delta between expected spending and actual spending will represent cost savings. DC may also compare a cohort of individuals who have enrolled in the HH program with a cohort of similar individuals who are eligible for the program but not enrolled.

DC will also compare costs related to emergency room utilization, hospitalizations, nursing facility admissions, pharmacy utilization, etc. This will enable DC to understand the overall impact of the program, not just on total spending, but on whether utilization reflects the types of services expected for a given patient (pharmacy, primary care, substance abuse treatment, etc.) or is found in areas that could still indicate poor care coordination (like ER and hospital inpatient). DC will analyze each HH for its overall impact on total cost of care and health care utilization, and then compare their performance to other HHs in DC to inform future policy decisions and ways to promote continuous quality improvement.

Describe how the State will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

iCAMS) will serve as the centerpiece of a comprehensive health information technology/exchange (HIT/E) solution for the DC's HH program. This system, which all HHs will be required to use or connect to, will serve as the single platform for capturing, tracking and claiming services provided to enrolled HH individuals including the six core HH services. iCAMS will serve as the platform through which HHs receive and store information gathered via interfaces to entities such as: 1) CRISP (hospital admission, discharge and transfer feeds, lab and radiology results, etc.); 2) DC's FQHCs; 3) DC's MMIS from which periodic feeds of Medicaid claims and encounter data will be generated and uploaded into iCAMS; and 4) other administrative systems such as the DC Access System (DCAS), the DC's integrated eligibility determination system. The HH will be charged with acting on relevant information received through iCAMS and ensuring that each individual record is complete and up-to-date. If relevant information is not available through electronic health information exchange, the HH is charged with obtaining it from the appropriate partner agency or group.

iCAMS will support the following essential HH program functions: 1) Initial screening and health/functional assessment, risk analysis and stratification; 2) Proactive alerts to HHs for – at a minimum - emergency room utilization and inpatient hospitalization; 3) Care plan development enhanced by best practices and real-time intelligence about a patient's status; and 4) Care plan administration where multiple HH staff will be able to access and work off a single care plan in a highly secure system environment.

Quality Measurement

☑ **The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.**

☑ **The State provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.**

States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:

Evaluations

☑ **The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.**

Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:

Hospital Admissions

Measure:

For all-cause 30-day readmissions:

Measure Specification, including a description of the numerator and denominator.
DHCF will calculate the percentage of acute inpatient (i.e., index hospital) stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission for HH enrollees age 18 and older. Data are reported in the following categories:
• Count of Index Hospital Stays (denominator).
• Count of 30-Day Readmissions (numerator).
• Average Adjusted Probability of Readmission (rate).
DHCF will calculate and report this measure for two age groups: age 18 to 64 and 65 and older. The measure will include all paid, suspended, pending, and denied claims.
Data Sources:
MMIS claims and encounter data
Frequency of Data Collection:

○ **Monthly**

- Quarterly
- Annually
- Continuously
- Other

Daily

Measure:

Rate of Inpatient Hospital Utilization

Measure Specification, including a description of the numerator and denominator.
DC will calculate the rate of acute inpatient care and services (total, maternity, mental health, surgery, and medicine) per 1,000 enrollee months among HH enrollees.
The following methodology will be used:
• Discharge: Total number of discharges for each group.
• Discharge rate (discharges/1,000 enrollee months): Calculate the discharge rate for total inpatient, maternity, mental health, surgery, and medicine by dividing the number of discharges by the number of enrollee months and multiply by 1,000, as follows:
• Discharge rate = (Number of discharges/number of enrollee months) x 1,000
• Days: Total number of days incurred for each group.
• Days rate (days/1,000 enrollee months): Calculate the days rate for total inpatient, maternity, mental health, surgery, and medicine by dividing the total number of days incurred by the number of enrollee months and multiply by 1,000 as follows:
• Days rate = (Total days incurred/enrollee months) × 1,000
Data Sources:
MMIS claims and encounter data.
Frequency of Data Collection:

- Monthly
- Quarterly
- Annually
- Continuously
- Other

Daily

Emergency Room Visits

Measure:

Total Emergency Room visits by enrollee months per 1,000 Health Home enrollees

Measure Specification, including a description of the numerator and denominator.
ED Visit Rate = (Number of ED visits/number of enrollee months) x 1,000, as specified in the required Health Home core measures set.
Data Sources:
MMIS claims and encounter data.
Frequency of Data Collection:

- Monthly
- Quarterly
- Annually
- Continuously
- Other

Daily

Skilled Nursing Facility Admissions

Measure:

The number of admissions to a nursing facility from the community that result in a short-term (less than 101 da

Measure Specification, including a description of the numerator and denominator.

• Short Term Admission Rate = (Number of short term admissions/number of enrollee months) x 1,000
• Long Term Admission Rate = (Number of long term admissions/number of enrollee months) x 1,000
Data Sources:
MMIS claims and encounter data.
Frequency of Data Collection:

- (●) **Monthly**
- ( ) **Quarterly**
- ( ) **Annually**
- ( ) **Continuously**
- ( ) **Other**

Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to the following:

Hospital Admission Rates
Hospital admissions are collected through claims data for admits provided under fee-for-service and through encounter data for admits provided under risk based managed care.

Chronic Disease Management
A comprehensive care plan for the HH program is embedded in iCAMS. Each individual's care plan will include specific sub-plans for each relevant chronic disease, such as diabetes, heart disease, etc. DC's evaluation will monitor HH use of the disease-specific care plans, including whether a plan has been developed and regularly updated. Each disease-specific plan will have a limited set of outcome metrics (for example, viral load for patients with HIV) that will be tracked in iCAMS for evaluation purposes. iCAMS data will be supplemented with selected claims data to monitor compliance with evidence-based protocols and proper pharmacy utilization.

Coordination of Care for Individuals with Chronic Conditions
Chronic disease management data is collected through administrative claims/encounter data, NCM assessments, HH payment records, and HH encounter data verifying services received by individuals (e.g., primary care, mental health, SUD treatment, mental health services, prescriptions, etc.). This data is obtained through DC's MMIS payment system. NCM notes and assessments provide evidence of interaction and referrals and will be evaluated at time of monitoring.

Assessment of Program Implementation
DC HH program will monitor:
• Rate of enrollment of eligible individuals into HH services;
• Rate of completed assessments;
• Rate of completed care plans;
• Frequency of and type of services provided to HH enrollees;
• Volume of HH services received relative to consumer need (tracking whether high acuity individuals are receiving the highest levels of services)

Processes and Lessons Learned
DC will implement a process improvement initiative that will track performance and provide technical assistance to help Health Home providers improve quality and outcomes.

Assessment of Quality Improvements and Clinical Outcomes
DC will implement quality and process improvement programs that will track performance and provide technical assistance to help HH providers improve quality and outcomes. Participation in these quality improvement programs will be required of HHs.

Estimates of Cost Savings

- [x] **The State will use the same method as that described in the Monitoring section.**

If no, describe how cost-savings will be estimated.

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PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 80 per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.