MEDICAID MODEL DATA LAB

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State: Ohio
Health Home Services Forms (ACA 2703)
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Transmital Numbers (TN) and Effective Date

Please enter the numerical part of the Transmital Numbers (TN) in the format YY-0000 where YY = the last two digits of the year for which the document relates to, and 0000 = a four digit number with leading zeros. The dashes must also be entered. State abbreviation will be added automatically.

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Effective Date

10/01/2012

3.1 - A: Categorically Needy View

Attachment 3.1-H

Page 1

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

☑ Health Home Services

How are Health Home Services Provided to the Medically Needy?

Not provided to Medically Needy

i. Geographic Limitations

Targeted Geographic Basis

If Targeted Geographic Basis,

Health home services will be implemented on a targeted geographic basis. The geographic areas to be implemented as of the effective date of this SPA are Butler County, Adams County, Scioto County, Lawrence County, and Lucas County.

ii. Population Criteria

The State elects to offer Health Home Services to individuals with:

☐ Two chronic conditions
☐ One chronic condition and the risk of developing another
☑ One serious mental illness

from the list of conditions below:

☑ Mental Health Condition
☐ Substance Use Disorder
☐ Asthma
☐ Diabetes
☐ Heart Disease

☐ BMI Over 25

☐ Other Chronic Conditions Covered?

Description of Other Chronic Conditions Covered.

iii. Provider Infrastructure

☑ Designated Providers as described in §ection 1945(h)(5)

The State will establish Medicaid health homes for beneficiaries who meet the State's definition of serious and persistent mental illness (which includes adults with serious mental illness [SMI] and children with serious emotional disturbance [SED]), initially using a regional approach. Ohio's Community Behavioral Health Centers (CBHCs) will be eligible to apply to become Medicaid health homes for Medicaid beneficiaries with SPMI. The goals of Ohio's CBHC health homes for Medicaid beneficiaries with SPMI are aligned with those of CMS. They are as follows: improve the integration of physical and behavioral health care; lower the rates of hospital emergency department (ED) use; reduce hospital admissions and re-admissions; reduce healthcare costs; decrease reliance on long-term care facilities; improve the experience of care, quality of life and consumer satisfaction and improve health outcomes. Moreover, we fully expect to achieve better care coordination and management of health conditions as well as increase the use of preventive and wellness management services.

Ohio will employ a two-prong approach to assure access for those eligible Medicaid beneficiaries with SPMI to health homes in targeted geographic regions based upon consumer choice.

1. Eligible Medicaid beneficiaries with SPMI, who are currently being served at a CBHC who is an eligible health home, will be oriented to and engaged in the health home by the CBHC health home. These beneficiaries will be notified by the CBHC health homes and will be given the option of opting out of health home services. Additionally, should beneficiaries desire to receive health home services from another health home provider they will be able to do so. Eligible Medicaid beneficiaries with SPMI who are currently being served at a CBHC that is not a health home will have the option of receiving health home services at one of the CBHC health home sites in their targeted geographical region.

2. Those beneficiaries presenting in the hospital ED, or as an inpatient, who appear to possibly meet the criteria for health home services may be referred to a health home provider in their geographic area. Similarly, referrals to health homes may come from specialty providers, primary care providers, managed care plans or other sources in the community. For these new referrals, eligibility for health home services will be determined at the CBHC health home. CBHC health homes will be responsible for notifying other treatment providers about the goals and types of health home services as well as encouraging participation in care coordination efforts.

In addition, the state will notify eligible Medicaid Beneficiaries within targeted geographical regions via U.S. mail and other methods necessary about the availability of health home services. The state also plans to partner with the consumer and family advocacy organizations to develop consumer and family education programs about Medicaid Health Homes. NAMI-Ohio and Ohio Empowerment Coalition will assist the departments in efforts to educate and inform family members and consumers regarding the availability of health home services.

Community behavioral health centers will serve as designated providers for individuals with SPMI and deliver services through a multi-disciplinary team of health care professionals. CBHCs will be required to meet state-defined qualifying core elements that assure coordination of comprehensive medical, behavioral, long-term care and social services that are timely, quality driven and integrated. CBHC health homes will be required to demonstrate the integration of behavioral health and primary care services by directly providing or establishing written agreements with primary care practices. A health home must provide a minimum level of medical screening and treatment services consistent with current professional standards of care. CBHC health homes will be required to establish written agreements with primary care practices that support bi-directional, integrated care. Additionally, CBHC health homes are required to establish partnerships and coordinate with other health care resources to address identified client needs, which include, but are not limited to: hospitals, medical service providers, specialists (including OB/GYNs and substance abuse treatment specialists), long-term care service and support providers, managed care plans and other providers as appropriate to meet beneficiaries' needs.

Each CBHC health home must establish a health home team led by a dedicated Care Manager who will provide health home services, and coordinate and facilitate beneficiaries' access to services in accordance with a single, integrated care plan. The CBHC must also identify other health care team members necessary to comprehensively and holistically meet the beneficiaries' needs. While the composition of the team of health care professionals is flexible and is expected to change as the needs of the health home beneficiary change over time, the health home team provides consistency and continuity of care for the beneficiary.

Medical leadership is essential to systematically implement standards of quality care. Clinical personnel with experience in Patient Centered Medical Home transformation shall espouse the expertise of change improvement science (e.g., IHI's Breakthrough Series Model) to drive enhanced system performance leading to improved clinical outcomes. To that end, the Embedded Primary Care Clinician is integral to the success and demonstration of integrated care in CBHC health homes. The Embedded Primary Clinician assesses, monitors and consults on the routine, preventive, acute and chronic physical health care needs of clients.

Core CBHC health home team members and roles:

- Health Home Team Leader: Provides administrative and clinical leadership and oversight to the health home team and monitors provision of health home services. A key function of the Team Leader role is to champion for health home services and motivate and educate other staff members. The Health Home Team Leader must possess a strong health management background and an understanding of practice management, data management, and managed care. The Health Home Team Leader must also have training and experience in quality improvement. The Health Home Team Leader will monitor and facilitate clinical processes and components of Health Homes, which include but are not limited to: consumer identification and engagement; completion of comprehensive health and risk assessments; development of care plans; scheduling and facilitation of treatment team meetings; provision of health home services; monitoring consumer status and response to health coordination and prevention activities; and development, tracking and dissemination of outcomes. The additional clinical and administrative duties will include hiring and training of staff, providing feedback regarding staff performance, conducting performance evaluations, providing direction to staff regarding individual cases, and monitoring overall team performance and plan for improvement.

- Embedded Primary Care Clinician: Participates in the provision of health home services including identification of consumers, assessment of service needs, care plan development, development of treatment guidelines, and monitoring of health status and service use. The Embedded Primary Care Clinician will provide education and consultation to the health home team and other team members regarding best practices and treatment guidelines in screening and management of physical health conditions as well as engage with, and act as liaison between, the treating primary care provider and the team. The Embedded Primary Care Clinician will also meet with Care Managers individually to review challenging and complex cases as needed. The Embedded Primary Care Clinician role can be conducted by any of the following professionals: primary care physicians, pediatricians, gynecologists, obstetricians, Certified Nurse Practitioners with a primary care scope of practice, Clinical Nurse Specialists with a primary care scope of practice, and Physician Assistants. It is strongly preferred that the Embedded Primary Care Clinician also functions as the treating primary care clinician whenever possible and may hold dual roles on the health home team.

- Care Manager: Is accountable for overall care management and care coordination and able to both provide and coordinate all health home services. A single care management record will be agreed to and shared by all team professionals and patient case reviews will be conducted on a regular basis. The Care Manager will be responsible for overall management and coordination of the beneficiary's care plan which will include both medical/behavioral health (including substance abuse), long-term care, and social service needs and goals. Care Managers can utilize Qualified Health Home Specialists in the provision of some components of health home services. Care Managers must have the necessary credentials and skills to be able to conduct comprehensive assessments and treatment planning. Care Managers will have formal training as well as practical experience in behavioral health and possess core and specialty competencies and skills in working with the SPMI population. Care Managers will also need to demonstrate either formal training or a strong knowledge base in chronic physical health issues and physical health needs of the SPMI population and must be able to function as a member of an inter-disciplinary team. Finally, Care Managers must be knowledgeable and experienced in community resources and social support services for the SPMI population.

- Qualified Health Home Specialist: Assists and supports Care Managers with care coordination, referral/linkage, follow-up, family/consumer support and health promotion services and may include Peer Support Specialists as well as other health professionals or credentialed personnel with commensurate experience.

CBHCs will be supported in transforming service delivery by participating in statewide learning activities. Given CBHCs' varying levels of experience with organizational change and clinical best practice implementation, the State will assess providers to determine learning needs. CBHCs will therefore participate in a variety of learning supports, up to and including learning communities, specifically designed to instruct CBHCs in the provision of health home services utilizing a whole person approach which integrates behavioral health, primary care, long-term care services and supports, and other needed services and supports. Learning activities may be supplemented with ongoing health home team calls to reinforce the learning sessions, technical assistance, and periodic program reporting (data and narrative) and feedback. Learning activities will support providers of health home services in addressing the following components:

- Providing quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
- Coordinating and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
- Coordinating and providing access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
- Coordinating and providing access to mental health and substance abuse services;
- Coordinating and providing 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);
- Coordinating and providing access to chronic disease management, including self-management support to individuals and their families;
- Coordinating and providing access to individual and family supports, including referral to community, social support, and recovery services;
- Coordinating and providing access to long-term care supports and services;
- Developing 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;
- Demonstrating a capacity to use health information technology to link services, facilitate communication among team members and between the health home team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate, and;
- Establishing 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.

☐ Team of Health Care Professionals as described in §ection 1945(h)(6)

☐ Health Team as described in §ection 1945(h)(7), via reference to §ection 3502

iv. Service Definitions

Comprehensive Care Management

Service Definition

Comprehensive care management begins with the identification of individuals who are potentially eligible to receive health home services. The CBHC health home will be responsible for identifying individuals with severe and persistent mental illness who are currently affiliated with the health home site. SPMI individuals without a CBHC affiliation or a routine source of health care may be identified through referral from another provider or an administrative data review and connected to a CBHC health home to begin the comprehensive care management process. The next step is for the CBHC to engage the eligible individual and his/her family by explaining the benefits of participation and receiving health home services, and the right to opt-out of health home services.

The CBHC health home will complete a comprehensive assessment of the individual's physical health, behavioral health (i.e., mental health, substance abuse disorders), long-term care and social needs. The assessment must account for the cultural and linguistic needs of the individual and use relevant comprehensive data from a variety of sources, including the individual/family, caregivers, medical records, team of health professional, etc. At a minimum, the CBHC health home will reassess the individual at least once every ninety days. Based on the health assessment, the CBHC health home will assemble a team of health professionals, and establish and negotiate roles and responsibilities for each member of the team, including the accountable point of contact. The CBHC health home will develop and continuously update a single, integrated, person-centered care plan that will include prioritized goals and actions with anticipated timeframes for completion and will reflect the individual's preferences. Prior to implementation of the care plan, a communication plan must be developed to ensure that routine information exchange (clinical patient summaries, medication profiles, updates on patient progress toward meeting goals), collaboration, and communication occurs between the team members, providers, and the individual/family.

The CBHC health home will frequently and routinely monitor the care plan to determine adherence to treatment guidelines and medication regimes, barriers to care, or any clinical and non-clinical issues that may impact the individual's health status or progress in achieving the goals and outcomes outlined in the care plan. As part of the monitoring, the CBHC and team of health professionals are expected to adhere to the communication plan when providing updates and progress reports on the individual.

The Health Home Team Leader, the Embedded Primary Care Clinician, and the Care Manager will participate in the comprehensive care management activities and the comprehensive care management service components will be delegated among the health home team members as follow: The health home Team Leader will be responsible for initially screening all new referrals, tracking and facilitating transfer/transition of new cases on to the health home team. The Team Leader will also be responsible for reviewing the list of new cases with the entire team during regular team meetings and assigning each health home enrollee to a designated Care Manager and Qualified Health Home Specialist based on the individual's preferences, needs and staff availability. The other team members can also help identify and facilitate transition of new cases to the team in collaboration with the Team Leader. A licensed clinician Care Manager will be responsible for a designated caseload, completion of the CBHC's standardized health risk assessment, as well as the CBHC's comprehensive health assessment and care plan including a crisis plan with input from other team members. The Care Manager will support and engage the individual and family in the assessment process and the development of care plan which will include the prioritization of goals. The Embedded Primary Care Clinician will be responsible for reviewing the assessment and health data and formulating goals/interventions for physical health care which will be included in the care plan. The Care Manager will provide specific interventions for managing chronic diseases identified in the assessment and care plan under the supervision of the Team Leader and in consultation with the primary care clinician. All members of the health home team will routinely monitor the enrollee's symptoms and functioning, and conduct ongoing assessment of the enrollee's needs. The Team Leader will review and monitor timeliness and quality of assessments and care plans, and ensure that health home enrollees receive comprehensive care management service. The Team Leader and Embedded Primary Care Clinician may also complete some components of the comprehensive assessments and care plans and provide specific care management interventions.

The methods of health home services delivery will consist of: service delivery to the beneficiary and may include other individuals who will assist in the beneficiary's treatment; service delivery may be face-to-face, by telephone, and/or by video conferencing; service delivery may be in individual, family or group format; and service delivery is not site-specific and the health home services should be provided in locations and settings that meet the needs of the health home beneficiary.

Ways Health IT Will Link

The State will phase-in use of HIT to support the delivery of CBHC health home services. In recognition of the varying levels of HIT (i.e., electronic medical records, registries, etc.) utilized by CBHC health homes, the State will initially require that CBHC health homes are able to receive utilization data electronically from a variety of sources. The data will, at a minimum, include clinical patient summaries (e.g., diagnosis, medication profiles, etc.) and real-time notifications of a patient's admission to, or discharge from, an emergency department

or inpatient facility. Within twelve months of receiving designation as a Health Home provider, the CBHC must acquire (or adopt) an electronic health record product that is certified by the Office of the National Coordination for Health Information Technology. Within twenty-four months of receiving designation as a health home provider, the CBHC must demonstrate that the electronic health record is used to support all health home services, including population management. The CBHC health home will also be required to participate in the statewide Health Information Exchange, when available in their region.

Following auto-assignment of beneficiaries into health homes and as part of initial Comprehensive Care Management activities, CBHCs will receive health utilization profiles on health home beneficiaries. CBHC health homes will also be required to develop internal processes in order to act on and disseminate the data and demonstrate how data will be utilized to continue ongoing Comprehensive Care Management services. Utilization profiles may be supplied to the CBHC health home no less than quarterly.

Care Coordination

Service Definition

Care coordination is the implementation of the single, integrated care plan. With a person-centered focus, the CBHC will facilitate and direct the coordination, communication, and collaboration which is necessary for the individual to demonstrate progress on the goals/actions of the care plan and achieve optimal health outcomes. This will include, but not be limited to, the following: providing assistance to the consumer in obtaining health care (i.e., primary and specialty medical care, mental health, substance abuse services and developmental disabilities services, long-term services and supports, and ancillary services and supports); performing medication management and reconciliation; tracking tests and referrals with the necessary follow up; sharing the crisis plan, assisting with and coordinating prevention, management and stabilization of crises and ensuring post-crisis follow-up care is arranged and received; participating in discharge planning; and making referrals to community, social and recovery supports. The CBHC health home will be required to assist the individual with making appointments and validating that the services were received by the individuals.

Although care coordination requires participation of all health home team members in implementation of the care plan, the Care Manager will have the lead care coordinator role across all providers and settings. The Embedded Primary Care Clinician may have a lead role for the coordination of physical health care needs and communication with the treating primary care clinician and medical specialists as appropriate. The Team Leader will take the lead for developing general care coordination and communication protocols for use with external and internal providers. The Team Leader will also serve as the universal point of contact and care coordinator for all consumers on the team and be the back-up for the Care Manager and Qualified Health Home Specialist. The Care Manager will utilize Qualified Health Home Specialists in coordinating some aspects of the care plan such as referrals to specialists, implementation of discharge plan, accessing housing and other community resources, and obtaining entitlements. The Care Manager will also need to coordinate with other team members such as the nurse on medication management and reconciliation, tracking of labs and results of consults.

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Ways Health IT Will Link

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In the delivery of Care Coordination services, all CBHC health homes will be required to use utilization data and other information to develop /update the integrated care plan, establish relationships with treatment providers (e.g., hospital, LTC, Rx), share information with other providers to facilitate their treatment of clients, conduct medication management and reconciliation, connect clients with necessary social supports, utilize lab portals to retrieve or develop auto-generated letters that notify PCPs of lab values. CBHC health homes will also be required to develop and utilize tracking systems (e.g., track women who are recommended to have a mammogram) to identify delivered and needed services that links to the Care Management plan. In addition, CBHC health home must have the ability to take patient summary info and place it in formats that are useful for the client. If available, develop a unified care plan electronically. If the client chooses not to receive primary care services at the CBHC health home site, then the CBHC must demonstrate how primary care is integrated at the CBHC site.

Health Promotion

Service Definition

Health promotion services are intended to equip the individual/family with relevant knowledge and skills which will: increase his/her understanding of diseases/conditions identified in the assessment, promote self-management, and improve quality of life and daily functioning. This may be accomplished through the following examples: education about wellness and healthy lifestyle choices; provision of or referrals to evidence based wellness programs, such as Tobacco Cessation, Weight Management, Chronic Disease Management Programs, Wellness Management and Recovery, etc.; and connections to peer supports. A focus of health promotion will be to support and engage the individual and the family in the development, implementation and monitoring of the care plan. By empowering the individual and promoting self-advocacy, there will be an increased ability to be proactive in the self-management of existing conditions, increase the utilization of preventative services, and accessing care in appropriate settings.

Health promotion can be provided by any member of the health home team. The Care Manager, as the accountable point of contact has the lead responsibility for providing or arranging for health promotion services based on the identified needs in the assessment and goals in the care plan. All members of the team will be able to educate clients and families regarding the primary condition and chronic diseases and teach self-management skills. The Embedded Primary Care Clinician will provide education on physical health and preventive care as needed. Other health promotion services such as tobacco cessation and treatment may be provided by a Care Manager or Qualified Health Home Specialist with specialized training or Tobacco Treatment Specialist certification. Care Managers and Qualified Health Home Specialists with peer background will co-lead Chronic Disease Self-Management Programs (CDSMP), Wellness Management and Recovery (WMR), and Wellness Recovery Action Plans (WRAP) groups. The Team Leader will have the responsibility for reviewing patient data and developing health promotion programming and resources with input from the team. The Team Leader will also provide direct training or arrange ongoing in-service training for Care Managers and Qualified Health Home Specialists in evidence-based health promotion interventions and monitor provision of health promotion services.

The methods of health home services delivery will consist of; service delivery to the beneficiary and may include other individuals who will assist in the beneficiary's treatment; service delivery may be face-to-face, by telephone, and/or by video conferencing; and service delivery may be in individual, family or group format; service delivery is not site-specific and the health home services should be provided in locations and settings that meet the needs of the health home beneficiary.

Ways Health IT Will Link

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used to support all health home services, including population management. The CBHC health home will also be required to participate in the statewide Health Information Exchange, when available in their region.

HIT supports for Health Promotion involves CBHCs use of electronically received health utilization profiles that connect clients with necessary social supports via phone, fax or web- based commensurate with providers capacity and referral source requirements.

Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)

Service Definition

Comprehensive transitional care services are designed to ensure continuity of care and prevent unnecessary inpatient readmissions, emergency department visits and/or other adverse outcomes, such as homelessness. The CBHC health home will develop arrangements with inpatient facilities, emergency departments and residential facilities for prompt notification of an individual's admission and/or discharge to/from a hospital emergency department, inpatient unit or residential facility. The CBHC health home will coordinate and collaborate with inpatient facilities, hospital emergency departments, residential facilities and community partners to ensure that a comprehensive discharge plan and/or transition plan, and timely and appropriate follow up is completed for an individual who is transitioning to/from different levels and settings of care. The CBHC health home will conduct and/or facilitate effective clinical hand offs that include timely access to follow-up post discharge care in the appropriate setting, timely receipt and transmission of a transition/discharge plan from the discharging entity, and medication reconciliation.

The Care Manager will be the accountable team member for providing comprehensive transitional care service including the development and coordination of a discharge and transition plan. However, other members of the health home team will provide input in the development and assist with the implementation of the discharge and transition plan. The Care Manager is responsible for exchanging or facilitating exchange of medical records such as the care plan, crisis plan, list of current medications, the most recent psychiatrist note and any other medical documents necessary to facilitate continuity of care during a crisis, hospitalization, incarceration or admission to a residential program. Hospital treatment team meetings will be attended by the Care Manager whenever possible or another team member if the Care Manager is not available. Qualified Health Home Specialists will assist with physical discharge process, assisting the client with returning home and community and linking the client to follow-up appointments. The Care Manager will review the discharge records including after-care plan and medications, update care plan accordingly, coordinate with other team members including family, psychiatrist, the hospital liaison worker, nurse and pharmacist and re-engage and re-orient the consumer to the community-based care. The Team Leader will track team clients in crisis, hospitalized or incarcerated, conduct case reviews, review discharge/transition plans, monitor warm hand-off and smooth transition of clients back to community.

The methods of health home services delivery will consist of; service delivery to the beneficiary and may include other individuals who will assist in the beneficiary's treatment; service delivery may be face-to-face, by telephone, and/or by video conferencing; and service delivery may be in individual, family or group format; service delivery is not site-specific and the health home services should be provided in locations and settings that meet the needs of the health home beneficiary.

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HIT supports for Comprehensive Transitional Care involve CBHCs use of electronically received health utilization profiles, which the notify CBHC health home about inpatient hospital admissions. The State will also make health home assignment information available to any Medicaid provider through the secure provider web portal. Providers will be able to access the portal to determine if consumers are enrolled in a health home.

Individual and Family Support Services (including authorized representatives)

Service Definition

Individual and family support services include, but are not limited to, the following: providing expanded access and availability of services along with continuity in relationships between the individual/family, provider(s), and the Care Manager; supporting the delivery of person centered care; assisting with accessing natural support systems in the community; performing outreach and advocacy for the individual/family to identify and obtain needed resources (e.g., transportation); educating and teaching the individual on self-management techniques; facilitating further development of daily living skills; assisting with obtaining and adhering to medication and other prescribed treatments ; providing interventions that address symptoms, and behaviors and assist the health home enrollee in eliminating barriers to seeking or maintaining education, employment or other meaningful activities related to his or her recovery-oriented goal; providing opportunities for the individual/family to participate in the assessment and care plan development/implementation, including providing access to electronic health records or other clinical information; and making referrals to community/social/recovery supports. Health home services will also be delivered in a manner that takes into account the individual's and family's preferences and is culturally and linguistically appropriate. Individuals and their families will be integral to the quality improvement process by providing feedback on experience/satisfaction of care through surveys or by participating in patient/family advisory councils.

Individual and family supports will be provided by all members of the team. Clients will be served by a constant core team to assure continuity of relationship and support. CBHC health home sites are expected to provide expanded and enhanced access to staff and services for support and client-centered care. Provision of peer support will be provided by the Qualified Health Home Specialist with peer specialist qualification. Care Managers and Qualified Health Home Specialists will also assist and link clients to natural supports, advocacy organizations, and support or self-help groups in their communities.

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HIT supports for Individual & Family Support Services will involve CBHCs use of electronically received health utilization profiles that, auto-generate communications sent to patients and family members of next appointment and establishment of a "tickler" system (e.g., e-mail, postcard, phone call) to remind clients to schedule routine exam (dental exam, vision checks, medical test such as lab work, physical exam, mammogram, etc.). CBHCs will also be encouraged to develop internet capacity for information about wellness,

promotional information, and supports access to services.

Referral to Community and Social Support Services

Service Definition

The CBHC health home will offer and/or arrange for onsite and offsite community and social support services through effective collaborations with social service agencies and community partners. The CBHC health home will identify and provide referrals to community, social, or recovery support services such as maintaining eligibility for benefits, obtaining legal assistance, and housing. The CBHC health home will assist the consumer in making appointments; validate the service was received; and complete any follow up as necessary.

Care Managers will be responsible for identifying non-clinical services and needs that require referrals to community and social supports during the comprehensive assessment with input from individual and family and other team members. However, Qualified Health Home Specialists will largely initiate referrals to community resources and social supports, assist with the completion of paperwork, ensure that needed services, resources and supports are acquired and provide status reports and updates to the team. The Team Leader will monitor team's referral process for community and social supports identify/compile community resources and assist with complex cases.

The methods of health home services delivery will consist of; service delivery to the beneficiary and may include other individuals who will assist in the beneficiary's treatment; service delivery may be face-to-face, by telephone, and/or by video conferencing; and service delivery may be in individual, family or group format; service delivery is not-site specific and the health home services should be provided in locations and settings that meet the needs of the health home beneficiary.

Ways Health IT Will Link

The State will phase-in use of HIT to support the delivery of CBHC health home services. In recognition of the varying levels of HIT (i.e., electronic medical records, registries, etc.) utilized by CBHC health homes, the State will initially require that CBHC health homes are able to receive utilization data electronically from a variety of sources. The data will, at a minimum, include clinical patient summaries (e.g., diagnosis, medication profiles, etc.) and real-time notifications of a patient's admission to, or discharge from, an emergency department or inpatient facility. Within twelve months of receiving designation as a Health Home provider, the CBHC must acquire (or adopt) an electronic health record product that is certified by the Office of the National Coordination for Health Information Technology. Within twenty-four months of receiving designation as a health home provider, the CBHC must demonstrate that the electronic health record is used to support all health home services, including population management. The CBHC health home will also be required to participate in the statewide Health Information Exchange, when available in their region.

HIT supports for Referral to Community & Social Support Services will involve CBHCs use of electronically received health utilization profiles that connect clients with necessary social supports via phone, fax or web- based commensurate with providers capacity and referral source requirements.

v.Provider Standards

A community behavioral health center (CBHC) must meet state defined core requirements in order to qualify as a provider of health home services for individuals with serious and persistent mental illness (SPMI). CBHCs will be the only provider type recognized by the State as eligible to provide Health Home services for persons with SPMI, The State will contract with the approved CBHC Health Home for the provision of, and payment for, Health Home services. Unless otherwise indicated, CBHCs must meet the following minimum requirements prior to providing health home services:

a. Be certified by the Ohio Department of Mental Health as eligible to provide the following Medicaid covered community mental health services: pharmacological management, mental health assessment, behavioral health counseling and therapy, and community psychiatric support treatment. This certification includes achieving accreditation from any of the following national organizations: The Commission on Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or The Council on Accreditation for Children and Family Services.

b. Provide all of the following health home services as necessary and appropriate for beneficiaries: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family supports, referral to community and social support services, and the use of health information technology to support the delivery of health home services.

c. Demonstrate integration of physical and behavioral health by:

i. Achieving one of the following accreditations at the agency's next accreditation survey : 1) the CARF's Integrated Behavioral Health/Primary Care (IBHPC) Behavioral Health Core Program Standards; or 2) the Joint Commissions' Behavioral Health Care Accreditation Program Standards for Primary Physical Health Care; or 3) Council on Accreditation's Integrated Behavioral Health and Primary Care Supplement Standards; or 4) the National Committee for Quality Assurance recognition as a Patient Centered Medical Home (Level 1) within 18 months of becoming a CBHC health home; or 5) equivalent recognition standards as approved by the State.

ii. Ensuring that specific medical screening and treatment services, consistent with current professional standards of care, are provided to the Health Home consumer by directly providing the service on-site or assuring the service is provided through a written agreement with a primary care provider.

iii. Identifying a single point of contact for each MCP who shall work with the MCP on activities such as the following: informing the MCP of CBHC Health Home Care Management Team meetings, collaborating on the development of the assessment and care plans, facilitating data exchange with the MCP, etc.

iv. Establishing policies and written agreements with primary care providers for communication and integration between behavioral health and primary care if the CBHC does not have an ownership interest in a primary care organization or does not have embedded primary care services.

v. Establishing effective partnerships and referral/coordination processes with specialty providers, inpatient facilities, and managed care plans that support the delivery of health home services.

a. The CBHC must establish a partnership and a referral/coordination process with specialty providers and inpatient facilities. At a minimum, the referral/coordination process must address the roles of the CBHC and the partnering provider in coordinating and managing care for the consumer, including any necessary follow up with the consumer. The process shall include how and what type(s) of information will be exchanged in a HIPAA compliant manner between the CBHC and the partnering specialty provider or inpatient facility.

b. The CBHC must establish partnerships with managed care plans in the service area and develop written policies and procedures that include the following:

i. Notifying the MCP of referrals received by the CBHC for the MCP's members, and of any MCP member who is currently receiving health home services. The CBHC Health Home will collaboratively develop a transition plan with the MCP for any plan member that will receive health home services in order to prevent unnecessary duplication of, and avoid gaps in services.

ii. Forming a Care Management team that includes the CBHC Health Home core team, the health home enrollee, the enrollee's family/supports, the enrollee's primary care provider, and other providers, as appropriate, and the enrollee's managed care plan in order to effectively manage the enrollee's needs.

iii. Working collaboratively with the MCP to ensure all of the member's needs identified in the CBHC health home care plan are met. Ensure that the care plan is accessible to the MCP and providers involved in managing the enrollee's health care.

iv. Requesting care coordination supports from the MCP, if needed.

v. Collaborating with the MCP's designated single point of contact on such activities as the following: exchanging information about the plan's member, soliciting input to the development of the care plan, participating in Health Home team meetings, and assuring access to services that are outside the scope of the CBHC.

vi. Ensuring that if the CBHC has direct ownership of a primary care provider/practice that it seeks a contract with the MCPs in the service area for the provision of primary care services. If the CBHC has a co-located relationship or a referral/coordination relationship with a primary care provider for the provision of primary care services, the CBHC shall encourage the provider to seek a contract with the MCPs in the service area.

vii. Ensuring that the CBHC's collaborative care agreements are primarily with primary care providers who are contracted with the MCPs in the service area. Ensure that any established partnerships and referral/coordination processes with specialists and inpatient facilities, if applicable, also include those contracted with the MCPs in the service area. The CBHC shall work with the MCP to understand how credentialing may impact partnering providers who do not have current contracts with the MCPs in the service area. The CBHC shall also:

a. Provide a list of primary care providers and specialists/inpatient facilities to the MCP, for which the CBHC has integrated care agreements and referral/coordination processes, respectively. The CBHC shall refer to the plan's panel of providers when assisting the enrollee in obtaining necessary health care.

b. Collaborate with the MCP to ensure that the enrollee's selected/assigned PCP has a current, collaborative care agreement with the CBHC. If the enrollee requests a change to the selected PCP, the CBHC shall inform the MCP so that the plan's existing process to change the PCP is promptly initiated.

viii. Providing timely notification of all inpatient facility discharges and residential setting transitions to the managed care plan in order to ensure adequate and timely provision of follow up care. The CBHC Health Home will ensure that a discharge/transition plan is in place prior to the enrollee's discharge or transition. The CBHC will work with the MCP to ensure that post discharge services are prior authorized, if appropriate, and provided by the plan's contracted providers. The CBHC must ensure that the discharge/transition plan is integrated into the plan of care and communicated to the Care Management Team.

ix. Having the capacity to send electronic data to MCPs and to produce ad hoc reports to more effectively coordinate care.

d. Support the delivery of person-centered care by providing:

i. Expanded, timely access to health care services provided by the health home provider;

ii. Orientation of the patient to health home services;

The CBHC must provide the patient, family and caregivers with verbal information and/or written materials in a manner that is appropriate for the patient's needs and includes the following: an overview of health home services and how the consumer will benefit from the services; the ability to decline the services or terminate participation in the program; and how the patient, family and caregivers may participate in the delivery of health home services.

iii. Services that are delivered to the patient/family in a culturally and linguistically appropriate manner;

The CBHC must assess the racial and ethnic diversity of the population served and ensure that patients receive care in a way that is compatible with their cultural needs. The CBHC must record all special communication needs of the consumer in the care plan and the provision or related services offered to the consumer (e.g., identification of a hearing impairment and provision of sign language services). The CBHC must attempt to recruit and retain staff who are representative of the demographic(s) of the population served.

iv. A multi-disciplinary team based approach for the delivery of Health Home services through the ongoing use of an established team of members defined by the state;

Each CBHC health home will determine, assemble and maintain appropriate Health Home Team FTEs that are necessary to provide health home services and achieve the necessary health home outcomes.

CBHC health home team members must consist of:
Health Home Team Leader: Provides administrative and clinical leadership and oversight to the health home team and monitors provision of health home services. The minimum qualifications for the team leader position consist of a Master's Degree or higher in a healthcare related field with appropriate or applicable independent licensure(s) (LISW, PCC, IMFT, RN-MSN, licensed psychologist) as well as supervisory, clinical and administrative leadership experience. The state may consider other Master's Degree-level professionals in a healthcare related field such as a Master's Degree in public health, health management, and health administration and not require independent clinical licensure.

Embedded Primary Care Clinician: Participates in the provision of health home services including identification of consumers, assessment of service needs, care plan development, development of treatment guidelines, and monitoring of health status and service use. The Embedded Primary Care Clinician role can be conducted by any of the following professionals: primary care physicians, pediatricians, gynecologists, obstetricians, Certified Nurse Practitioners with a primary care scope of practice, Certified Nurse Specialists with a primary care scope of practice, and Physician Assistants.

Care Manager: Be accountable for overall care management and care coordination and able to both provide and coordinate all health home services. The minimum qualifications for the Care Manager include social workers with LSW or LISW, counselors with PC or PCC, Marriage and Family Therapists with MFT or IMFT, RN Nurses (including a 2 or 3 year RN degree) with extensive experience working with the SPMI population, and other qualified staff approved by the State.

Qualified Health Home Specialist: Assists with and provides care coordination, referral/linkage, follow-up, family/consumer support and health promotion services. The minimum qualifications for the qualified health home specialist are LPN nurses, CPST workers with four year degrees or 2 year Associate Degrees, wellness coaches, peer support specialists, certified tobacco treatment specialists, health educators and other qualified workers (e.g., community health workers with Associate Degrees or CPST workers with commensurate experience).

v. A single, integrated, person-centered care plan that coordinates all of the clinical and non-clinical needs;

The single integrated care plan must identify the consumer's needs (as identified in the comprehensive assessment), goals, interventions, and expected outcomes. The CBHC must provide an opportunity for the patient, family members, caregivers, and providers to offer input to the care plan. The care plan must be reviewed no less frequently than once a quarter and updated as appropriate.

vi. The ability to track tests and referrals for health care services, and coordinate follow up care as needed;

The CBHC must track lab and imaging tests until results are available. For any abnormal results that are identified, the CBHC must coordinate the notification to the patient and any necessary follow up with the prescribing provider.

The CBHC must also track all referrals for health care services, including referrals to specialists or community agencies. The CBHC must validate that the service was received and perform any necessary follow up.

vii. Generate point of care reminders for patients about services needed for preventive care and/or management of chronic conditions using patient information and clinical data.

The CBHC must incorporate the use of evidence based clinical guidelines and data of its population into patient care processes that proactively identifies and engages patients who are lacking critical services for conditions that are relevant to the population

e. Have the capacity to receive electronic data from a variety of sources to facilitate care management, care coordination, and comprehensive transitional care. At a minimum, this may include clinical patient summaries, medication profiles, and real-time notifications of a patient's admission to, or discharge from, an emergency department or inpatient facility.

f. Maintain a comprehensive and continuous quality improvement program capable of collecting and reporting data on utilization and health outcomes, and the ability to report to the State or its designee.

g. Participate in the Medicaid Health Homes Learning Community.

h. Serve as a current eligible provider in the Ohio Medicaid Program.

i. Have the capacity to serve Medicaid individuals who are eligible to receive health home services in the designated service area.

The CBHC will be required to maintain documentation in the care plan in order to demonstrate that Health Home services are being delivered in accordance with program rules and requirements. The CBHC must be compliant with the provider standards in order to maintain a designation as a Health Home provider.

While CBHCs will be the single provider type designated by the State to provide Health Home services for persons with SPMI, many consumers who are eligible to receive Health Home services will be enrolled in a Medicaid managed care plan. Therefore, the State recognizes that Medicaid managed care plans (MCPs) will play a critical role in supporting the CBHC Health Homes for their members. The contract between the State and the Medicaid MCPs will require that each MCP performs the following activities to support the CBHC Health Home:

a. Establishes a partnership with the CBHC Health Home and develops written policies and procedures that address the following components:
i. a delineation of responsibilities of the CBHC Health Home and the MCP in providing Health Home services and supports, respectively, in order to avoid duplications or gaps in services;
ii. identification of a single point of contact for each CBHC Health Home who will perform activities such as the following: collaborating on the development of the assessment and the care plan, facilitating data exchange with the CBHC Health Home, and participating on the CBHC's Health Home care management team;
iii. transmission of data, information and reports to the CBHC Health Home which will enhance the delivery of Health Home services and can include the following: clinical patient summaries; copies of prior assessments or care plans developed by the MCP; approved prior authorizations; same day notification of admissions/discharges for inpatient facility stays or emergency department visits; and grievances or consumer complaints related to the CBHC Health Home; and
iv. providing the CBHC Health Home with a list of contracted primary care, specialty and institutional providers to ensure that the Health Home's partner network includes providers that primarily serve the plan's members.

b. Develops a transition plan timely and in collaboration with the CBHC Health Home for each plan member that will receive Health Home services. The transition plan should confirm the start date for Health Home services and identify the member's primary care provider, the data/information that will be transferred to the CBHC Health Home, and the single point of contact designated for the CBHC Health Home.
c. Performs ongoing identification of the plan's members who have a diagnosis of SPMI and could benefit from receiving Health Home services. The MCP will contact these eligible members, educate the members about the benefits of receiving Health Home services, assist them in selecting a Health Home, and facilitate the referral to the selected Health Home.
d. Establishes and maintains a mechanism to track the plan's members who are receiving Health Home services.
e. Integrates all information/data transmitted by the CBHC Health Home or the State related to a member's receipt of Health Home services into the MCP's systems, such as member services, utilization management, etc.
f. Participates in comprehensive transitional care activities with the CBHC Health Home for members who are discharged from, or transferred between, care settings and which may include the following, discharge planning, primary care provider follow up, medication reconciliation and timely provision of post discharge services (e.g., durable medical equipment).
g. Integrates the results from the Health Homes quality measures into the plan's quality improvement program.
h. Participates in the Medicaid Health Homes Learning Community.

The State will routinely monitor the MCPs to ensure there is active and ongoing participation to support the CBHC Health Homes.

vi. Assurances

☑ A. The State assures that hospitals participating under the State plan or a waiver of such plan will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

☑ B. The State 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.

☑ C. The State will report to CMS information submitted by health home 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.

vii. Monitoring

A. Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications.

The state will use claims data and the HEDIS method to calculate the number of inpatient stays that were followed by an acute readmission for any diagnosis within 30 days.

B. Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications.

Health homes will be implemented in targeted geographic areas across the State. Changes in per member per month (PMPM) costs will be evaluated over time for the two distinct SPMI populations, those enrolled in health homes and those not enrolled in health homes. Those not enrolled in health home will serve as the control group.

The PMPM costs for the two SPMI populations will be calculated using a baseline period prior to health home implementation (e.g, state fiscal year 2011). The PMPM costs will then be calculated for each health home program year, which will be referred to as the projection year (e.g., calendar year 2013). The trend between the two periods (projection and baseline) for the control group will be calculated and

applied to the baseline value for the health home population, producing the expected costs for the health home population absent the influence of the health homes initiative. The actual projection year costs will be compared to the expected costs for the health home population to determine program savings associated with the health homes initiative. Monthly case rates paid to the health homes will be removed from program savings to determine the net savings to the health homes program.

For the above described cost savings calculation, all Medicaid services will be included within the PMPM costs, which includes long term care and support services. To ensure the most accurate comparison between the baseline period and the projection period (years 1 and 2 of the health home program), the same data collection methods will be used for both years, such as using the same amount of claims runout. To ensure the most appropriate comparison between the control group and the health home population, adjustments will be made to account for differences in population characteristics (such as eligibility and age group) and geographic influences on the mix of services that could impact the trends, where appropriate.

Enrollees with both Medicare and Medicaid coverage, referred to as dual eligibles, will be evaluated separately. Savings will be calculated to the extent that the necessary Medicare data is made available to Ohio for the calculation.

C. Describe the State's proposal for using health information technology in providing health home services under this program and improving 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).

The State will phase-in use of HIT to support the delivery of CBHC health home services. In recognition of the varying levels of HIT (i.e., electronic medical records, registries, etc.) utilized by CBHC health homes, the State will initially require that CBHC health homes are able to receive utilization data electronically from a variety of sources. The data will, at a minimum, include clinical patient summaries (e.g., diagnosis, medication profiles, etc.) and real-time notifications of a patient's admission to, or discharge from, an emergency department or inpatient facility. Within twelve months of receiving designation as a Health Home provider, the CBHC must acquire (or adopt) an electronic health record product that is certified by the Office of the National Coordination for Health Information Technology. Within twenty-four months of receiving designation as a health home provider, the CBHC must demonstrate that the electronic health record is used to support all health home services, including population management. The CBHC health home will also be required to participate in the statewide Health Information Exchange, when available in their region.

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CBHC health homes will also be required to develop internal processes in order to act on and disseminate the data and demonstrate how data will be utilized to continue ongoing Comprehensive Care Management services. Utilization profiles may be supplied to the CBHC health home no less than quarterly.

In the delivery of Care Coordination services, all CBHC health homes will be required to use utilization data and information supplied by the State to develop /update the integrated care plan, establish relationships with treatment providers (e.g., hospital, LTC, Rx), share information with other providers to facilitate their treatment of clients, conduct medication management and reconciliation, connect clients with necessary social supports, utilize lab portals to retrieve or develop auto-generated letters that notify PCPs of lab values. CBHC health homes will also be required to develop and utilize tracking systems (e.g., track women who are recommended to have a mammogram) to identify delivered and needed services that links to Care Management Plan. In addition, the CBHC health home must have the ability to take patient summary info and place it in formats that are useful for the client. If available, develop a unified care plan electronically. If the client chooses not to receive primary care services at the CBHC health home site, then the CBHC must demonstrate how primary care is integrated at the CBHC site.

HIT supports for Health Promotion involves CBHCs use of electronically received health utilization profiles that connect clients with necessary social supports via phone, fax or web- based commensurate with providers capacity and referral source requirements.

HIT supports for Comprehensive Transitional Care involve CBHCs use of electronically received health utilization profiles from the State, which notify CBHC health home as soon as possible about inpatient hospital admissions.

HIT supports for Individual & Family Support Services will involve CBHCs use of electronically received health utilization profiles that, auto-generates communications sent to patients and family members of next appointment and establishment of a "tickler" system (e.g., e-mail, postcard, phone call) to remind clients to schedule routine exam (dental exam, vision checks, medical test such as lab work, physical exam, mammogram, etc.). CBHCs will also be encouraged to develop internet capacity for information about wellness, promotional information, and supports access to services.

HIT supports for Referral to Community & Social Support Services will involve CBHCs use of electronically received health utilization profiles that connect clients with necessary social supports via phone, fax or web- based commensurate with providers capacity and referral source requirements.

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

viii. Quality Measures: Goal Based Quality Measures

Please describe a measureable goal of the health home model that will be operationalized utilizing measures within the domains listed below. The measures may or may not be tied to the services depending on the goal. If the measure is tied to a service, please complete the service-based quality measure section. If the measure is tied to a goal, please complete the goal-based measure section.

Measure

Goal 1:

Improve Cardiovascular Care

Clinical Outcomes

A. Cholesterol Management for Patients with Cardiovascular Conditions

B. Controlling High Blood Pressure

Data Source

Claims

Measure Specification

A. Numerator: Number of members in the denominator who had a LDL-C level of less than 100 mg/dl.
Denominator: Number Health Home members 18-75 years of age who were discharged alive for an acute myocardial infarction, coronary bypass graft, percutaneous coronary intervention, or ischemic vascular disease.

B. Numerator: Number of members in the denominator who had a systolic blood pressure of less than 140 and a diastolic blood pressure of less than 90
Denominator: Number Health Home members 18-85 years of age who had a primary or secondary diagnosis of hypertension

How Health IT will be Utilized

The Health Homes will submit an electronic claim, via MITS, once a month and, as part of that claim, will provide the state with the procedure and diagnosis codes and dates of service that will be utilized in the calculation of the performance measures. The methods for calculating the performance measures have been identified and the state will be providing the Health Homes with guidance on these methods. Medicaid claims data will be the data source for all of the measures, except for the Low Birth Weight and Client Perception of Care measures. The state will also explore using Medicare claims data as an additional data source so that the results will be as complete as possible.

The state plans to calculate all of the measures on a quarterly basis. Those results will be sent electronically to the Health Homes to provide them with timely, ongoing feedback that can be used in quality improvement efforts. In addition, the state will select an annual reporting period, such as calendar year 2013, to calculate the official results that will be the basis for any incentive payments or required corrective action plans. As the enrollment ramps up, the state will determine whether to calculate the annual report on a calendar year or state fiscal year basis.

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 2:

Improve Care Coordination

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

SAMHSA National Outcome Measures (NOMS):) General satisfaction with care; access to care; quality and appropriateness of care; participation in treatment; cultural competence

Data Source

The State will be conducting a mail survey of Health Home consumers using the MHSIP (Mental Health Statistics Improvement Program) survey for consumers age 18 and older and the YSS-F for parents/guardians of patients under age 18

Measure Specification

Numerator: Number of members in the denominator scoring 3.5 or higher on each of the instruments' subscales.

Denominator: The number of Health Home members completing 2/3 of the items in each subscale.

How Health IT will be Utilized

Findings from the MHSIP and YSS-F will be reported annually to each health home. Statewide averages and percents of positive responses on the instruments' subscales will be used to benchmark the performance of individual health homes. Results of specific subscales will be used in a performance improvement process with the health homes.

Quality of Care

Measure

A. Timely Transmission of Transition Record

B. Reconciled Medication List Received by Health Home

Data Source

Claims

Measure Specification

A. Numerator: Number of members in the denominator for whom a transition record was transmitted to the Health Home within 24 hours of discharge.
Denominator: Number of Health Home members discharged from an inpatient facility.

B. Numerator: Number of members in the denominator for whom a reconciled medication list was transmitted to the Health Home within 24 hours
Denominator: Number of Health Home members discharged from an inpatient facility.

How Health IT will be Utilized

The Health Homes will submit an electronic claim, via MITS, once a month and, as part of that claim, will provide the state with the procedure and diagnosis codes and dates of service that will be utilized in the calculation of the performance measures. The methods for calculating the performance measures have been identified and the state will be providing the Health Homes with guidance on these methods. Medicaid claims data will be the data source for all of the measures, except for the Low Birth Weight and Client Perception of Care measures. The state will also explore using Medicare claims data as an additional data source so that the results will be as complete as possible.

The state plans to calculate all of the measures on a quarterly basis. Those results will be sent electronically to the Health Homes to provide them with timely, ongoing feedback that can be used in quality improvement efforts. In addition, the state will select an annual reporting period, such as calendar year 2013, to calculate the official results that will be the basis for any incentive payments or required corrective action plans. As the enrollment ramps up, the state will determine whether to calculate the annual report on a calendar year or state fiscal year basis.

Goal 3:

Improve diabetes care

Clinical Outcomes

Measure

A. Comprehensive Diabetes Care: HbA1c level < 7.0%

B. Comprehensive Diabetes Care: LDL-C Screening, LDL-C <100 mg/dL

Data Source

Claims

Measure Specification

A. Numerator: Number of members in the denominator who had an HbA1c level of less than 7.0%.
Denominator: Number of Health Home members 18-75 years of age with type 1 or type 2 diabetes.

B. Numerator: (1) Number of members in the denominator who had a LDL-C screening ; (2) Number of members in the denominator who had a LDL-C value of less than 100 mg/dl.
Denominator: Number of Health Home members 18-75 years of age with type 1 or type 2 diabetes.

How Health IT will be Utilized

The Health Homes will submit an electronic claim, via MITS, once a month and, as part of that claim, will provide the state with the procedure and diagnosis codes and dates of service that will be utilized in the calculation of the performance measures. The methods for calculating the performance measures have been identified and the state will be providing the Health Homes with guidance on these methods. Medicaid claims data will be the data source for all of the measures, except for the Low Birth Weight and Client Perception of Care measures. The state will also explore using Medicare claims data as an additional data source so that the results will be as complete as possible.

The state plans to calculate all of the measures on a quarterly basis. Those results will be sent electronically to the Health Homes to provide them with timely, ongoing feedback that can be used in quality improvement efforts. In addition, the state will select an annual reporting period, such as calendar year 2013, to calculate the official results that will be the basis for any incentive payments or required corrective action plans. As the enrollment ramps up, the state will determine whether to calculate the annual report on a calendar year or state fiscal year basis.

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 4:

Improve Care for Persons with Asthma

Clinical Outcomes

Measure

Use of Appropriate Medications for People with Asthma

Data Source

Claims

Measure Specification

Numerator: Number of members in the denominator who were dispensed one or more prescriptions for inhaled corticosteroids, inhaled steroid combinations, antibody inhibitor, antiasthmatic combinations, leukotriene modifiers, mast cell stabilizers, or methylxanthines.

Denominator: Number of Health Home members 5-64 years of age with persistent asthma.

How Health IT will be Utilized

The Health Homes will submit an electronic claim, via MITS, once a month and, as part of that claim, will provide the state with the procedure and diagnosis codes and dates of service that will be utilized in the calculation of the performance measures. The methods for calculating the performance measures have been identified and the state will be providing the Health Homes with guidance on these methods. Medicaid claims data will be the data source for all of the measures, except for the Low Birth Weight and Client Perception of Care measures. The state will also explore using Medicare claims data as an additional data source so that the results will be as complete as possible.

The state plans to calculate all of the measures on a quarterly basis. Those results will be sent electronically to the Health Homes to provide them with timely, ongoing feedback that can be used in quality improvement efforts. In addition, the state will select an annual reporting period, such as calendar year 2013, to calculate the official results that will be the basis for any incentive payments or required corrective action plans. As the enrollment ramps up, the state will determine whether to calculate the annual report on a calendar year or state fiscal year basis.

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 5:

Improve Health Outcomes for Persons with Mental Illness

Clinical Outcomes

Measure

Proportion of Days Covered of Medication

Data Source

Claims

Measure Specification

Numerator: The number of members in each of the five denominators who met the Proportion of Days Covered threshold of 80%.

Denominator: There will be five separate denominators. The number of Health Home members who were prescribed a medication to treat: (1) cardiovascular disease or (2) mental illness or (3) diabetes or (4) asthma or (5) other chronic disease

How Health IT will be Utilized

The Health Homes will submit an electronic claim, via MITS, once a month and, as part of that claim, will provide the state with the procedure and diagnosis codes and dates of service that will be utilized in the calculation of the performance measures. The methods for calculating the performance measures have been identified and the state will be providing the Health Homes with guidance on these methods. Medicaid claims data will be the data source for all of the measures, except for the Low Birth Weight and Client Perception of Care measures. The state will also explore using Medicare claims data as an additional data source so that the results will be as complete as possible.

The state plans to calculate all of the measures on a quarterly basis. Those results will be sent electronically to the Health Homes to provide them with timely, ongoing feedback that can be used in quality improvement efforts. In addition, the state will select an annual reporting period, such as calendar year 2013, to calculate the official results that will be the basis for any incentive payments or required corrective action plans. As the enrollment ramps up, the state will determine whether to calculate the annual report on a calendar year or state fiscal year basis.

Experience of Care

Measure

SAMHSA National Outcome Measures (NOMS):) General satisfaction with care; access to care; quality and appropriateness of care; participation in treatment; cultural competence

Data Source

The State will be conducting a mail survey of Health Home consumers using the MHSIP (Mental Health Statistics Improvement Program) survey for consumers age 18 and older and the YSS-F for parents/guardians of patients under age 18

Measure Specification

Numerator: Number of members in the denominator scoring 3.5 or higher on each of the instruments' subscales.
Denominator: The number of Health Home members completing 2/3 of the items in each subscale

How Health IT will be Utilized

Findings from the MHSIP and YSS-F will be reported annually to each health home. Statewide averages and percents of positive responses on the instruments' subscales will be used to benchmark the performance of individual health homes. Results of specific subscales will be used in a performance improvement process with the health homes.

Quality of Care

Measure

A. Follow Up After Hospitalization for Mental Illness

B. Annual Assessment of Body Mass Index, Glycemic Control, and Lipids for People with Schizophrenia Who Were Prescribed Antipsychotic Medications

C. Screening for Clinical Depression and Follow-up Plan

D. Annual Assessment of Body Mass Index, Glycemic Control, and Lipids for People with Bipolar Disorder Who Were Prescribed Mood Stabilizer Medications

Data Source

Claims

Measure Specification

A. Numerator: Number of discharges in which members of the denominator had a follow-up visit with a mental health practitioner within 7 days of the discharge
Denominator: The number of discharges for Health Home members 6 years of age and older.

B. Numerator: The number of members in the denominator who had an assessment of BMI, a lab test to measure glycemic control, and a lipid screen.
Denominator: The number of Health Home members who had a primary or secondary diagnosis of schizophrenia on a Health Home claim, and who had at least two outpatient encounters on different days or one inpatient discharge, and who were prescribed an antipsychotic medication.

C. Numerator: The number of members in the denominator who received screening for depression.
Denominator: The number of Health Home members aged 18 and older.

D. Numerator: The number of members in the denominator who had an assessment of BMI, a lab test to measure glycemic control, and a lipid screen.
Denominator: The number of Health Home members who had a primary or secondary diagnosis of bipolar disorder on a Health Home claim, and who had at least two outpatient encounters on different days or one inpatient discharge, and who were prescribed a mood stabilizer medication.

How Health IT will be Utilized

The Health Homes will submit an electronic claim, via MITS, once a month and, as part of that claim, will provide the state with the procedure and diagnosis codes and dates of service that will be utilized in the calculation of the performance measures. The methods for calculating the performance measures have been identified and the state will be providing the Health Homes with guidance on these methods. Medicaid claims data will be the data source for all of the measures, except for the Low Birth Weight and Client Perception of Care measures. The state will also explore using Medicare claims data as an additional data source so that the results will be as complete as possible.

The state plans to calculate all of the measures on a quarterly basis. Those results will be sent electronically to the Health Homes to provide them with timely, ongoing feedback that can be used in quality improvement efforts. In addition, the state will select an annual reporting period, such as calendar year 2013, to calculate the official results that will be the basis for any incentive payments or required corrective action plans. As the enrollment ramps up, the state will determine whether to calculate the annual report on a calendar year or state fiscal year basis

Goal 6:

Improve Preventive Care

Clinical Outcomes

Measure

Percent of Live Births Weighing Less than 2,500 grams

Data Source

Vital Statistics

Measure Specification

Numerator: The number of live births weighing less than 2,500 grams.

Denominator: The number of live births by health home members.

How Health IT will be Utilized

The Ohio Department of Job & Family Services obtains, on a routine basis, data about live births, including the birth weight, from the Ohio Department of Health's vital statistics file. This information will be the data source to calculate the percent of live births weighing less than 2,500 grams.

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

A. Prenatal and Postpartum Care

B. Adult BMI Assessment

C. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

D. Adolescent Well-Care Visits

E. Adults' Access to Preventive/Ambulatory Health Services

F. Appropriate Treatment for Children with Upper Respiratory Infections

G. Annual Dental Visit (age 2-21)

H. Annual Dental Visit (age 22 and older)

Data Source

Claims

Measure Specification

A. Numerator: (1) The number of deliveries of live births where the member had a prenatal visit in the first trimester or within 42 days of enrolling in the Health Home; (2) The number of deliveries of live births where the member had a postpartum visit on or between 21 and 56 days after delivery.
Denominator: The number of deliveries of live births by Health Home members.

B. Numerator: The number of members in the denominator who had a BMI assessment.
Denominator: The number of health home members 18-74 of age who had an outpatient visit

C. Numerator: The number of members in the denominator who had a BMI assessment, counseling for nutrition, and counseling for physical activity.
Denominator: The number of health home members 3-17 years of age who had an outpatient visit with a PCP or OB-GYN.

D. Numerator: The number of members in the denominator who had one or more comprehensive well-care visits with a PCP or an OB/GYN practitioner.
Denominator: The number of health home members 12 -21 years of age.

E. Numerator: The number of members in the denominator who had an ambulatory or preventive care visit.
Denominator: The number of health home members aged 20 and older.

F. Numerator: The number of members in the denominator who were not dispensed an antibiotic prescription.
Denominator: The number of Health Home members 3 months-18 years of age who had a diagnosis of an upper respiratory infection.

G. Numerator: The number of members in the denominator who had one or more dental visits.
Denominator: The number of Health Home members 2 – 21 years of age.

H. Numerator: The number of members in the denominator who had one or more dental visits.
Denominator: The number of Health Home members 22 years of age and older.

How Health IT will be Utilized

The Health Homes will submit an electronic claim, via MITS, once a month and, as part of that claim, will provide the state with the procedure and diagnosis codes and dates of service that will be utilized in the calculation of the performance measures. The methods for calculating the performance measures have been identified and the state will be providing the Health Homes with guidance on these methods. Medicaid claims data will be the data source for all of the measures, except for the Low Birth Weight and Client Perception of Care measures. The state will also explore using Medicare claims data as an additional data source so that the results will be as complete as possible.

The state plans to calculate all of the measures on a quarterly basis. Those results will be sent electronically to the Health Homes to provide them with timely, ongoing feedback that can be used in quality improvement efforts. In addition, the state will select an annual reporting period, such as calendar year 2013, to calculate the official results that will be the basis for any incentive payments or required corrective action plans. As the enrollment ramps up, the state will determine whether to calculate the annual report on a calendar year or state fiscal year basis.

Goal 7:

Reduce Substance Abuse

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

A. Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment

B. Smoking & Tobacco Use Cessation

Data Source

Claims

Measure Specification

A. Numerator: (1) The number of members in the denominator who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis; (2) The number of members in the denominator who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
Denominator: The number of Health Home members 13 years and older who had a new episode of AOD dependence.

B. Numerator: The number of members in the denominator who received tobacco cessation intervention.
Denominator: The number of Health Home members of any age who are tobacco users.

How Health IT will be Utilized

The Health Homes will submit an electronic claim, via MITS, once a month and, as part of that claim, will provide the state with the procedure and diagnosis codes and dates of service that will be utilized in the calculation of the performance measures. The methods for calculating the performance measures have been identified and the state will be providing the Health Homes with guidance on these methods. Medicaid claims data will be the data source for all of the measures, except for the Low Birth Weight and Client Perception of Care measures. The state will also explore using Medicare claims data as an additional data source so that the results will be as complete as possible.

The state plans to calculate all of the measures on a quarterly basis. Those results will be sent electronically to the Health Homes to provide them with timely, ongoing feedback that can be used in quality improvement efforts. In addition, the state will select an annual reporting period, such as calendar year 2013, to calculate the official results that will be the basis for any incentive payments or required corrective action plans. As the enrollment ramps up, the state will determine whether to calculate the annual report on a calendar year or state fiscal year basis.

Goal 8:

Improve Appropriate Utilization / Site of Care

Clinical Outcomes

Measure

A. Ambulatory Care Sensitive Condition Hospitalization Rate

B. Inpatient and Emergency Department (ED) utilization Rate

C. All-Cause Readmission

Data Source

Claims

Measure Specification

A. Numerator: The number of acute care hospitalizations for ambulatory care sensitive conditions for members in the denominator.
Denominator: Number of Health Home members under age 75 at mid-year.

B. Numerator: (1) The number of inpatient discharges for Health Home members; (2) The number of emergency department visits for Health Home members; (3) The number of AOD inpatient discharges for Health Home members; (4) The number of mental health inpatient discharges for Health Home members.
Denominator: Number of member months for Health Home members.

C. Numerator: The number of acute inpatient stays by members in the denominator that were followed by an acute readmission for any diagnosis within 30 days.
Denominator: The number of acute inpatient stays by Health Home members 18 years of age and older.

How Health IT will be Utilized

The Health Homes will submit an electronic claim, via MITS, once a month and, as part of that claim, will provide the state with the procedure and diagnosis codes and dates of service that will be utilized in the calculation of the performance measures. The methods for calculating the performance measures have been identified and the state will be providing the Health Homes with guidance on these methods. Medicaid claims data will be the data source for all of the measures, except for the Low Birth Weight and Client Perception of Care measures. The state will also explore using Medicare claims data as an additional data source so that the results will be as complete as possible.

The state plans to calculate all of the measures on a quarterly basis. Those results will be sent electronically to the Health Homes to provide them with timely, ongoing feedback that can be used in quality improvement efforts. In addition, the state will select an annual reporting period, such as calendar year 2013, to calculate the official results that will be the basis for any incentive payments or required corrective action plans. As the enrollment ramps up, the state will determine whether to calculate the annual report on a calendar year or state fiscal year basis.

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 9:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 10:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Measure

Quality of Care

Data Source

Measure Specification

How Health IT will be Utilized

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

viii. Quality Measures: Service Based Measures

Service

☐ Comprehensive Care Management

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Care Coordination

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Health Promotion

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Individual and Family Support Services (including authorized representatives)

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Referral to Community and Social Support Services

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

ix. Evaluations

A. Describe how the State will collect information from health home providers for purposes of determining the effect of this program on reducing the following (include the data source and frequency of data collection):

i. Hospital admissions

Description

Use of HEDIS data inpatient general hospital/acute care, inpatient alcohol and other drug services, and inpatient mental health services discharges (IPU, IAD and MPT measures).

Data Source

Claims

Frequency of Data Collection

Annual

ii. Emergency room visits

Description

Use of HEDIS data for ED visits (part of ambulatory care (AMB) measure).

Data Source

Claims

Frequency of Data Collection

Annual

iii. Skilled Nursing Facility admissions

Description

Use of HEDIS data codes for discharges for skilled nursing facility services (part of inpatient utilization – non-acute care (NON) measure).

Data Source

Claims

Frequency of Data Collection

Annual

i.

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

Hospital admission rates

The state will use claims data and HEDIS methods to calculate admission rates for general hospital/acute care, inpatient alcohol and other drug services, and inpatient mental health services discharges. In addition, the state will use claims data and the HEDIS method to calculate the number of inpatient stays that were followed by an acute readmission for any diagnosis within 30 days.

ii. Chronic disease management

The state will use claims data to calculate performance measures to monitor the management of the following chronic diseases/conditions: heart disease, hypertension, obesity, diabetes, asthma, schizophrenia, bipolar disorder, and alcohol and other dependence.

iii. Coordination of care for individuals with chronic conditions

The state will use claims data to determine whether Health Homes received a reconciled medication list at the time of discharge and to monitor whether transition records were transmitted to Health Homes within 24 hours of a discharge.

iv. Assessment of program implementation

The state has selected 26 performance measures that will be used to evaluate clinical outcomes and for the purposes of quality improvement.

v. Processes and lessons learned

The State will develop Medicaid Health Home Learning Communities as an ongoing quality improvement effort. The Learning Communities will elicit feedback to understand any operational barriers of implementing health home services, review evaluation data and reports, and review relevant program feedback to determine which elements of the health home service delivery are working and which are not.

vi. Assessment of quality improvements and clinical outcomes

The state has selected 26 performance measures that will be used to evaluate clinical outcomes and for the purposes of quality improvement.

vii. Estimates of cost savings

Health homes will be implemented in targeted geographic areas across the State. Changes in per member per month (PMPM) costs will be evaluated over time for the two distinct SPMI populations, those enrolled in health homes and those not enrolled in health homes. Those not enrolled in health home will serve as the control group.

The PMPM costs for the two SPMI populations will be calculated using a baseline period prior to health home implementation (e.g, state fiscal year 2011). The PMPM costs will then be calculated for each health home program year, which will be referred to as the projection year (e.g., calendar year 2013). The trend between the two periods (projection and baseline) for the control group will be calculated and applied to the baseline value for the health home population, producing the expected costs for the health home population absent the influence of the health homes initiative. The actual projection year costs will be compared to the expected costs for the health home population to determine program savings associated with the health homes initiative. Monthly case rates paid to the health homes will be removed from program savings to determine the net savings to the health homes program.

For the above described cost savings calculation, all Medicaid services will be included within the PMPM costs, which includes long term care and support services. To ensure the most accurate comparison between the baseline period and the projection period (years 1 and 2 of the health home program), the same data collection methods will be used for both years, such as using the same amount of claims runout. To ensure the most appropriate comparison between the control group and the health home population, adjustments will be made to account for differences in population characteristics (such as eligibility and age group) and geographic influences on the mix of services that could impact the trends, where appropriate.

Page

Enrollees with both Medicare and Medicaid coverage, referred to as dual eligibles, will be evaluated separately. Savings will be calculated to the extent that the necessary Medicare data is made available to Ohio for the calculation.

3.1 - B: Medically Needy View

Attachment 3.1-H

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

☐ Health Home Services

i. Geographic Limitations

If Targeted Geographic Basis,

ii. Population Criteria

The State elects to offer Health Home Services to individuals with:

☐ Two chronic conditions
☐ One chronic condition and the risk of developing another
☐ One serious mental illness

from the list of conditions below:

☐ Mental Health Condition
☐ Substance Use Disorder
☐ Asthma
☐ Diabetes
☐ Heart Disease
☐ BMI Over 25
☐ Other Chronic Conditions Covered?

Description of Other Chronic Conditions Covered.

iii. Provider Infrastructure

☐ Designated Providers as described in §ection 1945(h)(5)

☐ Team of Health Care Professionals as described in §ection 1945(h)(6)

☐ Health Team as described in §ection 1945(h)(7), via reference to §ection 3502

iv. Service Definitions

Comprehensive Care Management

Service Definition

Ways Health IT Will Link

Care Coordination

Service Definition

Ways Health IT Will Link

Health Promotion

Service Definition

Ways Health IT Will Link

Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)

Service Definition

Ways Health IT Will Link

Individual and Family Support Services (including authorized representatives)

Service Definition

Ways Health IT Will Link

Referral to Community and Social Support Services

Service Definition

Ways Health IT Will Link

v.Provider Standards

vi. Assurances

☐ A. The State assures that hospitals participating under the State plan or a waiver of such plan will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

☐ B. The State 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.

☐ C. The State will report to CMS information submitted by health home 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.

vii. Monitoring

A. Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications.

B. Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications.

C. Describe the State's proposal for using health information technology in providing health home services under this program and improving 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).

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

viii. Quality Measures: Goal Based Quality Measures

Please describe a measureable goal of the health home model that will be operationalized utilizing measures within the domains listed below. The measures may or may not be tied to the services depending on the goal. If the measure is tied to a service, please complete the service-based quality measure section. If the measure is tied to a goal, please complete the goal-based measure section.

Measure

Goal 1:

Clinical Outcomes

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 2:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 3:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 4:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 5:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 6:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 7:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 8:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 9:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 10:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions

Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

viii. Quality Measures: Service Based Measures

Service

☐ Comprehensive Care Management

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Care Coordination

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Health Promotion

Measure

Clinical Outcomes

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Individual and Family Support Services (including authorized representatives)

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Referral to Community and Social Support Services

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

ix. Evaluations

A. Describe how the State will collect information from health home providers for purposes of determining the effect of this program on reducing the following (include the data source and frequency of data collection):

i. Hospital admissions

Description

Data Source

Frequency of Data Collection

ii. Emergency room visits

Description

Data Source

Frequency of Data Collection

iii. Skilled Nursing Facility admissions

Description

Data Source

Frequency of Data Collection

i.

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

Hospital admission rates

ii.

Chronic disease management

iii. Coordination of care for individuals with chronic conditions

iv. Assessment of program implementation

v.

Processes and lessons learned

vi. Assessment of quality improvements and clinical outcomes

vii. Estimates of cost savings

4.19 – B: Payment Methodology View

Attachment 4.19-B

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

Payment Methodology

Payment Type: Per Member Per Month

Provider Type

Designated Community Behavioral Health Centers (CBHCs)

Description

A. Effective for dates of service on or after October 1, 2012, health home services are reimbursed using a monthly case rate based on cost information provided in accordance with guidance in OMB Circular A-87 "Cost Principles for State, Local and Indian Tribal Governments" in the Federal Register/ Vol 70, No 168/Wednesday, August 31, 2005; or OMB Circular A-122 "Cost Principles for Non-Profit Organizations" in the Federal Register/Vol70, No 168/Wednesday, August 31, 2005; or the Medicare Provider Reimbursement Manual, Part 1, as applicable to the health home depending on its organizational type. The only allowable costs that can be reported are the costs related to the provision of services to Medicaid Health Home enrollees for the Health Home submitting cost information.

Providers must submit claims in order to receive case rates for health homes services. A claim can be submitted if any of the health home service components are rendered during the billing month to an eligible individual. Only one claim per individual will be reimbursed per calendar month.

The health home must provide the following information for the purposes of determining the monthly case rate:

1. Medicaid Health Home Enrollee Caseload. The caseload is based on the estimated population to be served by the health home.
2. Medicaid Dedicated Health Home Staffing Costs. For each required team member dedicated to Medicaid health home enrollees, the following staffing information must be provided for the home team member role (health home team leader, embedded primary care clinician, care manager, and qualified health home specialist):

a. Professional credentials. Credentials are determined by the health home and must align with staff roles and requirements as described in Attachment 3.1-A.

b. Staffing ratios. Staffing ratios are established by the State for the health home to meet the need of the population being served.

c. Number of full-time equivalent employees (FTEs). The number of FTEs is equal to the projected monthly caseload divided by the staffing ratio for each team member role.

d. Annual salary. The annual salary includes both direct and indirect service costs for Medicaid Health Homes enrollees services associated with each team member role, including time allocated to activities such as the provision of clinical supervision, documentation, oversight, and quality assurance when a team member has a primary or significant responsibility for such activities.

e. Annual staffing costs. The annual staffing cost for each team member role is equal to the annual salary multiplied by the number of FTEs.

3. Indirect Costs Related to the Provision of Health Home Services of Medicaid Enrollees.

a. The only indirect costs that can be reported are those related to the provision of Health Homes services for Medicaid enrollees.

b. Indirect costs must be identified, allocated, and reported using the uniform cost reporting principles in accordance with OMB Circular A-87 "Cost Principles for State, Local and Indian Tribal Governments," or OMB Circular A-122 "Cost Principles for Non-Profit Organizations," or the Medicare Provider Reimbursement Manual Part 1, as applicable to the health home depending on its organizational type.

c. For purposes of rate setting, indirect costs must be reported on an estimated annual basis.

B. Calculation of the monthly case rate. The Medicaid Dedicated Health Home Staffing Costs for each team member role added to the Indirect Costs Related to the Provision of Health Home Services of Medicaid Enrollees equals the Medicaid Health Homes enrollee total annual cost. The monthly case rate for Medicaid Health Homes is calculated as follows:

1. Divide the Medicaid Health Homes enrollee total annual cost by the caseload; then

2. Divide the result of the calculation in paragraph B.1. of this rule by twelve.

C. The provider's cost will be reviewed annually to determine whether it is necessary to rebase the case rate, based on the information from the provider's actual costs for the prior year.

D. A provider's monthly case rate as determined in accordance with paragraphs B. and C. is effective until sufficient baseline information has been collected to determine a performance component for purposes of setting subsequent rates, and CMS has approved an amendment to this item of Attachment 4.19-B reflecting the performance-based reimbursement methodology.

E. Providers will be required to report all budgeted and actual costs associated with health home services on the uniform cost report.

F. Health home service payments are not subject to cost reconciliation.

G. Health home 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 health homes, and other state plan services).

☐ Tiered?

Payment Type: Alternate Payment Methodology

Provider Type

N/A

Description

N/A

☐ Tiered?