

Ohio Medicaid Health Home

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**PROVIDER TRAINING
SEPTEMBER 2012**

Agenda

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- **Welcome & Introductions 9:00 – 9:30**
- **Background & Overview**
- **Clinical Implementation 9:30 – 10:30**
- **Managed Care 10:30 – 11:00**
 - **Coordinated Services Program**
- **Hospitals, Other Programs, Providers & Services 11:00 – 12:00**
- **Lunch 12:00 – 1:00**

Agenda - Continued

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- Security & Privacy 1:00 – 1:30
- Consumer Enrollment 1:30 – 2:00
- Data Exchange Between Payers & Health Homes
- Performance Measures 2:00 – 2:45
- Break 2:45 – 3:00
- ODJFS Provider Portal 3:00 – 3:15
- Provider Enrollment, Billing & Reimbursement
3:15 – 3:30
- Q & A 3:30 – 4:30
- Next Steps

Background & Overview

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Health Home Eligibility

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Client Eligibility

- Adults and children who meet the State of Ohio definition of severe and persistent mental illness (SPMI), which includes adults with serious mental illness and children with serious emotional disturbance, are eligible for health home services in community mental health agencies

Provider Eligibility

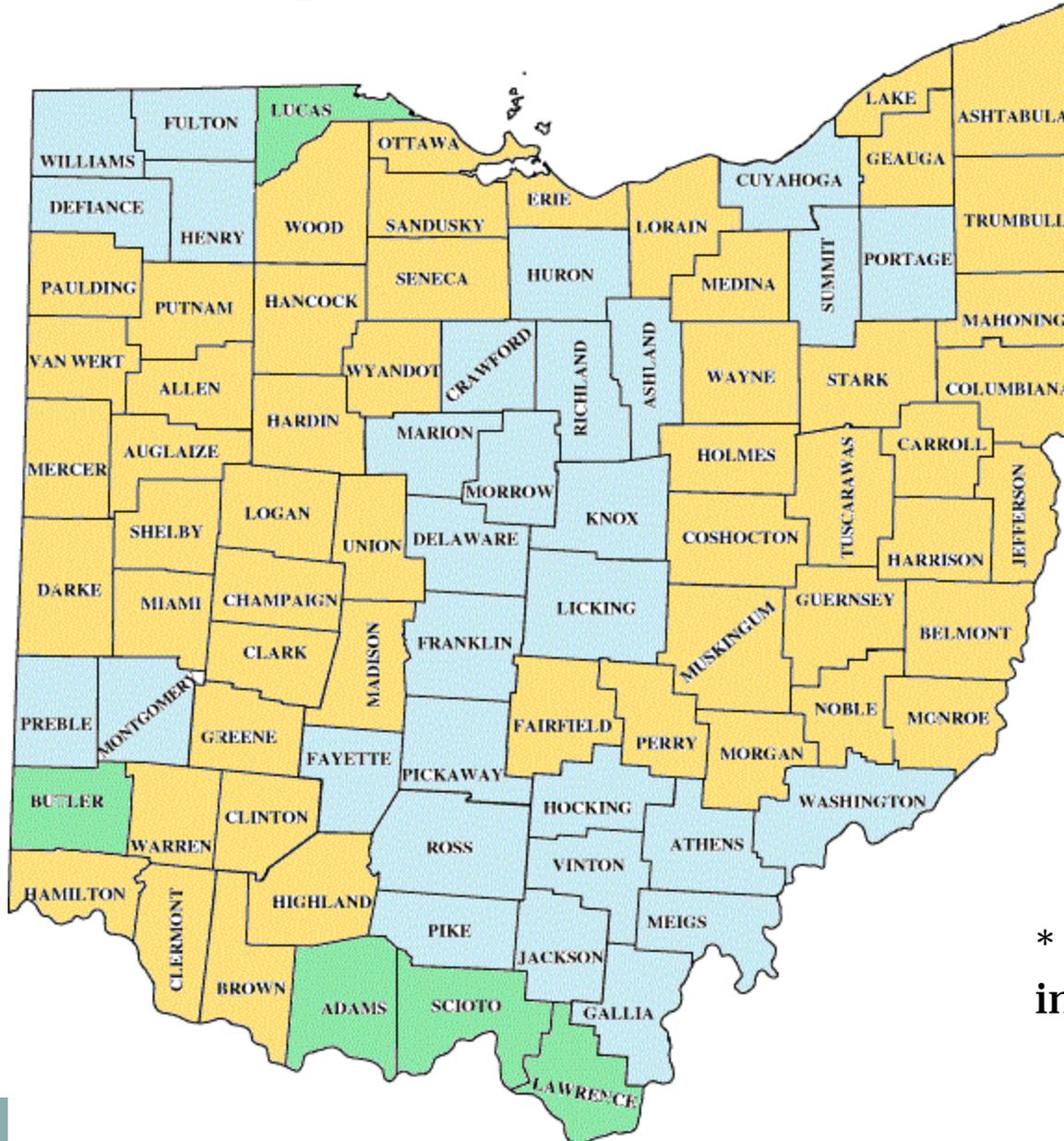
- Community Mental Health Agencies (CMHAs) that are certified to provide the Health Home service for individuals with SPMI and meet requirements as set forth in the SPA and OAC

Health Home Service Areas and Regional Implementation Schedule

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- Phase I will be implemented in October 2012 in the following counties: Butler, Adams, Scioto, Lawrence, and Lucas.
- Phase II is tentatively scheduled for implementation in April 2013 in the following counties: Fulton, Williams, Defiance, Henry, Cuyahoga, Summit, Portage, Huron, Crawford, Richland, Ashland, Marion, Morrow, Delaware, Knox, Franklin, Licking, Preble, Montgomery, Fayette, Pickaway, Hocking Ross, Vinton, Athens, Washington, Pike, Jackson, Gallia, and Meigs.
- Phase III is tentatively scheduled for implementation in July 2013 in the remaining Ohio counties.

Health Home for SPMI Implementation Schedule based on Letters of Intent*



Recommended Implementation Schedule

Green - October 2012

Blue - April 2013

Yellow - July 2013

* Non-binding letters of intent as submitted by CBHCs

OHIO MEDICAID HEALTH HOMES

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CLINICAL WORK & IMPLEMENTATION

TARGET POPULATION

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Target Population: Health Home Service Population Criteria

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- **Serious and Persistent Mental Illness (SPMI):**
 - Must be 18 years of age or older
 - Must meet criteria for any of the DSM-IV TR diagnoses, except the exclusionary diagnoses (DD, AOD, V Codes & Dementia)
 - Treatment history criteria
 - GAF Score of 50 or below

Target Population: Health Home Service Population Criteria

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- **Serious and Persistent Mental Illness (SPMI) *cont.***
 - **Treatment history criteria**
 - ✦ Continuous treatment of 12 months or more, or a combination of, the following treatment modalities: inpatient psychiatric treatment, partial hospitalization or 12 months continuous residence in a residential program (e.g., supervised residential treatment program, or supervised group home); or
 - ✦ Two or more admissions of any duration to inpatient psychiatric treatment, partial hospitalization or residential programming within the most recent 12 month period; or
 - ✦ A history of using two or more of the following services over the most recent 12 month period continuously or intermittently (this includes consideration of a person who might have received care in a correctional setting): psychotropic medication management, behavioral health counseling, CPST, crisis intervention.
 - ✦ Previous treatment in an outpatient service for at least 12 months, and a history of at least two mental health psychiatric hospitalizations; or
 - ✦ In the absence of treatment history, the duration of the mental disorder is expected to be present for at least 12 months.

Target Population: Health Home Service Population Criteria

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- **Serious Mental Illness (SMI) :**
 - Must be 18 years of age or older
 - Must meet any of the DSM-IV TR diagnoses, except the exclusionary diagnoses (DD, AOD, V Codes & Dementia)
 - Treatment history criteria
 - Assessment of impaired functioning measured by the Global Assessment of Functioning scale (GAF) (score of 40 to 60)

Target Population: Health Home Service Population Criteria

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- **Serious Mental Illness (SMI) *cont.***

- **Treatment history criteria**

- ✦ Continuous treatment of 6 months or more, or a combination of, the following treatment modalities: inpatient psychiatric treatment, partial hospitalization or six months continuous residence in a residential program (e.g., supervised residential treatment program, or supervised group home); or
- ✦ Two or more admissions of any duration to inpatient psychiatric treatment, partial hospitalization or residential programming within the most recent 12 month period; or
- ✦ A history of using two or more of the following services over the most recent 12 month period continuously or intermittently (this includes consideration of a person who received care in a correctional setting): psychotropic medication management, behavioral health counseling, CPST, crisis intervention; or
- ✦ Previous treatment in an outpatient service for at least six months, and a history of at least two mental health psychiatric hospitalizations; or
- ✦ In the absence of treatment history, the duration of the mental disorder is expected to be present for at least 6 months.

Target Population: Health Home Service Population Criteria

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- **Serious Emotional Disturbance (SED):**
 - Must be 17 years of age or younger
 - Must meet criteria for any of the DSM-IV TR diagnoses, except the exclusionary diagnoses (Developmental disorders, Substance use disorders, and V Codes)
 - Duration of the mental health disorder has persisted or is expected to be present for 6 months or longer
 - Assessment of impaired functioning as measured by the Global Assessment of Functioning scale (GAF Score of below 60)

Target Population: Health Home Service Requirements

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- **Health Home Service Providers are required to:**
 - Ensure capacity to serve all eligible consumers within the **designated service area**
 - Provide health home service to **ONLY** eligible consumers
 - Use the criteria for serious and persistent mental illness (SPMI), serious mental illness (SMI) and serious emotional disturbance (SED) as described in the rule when identifying eligible consumers
 - Determine the eligibility of consumers for the health home service

Target Population: Methodology for Identifying Eligible Consumers

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- ODMH does not prescribe a specific format or methodology
- Health home providers are not required to show proof or documentation of the methodology used for determining consumer's eligibility
- Health Home providers may use a combination of approaches when identifying eligible consumers such as:
 - ✦ EHR based identification
 - ✦ Medical Record Review by Group or Individual Staff
 - ✦ Standardized Form

Target Population: Designated Service Area

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- **Health home provider's designated service area includes:**
 - Service locations within approved regions (Counties) per the State Plan Amendment; AND
 - Consumers currently receiving services at the approved service locations; and
 - New or returning consumers referred to health home.
- **Consumer's county of residence is not relevant to receiving health home service**

Target Population: Managing Referrals to Health Home Service

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- **Referral Sources for Health Home Service will include:**
 - Hospital Emergency Departments (mandatory referral source)
 - Hospital Inpatient Psychiatric Units
 - Managed Care Plans
 - Mental health treatment providers
 - Specialty providers
 - County children services
 - Self-referrals
 - Other community providers
- **Health Home Provider should:**
 - Inform potential referral sources about referral process and capacity
 - Train intake staff regarding health home service referrals
 - Respond and accept referrals in a timely manner
 - Track number and type of referrals, and wait time
 - Follow up with the referral sources on the outcome of the referrals and
 - Provide an explanation of the reasons for denial of the health home service as appropriate

Health Home Consumers

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Health Home Consumers: Communication

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- **Health Home providers should have a health home consumer communication plan that includes:**
 - Seamless transition of consumers to health home service including continuity of providers
 - Engagement and outreach strategies such as letters, phone outreach, home visits and in-office appointments
 - Training of agency staff on the communication plan including front desk receptionists, current case managers, and other health home team staff (e.g. standard health home script)
 - Other venues of communication and information as needed

Health Home Consumers: Orientation

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- **The health home provider must provide the health home member and/or guardian with an orientation that is appropriate for the health home member's needs and includes the following:**
 - An overview of health home service
 - The general nature and goals of health home service
 - An explanation of the consumer's right to decline services
 - Information about the hours during which the services are available and how the consumer, family and caregivers may participate in the delivery of health home service
- **Health home provider must demonstrate orientation of consumers to health home service**

Health Home Consumers: Informed Consent

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- ODMH OAC - 5122-27-04 Consent for treatment still applies, and requires agencies to have in place policies and procedures for obtaining written informed consent for treatment.
- Health Home provider must have documentation of informed consent.
- It is recommended that the informed consent for the health home service include:
 - The diagnosis and the other eligibility criteria
 - The nature and purpose of the health home service
 - The risks and benefits of the health home service
 - Alternatives to the health home service
 - The risks and benefits of not receiving the health home service

Health Home Consumers: Exchange of Treatment Information and Medical Records

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- **Health home provider should:**
 - Comply with current statutes and rules when exchanging treatment information;
 - Update and revise, in accordance with the applicable statutes and rules, the following as needed:
 - ✦ Consent for Treatment
 - ✦ HIPAA and Patient Privacy Notice
 - ✦ Authorization for Release of Information
 - Inform consumers about any changes in agency's practices
- **ODMH OAC - 5122-27-08 Release of information, by reference, applies the information disclosure provisions of ORC 5122.31 to certified agency services.**

HEALTH HOME SERVICE

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Health Home Service Components

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Health home service providers are required to have the capacity to provide all components of the health home service as described in the health home service rule.

Health Home Service Delivery Format

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- **Health home service may be:**
 - Provided to the consumer and any other individuals who will assist in the consumer's treatment;
 - Delivered face-to-face, by telephone, and/or by video;
 - Delivered in individual, family and group format;
 - Performed in locations and settings that meet the needs of the health home consumer.

Health Home Service Components: Comprehensive Care Management

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- Identification of consumers who are SPMI and potentially eligible for health home services;
- Recruit and engage consumers through discussing the benefits and responsibilities of participating and any incentives for active participation and improved health outcomes;
- Conduct comprehensive health assessment; form a team of health care professionals to deliver health home services based on the consumer's needs; establish and negotiate roles and responsibilities, including the accountable point of contact;
- Develop, review and update the care plan
- Develop Crisis and Contingency Plan
- Develop Communication Plan

Health Home Service Components: Comprehensive Care Management Highlights

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- **Comprehensive Assessment should include;**
 - Medical, behavioral, long-term care and social service needs
 - Reassessment of the consumer and review of the existing assessment at least every 90 days
 - Updates as neededODMH Mental Health Assessment service standards still apply.
- **Single Integrated Care Plan should:**
 - Be based on the results of the comprehensive assessment
 - Include consumer and family participation
 - Reviewed at least every 90 days
 - Updated as neededODMH Individualized treatment plan standards still apply.
- **Crisis and Contingency Plan should:**
 - Be developed for select consumers who are at risk of hospitalization or decompensating
- **Communication Plan should:**
 - Be developed for all consumers
 - Include and be shared with family, significant others, other service and treatment providers

Health Home Service Components: Care Coordination

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- Implementation of individualized treatment plan;
- Assist consumer in obtaining health care, including mental health, substance abuse services and developmental disabilities services, ancillary services and supports;
- Medication management, including medication reconciliation;
- Track tests and referrals and follow-up as necessary;
- Coordinate, facilitate and collaborate with consumer, family, team of health care professionals, providers;
- Monitor care plan and the individual's status in relation to his or her care plan goals;
- Provide clinical summaries and consumer information along with routine reports of treatment plan compliance to the team of health care professionals, including consumer/family.

Health Home Service Components: Care Coordination Highlights

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- **Health home service provider should share with other providers and implement the following:**
 - Integrated Care Plan
 - Communication Plan
 - Crisis and Contingency Plan
 - Monthly clinical summary reports

Health Home Service Components: Health Promotion

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- **Health Promotion**

- Provide education to the consumer and his or her family /guardian/significant other that is specific to his/her needs as identified in the assessment;
- Assist the consumer to acquire symptom self-monitoring and management skills so that the consumer learns to identify and minimize the negative effects of the chronic illness that interests with his/her daily functioning;
- Provide or connect the consumer with the services that promote healthy lifestyle and wellness and are evidence based;
- Actively engage the consumer in developing and monitoring the care plan;
- Connect consumer with peer supports including self-help/self-management and advocacy groups;
- Develop consumer specific self-management plan anticipating possible occurrence or re-occurrences of situations required an unscheduled visit to health home or emergency assistance in a crisis;
- Population management through use of clinical and consumer data to remind consumers about services need for preventive/chronic care;
- Promote health behavioral and good lifestyle choices;
- Educate consumer about accessing care in appropriate settings.

Health Home Service Components: Health Promotion Highlights

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- **Chronic disease self-management**
- **Tobacco cessation**
- **Weight management**
- **Nutritional counseling**
- **Exercise and fitness**
- **Preventive services and screenings**

Health Home Service Components: Comprehensive Transitional Care and Follow-up

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- Facilitate and manage care transitions (inpatient to inpatient, residential, community settings, pediatric to adult) to prevent unnecessary inpatient admissions, inappropriate emergency department use and other adverse outcomes such as homelessness;
- Develop a comprehensive discharge and/or transition plan with short-term and long-term follow-up;
- Conduct or facilitate clinical hand-offs as face-to-face interactions between providers to exchange information and ask questions;

Health Home Service Components: Comprehensive Transitional Care and Follow-up Highlights

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- **Discharge/Transition Planning**
- **Warm Clinical Hand-off**
- **Medication Reconciliation**
- **Timely Transmission of Discharge Record**
- **Timely follow-up by a mental health treatment provider after hospital discharge**

Health Home Service Components: Individual and Family Support

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- Provide expanded access and availability;
- Provide continuity in relationships between consumer/family with physician and care manager;
- Outreach to the consumer and their family and perform advocacy on their behalf to identify and obtain needed resources such as medical transportation and other benefits to which they may be eligible;
- Educate the consumer in self-management of their chronic condition;
- Provide opportunities for the family to participate in assessment and care plan development;
- Ensure that health home services are delivered in a manner that is culturally and linguistically appropriate;
- Referral to community supports; assist with “natural supports;”
- Promote personal independence; empower consumer to improve their own environment;
- Include the consumer family in the quality improvement process including surveys to capture experience with health home services; use of a patient/family advisory council at the health home site;
- Allow consumers/families access to electronic health record information or other clinical information.

Health Home Service Components: Individual and Family Support Highlights

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- **Seamless Transition to health home service**
- **Continuity of providers**
- **Orientation of Consumer and Family to health home service**
- **Expanded Access**
- **Culturally and Linguistically appropriate services**
- **Consumer/family participation in quality improvement process**
- **Access to peer support**

Health Home Service Components: Referral to Community & Social Support Services

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- Provide referrals to community/social/recovery support services;
- Assist consumers in making appointments and validating that the consumer attended the appointment and the outcome of the visit and any needed follow-up.

HEALTH HOME TEAM COMPOSITION

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Health Home Team Composition

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A health home provider shall utilize an integrated, multidisciplinary team to deliver health home service. Licensed, certified or registered individuals shall comply with current, applicable scope of practice and supervisory requirements identified by appropriate licensing, certifying or registering bodies.

Health Home Team Composition

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● Health Home Team Leader

○ Minimum qualifications:

- Licensed independent social worker, professional clinical counselor, independent marriage and family therapist, registered nurse with a master of science in nursing, certified nurse practitioner, clinical nurse specialist, psychologist or physician.

○ Supervisory, clinical and administrative leadership experience.

○ Health management experience, and competence in practice management, data management, managed care and quality improvement.

○ Responsibilities:

- Provide administrative and clinical leadership and oversight to the health home team, and monitor provision of health home service.
- Monitor and facilitate 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 service, consumer status and response to health coordination and prevention activities, and development, tracking and dissemination of outcomes.

Health Home Team Composition

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- **Embedded Primary Care Clinician**

- **Qualifications:**

- Primary care physician, internist, family practice physician, pediatrician, gynecologist, obstetrician, certified nurse practitioner with primary care scope of practice, clinical nurse specialist with primary care scope of practice, or physician assistant.

- **Responsibilities:**

- Provide health home service including identification of consumers, assessment of service needs, development of care plan and treatment guidelines, and monitor health status and service use.
- 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 a liaison between, the treating primary care provider and the team.
- Meet individually as needed with care managers to review challenging and complex cases.
- It is preferred, but not required, that the embedded primary care clinician also functions as the treating primary care clinician and thus may hold dual roles on the health home team.

Health Home Team Composition

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- **Care Manager**

- **Minimum qualifications:**

- Licensed social worker, independent social worker, professional counselor, professional clinical counselor, marriage and family therapist, independent marriage and family therapist, registered nurse, certified nurse practitioner, clinical nurse specialist, psychologist or physician.
- Possess core and specialty competencies and skills in working with persons with SPMI, including assessment and treatment planning.
- Demonstrate either formal training or a strong knowledge base in chronic physical health issues and physical health needs of persons with SPMI and be able to function as a member of an inter-disciplinary team.
- Knowledge of community resources and social support services for persons with SPMI.

- **Responsibilities:**

- Accountable for overall care management and care coordination, and both provide and coordinate all of the health home service.
- Responsible for overall management and coordination of the consumer's care plan, including physical health, behavioral health, and social service needs and goals.
- Conduct comprehensive assessments and develop care plans.
- Conduct case reviews on a regular basis.

Health Home Team Composition

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- **Qualified Health Home Specialist**
 - **Minimum qualifications:**
 - ✦ Pharmacist, licensed practical nurse; qualified mental health specialist with a four-year degree, two-year associate degree or commensurate experience; wellness coach; peer support specialist; certified tobacco treatment specialist, health educator or other qualified individual (e.g., community health worker with associate degree).
 - **Responsibilities:**
 - ✦ Assist with care coordination, referral/linkage, follow-up, consumer, family, guardian and/or significant others support and health promotion services.

Health Home Service Documents

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Comprehensive Health Assessment

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Comprehensive Health Assessment should include;

- Medical, behavioral, long-term care and social service needs
- Reassessment of the consumer and review of the existing assessment at least every 90 days
- Updates as needed
- **ODMH (OAC 5122-29-04) Mental health assessment service standards still apply**
- **ODMH does not prescribe a specific format or template**

Single Integrated Care Plan

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- **Single Integrated Care Plan should:**
 - Be based on the results of the comprehensive assessment
 - Include clinical and non-clinical service needs
 - Include consumer and family participation
 - Be reviewed at least every 90 days
 - Be updated as needed
 - Be signed by all treatment providers
 - Include health home service components
 - Be shared with all providers
- **ODMH (OAC 5122-27-05) Individualized service plan still applies**
- **ODMH does not prescribe a specific format or template**

Progress Note

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- **Progress Note should:**
 - Be based on medical necessity
 - Support the monthly health home service claim
 - Include health home services provided by the team
- **ODMH (OAC 5122-27-06) Progress Note Rule still applies**
- **ODMH does not prescribe a specific format or frequency of progress note documentation**

Health Home and Medicaid Managed Care Plan (MCP) requirements

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AMERIGROUP
BUCKEYE COMMUNITY HEALTH PLAN
CARESOURCE
MOLINA HEALTHCARE
PARAMOUNT
UNITED HEALTHCARE
WELLCARE

How will HH know which clients are in an MCP?

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- **MCP card**
- **ODJFS portal**
- **Patient Utilization Profile – demographic portion**

Managed Care Plan & Health Home Requirements

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- Health Home services will be available to individuals with SPMI who are enrolled in a managed care plan (MCP).
- MCPs will play a critical role in supporting the CMHC Health Home to ensure all of its members receiving Health Home services have their needs met.
 - Expectations outlined in the contract between ODJFS and the MCPs
 - Effective July 1, 2012

Managed Care Plan & Health Home Requirements

Establishing the Partnership

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- **MCPs and Health Homes are expected to establish relationships and partnerships with one another**
 - Accomplished before the Health Home provides services to consumers who enrolled in an MCP
- **Both MCPs and Health Homes must develop written policies and procedures that delineate the responsibilities of the CMHA Health Home and the MCP in providing the Health Home services and supports, respectively, in order to avoid duplication or gaps in services**

Managed Care Plan & Health Home Requirements

Consumer Enrollment in Health Homes

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- **Within 5 business days of being notified that a member is receiving Health Home services, the MCP must contact the CMHC Health Home to:**
 - Confirm the start date for Health Home services
 - Identify the member's primary care provider, as selected by the member or that the MCP and CMHC Health Home agree is the best option to deliver primary care for the member
 - ✦ If the primary care provider is not currently contracted with the MCP, the MCP must use its best efforts to contract with the primary care provider in order to promote continuity of care
 - Identify a single point of contact
 - Identify the data/information that will be transferred from the MCP to the CMHC Health Home
 - Collaboratively develop a transition plan for members.
 - ✦ The transition period must be concluded within thirty (30) days of the MCP being informed that a member is receiving Health Home services in order to prevent unnecessary duplication of, or gaps in, services

Managed Care Plan & Health Home Requirements

Single Point of Contact

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HH and MCPs must identify a single point of contact to work with each other on activities such as the following:

- Collaboration on comprehensive assessment and care plan development
- Participation in health home team meetings
- Facilitation of information and data exchange
- Assisting the consumer with access to services that may be outside of the scope of the health home provider

Managed Care Plan & Health Home Requirements

CMHC Health Home Care Management Team

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- Health Home will form a care management team to effectively manage the consumer's needs that includes the health home provider team, the health home consumer and his/her family/supports and primary care provider, a representative from the consumer's MCP, and other providers, as appropriate
 - Notify the MCP's single of point of contact about scheduled team meetings.
- MCP will participate on the CMHC Health Home's Care Management Team to collaborate on the development of the assessment and the care plan, facilitate data exchange with the CMHC Health Home, etc.

Managed Care Plan & Health Home Requirements

Care Plan Implementation

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- Work collaboratively with the MCP to ensure all of the consumer's needs identified in the health home integrated care plan are met
- Request Health Home and/or care coordination supports from the MCP. In collaboration with the HH, the MCP may provide the following supports:
 - Assistance with arranging transportation, scheduling appointments, facilitating transitions of care, providing education to the member, lending plan staff to serve as clinical consultants/resources to the core CMHC Health Home team, etc.
- Ensure that the integrated care plan is accessible to the MCP and providers involved in managing the consumer's health care

Managed Care Plan & Health Home Requirements

Information Exchange

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- **MCPs are expected to transmit data, information, and reports to the HH:**
 - Minimum set of reports and data that should be sent by the MCP to the HH
 - ✦ Care management documentation (e.g., recent assessment, care plan, progress notes)
 - ✦ Approved prior authorizations for future services
 - ✦ Same day notification of admissions and discharges from an IP facility or ED visit
 - ✦ Clinical patient summaries
 - ✦ Summaries of HH clients' contacts with the MCPs (e.g., Nurse advice line, member services, etc)
 - ✦ Enrollment of the client in the MCP's Coordinated Services Program
 - ✦ Grievances or consumer complaints related to the CMHC Health Home
 - First transmission of data should be within 30 calendar days of an MCP receiving notice of the HH start date.
 - Ongoing - routine data exchange schedule and identification of other information/reports that may be meaningful to the Health Home
- **HH should have the capacity to send electronic data to MCPs and to produce ad hoc reports to more effectively coordinate care**

Managed Care Plan & Health Home Requirements

Comprehensive Transitional Care

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- **Health home will:**
 - Provide timely notification of all inpatient facility discharges and residential setting transitions to the MCP
 - Ensure that a discharge or transition plan is in place prior to the consumer discharge or transition
 - Work with the MCP to ensure that post discharge services are prior authorized, if appropriate, and provided by the plan's contracted providers
 - Integrate the discharge/transition plan into the care plan and communicated to the care management team
- The MCP will participate in comprehensive transitional care activities with the HH which may include discharge planning, primary care provider follow up, medication reconciliation, and timely provision of post discharge services (e.g., durable medical equipment)

Managed Care Plan & Health Home Requirements

Partnering Providers

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- MCPs should inform the HH of contracted primary care providers, inpatient facilities, and specialists who may provide services to the HH clients
- HH should refer to the plan's panel of providers when assisting the consumer with obtaining necessary health care services.
- HH should provide a list and periodic updates of primary care providers, specialists, inpatient facilities, and other providers, as appropriate, to the MCP, for which the health home provider has established relationships
- MCPs should educate the HH about provider credentialing requirements in the event any of its partnering providers are interested in contracting with the MCP

Managed Care Plan & Health Home Requirements

Primary Care Providers

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- Partnering primary care providers may be co-located with the CBHC Health Home, directly owned by the CBHC Health Home, or in a referral and coordination relationship with the CBHC Health Home
- If the health home provider has direct ownership of or membership in a primary care provider, or practice, it seeks a contract with the MCPs in the service area for the provision of primary care services.
- If the health home provider has a co-located relationship or a referral, or coordination, relationship with a primary care provider for the provision of primary care services, the health home provider shall encourage the provider to seek a contract with the MCPs in the service area
- The MCP must then use its best efforts to contract with CMHC Health Home partnering primary care providers who may not currently be a part of the plan's panel of providers

Managed Care Plan & Health Home Requirements

Primary Care Provider Selection

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- Collaborate with the MCP to ensure that the consumer's selected, or assigned, primary care provider is informed the member is enrolled with a health home service provider and provided with information as required
- If the consumer requests a change to the selected primary care provider, the health home provider shall inform the MCP so that the plan's existing process to change the primary care provider is promptly initiated.

Managed Care Plan & Health Home Requirements

On-going Collaboration

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- **On a routine basis, the MCP must:**
 - Perform ongoing identification of members who have a diagnosis of SPMI and who could benefit from receiving Health Home services
 - Contact and educate members about the benefits of Health Home services, assist the members in selecting a CMHC Health Home, and then facilitate the referral of the members to the selected CMHC Health Home
 - Establish and maintain a mechanism to track the plan's members who are receiving Health Home services
 - Integrate all information/data transmitted by the CMHC or ODJFS related to a member receiving Health Home services into any appropriate system or database that is maintained by the MCP, including member assessments, care management notes, discharge plans, care plans, etc;
 - Integrate the results from the Health Homes' metrics into the plan's overall quality improvement program
 - Participate in the Medicaid Health Homes Learning Community which will consist of the CMHC Health Homes, the Ohio Department of Mental Health, the MCPs and ODJFS

Coordinated Services Program (CSP)

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(ALSO KNOWN AS “LOCK IN”)



Coordinated Services Program (CSP)

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- Program that requires a Medicaid consumer to obtain certain services from a designated pharmacy/provider.
- Consumers may be proposed for enrollment if utilization demonstrates a pattern of receiving services in an amount or frequency that exceeds medical necessity.
- Consumers identified through administrative claims data, referrals, etc.
- Enrollment started in Spring 2012 – currently operational only with Medicaid managed care plans (MCPs).
- Consumers notified of the following by their MCPs:
 - Proposed enrollment;
 - Explanation of Coordinated Services Program;
 - Request to choose designated pharmacy and confirm primary care provider (PCP) within 30 days of receiving notice; and
 - State hearing rights.

Coordinated Services Program – cont.

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- **Initial enrollment is 18 months.**
 - Enrollment may be extended for additional 18 months if utilization continues to demonstrate concerning patterns.
- **Once enrolled in the CSP, consumers will:**
 - Still be eligible for all medically necessary services covered by Ohio.
 - Except in an emergency – receive all pharmacy services from the designated pharmacy listed on their member identification card.
 - Have ability to request a change to designated pharmacy and primary care provider.
 - ✦ State hearing rights applicable if MCP denies request to change designated pharmacy.
 - Receive care management from the managed care plan.
- **Total enrollment as of August 2012 is 78 MCP consumers.**
- **Refer to OAC 5101: 3-20-01 for more information.**

Coordinated Services Program: Implications for CMHC Health Home

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- **Understanding of the Coordinated Services Program.**
- **Receive CSP enrollment information from the MCPs for consumers receiving Health Home services.**
- **Familiar with CSP consumer's designated pharmacy and assigned primary care provider.**
- **Care management requirement will be fulfilled by the CMCH Health Home.**

Health Home and Hospitals

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Hospital ED – HH SPA Assurance

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- The State assures that hospitals participating in the Medicaid program will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital ED to HH
- All providers, including hospitals, will have access to the client's HH information to facilitate timely communication and coordination
- HH are accountable to work with hospitals in their service area and incorporate referral mechanisms to help reduce inappropriate ED and inpatient utilization

Hospitals & HH Referrals

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Hospitals and EDs will refer potentially eligible clients to HHs within their service area

- HH are expected to develop internal policies and procedures and share information with hospitals to coordinate new client referrals
- HH expected to provide expanded timely access to HH services including acceptance of referrals
 - State is not mandating a HH response time
- HH will assess and determine eligibility for each referral
 - If client is NOT SPMI then HH is encouraged to work with ED to find appropriate care setting

Hospital ED - Follow Up Appointments

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If a patient is stabilized in the ED but needs a follow up appointment, how is the health home accountable for assuring appointment takes place in a timely manner?

- *HH are expected to provide or arrange timely, comprehensive, and quality services including medication assistance through integration of primary care, network of diverse providers and collaboration with Managed Care Plans.*

Hospital & HH Transition from Inpatient

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What is the obligation (including timeliness) of HH to transition patients from inpatient settings?

- HH will receive notifications of inpatient FFS psychiatric admissions in order to coordinate care and begin the transition process as soon as possible.
- Transition to an outpatient setting is a shared responsibility between the HH and hospital
 - *warm handoff*
- HH are required to provide or arrange for 24/7 crisis support in case of a crisis or emergency

Hospital Training Opportunities

71

- 1. September 21 Webinar for OHA members and ODMH hospitals to highlight Ohio's health home model, share information about the state's implementation planning efforts, and facilitate provider and local system readiness**
- 2. MHTL - ODJFS formal communication mechanism to communicate program information, rules changes, etc. with providers and ultimately published as part of the Medicaid Provider Handbook (eManuals) on JFS' website**

Health Home and Other Programs/Providers

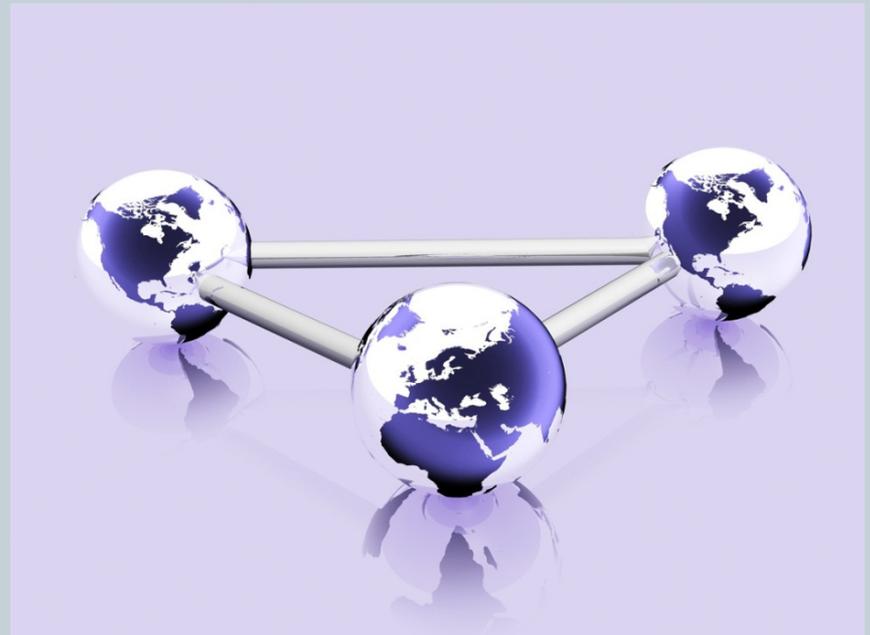
72



How does a health home interface with other services and/or programs?

73

- ICDS
- DODD
Targeted Case Management
- Treatment Foster Care
- ACT/IHBT
- Peer Support



How do health homes interface with ICDS* for the Medicare & Medicaid Dual-Eligible Population?

74

- **Payment for all services, including the Health Home, will be through the ICDS**
- **Payment by the ICDS will be at the established fee-for-service rate**
- **Consumers may receive care coordination through Health Homes for the life of the ICDS demonstration**
- **Contract and other ICDS requirements and/or details are currently being developed**

* Integrated Care Delivery System

How do health home services interface with DODD targeted case management (TCM)?

75

- A developmental disability diagnosis without the presence of a SPMI diagnosis does not qualify a person for health home service
- Targeted case manager authorizes DODD waiver services
- Recommendation is that CBHC health home providers continue to work with DODD TCM providers to assure a client does not lose their TCM and therefore waiver services
- Goal is to assure continuity of care and that the client's needs are met

Health Home Service & AoD TCM

76

- In the short term, AoD Targeted Case Management (H0006) will not be denied among Health Home participants provided the TCM services do not duplicate what is being reimbursed as a Health Home service
- The provision of AoD TCM among Health Home participants will be monitored by the state
- Future policy decisions will be informed by this monitoring

Can children in foster care participate in a health home?

77

- **Children in foster care can receive health home service if they meet the SED criteria and the client/parent/guardian chooses enrollment in the Health Home**
- **ODMH encourages therapeutic foster care providers to assess whether they could potentially meet health home provider requirements**

HH and Other Providers

78

- Other partners include but are not limited to: specialty care providers, long term care providers, community care providers, pharmacists, consumer operated service centers
- HH should develop an outreach plan
- HH should work with the existing MCP network of providers
- Share integrated care plan or other medical records/test results as appropriate
- Include in team meeting as necessary

HH and Future Medicaid Services

79

- **Assertive Community Treatment**
- **Intensive Home Based Treatment**
- **Peer Support**

- **HH should include clients that would benefit from HH since the above services are not yet reimbursed by Medicaid**

- **Policies, benefits and reimbursement related to these new services will be coordinated with that of the HH design.**

Health Home and CPST

80



HH and CPST

81

- **HH should work within their own organization and across other CMHAs to assure appropriate transition from CPST that is consistent with client choice**
- **Transition between HH and CPST should occur in a coordinated manner**

HH and CPST – Spend Down

82

- A client participating in a HH and on spend down CAN receive CPST services that will count towards meeting their spend down
- HH service may be reimbursed once Medicaid eligibility occurs for the month

Can a client receive CPST from another provider while receiving health home services?

83

- **All CPST activities are now incorporated in the health home service**
- **If a client is enrolled in a health home, activities formerly provided under CPST are included in the health home and are no longer separately reimbursable for that client**
 - In rare instances, when a client chooses to not participate in health homes, they can continue to receive CPST services

HH and CPST

84

- **CPST can continue to be provided to:**
 - Clients who do not meet SPMI criteria
 - ✦ Use Modifier U1 with H0036 when billing CPST
 - Clients with SPMI who choose to not participate in the health home
 - ✦ Use Modifier U2 with H0036 when billing CPST
- **State will track and monitor the use of CPST in these circumstances**
- **Current CPST limits will remain in place**

MITs Edits for HH - *S0281* and CPST - *H0036*

85

Scenario 1:

CMHC that previously provided CPST is also the current Health Home

- S0281 and CPST cannot be provided to a client who has been assigned to that HH in the same month except when
 - CPST (H0036) is rendered by the client's health home any day during the first calendar month of the provider's enrollment as a health home, up until the date the recipient is enrolled in the health home.
- CPST (H0036) will be denied as of the day the client is enrolled in the HH assignment plan

Scenario 2: The CPST provider is not the Health Home & the consumer is transitioning from the CPST provider to the Health Home

- The original CPST provider may bill for CPST until the date the recipient is enrolled in the health home.
- HH can bill for the month as of the date the client is enrolled in the HH.
- Once the client is enrolled in the HH, the CPST provider can no longer bill CPST.
- The transition between providers will need to be coordinated by both parties

Scenario 3: Health Home provider is different from the CPST provider & the consumer is transitioning from the Health Home to the CPST provider

- The new CPST provider cannot bill until the consumer has been dis-enrolled by the HH (*i.e. no longer assigned to HH*).
- CPST claims will deny for dates of service prior to the HH dis-enrollment date
- The transition between providers will need to be coordinated by both parties

Scenario 4: Health Home provider is also CPST provider & the consumer is transitioning from the Health Home Service back to receiving CPST

- CPST cannot be billed until the consumer dis-enrolls from HH (*i.e. no longer assigned to HH*).
- CPST claims will deny for dates of service prior to the HH dis-enrollment date.
- Transition should occur within provider

Scenario 5: Consumer changes Health Homes during the month

- Two health home claims will not be paid for the same month.
- The transition between providers will need to be coordinated by the Health Homes.

Security and Privacy

90



5122.31

91

OHIO'S STATUTE GOVERNING
EXCHANGE OF PSYCHIATRIC
TREATMENT INFORMATION IN
THE PUBLICLY FUNDED
MENTAL HEALTH SYSTEM

Exchange of Psychiatric Treatment Information

92

Statute Changes included in HB1, *HB153* and the Mid-biennium Review:

1. ORC 5122.31 (A) (7): "That hospitals within the department, other institutions and facilities within the department, *hospitals licensed by the department under section 5119.20 of the Revised Code*, and community mental health agencies may exchange psychiatric records and other pertinent information with *payors and* other providers of treatment and health services if the purpose of the exchange is to facilitate continuity of care for a patient"

Exchange of Psychiatric Treatment Information

2. ORC 5122.31(B): “Before records are disclosed pursuant to divisions (A) (3), (6), ~~(7)*~~, and (9) of this section, the custodian of the records shall attempt to obtain the patient’s consent for the disclosure. No person shall reveal the contents of a medical record of a patient except as authorized by law.”

**(7) was removed in the MBR*

Purpose of Statute Change

94

The law change was enacted in the Biennial Budget, House Bill 1, in order to accomplish the following objectives:

- improve quality and expedite continuity of care for Ohio's recipients of mental health services
- bring mental health information exchange requirements in Ohio more in line with HIPAA regulations and other health information exchange standards
- decrease unnecessary administrative burden for Ohio's community mental health providers who are struggling to survive in the current financial crisis
- better position ODMH and the mental health system to integrate with electronic medical record and electronic health record exchange policy

Statute Applicability

95

- This change means that, unless a consumer requests restrictions, exchanges of mental health information by agencies and hospitals in the publicly funded mental health system with *payors and* other treatment and health services providers for continuity of care purposes will no longer require a separate authorization for release of information.
- The changes enacted in HB 153 were adopted to include licensed private psychiatric hospitals in the list of entities authorized to exchange records for purposes of continuity of care, and to add payers to the list of entities with which records may be exchanged for purposes of continuity of care. These changes were intended to correct unintentional omissions from the original amendment.

Statute Applicability

96

- The change enacted in the MBR was adopted to eliminate the requirement that an entity exchanging records for purposes of continuity of care attempt to obtain the patient's consent for each exchange. This additional consent solicitation requirement was duplicative in light of the general consent for treatment and the notice of privacy practices, and contrary to the purpose and intent of the larger statutory change.

Other Sharing of Information

97

- **The amendments to ORC 5122.31 support the HH sharing of psychiatric and other pertinent information with providers of treatment and health services**
- **HH will need independent authority to share information with other types of entities, such as housing providers, or to share other types of information, such as records or information pertaining to the identity, diagnosis or treatment of any individual that are maintained by a federally assisted drug or alcohol abuse treatment program**

ODJFS and Health Home Business Associate & Data Sharing Agreement (BAA)

98

- In order for Ohio Medicaid to share MITS claims history with HHs, HHs must enter into a Business Associate Agreement/Data Sharing Agreement with Ohio Medicaid
- This will assure proper authority and protections are in place to exchange PHI
- BAA is available on the ODMH health home website
- ODJFS will produce and send specific contract language and facilitate the contract signature process

BUSINESS ASSOCIATE REQUIREMENTS UNDER HIPAA

99

Definitions. The definitions contained in this Section are derived from federal law. Should there be any conflict between the meanings assigned in this Contract and the meanings defined in applicable federal law (even in the event of future amendments to law that create such conflict), the definitions found in federal law shall prevail.

1. HIPAA means the Health Insurance Portability and Accountability Act of 1996, The American Recovery and Reinvestment Act of 2009 (ARRA) and any other related federal statutes and regulations
2. DEPARTMENT means that part of the Ohio Department of Job and Family Services that is considered a Covered Entity pursuant to HIPAA.
3. Covered Entity means a health plan, a health care clearinghouse, or health care provider. (45 C.F.R. 160.103)
4. Business Associate means a person or entity that, on behalf of the Covered Entity, performs or assists in the performance of a function or activity that involves the use or disclosure of Protected Health Information. (45 C.F.R. 160.103)
5. Protected Health Information (hereinafter PHI) means information received from or on behalf of a Covered Entity that meets the definition of PHI as defined by HIPAA, ARRA, and the regulations promulgated by the United States Department of Health and Human Services, specifically 45 C.F.R. 164.501 and any amendments thereto. (45 C.F.R. 164.501)

BAA, cont.

100

CONTRACTOR acknowledges that the DEPARTMENT through its relationship to the Office of Ohio Health Plans, Ohio Department of Job and Family Services, is a Business Associate of the Covered Entity under HIPAA. CONTRACTOR further acknowledges that CONTRACTOR is a Business Associate of the DEPARTMENT, and, in carrying out the work described in this Contract, the CONTRACTOR agrees to comply with all of the following provisions:

1. Permitted Uses and Disclosures. The CONTRACTOR shall not use or disclose PHI except as provided in this Contract or as otherwise permitted under HIPAA regulations, ARRA or other applicable law.
2. Safeguards. The CONTRACTOR shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI that it creates, receives, maintains, or transmits on behalf of the DEPARTMENT.
3. Reporting of Disclosures. The CONTRACTOR shall promptly report to the DEPARTMENT any knowledge of uses or disclosures of PHI that are not in accordance with this Contract or applicable law. In addition, in as timely a manner as practicable, the CONTRACTOR shall mitigate any adverse effects of such a breach of confidentiality to the greatest extent possible.

BAA, cont.

101

4. Agents and Subcontractors. CONTRACTOR shall ensure that all its agents and subcontractors that receive PHI from or on behalf of the CONTRACTOR and/or the DEPARTMENT agree to the same restrictions and conditions that apply to CONTRACTOR with respect to the use or disclosure of PHI.

5. Accessibility of Information. The CONTRACTOR shall make available to the DEPARTMENT such information as the DEPARTMENT may require to fulfill its obligations to provide access to, provide a copy of, and account for disclosures with respect to PHI pursuant to HIPAA, ARRA, and any other applicable regulations promulgated by the United States Department of Health and Human Services, including, but not limited to, 45 C.F.R. 164.524 and 164.528 and any amendments thereto.

6. Amendment of Information. The CONTRACTOR shall make PHI available to the DEPARTMENT so that the DEPARTMENT may fulfill its obligations pursuant to HIPAA to amend the information. As directed by the DEPARTMENT, CONTRACTOR shall also incorporate any amendments into the information held by the CONTRACTOR and shall ensure incorporation of any such amendments into information held by CONTRACTOR agents or subcontractors.

BAA, cont.

102

7. **Disclosure.** The CONTRACTOR shall make available to the DEPARTMENT and to the Secretary of the U.S. Department of Health and Human Services any and all internal practices, documentation, books, and records related to the use and disclosure of PHI received from the DEPARTMENT, or created or received by the CONTRACTOR on behalf of DEPARTMENT. Such access is for the purpose of determining the DEPARTMENT compliance with HIPAA, regulations promulgated by the United States Department of Health and Human Services, and any amendment thereto.

8. **Material Breach.** In the event of material breach of CONTRACTOR obligations under this ARTICLE, the DEPARTMENT may immediately terminate this Contract as set forth in ARTICLE V, Section B. Termination of this Contract shall not affect any provision of this Contract which, by its wording or its nature, is intended to remain effective and to continue to operate after termination. Should breach of this contract by CONTRACTOR result in any type of civil penalty imposed upon the DEPARTMENT, CONTRACTOR shall indemnify the DEPARTMENT for that breach.

9. **Return or Destruction of Information.** Upon termination of this Contract and at the request of the DEPARTMENT, the CONTRACTOR shall return to the DEPARTMENT or destroy all PHI in CONTRACTOR possession stemming from this CONTRACT, and shall not keep copies of the PHI except as requested by the DEPARTMENT or required by law. If the CONTRACTOR, its agent(s), or subcontractor(s) destroy any PHI, then the CONTRACTOR will provide to the DEPARTMENT documentation evidencing such destruction. Any PHI retained by the CONTRACTOR shall continue to be extended the same protections set forth in this Section and HIPAA regulations for as long as it is maintained.

Data/Information Exchange Between Payers & Health Homes/Performance Measures

103

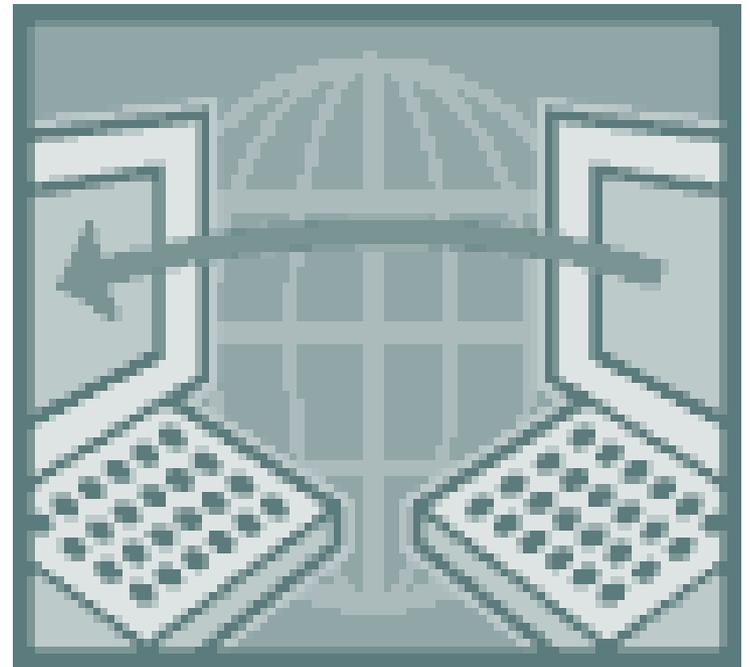
STATE AND HEALTH HOME

Client Enrollment

Utilization Profile

Prior Authorization/Pre-Certification

HEALTH HOME AND PARTNERS



Consumer Enrollment/Assignment/Affiliation

104



Client Enrollment In Health Homes

105

- Client can only participate in one health home at a time
- HH providers will be able to enroll members on the day they present or a future date. Health Homes may not back date enrollment.
- Client must be actively enrolled in Medicaid in order to enroll into a Health Home
- Providers should check Medicaid eligibility portal
- If a client is on spend down HHs may not future date the client's enrollment – only exception is if the client has “recurring Medicaid spend down”
- If a client goes on and off Medicaid (spend down) the assignment plan will remain open → no need to reassign each month
- Providers must dis-enroll the client (i.e. enter an end date) ASAP if the client is no longer part of health home. Important to comply with HIPAA confidentiality requirements.
- Enrollment by the Health Home is required before HH service can be paid

Client Enrollment In Health Homes

106

Beginning October 2012

- **HHs submit to JFS excel spreadsheets of Enrollees**
- **Excel spreadsheet will be used to generate utilization history for each client (see more on next slides)**
- **HHs will be able to send in multiple files until MITS functionality is finished to enroll and search HH members via portal**

Coming later Fall 2012:

Full HH functionality within MITS Web Portal

Health Home Member Enrollment File – Fields and Format

107

- **Excel Spreadsheet must include the following fields:**
 - **First name**
 - **Last name**
 - **Medicaid recipient ID**
 - **Provider Medicaid number**
 - **DOB**
 - **Gender**
 - **SSN**
 - **HH Date of enrollment**
 - **HH Enrollment end date (default to 2299)**
 - **Type of Health Home (default to MHOME)**
- See template provided in Appendices**

Utilization Profile

108



Client Utilization Profiles - General

109

- Profiles generated from files submitted by HHs
- Files returned electronically from JFS to HH's FTP Server
- Sections of Health Home Client Profile:
 1. Demographic and Health Summary for each client
 2. ODJFS Medicaid FFS claims and MCP encounter utilization data
 1. Initial report = 2 years of data (except for Rx and Lab)
 2. Subsequent reports will be monthly updates
 3. ODMH Regional Psychiatric hospital utilization

Client Utilization Profiles - General

110

- HP will routinely run profiles
- ODJFS will pick up HP files and send to HHs
- Initial file = 2 years; then monthly updates
- Does not replace the need for HH to work with MCP to receive current information
- Based on initial review, HH should reach out to other providers
- See file layout on ODMH Health home website
- If a provider does not receive a client utilization profile back, there was an error associated with that client (e.g. Not Medicaid eligible on the date of enrollment, mismatch between client name, DOB, Medicaid ID, etc.)

Health Home Client File Flow

111

- Health Home will send files from their FTP server (see next slide) to an ODJFS FTP server address TBD
- ODJFS will transfer files to HP to generate claims history report
- ODJFS will also transfer files to ODMH to add state hospital claims history
- HP and ODMH will transfer files back to ODJFS
- ODJFS will transfer files back to Health Homes FTP servers

Secure File Transfer From and To Health Homes

112

- Health Homes must establish a HIPAA compliant FTP internet location to which ODJFS can “push” files containing protected health information
- If Health Homes don’t already have FTP capacity, this service can be purchased from many internet service providers or other vendors offering similar subscription services.
- Subscription rates vary but are between \$20 – 30 per month

Health Home Quality Measures

113



Health Home Service: Quality Improvement Requirements

114

Health Home provider must have existing capacity to collect and report data and meet health home performance measurement requirements which consist of mandatory Centers for Medicare and Medicaid Services core measures and measures established by the Ohio department of mental health in conjunction with stakeholder input.

Health Home Quality Measures

115

CMS Core Measures

1. Timely Transmission of Transition Record
2. Screening for Clinical Depression and Follow-up Plan
3. Adult BMI Assessment
4. Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment
5. Ambulatory Care Sensitive Conditions Hospitalization Rate
6. All-Cause Readmissions
7. Follow-Up After Hospitalization for Mental Illness

State Selected Measures

1. Cholesterol Management for Patients With Cardiovascular Conditions
2. Controlling High Blood Pressure
3. Reconciled Medication List Received by Health Home
4. Comprehensive Diabetes Care: HbA1c level Less Than 7.0%
5. Comprehensive Diabetes Care: LDL-C Screening and LDL-C Less Than 100 mg/dl
6. Use of Appropriate Medications for People with Asthma

Health Home Quality Measures- continued

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CMS Core Measures

1. Timely Transmission of Transition Record
2. Screening for Clinical Depression and Follow-up Plan
3. Adult BMI Assessment
4. Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment
5. Ambulatory Care Sensitive Conditions Hospitalization Rate
6. All-Cause Readmissions
7. Follow-Up After Hospitalization for Mental Illness

State Selected Measures

7. Annual Assessment of Body Mass Index, Glycemic Control, and Lipids for People with Schizophrenia Who Were Prescribed Antipsychotic Medications
8. Annual Assessment of Body Mass Index, Glycemic Control, and Lipids for People with Bipolar Disorder Who Were Prescribed Mood Stabilizer Medications
9. Percent of Live Births Weighing Less than 2,500 grams
10. Prenatal and Postpartum Care
11. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Health Home Quality Measures-continued

117

CMS Core Measures

1. Timely Transmission of Transition Record
2. Screening for Clinical Depression and Follow-up Plan
3. Adult BMI Assessment
4. Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment
5. Ambulatory Care Sensitive Conditions Hospitalization Rate
6. All-Cause Readmissions
7. Follow-Up After Hospitalization for Mental Illness

State Selected Measures

12. Adolescent Well-Care Visits
13. Adults' Access to Preventive/Ambulatory Health Services
14. Appropriate Treatment for Children with Upper Respiratory Infections
15. Annual Dental Visit
16. Smoking and Tobacco Use Cessation
17. Inpatient and Emergency Department (ED) utilization Rate
18. Client Perception of Care - National Outcome Measure (SPMI Health Home)
19. Proportion of Days Covered of Medication

CMS Core Measures

118

Goal: Improve Care Coordination

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
Timely Transmission of Transition Record	Claims	AMA Physician Consortium for Performance Improvement (NQF-648)	Number of Health Home members discharged from an inpatient facility.	Number of members in the denominator for whom a transition record was transmitted to the Health Home within 24 hours of discharge.	Health Homes will report with CPT-2 code 1110F (patient discharged from inpatient facility) with modifier U3.

CMS Core Measure

119

Goal: Improve health outcomes for people with mental illness

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
Screening for Clinical Depression and Follow-up Plan	Claims	Ohio Method	The number of Health Home members aged 18 and older.	The number of members in the denominator who received screening for depression.	If CPT = 90801 or H0031 then will be compliant for screen. If provtype 04 with specialty 042, 20 with specialty 213, 42 with specialty 420, 51 with specialty of 511 or 512, 65 with specialty of 213, 72 with specialty of 213, 84 with specialty of 840 or 841, then will be compliant with follow-up.

CMS Core Measures

120

Goal: Improve Preventive Care

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
Adult BMI Assessment	Claims	HEDIS	The number of Health Home members 18-74 years of age who had an outpatient visit.	The number of members in the denominator who had a BMI assessment.	Health homes to report BMI using CPT-2 code 3008F(BMI). Also will count CPT2 2001F (weight recorded) or CPT G8417-G8420 or ICD-9 of V85.0-V85.5.

CMS Core Measures

121

Goal: Reduce Substance Abuse

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment	Claims	HEDIS (NQF 004)	The number of Health Home members 13 years and older who had a new episode of AOD dependence.	(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.	

CMS Core Measures

122

Goal: Improve Appropriate Utilization/Site of Care

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
Ambulatory Care Sensitive Conditions Hospitalization Rate	Claims	Canadian Institute for Health Information	Number of Health Home members discharged from an inpatient facility.	The number of acute care hospitalizations for ambulatory care sensitive conditions for members in the denominator.	

CMS Core Measures

123

Goal: Improve Appropriate Utilization/Site of Care

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
All-Cause Readmissions	Claims	HEDIS	The number of acute inpatient stays by Health Home members 18 years of age and older.	The number of acute inpatient stays by members in the denominator that were followed by an acute readmission for any diagnosis within 30 days.	

CMS Core Measures

124

Goal: Improve health outcomes for people with mental illness

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
Follow-Up After Hospitalization for Mental Illness	Claims	HEDIS (NQF 576)	The number of discharges for Health Home members 6 years of age and older.	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.	Includes provtype 04 with specialty 042, 20 with specialty 213, 42 with specialty 420, 51 with specialty of 511 or 512, 65 with specialty of 213, 72 with specialty of 213, 84 with specialty of 840 or 841. May need two measures. The % who had a follow-up visit with Health Home and the % who had a follow-up visit with a non Health Home mental health provider. Visits include ODMH services 90862, H0031, 90801, H0004, S9484, S0201 (with ODMH provtype). Health Home will report a visit with CPT-2 code of 1110F (patient discharged from an inpatient facility) with a modifier of U4.

State Selected Measures

125

Goal: Improve Cardiovascular Care

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
Cholesterol Management for Patients With Cardiovascular Conditions	Claims	HEDIS	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.	Number of members in the denominator who had a LDL-C level of less than 100 mg/dl.	Health Homes will report most recent LDL-C value using CPT-2 codes 3048F (LDL-C < 100), 3049F (LDL-C 100-129), 3050F (LDL-C greater than or equal to 130).

State Selected Measures

126

Goal: Improve Cardiovascular Care

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
Controlling High Blood Pressure	Claims	HEDIS (NQF 18)	Number Health Home members 18-85 years of age who had a primary or secondary diagnosis of hypertension	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.	Health Homes will report systolic blood pressure using CPT-2 codes 3074F (systolic < 130), 3075F (systolic 130-139), 3077F (systolic greater than or equal to 140); will report diastolic blood pressure using codes 3078F (diastolic < 80), 3079F (diastolic 80-89), 3080F (diastolic greater than or equal to 90).

State Selected Measures

127

Goal: Improve Care Coordination

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
Reconciled Medication List Received by Health Home	Claims	AMA Physician Consortium for Performance Improvement (NQF-646)	Number of Health Home members discharged from an inpatient facility.	Number of members in the denominator for whom a reconciled medication list was transmitted to the Health Home within 24 hours of discharge.	Health Homes to report using CPT-2 code 1111F (discharge medications reconciled with current medication list).

State Selected Measures

128

Goal: Improve Diabetes Care

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
Comprehensive Diabetes Care: HbA1c level Less Than 7.0%	Claims	Ohio Method	Number of Health Home members 18-75 years of age with type 1 or type 2 diabetes.	Number of members in the denominator who had an HbA1c level of less than 7.0%.	Health Homes to report using CPT-2 codes 3044F(HbA1c < 7%), 3045F (HbA1c 7-9%), 3046F(HbA1c greater than 9%).

State Selected Measures

129

Goal: Improve Diabetes Care

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
Comprehensive Diabetes Care: LDL-C Screening and LDL-C Less Than 100 mg/dl	Claims	HEDIS	Number of Health Home members 18-75 years of age with type 1 or type 2 diabetes.	(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.	Health Homes will report most recent LDL-C value using CPT-2 codes 3048F (LDL-C < 100), 3049F (LDL-C 100-129), 3050F (LDL-C greater than or equal to 130).

State Selected Measures

130

Goal: Improve care for persons with asthma

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
Use of Appropriate Medications for People with Asthma	Claims	HEDIS (NQF 36)	Number of Health Home members 5-64 years of age with persistent asthma.	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.	

State Selected Measures

131

Goal: Improve health outcomes for people with mental illness

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
<p>Annual Assessment of Body Mass Index, Glycemic Control, and Lipids for People with Schizophrenia Who Were Prescribed Antipsychotic Medications</p>	<p>Claims</p>	<p>Ohio Method</p>	<p>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.</p>	<p>The number of members in the denominator who had an assessment of BMI, a lab test to measure glycemic control, and a lipid screen.</p>	<p>Clinical diagnosis will be reported on monthly claim by Health Homes. Denom. will include those with a primary or secondary schizophrenia dx (295.x) on a Health Home claim, and at least two visits or one inpatient admit, and who received an antipsychotic med. Margaret has list of NDC codes or therapeutic classes of antipsychotic meds. Health Home to report BMI with CPT2 code 3008F. Also will count CPT2 2001F or CPT G8417-G8420 or ICD-9 of V85.0-V85.5; glycemic control (3044F, 3045F, 3046F, 82947, 82948, 82951, 82962); lipids (80061, 83700, 83701, 83704, 83721, 83718, 3048F, 3049F, 3050F, 3011F)</p>

State Selected Measures

132

Goal: Improve health outcomes for people with mental illness

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
Annual Assessment of Body Mass Index, Glycemic Control, and Lipids for People with Bipolar Disorder Who Were Prescribed Mood Stabilizer Medications	Claims	Ohio Method	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.	The number of members in the denominator who had an assessment of BMI, a lab test to measure glycemic control, and a lipid screen.	Clinical diagnosis will be reported on monthly claim by Health Homes. Denom. will include those with a primary or secondary bipolar dx (296.0, 296.1, 296.4, 296.5, 296.6, 296.7) on a Health Home claim, and at least two visits or one inpatient admit, and who received a mood stabilizer. Margaret has list of NDC codes or therapeutic classes of mood stabilizers. Health Home to report BMI with CPT2 code 3008F. Also will count CPT2 2001F or CPT G8417-G8420 or ICD-9 of V85.0-V85.5; glycemic control (3044F, 3045F, 3046F, 82947, 82948, 82951, 82962); lipids (80061, 83700, 83701, 83704, 83721, 83718, 3048F, 3049F, 3050F, 3011F)

State Selected Measures

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Goal: Improve Preventive Care

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
Percent of Live Births Weighing Less than 2,500 grams	Vital Statistics	Children's Health Insurance Program Reauthorization Act	The number of live births by Health Home members.	The number of live births weighing less than 2,500 grams.	

State Selected Measures

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Goal: Improve Preventive Care

Performance Measure	Data Source	Base Method	Denominator	Numerator
Prenatal and Postpartum Care	Claims	HEDIS	The number of deliveries of live births by Health Home members.	(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.

State Selected Measures

135

Goal: Improve Preventive Care

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Claims	HEDIS	The number of Health Home members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN.	The number of members in the denominator who had a BMI assessment, counseling for nutrition, and counseling for physical activity.	Health homes to report BMI using CPT-2 code 3008F (BMI). Also will count CPT2 2001F (weight recorded) or CPT G8417-G8420 or ICD-9 of V85.5.

State Selected Measures

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Goal: Improve Preventive Care

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
Adolescent Well-Care Visits	Claims	HEDIS	The number of Health Home members 12-21 years of age.	The number of members in the denominator who had one or more comprehensive well-care visits with a PCP or an OB/GYN practitioner.	

State Selected Measures

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Goal: Improve Preventive Care

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
Adults' Access to Preventive/Ambulatory Health Services	Claims	HEDIS	The number of Health Home members aged 20 and older	The number of members in the denominator who had an ambulatory or preventive care visit.	Codes 99385-99387 and 99395-99397 are not covered in FFS.

State Selected Measures

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Goal: Improve Preventive Care

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
Annual Dental Visit	Claims	HEDIS	(1) The number of Health Home members ages 2-21; (2) The number of Health Home members ages 22 and older.	The number of members in each denominator who had one or more dental visits.	

State Selected Measures

139

Goal: Improve Preventive Care

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
Appropriate Treatment for Children with Upper Respiratory Infections	Claims	HEDIS	The number of Health Home members 3 months-18 years of age who had a diagnosis of an upper respiratory infection.	The number of members in the denominator who were not dispensed an antibiotic prescription.	

State Selected Measures

Goal: Reduce Substance Abuse

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
Smoking and Tobacco Use Cessation	Claims	Ohio Method	The number of Health Home members of any age who are tobacco users.	The number of members in the denominator who received tobacco cessation intervention.	Revised Measure: % of tobacco users who received cessation intervention. Dx codes to identify tobacco users: 305.1, 649.0, 989.84, CPT2 codes to identify tobacco users 1034F (current tobacco smoker), 1035F (current smokeless tobacco user). CPT2 codes to identify cessation intervention: 4000F (tobacco cessation counseling), 4001F (tobacco cessation - pharmacologic therapy), 4004F (tobacco cessation intervention). Will also count a prescription for Chantix or a smoking cessation patch (therapeutic classes J3A, J3C, and H7N).

State Selected Measures

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Goal: Improve Appropriate Utilization/Site of Care

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
Inpatient and Emergency Department (ED) utilization Rate	Claims	HEDIS	Number of member months for Health Home members.	(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.	

State Selected Measures

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Goal: Improve Health Outcomes for Persons with Mental Illness

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
Proportion of Days Covered of Medication	Claims	Ohio Method	There will be four 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.	The number of members in each of the five denominators who met the Proportion of Days Covered threshold of 80%.	Therapeutic Classes for cardiovascular and mental illness meds are listed in Ther. Classes worksheet. NDCs for asthma are listed in the NDCs for Asthma worksheet. NDCs for diabetes are listed in the NDCs for Diabetes worksheet.

State Selected Measures

143

Goal: Improve Care Coordination

Performance Measure	Data Source	Base Method	Denominator	Numerator	Supplemental Method
Client Perception of Care - National Outcome Measure (SPMI Health Home)	ODMH administered Survey	SAMHSA NOMS (MHSIP) (YSS-F)	The number of Health Home members completing 2/3 of the items in each subscale	Number of members in the denominator scoring 3.5 or higher on each of the instruments' subscales.	

Health Services Advisory Group (HSAG)

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- Health Services Advisory Group, Inc. (HSAG) is a health care quality improvement and quality review organization.
- HSAG offers outcomes measurement and quality improvement interventions.
- ODJFS is considering contracting with HSAG to:
 - Conduct quarterly analyses of Health Home Quality Measures data;
 - Produce quarterly reports on Health Home Quality Measures;
 - Disseminate the reports/results in Excel spreadsheets; and
 - Provide technical assistance to the Health Homes.



ODJFS PROVIDER PORTAL

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MIT'S Health Home Portal Features

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Target: Fall 2012

- Create ability for HHs to enroll clients with SPMI through their secure web portal page
- Create a web portal search function for HHs to search current or previous clients assigned to their own health home

MIT'S Health Home Portal Features

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Alerting Health Homes of Psychiatric Admissions

- **Functionality target: Fall 2012**
- **Building e-mail alerts sent to HHs that a hospital has requested precertification of psychiatric inpatient admission for a HH member**
- **Also building a search function in MIT'S web portal for psychiatric inpatient admissions**
- **FFS clients only- HHs will have to arrange for similar info from MCPs**
- **More detail to be covered in future training**

Provider Enrollment & Billing

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ODJFS Provider Enrollment: Adding HH service

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- ODMH certifies the CBHC to provide health home service
 - ODMH will post a list of certified health homes for each county on the Health Home website
- ODMH sends the list of HH providers to ODJFS
- ODJFS will enroll HH providers in correct provider type and specialty
- This will authorize HH providers to bill HCPC code S0281

Requirements for Billing HH Service

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- Health Home service = HCPC S0281
- Available for both FFS and MCP recipients
- One unit of S0281 may be billed once per recipient, per health home, per calendar month
- Modifiers cannot be used on code S0281 – claim will deny
- Require SPMI primary dx codes; subsequent dx fields can be any dx code
- MITS will include a new health home provider contract effective 10/1/2012

Requirements for billing HH Service

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- **HHs asked to submit CPT Category II codes for HH Service, HCPC code S0281**
 - CPTII codes can be submitted in conjunction with S0281 or on a claim line by itself
 - will be paid at \$0 so even if charges are submitted it will pay at \$0
- **Health home claims are not covered by Medicare so it is not necessary to first bill Medicare and wait for denial prior to submitting claim for S0281 to ODJFS**
 - Consistent with current ODMH Medicaid processing

Reimbursement

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Reimbursement

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- **Must be a valid MHOME provider with a specialty of 843**
- **Client must have been successfully assigned to the HH home submitting the claim**
- **Client's HH effective dates must align with billing month of service**
- **Cannot overlap with another client assignment plan**
- **Cannot overlap with PACE**
- **Cannot be before October 1**
- **CAN overlap with MCP assignment plan**

Comprehensive Monthly Case Rate

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- **Providers will be paid a monthly case rate for coordinating ALL aspects of a recipient's medical care and rendering various activities which are all allowed as part of the Health Home service**

When and/or how often will the monthly case rate be reviewed/updated?

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- Providers' monthly case rates will be reviewed annually to determine whether or not it is necessary to rebase the case rate(s)
 - This review will be based on all providers' actual costs for the prior year
- Cost based case rate methodology is in effect until sufficient baseline information is collected to determine a performance component for setting subsequent rates
- CMS must approve an approach to transition from the cost based methodology
- In accordance with ODMH application, staffing changes must be immediately reported to ODMH

Future Training Opportunities

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- **Webinars**
 - Follow up from today
 - MITS Portal Functionality
 - Others
- **Learning Communities**
- **Training Opportunities**
- **Informational Forums**
- **ODMH Health Home Website**

Questions?

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