

Ohio Medicaid Health Home Program

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**HEALTH HOME INFORMATIONAL FORUMS
KICK-OFF WEBINAR**

**APRIL 12, 2012
9:30AM – 11:00 PM**

Frame

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- **Webinar Objective:** Provide background information, highlight Ohio's health home model and summarize implementation planning efforts
- **Informational Forum Objective:** Develop an increased understanding of Ohio's health home model to facilitate provider and local system readiness

Informational Forums

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Date	Place	Time
April 20	Akron	1:00 PM – 4:00 PM
April 23	Columbus	1:00 PM – 4:00 PM
May 3	Cleveland	1:00 PM – 4:00 PM
May 4	Athens	1:00 PM – 4:00 PM
May 7	Toledo	1:00 PM – 4:00 PM
May 8	Cincinnati	1:00 PM – 4:00 PM
May 10	Dayton	1:00 PM – 4:00 PM

A Health Home is ...

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- A new service delivery model for Medicaid consumers with uncoordinated care
- Whole person care coordination / care management for consumers with complex conditions
- Person-centered planning approach to identify needed services and supports
- Consideration of the needs of the person without compartmentalizing aspects of the person, his/her health, or his/her well-being
- Providing care and linkages to care that address all of the clinical and non-clinical needs

Related to, but Not the Same as, the Patient-Centered Medical Home

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- Use Patient-Centered Medical Home (PCMH) as foundation for Medicaid Health Homes
- Medicaid Health Homes expand on PCMHs by:
 - Focusing on patients with multiple chronic and complex conditions;
 - Coordinating across medical, behavioral, and long-term care; and
 - Building linkages to community, social supports, & recovery services
- Focus on outcomes – reduced ED & hospital admissions & readmissions, reduced reliance on LTC facilities, improved experience of care and quality of care

What are Medicaid Health Home services?

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ACA defines Medicaid health home services as:

- (1) comprehensive care management;
- (2) care coordination and health promotion;
- (3) comprehensive transitional care/follow-up;
- (4) patient and family support;
- (5) referral to community and social support services; and
- (6) use of HIT to link services

Ohio's Health Home

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- Budget bill authorized Ohio Medicaid to design a health home model and implementation strategy
- Medicaid teamed with ODMH to focus first on persons with serious mental illness (SMI), severe emotional disturbance (SED), serious & persistent mental illness (SPMI)
- Health Homes for those with SPMI will be implemented initially, region by region, 10/1/2012
- Draft state plan amendment (SPA) submitted to federal government, 12/23/2011

Ohio Medicaid Health Home Program Goals

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- Improve care coordination
- Improve Integration of Physical and Behavioral Health Care
- Improve health outcomes
- Lower rates of hospital emergency department use
- Reduce hospital admissions and readmissions
- Decrease reliance on LTC facilities
- Improve the experience of care and quality of life for the consumer
- Reduce healthcare costs

Health Homes for those with SPMI

Provider Infrastructure

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- **Health Home Team Requirements**

- The health home team composition was developed with BH/PH integration, multi-disciplinary team approach, quality care and innovation in mind.
- While the team composition is flexible and is expected to change as the needs of the health home beneficiary change overtime, a core team consisting of required members will remain stable in order to maintain consistency and continuity of care for the SPMI beneficiary given the importance of establishing rapport and building trust for long-term with this population.
- Ohio health homes will use multidisciplinary teams of medical, mental health, substance abuse treatment providers, social workers, nurses and other care providers led by a dedicated care manager who will assure enrollees receive needed medical, behavioral, & social services in accordance with a single, integrated care plan.
- All team members will be responsible for reporting back to the care manager on patient status, treatment options, actions taken and outcomes as a result of those interventions

Health Homes for those with SPMI

Provider Infrastructure

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● Health Home Team Leader

- Provide administrative and clinical leadership and oversight to the health home team and monitor provision of health home services. A key function is to be the champion for the health home, motivate and educate other staff members.
- The minimum qualifications consist of a Master's Degree or higher in a healthcare related field with appropriate or applicable independent licensure (LISW-S, PCC-S, IMFT-S, 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, health administration & not require independent clinical licensure.
- Must demonstrate a strong health management background and an understanding of practice management, data management, managed care and quality improvement.
- Monitor and facilitate: consumer identification & engagement process, completion of comprehensive health & risk assessments, development of care plans, scheduling & facilitation of treatment plan meetings, provision of health home services, consumer status and response to health coordination & prevention activities, development, tracking and dissemination of outcomes.
- Additional clinical and administrative duties will include hiring and training of staff, providing feedback regarding staff performance, conducting performance evaluations, giving direction to staff regarding individual cases, and monitoring overall team performance & plan for improvement.

Health Homes for those with SPMI

Provider Infrastructure

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- **Embedded Primary Care Clinician**
 - Participate in provision of health home services including identification of consumers, assessment of service needs, development of care plan and treatment guidelines, monitoring of health status 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 with care managers individually to review challenging and complex cases as needed.
 - Can be any of the following professionals: primary care physicians, pediatricians, gynecologists, obstetricians, Certified Nurse Practitioners with 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.

Health Homes for those with SPMI

Provider Infrastructure

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- **Care Manager**

- Accountable for overall care management and care coordination and be able to both provide and coordinate all of the health home services. A single care management record will be agreed to and shared by all team professionals and case reviews will be conducted on a regular basis.
- Responsible for overall management and coordination of the beneficiary's care plan which will include both medical/behavioral health and social service needs and goals.
- Care managers must have the necessary credentials and skills to be able to conduct comprehensive assessments and treatment planning. 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 3 year RN degree) with extensive experience working with the SPMI population, and other qualified staff approved by the State.
- Must have formal training as well as practical experience in behavioral health and possess core and specialty competencies and skills in working with SPMI population.
- Must 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.
- Must be knowledgeable and experienced in community resources and social support services for the SPMI population.

Health Homes for those with SPMI

Provider Infrastructure

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- **Care Manager Aid** (a.k.a. Qualified Health Home Worker)
 - Assist with care coordination, referral/linkage, follow-up, family/consumer support and health promotion services.
 - May be any of the following: 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.)

Health Homes for those with SPMI

Provider Infrastructure

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- **Health Home Team Requirements *cont.***
 - **The Health Home Core Team will be coordinating with the following resources to address identified client needs:**
 - ✦ psychiatrists, psychiatric mental health nurses, and other behavioral health treatment specialists including substance abuse treatment specialists, trauma therapists, housing specialists, benefit specialists, vocational/employment specialists, nutritionists/dieticians, pharmacists, Adult Care Facilities, Home Health providers, social welfare program staff, criminal justice system staff, schools, SNFs and other representatives as appropriate to meet the beneficiary's needs.

Health Home Service Components

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- **Comprehensive Care Management**
 - 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 and update the care plan.

Health Home Service Components

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● Care Coordination

- 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;
- Develop a crisis management and contingency plan working with the individual, family and significant others;
- Assist consumer in obtaining referrals to community, social and recovery supports, making appointments and validating that the consumer received the service;
- Monitor care plan and the individual's status in relation to his or her care plan goals;
- Reassess the consumer at least once every 90 days to determine if a change is needed in the treatment plan or if there is a change in health status;
- 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

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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

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- **Comprehensive Transitional Care**
 - Coordinate with providers;
 - Facilitate and manage care transitions (inpatient to inpatient, residential, community settings) 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

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- **Individual & Family Support Services**
 - 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

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- **Referral to Community & Social Support Services**
 - 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.

Core Elements & Provider Standards

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- Community Behavioral Health Centers (CBHC) will be eligible to become health homes for SPMI population
- At a minimum, be certified by ODMH as eligible to provide all of the following Medicaid covered community mental health services*:
 - 1) pharmacological management,
 - 2) mental health assessment (physician and non-physician),
 - 3) behavioral health counseling and therapy (individual & group),
 - 4) community psychiatric support treatment (individual and group).

**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.*

Core Elements & Provider Standards, cont.

At a minimum, the CBHC must also meet the following requirements:

- Provide all the health home services: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family supports, and referral to community and social support services.
- Demonstrate physical and behavioral health integration by receiving one of the following certifications within 18 months of becoming a CBHC health home provider:
 - 1) the CARF's Integrated Physical Health/Behavioral Health Core Program; or
 - 2) the Joint Commissions' Physical Health Standards module; or
 - 3) the National Committee for Quality Assurance recognition as a Patient Centered Medical Home (Level 1); or
 - 4) equivalent recognition standards as approved by the State.

Core Elements & Provider Standards, cont.

- CBHCs that do not have an ownership interest in a primary care organization or do not have embedded, onsite or co-located primary care practitioners must establish evidence of bi-directional and integrated primary care /behavioral health services through use of a contract, memoranda of agreement or other written agreements approved by the State.
- CBHCs must also establish relationships with managed care plans, specialty (including substance abuse), long-term care, hospital and other providers (e.g., nutritionists, housing, etc.) to facilitate health home beneficiaries' access to needed services.

Core Elements & Provider Standards, cont.

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Support the delivery of person-centered care by providing:

- Expanded, timely access (i.e., within normal operating hours and after-hours for routine and urgent care issues) to health care services, preventive/health promotion services and mental health and substance abuse services.
- Orientation of the patient to Health Home services;
- Services in a culturally and linguistically appropriate manner.
- A multi-disciplinary team based approach for the delivery of Health Home services through the continual use of an established team of core members defined by the state

Core Elements & Provider Standards, cont.

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Support the delivery of person-centered care by also providing:

- A single, integrated, and person-centered care plan that coordinates all of the clinical and non-clinical needs.
- The ability to track tests and referrals for health care services, and coordinate follow up care as needed.
- Point of care reminders for patients about services needed for preventive care and/or management of chronic conditions by using patient information and clinical data.

Core Elements & Provider Standards, cont.

- Have the capacity to receive electronic data from a variety of sources to facilitate care management, care coordination, and comprehensive transitional care.
 - This includes, at a minimum, 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.
- 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.

Core Elements & Provider Standards, cont.

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- Participate in the Medicaid Health Homes Learning Communities.
- Serve as a current eligible provider in the Ohio Medicaid Program.
- Have the capacity to serve all Medicaid individuals who are eligible to receive health home services in the designated service area.

SPMI Target Population

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- **Persons who are SPMI, SMI or SED**
 - For health home purposes, this group is collectively referred to as clients with SPMI
 - Persons currently receiving services at the CBHC
 - Persons referred to health home from hospitals, specialty providers, MCP or other referral sources
 - CBHC will be responsible for determining if the client meets criteria

SPMI Target Population, cont.

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- Health home must identify Medicaid clients with SPMI by entering key data into the ODJFS web portal
- Information will be ultimately used to
 - validate claim payments against date span,
 - provide a mechanism for MCPs, hospitals, other specialty providers to determine a client's health home affiliation

Health Home Population Criteria: Serious and Persistent Mental Health Condition

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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

Health Home Population Criteria: Serious and Persistent Mental Health Condition

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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.

Health Home Population Criteria: Serious and Persistent Mental Health Condition

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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)
 - Assessment of impaired functioning measured by the Global Assessment of Functioning scale (GAF) (score of 40 to 60)
 - Treatment history criteria

Health Home Population Criteria: Serious and Persistent Mental Health Condition

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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.

Health Home Population Criteria: Serious and Persistent Mental Health Condition

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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)

Health Home and MCP Model Options

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- CMS Integrated Care Resource Center describes six different options for how states can develop health home approaches to compliment but not duplicate services and reimbursement within the managed care delivery system.
- Ohio is pursuing:
 - Option 1: The Health Home will be operated outside of the MCPs
 - Approach to Addressing Duplication: Approach B

Health Home and MCP – Approach B

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Approach B: Ohio will require MCPs to perform functions to support CBHC Health Homes that are designed to foster improved collaboration between physical and behavioral health care providers and improved outcomes for Medicaid beneficiaries. These functions will be performed by the managed care plans in lieu of providing high risk care management services to their members who are eligible to receive Health Home services.

Health Home and MCP **key** points

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CBHC Health Homes & Managed Care Plans

- MCP members enrolled in health homes will have **all** services coordinated through the CBHC health home
- Health home and MCP must establish a collaborative partnership to
 - provide necessary supports to client and
 - avoid duplication or gaps in services

Health Home and MCP **key** points, cont.

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- ODJFS announced five MCPs as the tentative selections for the Ohio Medicaid population
 - ODJFS will plan to sign agreements with MCP - August
- Enrollment scheduled to begin in January 2013
- State working internally to develop a plan to
 - mitigate any transition-related issues related to relationships between the BH providers and MCPs
 - ensure smooth implementation of CBHC Health Homes

Data Sharing and Information Exchange

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- State will develop data sharing and information exchange strategies to support health homes
 - Patient profile data - patient demographics and historical utilization data
 - Real time data
- Goal is to develop a comprehensive standardized approach
- ODMH will solicit provider input to validate what data would be most meaningful and how often it should be updated

Health Home and Data Sharing

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Patient Profile

- Proposed utilization data set would include
 - ✦ Demographics
 - ✦ Affiliation with MCP and PCP
 - ✦ 24 months of summary level data
 - ✦ Data sources would include FFS and MCP Encounter level data
 - ✦ For each Service and/or drug

Health Home and Data Sharing

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- Real time data exchange
 - Health homes and psychiatric hospitals
 - Health homes and general hospitals (inpatient and emergency department)
 - Health homes and MCPs
 - Integrated Care Plan

Use of Health Information Technology

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- Within 12 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 Coordinator for Health Information Technology.
- Within 24 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 must also participate in the statewide Health Information Exchange.

Use of Health Information Technology

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- **Comprehensive Care Management**
 - Day One Requirements - The CBHC health home must:
 - ✦ Receive electronically the health utilization profile;
 - ✦ Develop internal processes to be able to act on and disseminate the data;
 - ✦ Demonstrate how data will be utilized.
 - Future Requirements
 - ✦ The state will continue to build the capacity to exchange data through the HIE.

Use of Health Information Technology

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- **Care Coordination**

- **Day One Requirements – The CBHC health home must:**

- ✦ Utilize Health Utilization Profile information to:
 - Develop /update the integrated care plan
 - Establish relationship with treatment providers (e.g., hospital, LTC, Rx)
 - Share information with other providers to facilitate their treatment of clients
 - Medication management and reconciliation
 - Connect clients with necessary social supports
- ✦ Utilize lab portals (retrieve) & auto-generated letters that notify PCPs of lab values.
- ✦ Utilize electronic or paper tracking systems to identify patient movements → Loops back to Care Management and ability for providers to take patient summary info and develop a format that is useful for the client.
- ✦ If available, develop a unified care plan electronically.

- **Future Requirements**

- ✦ The state will continue to build the capacity to exchange data through the HIE.

Use of Health Information Technology

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- **Health Promotion**

- **Day One Requirements – The CBHC health home must:**

- ✦ Receive electronically the health utilization profile
- ✦ Auto-generate letters that notify PCPs of lab values
- ✦ Develop website that contains wellness, promotional information, and supports access to services.
- ✦ Develop audio visual aides to support health promotion
- ✦ Establish a “tickler” system (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.)

- **Future Requirements**

- ✦ The state will continue to build the capacity to exchange data through the HIE.

Use of Health Information Technology

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- **Comprehensive Transitional Care**

- **Day One Requirements – The CBHC health home must:**

- ✦ CBHC health home must receive electronically the health utilization profile
- ✦ Inpatient Admissions – goal is to inform CBHC health home as soon as a hospital admission occurs
 - ODMH Regional Psychiatric Hospital Admission
 - Psychiatric general Hospital Admission
 - General medical admission of an MCP enrollee with a CBHC Health Home
 - General medical admission of an Non-MCP enrollee with a CBHC Health Home
 - Nursing Facilities
 - Children moving in and out of foster care
- ✦ Hospital ED Visits

- **Future Requirements**

- ✦ The state will continue to build the capacity to exchange data through the HIE.

Use of Health Information Technology

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- **Individual & Family Support Services**
 - **Day One Requirements – The CBHC health home must:**
 - ✦ CBHC health home must receive electronically the health utilization profile.
 - ✦ Use of website, YouTube, FaceBook, secure Email and voice mail.
 - ✦ Auto-generated letters that gets sent to patients and family members of next appointment.
 - ✦ Establish a “tickler” system (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.)
 - ✦ Establish capacity to develop website that contains wellness, promotional information, and supports access to services.
 - **Future Requirements**
 - ✦ The state will continue to build capacity to exchange data through HIE.

Use of Health Information Technology

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- **Referral to Community & Social Support Services**
 - Day One Requirements – The CBHC health home must:
 - ✦ Receive electronically the health utilization profile.
 - Utilization profiles will be used to determine supports.
 - ✦ Connect clients with necessary social supports via call, fax or web based.
 - Done commensurate with providers capacity and referral source requirements.
 - Future Requirements
 - ✦ The state will continue to build the capacity to exchange data through the HIE.

Health Home Quality Metrics & Performance Measures

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- Providers will be required to report on quality metrics and performance measures as a condition of payment
- Measures consists of mandatory CMS core measures and state identified measures
- The goal is to derive as much information as possible from claims data

Health Home Quality Measures & Outcome Requirements

SPMI Health Homes Measures - Draft 12/13/11		CMS quality reporting guidance - in addition to the Core measures, quality measures that map to the program goals articulated by the State must be identified/selected. ²											
Group	Name	Program Goal	Adult	Child	CMS Reporting Guidance ¹	Source	Data Source	Stage 1 Meaningful Use	MC 2013	CHIPRA/ Adult Medicaid	SPA Domain	SPM1	PH
1	II	IVD:Cholesterol Mgmt.-LDL-C Screening, LDL Control (<100 mg/dL) (18 - 75 years)	✓		not on CMS list	NCQA/HEDIS	Claims	Yes	Y	Adult	Clinical Outcomes	✓	✓
2	II	Controlling High Blood Pressure (Patients with Hypertension <140/90) (18 - 85 years)	✓		Recommended	NCQA/HEDIS, NQF 18	Claims, EMR	Yes	Y	Adult	Clinical Outcomes	✓	✓
3	I	Timely Transmission of Transition Record to Healthcare Professional: discharged to home or other facility, w/in 24 hrs of disch. (for IP facility discharges)	✓	✓	Core	AMA-PCPI (NQMC - CMS), NQF-548	Claims, EMR	Yes		Adult	Quality of Care	✓	✓
4	III	Medication Reconciliation Post-Discharge (MRP)	✓	✓	Recommended	NQMC, NCQA/HEDIS, NQF 646/97	Claims, EMR					✓	✓
5	II	Comprehensive Diabetes Care: A1c level < 7.0% (controlled) (18 -64)	✓		Recommended	NCQA/HEDIS	EMR		Y	Adult	Clinical Outcomes	✓	✓
6	II	Diabetes:Cholesterol Mgmt.-LDL-C Screening, LDL Control (<100 mg/dL) (18 - 75 years)	✓		Recommended	NCQA/HEDIS	Claims	Yes	Y	Adult	Clinical Outcomes	✓	✓
7	II	Use of Appropriate Medications for People with Asthma (5-64)	✓	✓	Recommended	NCQA/HEDIS, NQF 36	Claims	Yes	Y	Adult	Quality of Care	✓	✓
8	I	Follow Up After Hospitalization for Mental Illness, 7-day - visit with MH practitioner (6+ yrs)	✓	✓	Core	NCQA/HEDIS, NQF 576	Claims		Y	CHIPRA/ Adult	Quality of Care	✓	✓
9	II	Schizophrenia 2: Annual assessment of weight/BMI, glycemic control, lipids	✓	✓	Recommended	CMS / (Rand)	Claims, EMR			Adult	Quality of Care	✓	✓
10	I	Screening for Clinical Depression and Follow-up Plan (18 years and older)	✓		Core	NQF 418	EMR				Quality of Care	✓	✓
11	II	Bipolar Disorder - Annual assessment of weight/BMI, glycemic control, lipids	✓	✓	Recommended	CMS	Claims, EMR				Quality of Care	✓	✓
12	II	Percent of Live Births Weighing Less than 2,500 grams	✓	✓	not on CMS list	CHIPRA CORE	Vital Stats		Y	CHIPRA	Clinical Outcomes	✓	✓
13	II	Prenatal and Postpartum Care - Timeliness of Prenatal Care	✓	✓	not on CMS list	NCQA/HEDIS	Claims		Y	CHIPRA	Quality of Care	✓	✓
14	I	Adult BMI Assessment (18 - 74)	✓		Core	NCQA/HEDIS	Claims, EMR				Quality of Care	✓	✓
15	II	Weight Assessment: child/adolescent document weight/BMI (3-17)		✓	Recommended	AHRQ, NCQA	Claims, EMR					✓	✓
16	II	Adolescent Well-Care Visits (12- 21 years)		✓	not on CMS list	NCQA/HEDIS	Claims		Y	CHIPRA	Quality of Care	✓	✓
17	II	Adults' Access to Preventive/Ambulatory Health Services (20 and older) ³	✓		not on CMS list	NCQA/HEDIS	Claims		Y		Quality of Care	✓	✓
18	II	Appropriate Treatment for Children with Upper Respiratory Infections (3 mos. - 18)		✓	not on CMS list	NCQA/HEDIS	Claims		Y		Quality of Care	✓	✓
19	II	Annual Dental Visit (2-21 years) & (> 21 years)	✓	✓	not on CMS list	NCQA/HEDIS	Claims				Quality of Care	✓	
20	I	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment-Engagement of AOD Treatment (13 - 17/18+/Total)	✓	✓	Core	NCQA/HEDIS, NQF 004	Claims, EMR	Yes	Y	Adult	Clinical Outcomes	✓	✓
21	III	Smoking & Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Users to Quit, b. Discussing Cessation Medications, c. Discussing Cessation Strategies (18 years & older)	✓		Recommended	NCQA/HEDIS, NQF 27	EMR	Yes		Adult		✓	✓
22	I	Ambulatory Care - Sensitive Condition Admission (under age 75)	✓	✓	Core	NQMC Rosenthal	Claims				Clinical Outcomes	✓	✓
23	I	Inpatient & ED utilization - Mental Health, Substance Abuse, General/Acute	✓	✓		NCQA/HEDIS					Clinical Outcomes	✓	✓
24	I	Plan - All Cause Readmission (18 and older)	✓		Core	NCQA	Claims				Clinical Outcomes	✓	✓
25	II	Client Perception of Care - National Outcome Measure (SPMI Health Home)	✓	✓	not on CMS list	SAMHSA	Survey				Experience of Care	✓	
26	II	Medication adherence: Medication Possession Ratio (MPR)	✓	✓	not on CMS list		Claims				Quality of Care	✓	

¹ Core - required measure.
² Recommended - for use with State specific goals.

² Selected measures will apply to all individuals receiving Health Home services who meet the measure criteria.

³ Adult Preventive Health services - require initial comprehensive preventive medicine visit.

Group - I: Core (SPA/benchmarking), II: Benchmarking (not Core/SPA), III: Program/Policy design

Health Home Payment Approach

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- State will pay for health home services based on submission of fee-for-service (FFS) monthly claim (HCPCS code S0281)
- Monthly case rate will cover ALL health home service components
- CBHC can bill for health home services for clients on spend-down as soon as spend-down is met

Payment Approach, cont.

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- Separate payments will continue for
 - Community BH services treatment services (e.g., counseling)
 - Other treatment services (e.g., primary care & specialty services) through existing Medicaid payment mechanisms (MCPs or FFS).
- Case management or other types of coordination services will NOT be reimbursed for clients receiving health home services such as ODMH CPST, ODADAS Case Management, Help Me Grow Targeted Case Management, MCP care management

Proposed Health Home Rate Development

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- CBHC specific monthly case rate is designed to promote local innovation
- Rate Components will be weighted and adjusted over time
 - Cost component – will not be reconciled
 - Pay for performance component
- Initially, cost component weighted at 100%
- Parameters in place to assure costs and caseload size are within acceptable boundaries

Proposed Health Home Rate Development

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- Monthly case rate derived using a consistent, statewide methodology based primarily on team composition and caseload
 - The CBHC must determine caseload size but will need to have the capacity to serve the demand in the specified region (county, board, zip codes, etc.)
 - Team composition can vary by provider but must be within core team requirements.
 - The uniform cost report should serve as the basis for determining costs associated with health home services.

Milestones & Next Steps

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Item/Activity	Target Date
Information Forums	April 20 , 2012 – May 10, 2012
Consultation with CMS	Ongoing
Submit draft SPA to CMS for formal review	May 2012
File Administrative rules	June 2012
Implementation of CBHC Medicaid Health Homes - client identified and data exchanged	September 2012
Implementation of CBHC Medicaid Health Homes - payment begin	October 2012
Learning Communities begin	First Quarter 2013

For a complete list of Health Home documents,
please visit the following link:

<http://mentalhealth.ohio.gov/what-we-do/protect-and-monitor/medicaid/health-home-committees.shtml>

Questions ?

Additional questions can
be submitted to the
healthhomes@mh.ohio.gov