FINANCING AND POLICY CONSIDERATIONS FOR MEDICAID HEALTH HOMES FOR INDIVIDUALS WITH BEHAVIORAL HEALTH CONDITIONS

A Discussion of Selected States' Approaches

SAMHSA-HRSA

Center for Integrated Health Solutions

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SUMMARY

Individuals with a serious mental illness are at dramatically higher risk of premature death due to chronic medical illness, in part because of limited access to quality primary care.[1] According to recent state studies, Medicaid beneficiaries with these illnesses have higher rates of co-occurring physical health conditions[2] and higher total Medicaid costs (e.g., inpatient hospital, skilled nursing facility, pharmacy) than beneficiaries without serious mental illnesses.[3]

Substance use disorders often co-occur with mental illness. However, they have major independent negative effects on individuals' overall health and use of health services. Globally, nearly 4% of all deaths (2.5 million deaths per year) are alcohol-related, caused by injuries, cancer, cardiovascular diseases, and liver cirrhosis. Alcohol misuse is one of the four greatest risk factors (along with tobacco use, poor diet, and physical inactivity) for the development of some cardiovascular diseases, cancer, chronic lung diseases, and diabetes.[4]

The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) engaged Health Management Associates to outline key areas of a recently enacted provision of the Affordable Care Act[5] that permits Medicaid coverage of health homes, a service delivery model supporting care coordination and related supports for individuals with chronic conditions, including those with mental and substance use conditions. As of July 2013, the Centers for Medicare and Medicaid Services (CMS) had approved Medicaid health homes in twelve states (Alabama, Idaho, Iowa, Maine, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island, Washington, and Wisconsin). Five of the states (Missouri, New York, Ohio, Oregon, and Rhode Island) include "serious and persistent mental health condition" or "substance use disorder "as eligible chronic conditions under their health home benefit.

Financing and Policy Considerations for Medicaid Health Homes for Individuals with Behavioral Health Conditions: A Discussion of Selected States' Approaches discusses many of the approved states, but focuses largely on Missouri and Rhode Island, which were the first states in the nation, respectively, to receive federal approval for health home services coverage. This report has three purposes:

- To describe the overarching policy considerations for states and potential providers of health home services
- To discuss the roles of quality measurement and health information technology (HIT)
- To explore options and considerations for developing reimbursement methodologies and establishing payment rates.

The report is structured so a general overview of most aspects of health home service design and Medicaid State Plan Amendment (SPA) development precede a detailed description of specific policy areas (e.g., use of CMS core quality measures and available reimbursement options).

The report conveys what processes may be necessary for state governments to work with the Substance Abuse and Mental Health Services Administration (SAMHSA) and CMS in order to receive consultation and obtain approval for Medicaid health home services. The report also offers observations and recommendations for states interested in implementing the benefit. ***This report is not formal policy or guidance from SAMHSA, HRSA, CMS, or CIHS.***

BACKGROUND

Across the country, publicly funded primary care, acute care, and behavioral health care safety-net services operate as parallel systems, often with limited connection or interaction. The consequences of this fragmentation are significant. Research shows that individuals with serious mental illnesses die decades earlier than the general population, in part because of limited access to quality primary care (e.g., 60% of premature deaths for people with schizophrenia can be attributed to preventable or treatable medical conditions).[6] Because of limited access to quality primary care, many individuals with mental illness rely on emergency departments as a primary source of care, which results in avoidable expense and poor continuity in treatment of chronic medical and behavioral issues. The National Institute on Drug Abuse examined substance use disorders' impact on hospital emergency department use. In

2009, there were nearly 4.6 million drug-related hospital emergency department visits, of which 45% (2.07 million) were a consequence of drug abuse. The total number of drug-related emergency department visits increased 81% between 2004 (627,291) and 2009 (1,244,679). Emergency department visits due to non-medical use of pharmaceuticals increased by 98.4% during that same period.[7]

For the past two decades, Medicaid programs have become an increasingly important payer of behavioral health services. Nationally, Medicaid is the single largest payer for mental health services in the United States[8] and the nation's foremost purchaser of antipsychotic medications.[9] Nearly 27% of all inpatient hospital days paid for by Medicaid in 2003 were for mental health and substance abuse treatments.[10] In addition, Medicaid beneficiaries with mental illnesses and substance use disorders are more likely than other Medicaid beneficiaries to have one or more costly co-occurring physical health conditions.[11]

The Affordable Care Act significantly expands Medicaid eligibility and lays the groundwork for fundamental changes in the financing and delivery of behavioral health services. The Congressional Budget Office estimates the nation's Medicaid population will grow by an additional 17 million by 2019.[12] Other estimates indicate between one-fifth to one-third of the currently uninsured are people with mental illnesses and/or substance use disorders.[13]

Yet, these coverage expansions will take place in a context of highly fragmented and poorly coordinated care for people with mental illness — even for those who have Medicaid coverage. Ohio has recently documented poorly coordinated and fragmented care for people with mental illness and co-occurring physical health conditions.[14] According to the report, Ohio's adult Medicaid beneficiaries with serious mental illness:

- Represented about 10% of total Medicaid beneficiaries and accounted for 26% of total Medicaid expenditures in 2010.
- Suffered co-occurring chronic physical health conditions (i.e., heart disease, hypertension, diabetes, chronic respiratory conditions, dental disease) at rates higher than other adult Medicaid beneficiaries without serious mental illnesses.
- Experienced more than twice as many hospitalizations for certain ambulatory care-sensitive conditions15 than adults without a serious mental illness.
- Underwent double the number of emergency department visits for asthma than adults without a serious mental illness.

In Ohio, as in other states, the health homes option is an opportunity to make Medicaid coverage more meaningful for people with mental illness, and to address the major public health problem of widespread chronic illness and premature death among people with serious mental illness.

OVERARCHING HEALTH HOME POLICY AND CONSIDERATIONS

Overview of Health Homes

Section 2703 of the Affordable Care Act provides states an opportunity to receive federal funding for coverage of "Coordinated Care through a health home for Individuals with Chronic Conditions," also referred to as health home services. The optional health home benefit became officially available in January 2011, allowing approved states to receive enhanced federal funding for health home services at 90% of the state's Federal Medical Assistance Percentage (FMAP) rate[16] for eight consecutive quarters.

It is important to distinguish between health homes for individuals with chronic conditions and "medical homes." Among other differences, the health home option focuses on individuals with chronic conditions, while medical homes seek broad practice transformation across an entire primary care panel. Elaboration on this and other differences are presented in the provider infrastructure section.

A core purpose of Medicaid health homes is coverage for individuals with chronic health conditions of care coordination through well-defined services supporting whole person care. Health home services complement traditional medical, behavioral, and other services, but are not to supplant healthcare treatment services. States have considerable flexibility in defining target populations, service compo-

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nents, and payment methodologies for health home services. The scope and limits of these flexibilities are described below. As of July 2013, twelve states — Alabama, Idaho, Iowa, Maine, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island, Washington, and Wisconsin — have approved state plan amendments (SPAs) to establish health home services.[17] Several states have submitted additional health home SPAs under review by CMS.

The statute permits health homes to be established among designated providers, which may include physicians, clinics, community health centers (such as federally qualified health centers), community mental health centers, substance abuse service providers, or home health agencies, as examples. Teams of healthcare professionals (e.g., physicians, nurses, social workers, nutritionists) may be organized to deliver health home services through freestanding designated health home providers. Teams of healthcare professionals may also be virtual, based at hospitals, or employees of managed care organizations. As health homes proposals have developed over the course of 2011 and 2012, a prominent emphasis has been the integration of primary care and mental health services. So far, substance use disorders have not been a principal focus in states with approved SPAs, although Missouri, New York, and Oregon include substance use disorders among eligible chronic conditions for health homes. All health homes are required to address whole person care coordination needs, including substance use disorders. Technical assistance is provided by the Centers for Medicare & Medicaid Services through Mathematica Policy Research and the Center for Health Care Strategies (CHCS). Technical support is available to assist state Medicaid agencies in developing and implementing health home programs under Section 2703 of the Affordable Care Act.

CMS Guidance

CMS has not released regulations for health home services. Instead, guidance was provided in a November 16, 2010 State Medicaid Director's Letter and in several webinar presentations delivered to state Medicaid agencies and other interested parties over the course of 2011. Most recently, CMS released technical assistance documents on Medicaid health home services and can provide pre-submission assistance to a state as it shapes the SPA adding health home services.[18] CMS policy on Medicaid health homes continues to develop through dialogue with state Medicaid agencies and as states develop specific proposals for CMS consideration.

CMS guidance lays out basic operational parameters for health homes. The state Medicaid director letter also describes how states can apply for planning grants[19] of up to $500,000. CMS established a simple letter and budget-based process to request this funding. As of August 2012, 14 states and the District of Columbia received planning grants; the states include Alabama, Arizona, Arkansas, California, Idaho, Maine, Michigan, Nevada, New Jersey, New Mexico, North Carolina, Washington, West Virginia, and Wisconsin.

ELEMENTS OF A HEALTH HOME STATE PLAN AMENDMENT: REGULATORY AND STRATEGIC CONSIDERATIONS

The following section reviews the core elements of a SPA submission, with an eye to both the practical aspects of completing the SPA and the broader strategic decisions states face in each area.

Geographic and Implementation Flexibility

States may implement health home services statewide or on a sub-state geographic basis (e.g., regional or by county). States can define a sub-state scope for health homes and maintain flexibility to phase-in their health home programs geographically. States can phase-in health homes geographically by submitting multiple SPAs for different regions. Each SPA would have its own eight quarters of enhanced federal match. However, the state cannot receive the enhanced match for health home services to a particular beneficiary for more than eight quarters.

States can also submit multiple SPAs for multiple health homes programs with different start dates. These programs could involve different chronic illnesses, different geographic regions, or an alternative phase-in structure. For example, both Missouri and Rhode Island have one health home program focusing on members with chronic physical illness and one focusing on mental illness, each described in a separate SPA.

Population criteria

Section 2703 of the Affordable Care Act indicates that eligibility for Medicaid health homes requires beneficiaries to have:

- At least two chronic conditions (e.g., mental health condition, substance use disorder, asthma, diabetes, heart disease, a body mass index (BMI) greater than 25)
- One chronic condition and the risk of a second
- One serious and persistent mental health condition

States have flexibility to seek federal approval for additional qualifying chronic conditions and are not limited to the chronic conditions in the statute. For example, Missouri received CMS approval to include tobacco use as an indicator of risk for cardiovascular disease.

States have a great deal of flexibility to define beneficiary eligibility by specifying chronic conditions. However, states may not limit eligibility by age or exclude individuals based on a particular Medicaid eligibility category or delivery system.[20] Because health homes are a state plan service, CMS consistently communicates that states may not exclude individuals dually eligible for Medicare and Medicaid, children, home- and community-based services waiver populations, or any other categorical eligibility type from participation. CMS has generally ruled out diagnoses with age criteria as part of the definition. However, states may exclude individuals deemed medically needy or individuals who are eligible under a Section 1115 demonstration program.

States specify target populations to receive health home services to achieve a number of objectives:

- States hoping to foster comprehensive changes to primary care practice leverage a number of high volume chronic physical illnesses, in some cases supplemented by mental illness and substance use disorders. States taking this approach include Missouri in its primary care SPA, North Carolina, Iowa, Oregon, and New York. This approach will lead to a relatively high percentage of Medicaid beneficiaries eligible for health homes.
- States seeking to enhance care at mental health provider organizations have modeled clinical eligibility criteria on existing definitions of mental illness used by the state in its definition of eligibility for community behavioral health treatment. These states want health homes to change practice standards for community mental health and/or substance use treatment providers — both to strengthen behavioral healthcare care management and to foster integration of physical and behavioral healthcare. States taking this approach include Missouri in its Community Mental Health Center SPA, Rhode Island in its Community Mental Health Organization SPA, and Ohio.
- States wanting to create more coordinated, systemic response to opiate and other addictions plan to implement a hub and spoke health home approach for eligible beneficiaries. Vermont currently seeks CMS approval for a multipayer patient-centered medical home and a community treatment provider effort designed to integrated health systems for addictions treatment by expanding capacity of methadone treatment and supporting the provision of medication assisted treatment (MAT) through community health teams. By leveraging and more effectively coordinating existing primary care and addictions resources, Vermont plans to achieve greater savings, particularly in corrections and child welfare systems.
- States can focus on care management delivered through a specific provider type, define patient eligibility more narrowly, and tie eligibility standards for services to those providers. For example, one of Rhode Island's SPAs focused on patients at Comprehensive, Evaluation, Diagnosis, Assessment, Referral, Re-evaluation (CEDARR) Family Centers, who specialize in serving children and youth.

Provider Infrastructure

The health homes statutory language identifies three potential categories of health home providers: designated providers, a team of healthcare professionals, or a community health team. Of these, only the "community health team category" has a statutory definition that prescribes a specific staffing/provider model, leaving states considerable flexibility to define the "designated provider" and "team of healthcare professionals" categories.[21] States with approved or pending SPAs have included primary care providers, community mental health centers, acute care managed care organizations, managed behavioral health organizations, and specialized providers for children with special healthcare needs as designated providers. This last example, from one of Rhode Island's two health home programs, demonstrates that although states may not formally limit beneficiary eligibility based on age or eligibility category, they may limit participation to providers who focus on specific age groups.

There are important overlaps and distinctions between the health home state plan option and the concept of medical home.[22] The National Academy for State Health Policy defines medical homes as follows: "A medical home is defined as an enhanced model of primary care that offers whole-person, comprehensive, ongoing, and coordinated patient- and family-centered care. Public payers, especially Medicaid, have been leaders in these efforts, with the hopes of preventing illness, reducing wasteful fragmentation, and averting the need for costly emergency department visits, hospitalizations, and institutionalizations."[23] Both medical homes and Medicaid health homes emphasize the need for one provider responsible for comprehensive care management. However, the primary care medical home focuses on primary care physician practices as the locus of care. As noted above, other provider types or managed care organizations can serve as Medicaid health homes. In addition, health homes are directed strictly at Medicaid beneficiaries, while many medical home initiatives have been multipayer or not sponsored by insurers at all. The health home option focuses on individuals with chronic conditions, while primary care medical homes seek broad practice transformation across an entire primary care panel.

HEALTH HOMES AND MEDICAL HOMES

HEALTH HOMES	MEDICAL HOMES
Enhanced Medicaid reimbursement for services to individuals with approved chronic conditions	Serves all populations
May include primary care practices, community mental health organizations, addiction treatment providers, federally quality health centers, health home agencies, and other provider groups	Typically defined as physician-led primary care practices, but may include some mid-level practitioners such as nurse practitioners
Currently a Medicaid-only construct	Exist for multiple payers (e.g., Medicaid, commercial insurance)

Despite these important distinctions, states can use the Medicaid health homes option and SPA submission process as part of their Medicaid medical home strategy. CMS has approved Missouri to do this, and several other states have submitted similar proposals to CMS. States will need to align medical home's goal of practice transformation across the entire provider network with the health homes requirement that participation is limited to individuals with qualifying chronic conditions. Missouri accomplished this alignment by focusing its health homes payment on supporting care coordination staff who will work primarily with individuals with chronic conditions in primary care settings.

Health Home Services

According to the health homes statute and the corresponding CMS SPA framework, health homes must provide all six of the following services, as appropriate based on beneficiaries' changing needs:

1. Comprehensive care management
2. Care coordination

(States should choose one or the other of the above two terms as an umbrella term that covers the core service delivery model, as detailed below.)

3. Health promotion
4. Comprehensive transitional care
5. Individual and family support
6. Referral to community and support services

The health homes statute further indicates that states should document the "use of health information technology to link services." These six service components, together with the health IT linkage component, require that states have the capacity to manage a continuum of specialty and primary care health services and, at least, coordinate long-term care services and other supports. There has been significant diversity in how states employed these terms, with certain key commonalities. Each definition of a service includes the providers that will deliver that service and state variation in how they employ these service types depends on the providers' infrastructure. Appendix A contains partial service descriptions from selected states with approved SPAs.

- **COMPREHENSIVE CARE MANAGEMENT** and **CARE COORDINATION** tend to be the broadest service types, and states should choose one or the other as the umbrella term that covers the core service delivery model based on the nomenclature most consistent and comprehensible for the health home program's providers. Under one of these two terms, states describe the development of a comprehensive care plan and the provider or entity responsible for implementing and monitoring that care plan. Other elements of these service descriptions focus on tasks related to managing the use of formal health services and accurate transmission of key health information across the continuum of care.

  Notably, care management and care coordination are already a significant part of community mental health treatment; although care management often focuses on managing only behavioral health services and not assuring linkage to primary care. States have an opportunity to convert existing services to qualify as health homes and draw down a 90% match for community-based care management services for two years. CMS looks to states to augment the capacity of existing mental health providers in developing partnerships and collaborations with primary care so that health homes can effectively address the wide ranging needs of individuals with mental illnesses. In Missouri, this has involved a significant obligation for provider organizations to hire new physical healthcare coordinators and to monitor compliance with integrated treatment plans. Rhode Island has significantly upgraded community mental health organizations' provider service standards regarding assessment and monitoring of physical health needs and transitional care as a condition for health homes participation.

  According to the November 16, 2010 state Medicaid director letter:

  "States will be expected to develop a health home model of service delivery that has designated providers operating under a 'whole-person' approach to care within a culture of continuous quality improvement. A whole-person approach to care looks at all the needs of the person and does not compartmentalize aspects of the person, his or her health, or his or her well-being. We expect providers of health home services to use a person-centered planning approach to identifying needed services and supports, providing care and linkages to care that address all of the clinical and non-clinical care needs of an individual."

- **HEALTH PROMOTION** addresses member education, primary prevention, and wellness activities such as smoking cessation. Additionally, even if a state includes only chronic medical conditions for beneficiaries to be eligible for health home services, providers must screen for depression and substance use. Each state has its own definition of the six health home service components. Notably, states focusing on individuals with mental illnesses all discuss health promotion in a context of patient empowerment and emphasis on self-management of chronic conditions through involvement of informed and engaged patients and family members. New York is the first state to pay providers for program outreach and enrollment activities as part of their health homes reimbursement, an activity defined under health promotion.

- **COMPREHENSIVE TRANSITIONAL CARE** is the one service with statutory and federal regulatory requirements for a minimum level of service. All health homes are expected to have meaningful linkages with hospitals and to facilitate effective communication and care continuity in preparation for hospital discharge. The Affordable Care Act also specifically references measurement of skilled nursing facility utilization as a measure for health homes; comprehensive transitional care can include coordination of skilled nursing facility discharges and transitions, as well as coordination with home and community-based long-term supports and services. New York has required health homes to be networks that include both hospitals and

behavioral healthcare managers, placing a particular emphasis on transitional care and emergency department diversion capacity for individuals with serious behavioral conditions and complex chronic illnesses. Additionally, the Affordable Care Act requires that hospital emergency departments identify individuals in need of health home services. As an example, North Carolina's Community Care program, a single-source vendor for health home care management operating through 14 regional networks and a statewide care management agency, embedded nurse care managers in hospitals around the state to support transitional care management functions.

- **INDIVIDUAL AND FAMILY SUPPORT SERVICES** focus on providing education and care management supports to the beneficiary and his or her family members. State definitions address facilitating the delivery of person-centered care and performing outreach and advocacy for individuals and family members to identify and obtain needed resources. In providing such services, often by using peers, behavioral health providers emphasize self-management of mental illness and addiction, the importance of prescription medication adherence, and the development of crisis and relapse prevention plans. While primary care practices have similarly engaged in chronic illness management and related support services, efforts have typically centered on the individual, not family members, unless care involves children or adolescents.

- **REFERRAL TO COMMUNITY AND SUPPORT SERVICES** typically covers referrals to and coordination of services other than formal medical services. CMS has indicated that states should address somewhere in their service descriptions how the health home will coordinate long-term services and supports. States have flexibility where they incorporate this information, as no particular category references long-term services and supports by name and many of the initial states have chosen to do so under "referral to community and support services."

Provider Standards

States have taken a variety of approaches to defining provider standards. For states such as Rhode Island that target health homes to a specific provider type, standards correspond to that provider definition. Other states may have relevant national certification programs such as the National Committee for Quality Assurance (NCQA) or URAC. States using health homes to support implementation of patient-centered medical homes have the option to develop state-specific certification structures or to employ one of the national patient-centered medical homes recognition programs, or a combination of both.

All health home SPAs must propose a method to measure avoidable hospitalizations. Therefore, states must consider how community providers will interact with hospitals. CMS requires states to assure health homes' capacity to accept hospital and emergency department referrals as part of their SPA. This capacity is especially critical for states focusing on populations with serious mental illness.

However, formalizing relationships between providers can be time consuming and particularly difficult and complicated at the state level. New York structured its health home program to include a comprehensive continuum of care for high cost Medicaid beneficiaries. Networks selected have included hospitals, community mental health treatment, and intensive case management capacity. New York's SPA contains broad criteria for these networks under the provider standards section. However, in its implementation of these standards, as required by CMS, the state has undertaken a competitive procurement and contracting approach to provider selection in order to assure the caliber of health home networks.

States seeking to drive practice change in the mental health system face decisions regarding how additional health home provider standards will interact with existing capacity in mental health systems, including how they will affect the potential for new providers. To maximize the enhanced federal match over the available two years, those states converting some existing mental healthcare to health home services will want to consider the timing of the SPA's effective date and the provider capacity to meet new health homes standards and requirements.

Health Home Goals and Quality Measures

In the fall of 2011, CMS began requiring health home core quality measures, while allowing states flexibility to define additional measures around the state's goals. States should propose quality measures that relate to the health home program's stated goals. Quality measures should be consistent with the state's broader program description, in terms of what problems health homes intend to address, how health home services would fix the problem, and how a state would capture the program's impact through changes in clinical outcomes, quality of care, and experience of care. Each state must think meaningfully about how the services provided affect the goals and the outcomes they look to achieve. The quality measures should support the goals and tell the story of whether the goal was achieved using the core domains of quality of care, clinical outcomes, and experience of care.

Provider Payment

The reimbursement methodology section of CMS's online health homes SPA template is designed to feed into Section 4.19B (payment for services) of the Medicaid State Plan document. CMS requires states to provide detailed descriptions of their methodology for determining payment rates as part of the SPA approval process. An overview of the rate development methodology rather than actual rates is generally all that is required in the SPA itself. However, states should anticipate submitting a more detailed rate development description, including their proposed rates, to CMS as a document accompanying the SPA. Rate development can be actuarial and tied to anticipated service volumes relative to member acuity, but must be paid in connection to the rendering of a Medicaid allowed health home service. Alternatively, most initial health home states have used program-level data to support rates. These states have used expected provider staffing levels and non-staff costs for the anticipated enrolled populations.

Reimbursement does not have to be limited to fee-for-service arrangements. Many states' patient-centered medical home demonstrations have used a Medicaid primary care case management payment model in which the primary care manager receives monthly allotments not based upon beneficiary visits , but based on the documented rendering of a health home service. Moreover, managed care organizations can serve either as payers for health homes or as direct providers of health home services through their internal care management capacity. However, CMS will require states to describe in detail how they allocate managed care organization capitation between health homes and non-health homes components. While the complications involved in these allocations are beyond the scope of this paper, it is notable that CMS released guidance specific to states planning for managed care organizations to either pay for or provide health home services in Health Homes (Section 2703) Frequently Asked Questions available at the Integrated Care Resource Center's Health Homes section. This was followed by a longer February 2012 discussion of issues around managed care and health homes produced under a CMS technical assistance contract with Mathematica and the Center for Health Care Strategies, which is discussed in more detail later in the report.[24] These documents provide detail of states' options in structuring payment in managed care organization-based health homes.

An important aspect of health homes is the ability to move beyond payments for individual service encounters. Although the statute referenced per member per month (PMPM) payments, it explicitly allows other payment models. Therefore, states have flexibility regarding the structure of payments. Payment can be tiered by the acuity or severity of the member's chronic conditions or by the provider's capabilities to handle different levels of complexity or severity. For example, New York uses a claims-based grouper to assign PMPM rate cells to health home members. North Carolina's proposal tiers its PMPM health home payments by aged, blind and disabled (ABD) status, and non-ABD status in its SPA. Oregon tiers payments to primary care physicians based on level of medical home recognition.

Patient Enrollment

States have several options for enrollment.

- **MANDATORY ENROLLMENT:** In general, health homes must be a voluntary program that the Medicaid beneficiary agrees to

join. However, CMS indicated that it would consider state applications for a 1915(b) Freedom of Choice Waiver to implement a mandatory health homes program. As of this writing, all states with submitted SPAs are pursuing one of the voluntary approaches described below.

- **PASSIVE ENROLLMENT WITH AN OPT-OUT:** In this structure, states communicate — typically by mail — with individuals identified as eligible for health homes to inform them of their pending enrollment in the program and the process for opting out. States should anticipate that CMS will ask to review these outreach materials to ensure that a clear opt-out is offered. States using this framework should, in the same initial communication with the beneficiary, identify and assign a prospective health home provider and request new enrollees to either accept the assignment or choose another provider. For most states, both health homes eligibility and assignment to a provider will be based on claims. For example, Missouri's health home programs state that:

  > "Individuals eligible for health home services and identified by the state as being existing service users of a health home will be auto-assigned to eligible providers based on qualifying conditions. Upon enrollment, individuals assigned to a health home will be informed by the state via U.S. mail and other methods as necessary of all available health homes throughout the state. The notice will describe individuals' choice in selecting a health home as well as provide a brief description of health home services, and describe the process for individuals to opt-out of receiving treatment services from the assigned health home provider."

- Voluntary, provider-driven enrollment: In this structure, providers receive a prospective list of health home enrollees whom they have the responsibility for outreach, enrollment, and engagement in care. This option has the strength of limiting health homes payment to affirmatively engaged members. However, it can make budgetary projections difficult due to the uncertainty of what proportion of eligible individuals will enroll.

Historically, the process of enrollment outreach to Medicaid beneficiaries has proved challenging because of outdated or inaccurate beneficiary contact information. Providers typically are unable to locate a significant percentage of enrollees in health homes that use claims-based assignment. Health homes can offer new resources to help engage beneficiaries. States focusing on those with mental and substance use disorders may want to limit health home payment to members who successfully locate and engage in care. However, to maximize success, states may also subsidize outreach and engagement services to eligible beneficiaries that are not currently receiving regular specialty care or to eligible individuals that are not identified in claims records. New York has a voluntary enrollment structure, with an expectation that health home providers will conduct outreach and enrollment activities, including to individuals who have mental illnesses and no medical home. New York received CMS approval to pay health homes 80% of their PMPM for all Medicaid eligible enrollees for up to two periods of 3 months each while they find and engage them. New York's payment for outreach and engagement is provided after the eligible individual has been assigned to the health home provider.

Relationship to Existing Care Management Programs

CMS has emphasized that health homes should be responsible for all of their enrollee's care management and care coordination. CMS has also emphasized that Medicaid cannot duplicate payments, which means that Medicaid is not permitted to pay twice for the same service for the same beneficiary. (See the technical assistance resource Health Home Considerations for a Medicaid Managed Care Delivery System: Avoiding Duplication of Services and Payments.) Given that many recipients of health home services may also receive care management through managed care plans, home- and community-based waivers, or primary care case management programs, states will need to work out with CMS whether and how they can distinguish services to avoid duplicate payments.

Health homes should be responsible for all of their enrollee's care management and care coordination.

Health homes provide states a new opportunity to develop provider capacity for care coordination at the service site or within provider organizations. Health homes also present an opportunity to rationally organize and integrate multiple parallel case/care management programs for special needs populations. Furthermore, by incorporating and adapting existing care management programs into a health home program, states can draw down enhanced match for two years for these services.

New York and North Carolina both use health homes in part to streamline and integrate existing case/care management programs. In New York, targeted case management providers focusing on mental illness are linked in provider networks with hospitals and primary care providers through a competitive request for proposal (RFP) process that required applicants to build integrated networks. North Carolina is implementing health homes to help bring multiple, previously fragmented case/care management programs under its established Community Care program. North Carolina is also developing strong operational links between Community Care and its capitated managed behavioral health waiver to avoid duplication. In contrast, Oregon and Missouri mandate participating providers to develop new care coordination capacity as part of a practice transformation process.

Team Composition

Health homes afford community mental health providers the opportunity to provide services in an integrated manner. This will require a cultural shift for those providers that have not integrated physical and behavioral health approaches through strategies such as provider co-location. While a multidisciplinary team approach to treatment is the standard for most providers, placing primary and specialty care professionals on the same interdisciplinary team expands the team concept. Reconfigured physical and behavioral health clinical teams may include non-traditional members such as community health workers, peers, patient advocates, and medical assistants. Person-centered goal setting has also been a cornerstone of community behavioral health treatment planning. The health home model will require that this planning include primary care goals that are of equal importance as the goals for behavioral health.

Staff will need training on developing an effective integrated service system and on communicating with additional team members who utilize different approaches. In addition, consumers with a mental health or substance use disorder will need education on the importance of primary care for behavioral health conditions and how preventive medical care and self-care behaviors increase life expectancy and quality of life.[25]

Education for staff and clients must focus on the pivotal role of including primary care services. The emphasis for many community mental health providers has been the stabilization and management of mental illnesses and the need to support individuals as they work toward recovery. Integrating substance use and mental health services may challenge some community behavioral health providers, and the need to include primary care within the health home model potentially adds to this challenge. Substance use screening may prove equally problematic on the primary care side. Missouri's primary care health homes are required to conduct screening, brief intervention, and referral to treatment (SBIRT) for all patients, not just health home enrollees. Since the primary care providers had limited experience in SBIRT, the Missouri Department of Mental Health awarded $30,000 in SAMHSA SBIRT grants to providers to support their efforts.

A challenge for all health home team members will be the development of systems that allow routine and open sharing of information. Teams will have the option of meeting in-person or virtually. The use of an electronic health record and patient registry will become basic requirements for the effective sharing of treatment plans and clinical information.

Staffing of Health Homes

The staffing of health homes varies from state to state. While some states decide to use existing staff positions/descriptions for the required professionals comprising the health home team, the goals of the team are different from the traditional approach to service provision due to the emphasis on an integrated approach to care and the involvement of staff from both primary and specialty care settings. All team members must receive training and learn the new emphasis on care coordination, information sharing, and treatment goals that include both behavioral health and primary care.

As of October 2012, seven states have approved health home SPAs. All use different staffing plans. Though staff titles across states' core team members may be similar, their roles and functions may vary. Each approved SPA describes which health home service component is conducted by team members.

Missouri's community mental health center health home team staffing consists of a health home director, nurse care manager, pri-

mary care physician consultant, and administrative support staff. Optional team member may include the individuals' treating primary care physician, treating psychiatrist, and mental health case manager, as well as a nutritionist/dietician, pharmacist, peer recovery specialist, grade school personnel or other representative, as appropriate to meet the client's needs.[26]

New York's health homes use multidisciplinary teams of medical, mental health, and chemical dependency treatment providers, social workers, nurses, and other care providers led by a dedicated care manager who assures that enrollees receive needed medical, behavioral, and social services in accordance with a single plan of care. Optional team members may include nutritionists/dieticians, pharmacists, community health workers and outreach workers such as peer specialists and other representatives, as appropriate to meet the enrollee's needs (e.g., housing representatives, entitlement, employment).[27]

North Carolina's team of healthcare professionals centers on the primary care provider, which serves as the medical home and collaborates with regional care managers to manage care for high-cost, high-risk individuals. Care management staff are housed in regional networks and a statewide agency. Both are contracted by a single state vendor, Community Care of North Carolina, which is funded through PMPM payments for Medicaid beneficiaries. Regional care management staff includes nurses, social workers, and pharmacists.[28]

In Ohio, each community mental health agency health home must establish a health home team led by a dedicated care manager who coordinates and facilitates beneficiaries' access to services in accordance with a single, integrated care plan. An embedded primary care clinician assesses, monitors, and consults on clients' routine, preventive, acute, and chronic physical health care needs. Care managers are accountable for overall management and coordination of a beneficiary's care plan. State-defined qualified health home specialists assist and support care managers with care coordination, referral, follow-up, consumer/family support, and health promotion services.

Oregon's team of healthcare professionals is interdisciplinary and interprofessional and includes non-physician healthcare professionals such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, and other traditional and non-traditional healthcare workers authorized through state plan or waiver components. These professionals may operate in a variety of settings, including freestanding and any facilities described in the health home SPA, as well as virtually through use of technology.[29]

Rhode Island's community mental health organization health home team consists, at a minimum, of a Master's-level team coordinator (central coordinator for health home services), a psychiatrist, a registered nurse, Master's-level clinician, a community psychiatric supportive treatment specialist/hospital liaison, and a peer specialist.[30]

Table 2 lists the team of healthcare professionals supported under the health home services rate. Oregon and North Carolina are not included; while both states provide a comprehensive description of their reimbursement methodology for eligible health home providers, they do not delineate which professional team members health home payments would support.

POSITIONS FUNDED BY HEALTH HOME PAYMENTS IN FOUR STATES

Team of Healthcare Professionals Paid By Health Home Payment	Missouri	Rhode Island	New York	Ohio
Health Home Director/Coordinator	X	X		X
Nurse	X	X	X	
Care Manager (including Peer Support Specialist)		X	X	X
Primary Care Clinician/Consultant	X		X	X
Psychiatrist or Other Mental Health Professional	X	X	X	X
Substance Use Disorder Specialist			X	

QUALITY MEASUREMENT AND HEALTH HOMES

Background

In addition to its better-known policies to expand coverage, the Affordable Care Act invests in and supports numerous quality measurement and improvement activities under Medicare and Medicaid, representing a major shift in the way that CMS administers its programs. Since their inception in 1965, Medicare and Medicaid have largely been access-focused, providing insurance to the poor, elderly, and disabled populations so they could receive needed care. In 2001, the Institute of Medicine (IOM) published hard-hitting reports on the quality of U.S. healthcare and challenged both public and private payers to focus on the quality and value of the care they purchase. The Medicare program took up the challenge first, adding reporting requirements, publicly reported quality indicators, and quality improvement incentives. Such advances in quality measurement and reporting were made possible in part by a body of existing research on how chronic diseases affect Medicare populations. However, despite this evidence, the shift towards high quality care has not extended to all diseases, health services, or populations. The pace of change is relatively slow, and national quality indicators have only shown modest improvements in quality during the decade since the IOM reports.

The joint federal-state nature of the Medicaid program means that the development of quality measures for health homes involves both federal designation of national measures and state-specific measures subject to federal review. CMS has also required states to set quality standards within their managed care plans that can incorporate health home measures. Health plans are responsible for implementing, monitoring, and reporting on the quality indicators chosen by the states, with state oversight. States have almost universally directed their health plans to report a set of quality measures created in the private sector for use with commercial health plans. The HEDIS measures (Healthcare Effectiveness Data and Information Set) include timely use of preventive and primary care services, and appropriate management of the most common chronic illnesses. Currently, there are no quality measures of care or of continuity of care for all conditions, services, or populations. Notably, few measures exist for mental health and substance abuse treatment services.

The Affordable Care Act explicitly broadens the scope of public programs to include improving health, promoting prevention and wellness, and enhancing the patient experience, while also reducing or at least controlling the escalating cost of care. Health home statutory language mandates quality measurement; programs funded under the Affordable Care Act, including the enhanced payment for care coordination services associated with health homes, must collect and report quality measures to track achievement of program goals.

The rationale for quality measurement is two-fold. First, measurement focuses attention on the gaps between funders, beneficiaries, and providers' perception of the impact of care and the actual outcomes. Measurement leads to scrutiny of care processes and subsequent changes, which ideally leads to improved health outcomes. Second, data on outcomes allows for comparisons across providers, programs, or states, so that analysts and policymakers can assess the relative value of alternative programs or treatment strategies.

However, a major complicating factor is that measures do not exist for all the conditions or populations that may be treated and, even if they did, reporting on them would be financially and logistically challenging. For health homes, CMS/Medicaid has initially selected a subset of existing quality measures that have been tested for validity and reliability, and largely – though not entirely – exist in current data systems.[31]

Measuring Quality in Health Homes

In draft guidance,[32] CMS directs states developing health homes to include two types of quality measures: a core required set of quality indicators and a set of state-specific measures that correspond to the state's program goals. Together, these data will help CMS and states understand if health homes improve the health of the populations they serve.

CMS has further divided the types of quality measures they wish to receive into three categories:

1. **CLINICAL OUTCOME:** Measures that assess beneficiaries' health status and related healthcare utilization (e.g., reduced hospital admissions and readmissions, reduced hospital emergency department visits, improved adherence to psychotropic medications, controlled blood pressure).

2. **EXPERIENCE OF CARE:** Measures that assess beneficiaries' perceptions of care received.

3. **QUALITY OF CARE:** Measures that evaluate the processes used in the delivery of care such as completed needs assessment, a developed care plan, and regular receipt of services that maintain or improve health.

Each approved health home SPA contains the specific measures states have chosen to verify each of the required health home services and measure achievement of the goals. The list of measures to be undertaken by each state is extensive and includes both existing data from administrative sources and newly required information from patient charts, including electronic medical records.

CMS Health Home Core Quality Measures

CMS recommends eight health home core measures to assess individual level clinical outcomes and care processes. While states are not required to use these measures until the proposed regulations have been promulgated, CMS shared the core set in order to help states consider the design and implementation of their health home programs. These core measures were included in a State Medicaid Director letter in January 2013.

Core measures have very specific descriptions of both the numerator (the number of patients receiving the care) and the denominator (the number of patients eligible for the care), so all states and programs report data the same way. This consistency will facilitate comparisons across sites or populations. More detail on each measure can be found in Appendix B, but the core health home quality measures are:

- Adult Body Mass Index (BMI) Assessment
- Ambulatory Care Sensitive Condition Admission
- Care Transition — Transition Record Transmitted to Healthcare Professional
- Follow-Up After Hospitalization for Mental Illness
- Plan — All Cause Readmission
- Screening for Clinical Depression and Follow-Up Plan
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Controlling High Blood Pressure

State Specific Health Home Goals and Measures

CMS asks states to define goals for their health home services model and then identify quality measures that would reflect accomplishment of the goal. These measures will then supplement the required national core measures currently being finalized by CMS. If the state serves specific populations, the state should include measures applicable to their care. CMS suggests that the quality measure should address program goals and demonstrate whether the goal was achieved, while also addressing the core domains of quality of care, clinical outcomes, and experience of care.

For example, in its guidance, CMS sets a goal to "reduce emergency department visits by 10% for health home enrollees with a diagnosis of mental illness." Examples of measures that might be used to describe whether the state is meeting its goal may include, but are not limited to:

- **CLINICAL OUTCOMES:** Percentage of hospital emergency department visits for mental illness with the expectation that the percentage decrease over time.

- **QUALITY OF CARE:** Percentage of health home enrollees screened for mental illness.

- **QUALITY OF CARE:** Percentage care coordination enrollees receiving care after an emergency care visit in the past 6 months.

Missouri, New York, Ohio, Oregon, and Rhode Island identify individuals with mental illnesses or substance use disorders as eligible health home populations. Health home goals included in selected approved SPAs relevant to these populations are included in Table 3.

STATE GOALS OF APPROVED HEALTH HOME SPAS

State Goal	Missouri	Rhode Island	New York	Oregon	Ohio
Improve Care Coordination	X	X			X
Improve Receipt of Primary and Preventive Services	X	X	X	X	
Reduce Preventable Hospitalizations and Emergency Room Use		X	X	X	X
Improve Disease-Related Care for Chronic Conditions	X	X	X		X
Improve Outcomes for Persons with Mental Illness and/or Substance Use Disorders	X		X		X
Improve Transition to Mental Health, Primary Care or Long-Term Care Services		X		X	
Reduce Substance Abuse	X				X
Increase Patient Empowerment and Self-Management	X				

States are turning to existing quality measures to assess achievement of the state level goals. For example, Missouri intends to examine the health home's impact on adults with diabetes by using the HEDIS measures.

- **MEASURE:** Percent of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c < 8.0%
- **NUMERATOR:** For a given 90-day period, number of patients 18-75 years of age identified as having diabetes in a health home registry and a documented Hba1c test in the previous 12 months for whom the most recent documented Hba1c level is 0.8%
- **DENOMINATOR:** For a 90-day period, number of patients 18-75 years old identified as having diabetes in health home registry and having a documented Hba1c test in the previous 12 months
- **SOURCE:** Missouri community mental health centers are required to utilize a disease registry within the health home program to track patients with diabetes and other chronic diseases. Patients with diabetes can be identified through claims and crosschecked with the disease registry[33] to assess compliance with treatment standards.

To track patient experience, Rhode Island plans to use an existing survey: the Outcomes Evaluation Instrument (OEI). Other states may choose to use the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS). While expensive to administer, patient surveys provides the only factual source from consumers on their experience of care, including whether it met their needs.

Challenges of Collecting and Reporting Health Home Quality Measures

In 2010, a panel convened under CMS' auspices to identify a larger set of adult quality measures (as directed by the Affordable Care Act) and received feedback about the challenges of data collection, as well as the constraints on the availability of other desired measures. Despite this challenge, CMS is committed to the goal of addressing quality and it hopes to improve quality measurement over time. CMS asks states to work with provider organizations to provide feedback on the following points as they work to finalize the required set of measures:

1. Feasibility of implementing the core set on the SPA's effective date
2. Implementation barriers
3. Interim proxy measures can be reported to CMS when the state is unable to implement measures on the SPA's effective date and works with providers to phase in implementation within a one-year timeline.

To date, states have identified the following challenges:

1. Not all claims will be in the same data system because of multiple healthcare payers, especially when Medicare pays for some services and Medicaid for others. For example, knowing if a patient gets follow-up care within 48 hours of a hospital discharge may require linking the Medicare hospital claim with the Medicaid outpatient claim, or looking in the chart for evidence of a phone contact. Few states have access to real time Medicare claims data at this time, although CMS demonstrations are facilitating this process now.
2. States similarly have information coordination challenges between Medicaid and behavioral health agencies because different IT systems pay for different services. Some individuals receiving health home services often include members of managed care health plans that maintain their payment records in terms of encounters that do not align with fee for service claims. Medicaid managed care encounter data has generally been unavailable or less reliable than claims because of the numerous entities involved in its collection and production. Use of encounter data may require time-consuming analysis and improvement before it can be considered reliable.
3. Most clinical information is found only in the medical record, not in data submitted on the claim form. Unless a provider has an electronic health record, and sometimes even then, it can be a laborious process to review charts to extract clinical information such as, for example, BMI.
4. Electronic health records could be programmed to facilitate quality data collection, though those currently in the field would not necessarily include the CMS core performance measures or any state-developed measures. Retrofitting and retraining may be needed.
5. Not all services generate a claim, particularly care provided under a grant or contract. A number of states still use contracts rather than claims systems when spending federal mental health or substance abuse block grant dollars. Few outcomes measures exist or they are difficult to implement because data is required from multiple systems (i.e., educational or correctional records are not in the health data systems), so process measures are often substituted. However, goals are often to improve outcomes.

Development of Affordable Care Act-required data systems, greater incorporation of electronic health records, and ongoing dialogue between CMS and states will likely continue to overcome these challenges. Reporting, as well as improvements in reporting, is likely to be incremental. As more providers adopt electronic health records, data collection processes improve and better measures will assess quality.

USE OF HEALTH INFORMATION TECHNOLOGY IN HEALTH HOMES

Background

Historically, states and providers focused their investments in information technology (IT) on systems that streamlined operations and improved the administrative processes of healthcare — from practice management systems that improved clinician and staff productivity and ensured accurate billing, to Medicaid Management Information Systems (MMIS) used by state Medicaid agencies to process claims for services provided. Over the past decade — and particularly in the last several years as spurred by enactment of the Health Information Technology for Economic and Clinical Health (HITECH) Act as part of the American Recovery and Reinvestment Act of 2009 — there has been a surge of investment in health IT products and services designed to enhance the practice of medicine.

These IT products and services (e.g., electronic medical/health records and patient registries) enable the digitization and systematic capture, coding, synthesis, and analysis of clinical and health status information. Because these IT solutions focus on improving the quality of healthcare and associated outcomes, they are generally referred to as health IT (or HIT) products and services. The HITECH Act's passage has stimulated the development of health information exchanges (HIEs) across the country; these IT solutions provide for the secure, timely movement of healthcare information between provider organizations and sites of care. When HIT and HIE applications combine, the synergy has the potential to fundamentally transform healthcare delivery and management, particularly in service delivery models such as Medicaid health homes where care coordination, access to information, and timely decision support

about care and services is crucial. When properly deployed, HIT solutions linking multiple providers under HIE can empower providers by enhancing their triage and diagnostic capabilities and by enabling continuous, integrated care management and monitoring.

Although the federal government does not mandate the use of HIT solutions in health home services, HIT adoption has been strongly encouraged through various efforts. These include funding opportunities such as EHR provider incentive programs and EHR adoption grants to federally qualified health centers (FQHCs). Since states already use Medicaid management information systems (MMIS) and/or decision support systems to manage beneficiaries' demographic and clinical information, facilitate provider payment, and monitor service utilization, the U.S. Department of Health and Human Services encourages states — at least as a starting point — to utilize those systems to measure providers by, for instance, capturing quality measurement data.[34] For providers, leveraging HIT solutions will be key to minimizing administrative burdens while collecting and reporting on quality metrics and to demonstrate meaningful use of IT solutions to justify financial incentives.[35]

HIT to Support Care Coordination and Management

Providers, including those in states with approved Medicaid health home SPAs, fall within a wide spectrum of HIT adoption. In some instances, health home providers are more heavily reliant on the state or statewide systems for the IT infrastructure to operate high-performing health homes. In other cases, the providers themselves are forging ahead and developing HIT infrastructure that can eventually plug into the emerging HIT solutions being deployed by the state or a statewide HIE entity; in some cases states are supporting these efforts practices by providing electronic health record systems, registries, and data as well as support in implementing these new tools. For framing and illustration purposes, the following examples present two states implementing health home initiatives that fall at opposite ends of the spectrum of HIT adoption.

Missouri uses CyberAccess, a web-based EMR that captures Medicaid claims data for the state's Medicaid program (MO HealthNet) and is accessible to enrolled Medicaid providers, including community mental health centers, primary care practices, and schools. The tool is a HIPAA-client portal that enables providers to:

- Download paid claims data submitted for an enrollee by any provider over the past 3 years (e.g., drug claims, diagnosis codes, CPT codes).
- View the dates and the providers of hospital emergency department services.
- Identify clinical issues that affect an enrollee's care and obtain best practice information.
- Prospectively examine specific preferred drug lists and clinical edit criteria affecting a prescription for an individual enrollee and determine if a prescription meets the requirements for Medicaid payment.
- Electronically request drug prior authorizations or clinical edit overrides.
- Identify approved or denied prescription drug prior authorizations or clinical edit overrides or medical pre-certifications previously issued and transmit a prescription electronically to the enrollee's pharmacy of choice.
- Pre-certifications for inpatient services, diagnostic service and durable medical equipment electronically requested pre-certifications.
- Review laboratory and clinical trait data.
- Examine medication adherence information and calculate medication possession ratios.
- Offer counseling opportunities for pharmacists through a point of service medication therapy management module.
- Access primary care data.
- Access labs/scripts.
- Communicate across providers.

When Health IT and Health Information Exchange applications combine, the synergy has the potential to fundamentally transform healthcare delivery and management, particularly in service delivery models such as Medicaid health homes where care coordination, access to information, and timely decision support about care and services is crucial.

With its functionality and the rich data set contained within, CyberAccess gives providers access to a wealth of information in a timely, secure manner.

The state also maintains an initial and concurrent authorization tool on length of stay that requires hospitals to notify MO HealthNet (via accessing the online authorization tool) within 24 hours of a new admission for any Medicaid enrollee. The state also provides guidance on diagnosis, condition, and treatment for inpatient length of stay authorizations. The state is currently working towards developing capacity of a daily data transfer listing for all new hospital admissions and discharges.

In Missouri, the state mental health authority provides monthly electronic monitoring reports to each health home provider via a contracted data analytics contractor. The report enables health homes providers to know whether a patient's care complies with the state's expectations on clinical standards. By accessing electronic reports, providers are able, for example, to identify the percentage of patients in need of a fasting lipid profile who also require follow-up by the nurse care manager. Reports currently made available to community mental health center health homes on a monthly basis relate to prescription drug adherence, behavioral health pharmacy management, and disease management.

The above functionality complements the state's requirement that community mental health centers use an interoperable patient registry. The registry tracks annual metabolic screening results, monitors and measures care of individuals, sends automated care reminders, and produces exception reports for consideration in care planning. Providers are expected to routinely access a behavioral pharmacy management system to identify problematic prescribing patterns.

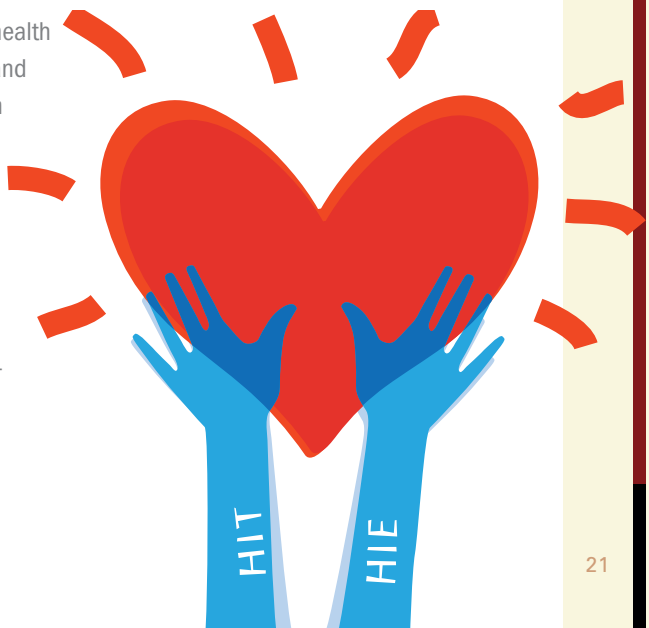
Finally, to encourage health home enrollees in managing their care and improving their health, CyberAccess offers personal health record functionality, including but not limited to:

- Claim/encounter data for the past 3 years
- Cardiac and diabetic risk calculators
- Chronic health condition information awareness
- A drug information library
- An online tool for creating a personal health plan
- Discussion lists to use with healthcare providers

These features of Missouri's health home IT structure position the state as a model for how HIT solutions can deploy in support of health home initiatives.

In Rhode Island, health home providers plan to leverage Behavioral Health On-Line Data (BHOLD), a web-accessible system to document co-occurring physical health conditions (e.g., hypertension, dyslipidemia, obesity, diabetes, asthma, COPD), which the state's seven community mental health organizations currently use to monitor service coordination and evaluate care needs. BHOLD is also used to collect environmental outcome information about patients such as employment and housing information. The system also serves as a patient registry and a longitudinal patient record accessible to both FQHCs and community mental health organizations.

Missouri's community mental health organization health homes will also receive health utilization profiles from the state — for the Medicaid fee-for-service population — and from the two Medicaid managed care organizations operating in the state. The health homes providers are also slated to receive limited information on historic utilization and medication reconciliation. The community mental health organizations and other entities serving as health home providers are also exploring the capabilities of the state's HIE, CurrentCare, to obtain hospital admission/discharge/transfer data, lab results, and filled prescriptions. The state is still progressing towards optimal adoption of HIT capabilities; its CurrentCare HIE platform and its relatively small program scale should enable it to continue deploying HIT capabilities to support its health home program.



REIMBURSEMENT AND RATE SETTING FOR HEALTH HOME SERVICES

Background

A key provision of Medicaid health homes is the ability to pay for services using PMPM or other alternative methodologies. States and service providers favor PMPM and monthly case rates over reimbursements based on 15-minute unit or other partial hour billing, and states can make a non-actuarially set PMPM amount. Providers commonly cite 15-minute unit billing as one barrier to effectively integrating physical and behavioral healthcare due to the burden of documenting each individual service rather than receiving reimbursement for a bundle of services. The other barrier is that some health home service components (i.e., care coordination and referral to community and social support services) were previously non-reimbursable unless a state covered services such as targeted case management services under its Medicaid state plan or payment rates sufficiently covered the costs of such inherent service components. As a result, there is little historical data to guide rate setting. Although the health home payment can be a per member per month payment, it must be made in connection to the rendering of a Medicaid allowed health home service.

Feedback to States about Establishing Health Home Payments

CMS requires states to ensure health home service payments will not duplicate other Medicaid payments. This includes duplication in payments for beneficiaries provided under fee-for-service or Medicaid managed care arrangements.

Non-Duplication among Beneficiaries

As discussed earlier in this report, states must ensure that enhanced FMAP payments of 90% federal match do not occur for a single beneficiary for more than eight consecutive quarters. States with multiple SPAs and different start dates must consider this requirement, and might consider tracking each individual participating in a Medicaid health home project, in order to prevent claiming the enhanced match in a second SPA. This limitation applies whether or not an individual beneficiary actually received care for all eight quarters in an initial health homes program, as the eight quarters must be consecutive and without a break between two SPAs. The state may not count an individual who receives services under one SPA under a subsequent SPA if there is a break in services for the individual moving from one SPA to another. For example, a state in which a beneficiary who begins to receive health home services for seven quarters following the SPA's effective date could only receive enhanced match for the final quarter under another SPA if it follows directly from the other 7 quarters; the state could not receive enhanced match for the final quarter in a SPA that starts at a later date.

This structure presents important considerations for states considering multiple SPAs with different start dates. For states that plan a phase-in based on geography, or based on when providers will be ready to participate, there is always the option of covering different phases (i.e., different target groups, providers, or geographical areas) in one SPA, forgoing some of the enhanced match for the later phases to maximize the eight quarters. The state must weigh the benefits of maximizing each phase's period of enhanced match through multiple SPAs against the administrative difficulty and budgetary impact of tracking and excluding individuals from any claiming of enhanced match in a later SPA. Notably, if it is likely that members may switch from one SPA to another — as people relocate or change providers — building a phase-in into multiple SPAs can actually reduce federal match revenue because the state is precluded from claiming the enhanced match when individuals switch SPAs but have a break in health home services. Since individuals could be eligible for multiple health home target populations or could be included as part of an initial regional implementation of health home services before the benefit is available statewide, states will need to track individual health home service users.

Since Missouri's benefit is statewide, the enhanced FMAP payment to the state began January 1, 2012 and ends December 31, 2014. However, some states plan to implement health home services on a regional basis before going statewide. For example, Ohio implemented health home services in five counties (Region 1) in October 1, 2012, with additional county implementation planned in 2013. Ohio will not receive enhanced FMAP payment for beneficiaries receiving services in Region 1 after September 30, 2014. When Ohio goes full-scale with health home services in 2013, the state will be able to receive enhanced FMAP only for individuals not part of the initial geographic region, even if the beneficiary moved to a part of the state where health home services will be newly implemented. In order for states to ensure non-duplication of payment across beneficiaries, it will need to identify each unique user of health homes services.

Non-Duplication of Services

Since Medicaid health home services could be similar to covered services under an existing state plan benefit, states will also have to assure CMS that beneficiaries receiving health home services will not also receive other duplicative services such as case management targeted for individuals with certain health conditions or waiver case management services. Since many managed care contracts include a care coordination component, CMS' Integrated Care Resource Center issued guidance to clarify how states may seek to structure health homes alongside managed care services to ensure non-duplication in a brief, Health Home Considerations for a Medicaid Managed Care Delivery System: Avoiding Duplication of Services and Payments.

States with approved health home SPAs included the following to assure CMS that duplication of services will not occur:

MISSOURI: "This primary care health home delivery design and payment methodology will not result in any duplication of payment or services between primary care health homes and managed care or any of the other delivery systems including waivers and state plan options."

NEW YORK: "The delivery design and payment methodology will not result in any duplication of payment between health homes and managed care" and "All of the above payment policies have been developed to assure that there is no duplication of payment for health homes services."

NORTH CAROLINA: "Health home service payments will not duplicate any other payment through the State Plan or waiver of the State Plan. The North Carolina Division of Medical Assistance will prevent duplication of payments and roles and responsibilities on an ongoing basis."

OHIO: "Health home service payments will not result in any duplication of payment or services between Medicaid programs, services, or benefits (i.e., managed care, other delivery systems including waivers, any future health homes, and other state plan services)."

OREGON: "Payments for case management or targeted case management services under the plan does not duplicate payments with Home and Community Based Services."

RHODE ISLAND: "The state assures that health home services under this submission will be separate and distinct and that duplicate payment will not be made for similar services available under other program authorities."

Establishing Health Home Payment Rates

States are considering a variety of factors in the development of health home payment rates, including costs of the healthcare team and indirect costs such as those related to program administration evaluation and reporting.

Payment Approach: Creating New Rates for Teams of Healthcare Professionals

Missouri built the community mental health center health home PMPM rate around the costs of the team of healthcare professionals who carry out the services described below. The state based the PMPM rate on the sum of team member and other costs necessary for administration of the benefit.

MISSOURI'S HEALTH HOME TEAM MEMBERS AND RATE-SETTING

Team Member	Full Time Employee (FTE)	Functions
Nurse Care Manager	1 FTE per 250 enrollees	a. Develops wellness and prevention initiatives b. Facilitates health education groups c. Participates in the initial treatment plan development for all of their health home enrollees d. Assists in developing treatment plan healthcare goals for individuals with co-occurring chronic diseases e. Consults with community support staff about identified health conditions f. Assists in contacting medical providers and hospitals for admission/discharge g. Provides training on medical diseases, treatments, and medications h. Tracks required assessments and screenings i. Assists in implementing Department of Mental Health Net HIT programs and initiatives (e.g., CyberAccess, metabolic screening) j. Monitors HIT tools and reports for treatment k. Tracks medication alerts and hospital admissions/discharges l. Monitors and reports performance measures and outcomes
Primary Care Physician Consultant	1 hour per enrollee per year	a. Participates in treatment planning b. Consults with team psychiatrist c. Consults regarding specific consumer health issues d. Helps coordinate with external medical providers
Health Home Director	1 FTE per 500 enrollees	a. Provides leadership to the implementation and coordination of health home activities b. Champions practice transformation based on healthcare home principles c. Develops and maintains working relationships with primary and specialty care providers, including inpatient facilities d. Monitors health home performance and leads improvement efforts e. Designs and develops prevention and wellness initiatives
Administrative Support	1 FTE support staff per 500 enrollees Non-PMPM paid staff training time Contracted services	a. Tracks referrals b. Provides training and technical assistance c. Manages data management and reporting d. Maintains schedules for health home team and enrollees e. Charts audits for compliance f. Reminds enrollees about keeping appointments, filling prescriptions, etc. g. Requests and sends medical records for care coordination

Rather than build the PMPM rate based on the costs of team members who deliver existing Medicaid services (as captured through uniform cost reports, for example), Missouri opted to establish a new team of healthcare professionals whose activities do not compete with existing efforts around the delivery of case management Medicaid services. For example, Missouri continues to provide reimbursement for community support services[36] under its fee-for-service benefit and does not include community support as part of the health home PMPM rate.

Payment Approach: Converting Existing Services to Health Home Services

Both New York and Rhode Island opted to convert existing case management services to health homes. New York is converting Medicaid enrolled targeted case management programs to designated health homes since the current programs provide similar comprehensive case management and community supports to help meet the extensive and complex needs of their clients.[37] Rhode Island converted community psychiatric supportive treatment,[38] a care coordination and support service, to a health home program and imposes additional requirements to ensure that the service meets federal coverage requirements. Rhode Island developed its monthly case rate based on personnel costs of individual team members, the team composition, and the overall estimated caseload to yield a single statewide average case rate. The rate also reflects operating and support costs.

RHODE ISLAND HEALTH HOME TEAM STAFF COMPOSITION

Health Home Team Staff Composition Qualifications (Team Serving 200 Clients)

Team Member	FTE
Health Home FTE Master's Team Coordinator	1.0
Psychiatrist	.5
Registered Nurse	2.5
Master's Level Clinician	.5
CPST Specialist – Hospital Liaison	1.0
CPST Specialist	5.5
Peer Specialist	.25
Total FTE Personnel	**11.25**

Payment Approach: Performance Incentive Payments

In addition to payments for staffing and allowable services costs, many states are interested in utilizing health home service payments to reward providers for achieving performance related outcomes. Missouri intends to amend its SPA to enable health home providers to share in savings resulting from achievement of improved health outcomes and reductions in hospital or pharmacy costs.

Additional State Costs

Although personnel costs represent the largest portion of payment rates, other factors play into the total program costs. Additional costs states should consider when developing health home services rates include:

- **STATE COSTS OF ADMINISTERING AND MONITORING THE BENEFIT:** This includes personnel costs of any additional (or backfilled) staff necessary to oversee delivery of health home services, develop program rules, conduct site visits, or monitor program compliance. CMS allows states to include overhead cost necessary to provide this service, but does not allow separate payment for start-up or infrastructure cost. CMS does not permit payment to help make providers qualified to render health home services.
- **STATE COSTS TO SUPPORT PRACTICE TRANSFORMATION:** CMS guidance requires that states specify in the SPA how it intends to help health home providers address a number of components (e.g., providing access to evidence-based services, coordinating access to prevention and health promotion services, establishing continuous quality improvement programs). Missouri's health home providers participate in a number of learning activities supported with either state or private foundation funding.
- **EVALUATION AND REPORTING:** CMS requires states to agree to participate in the federal evaluation of health home services required in the Affordable Care Act. State will need to report core measures data and other process-related information collected in the evaluation. In addition, states may need to factor in the costs associated with supplying health utilization and other data on health homes to CMS.
- **PATIENT IDENTIFICATION/TRACKING AND PROVIDER PAYMENT:** Reprogramming may need to occur in Medicaid data warehouse or other systems that facilitate beneficiary enrollment and provider payments.

Many of the costs may be claimable as indirect costs and others will not; states should discuss such costs with CMS to determine what Medicaid reimbursement is available.

OTHER CONSIDERATIONS

Integrated Care for Medicare/Medicaid Eligibles

Under other new Affordable Care Act opportunities, several states plan to integrate services and payments for individuals dually eligible for Medicare and Medicaid, including those with serious mental health conditions. Those states will grapple with identifying the most effective integrated care approaches for these Medicare/Medicaid eligibles (MMEs, CMS's preferred nomenclature for persons dually eligible for Medicare and Medicaid). This is especially true since the objectives of integrated care for MMEs are similar to health home goals (e.g., improving care management and care transitions, increasing patient engagement, integrating data for more effective care coordination and service delivery).

Since health home services may not exclude MMEs, a state cannot implement health homes for Medicaid-only populations and decide to address care coordination for MMEs through other means. Since many states are now delaying implementation of integrated care for MMEs, hopefully more time can be devoted to designing effective strategies that align health homes with other approaches (e.g., integrated Medicare and Medicaid funding) to achieve improved outcomes for all MMEs, including among individuals with serious mental health conditions.

Some state proposals contemplate a single entity responsible for coordinating medical, behavioral, long-term care, and prescription drug services. Such an approach may require a reconsideration of carved out and separately managed behavioral health services for MMEs. Other states, such as Michigan, propose to preserve existing managed behavioral health frameworks that use regional prepaid inpatient health plans to manage its capitated carve-out system. However, those states will also face challenges in structuring services and benefits for MMEs and Medicaid-only beneficiaries. A key question states will confront is whether implementing an integrated care strategy for MMEs negates the necessity of health home programs. The answer is it depends. If a state has data to support that the preponderance of total healthcare costs are among MMEs with chronic conditions, then implementing health home services for a broader Medicaid eligible population may not yield sufficient savings to sustain health homes. Therefore, obtaining and analyzing Medicare and Medicaid data is critical to decision-making. States embarking on integrated care strategies for MMEs have engaged in such analyses. Connecting those efforts to health home program design activities would extend the utility of the Medicare data and broaden states' understanding of the potential scope and impact of reform strategies involving MMEs.

Accountable Care Organizations

Numerous states are also involved in planning or supporting efforts to create accountable care organizations (ACOs). ACOs have emerged as critical redesigns of delivery systems in order to expand coverage and encourage providers to organize jointly to provide a full continuum of care and commit to improving quality while controlling cost. These providers are then rewarded for success.[39] Ohio and other states view health homes as the essential building block for ACOs since states expect health homes providers for individuals with mental illnesses to be accountable for whole-person care coordination and facilitating access to, and collaboration with, primary care and long-term services and supports. In essence, ACOs are the "neighborhood" in which health homes reside.

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Although Medicare, under the Medicare Shared Savings Program, defines the concept of ACOs, the concept is not yet defined in a Medicaid context. Therefore, there is significant opportunity for behavioral health providers and systems to work with state agencies to shape the design of ACO structures for the Medicaid safety net population. An important question for the community behavioral health system is whether to support singular initiatives to coordinate care (i.e., meeting health home eligibility requirements in states, deciding the appropriate role within an MME integration structure, ensuring provision of behavioral health services and coordination within individual primary care medical home efforts) or to formulate a strategy that considers the needs of individuals, particularly those newly insured in 2014, and effective structures to meet those needs. States are eager to receive guidance since their focus will be on implementing multiple, resource-intensive programs that limit ability of staff to focus on development of creative and innovative approaches.

CONCLUSION

Medicaid health homes provide an important opportunity for states to bridge one of the most significant barriers to integrated physical and behavioral healthcare — care coordination and communication across providers. While enhanced funding may lead many states to view health homes as a meaningful pursuit, that alone should not be the reason for coverage of the services. Careful attention and time should be devoted to planning the appropriate structure based on the unique circumstances of each state, the target population's care needs, and the existing provider infrastructure.

States should use the Health Home SPA template to begin answering questions about target populations, provider standards and infrastructure requirements, quality measures, and cost saving assumptions. Additionally, CMS offers technical assistance to states interested in submitting a health home SPA.

To be most effective, the selection of the target population should be rooted in data identifying cost saving opportunities and the commonalities across high-cost beneficiaries. In order to sustain health home services, states may rely on reduced spending in hospital emergency departments and inpatient settings to finance health home services. Therefore, selection of the appropriate target population is essential to the success of a state's health homes. To illustrate, a few questions states may want to address while planning health homes for individuals with serious mental health conditions include:

- What percentage of the total Medicaid population do individuals with serious mental health conditions represent?
- What percentage of total annual Medicaid costs do individuals with serious mental health conditions constitute?
- What percentage of total Medicaid community mental health spending is attributable to MMEs?
- What are the cost drivers among individuals with serious mental health conditions (e.g., pharmacy, hospital emergency department visits, hospital inpatient services, specialty behavioral health)? Can these be broken out into primary conditions and co-morbidities?
- What physical health conditions most frequently occur among individuals with serious mental health conditions?
- How does total Medicaid cost and utilization of individuals with serious mental health conditions compare with the cost and utilization of individuals without serious mental health conditions?

Without the ability to answer these and similar questions, states may find it difficult to establish the business case for implementing health homes and sustaining services beyond the two year enhanced payment period.

APPENDIX A – SELECTED STATES' HEALTH HOME SERVICE DESCRIPTIONS

Comprehensive Care Management

MISSOURI	Comprehensive care management services are conducted by the nurse care manager, primary care physician consultant, the health home administrative support staff and health home director with the participation of other team members and involve: identification of high-risk individuals and use of client information to determine level of participation in care management services; assessment of preliminary service needs; treatment plan development, which will include client goals, preferences, and optimal clinical outcomes; assignment of health team roles and responsibilities; development of treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions; monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines; and development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery, and costs.
NEW YORK	A comprehensive individualized patient-centered care plan will be required for all health home enrollees. The care plan will be developed based on the information obtained from a comprehensive health risk assessment used to identify the enrollee's physical, mental health, chemical dependency, and social service needs. The individualized care plan will be required to include and integrate the individual's medical and behavioral health services, rehabilitative, long-term care, and social service needs, as applicable. The care plan will be required to identify the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager, and other providers directly involved in the individual's care. The individual's care plan must also identify community networks and supports that will be utilized to address their needs. Goals and timeframes for improving the patient's health, their overall healthcare status, and the interventions that will produce this effect must also be included in the plan of care. The care manager will be required to make sure that the individual (or their guardian) plays a central and active part in the development and execution of their plan of care and that they are in agreement with the goals, interventions, and time frames contained in the plan. Family members and other supports involved in the patient's care should be identified and included in the plan and execution of care as requested by the individual. The care plan must also include outreach and engagement activities, which will support engaging the patient in their own care and promote continuity of care. In addition, the plan of care will include periodic reassessment of the individual's needs and goals and clearly identify the patient's progress in meeting goals. Changes in the plan of care will be made based on changes in patient need.
NORTH CAROLINA	Comprehensive care management involves active participation from primary care physicians, care managers, patient, and family/caregivers. It includes patient-identification and comprehensive assessment obtained through direct referrals, mining administrative claims data (e.g., risk stratification tools, frequent hospital and emergency room admissions), screenings and assessments, and chart reviews that identify gaps in care; developing an individualized care plan, the healthcare team, including the care manager, primary care physician, patient, and family/caregiver, and agreeing on goals in a care plan. The care manager ensures the patient's care plan is implemented, communicated, and coordinated across providers and delivery settings. Care manager interventions are identified and documented. The healthcare team monitors the patient's progress toward goal achievement on an ongoing basis, adjusting care plans as needed. The healthcare team uses quality metrics, assessment, survey results, and utilization of services to monitor and evaluate the impact of interventions.

OHIO	Comprehensive care management begins with the identification of individuals who are potentially eligible to receive health home services. The community behavioral health center health home will be responsible for identifying individuals with severe and persistent mental illness who are currently affiliated with the health home site. Individuals living with a serious and persistent mental illness without a community behavioral health center affiliation or a routine source of healthcare may be identified through referral from another provider or an administrative data review and connected to a community behavioral health center health home to begin the comprehensive care management process. The next step is for the community behavioral health center to engage the eligible individual and his/her family by explaining the benefits of health home services and the right to opt-out of health home services. The community behavioral health center health home will complete a comprehensive assessment of the individual's physical health, behavioral health (i.e., mental health, substance use), long-term care, and social needs. The assessment must account for the cultural and linguistic needs of the individual and use relevant comprehensive data from a variety of sources, including the individual/family, caregivers, medical records, team of health professional. At a minimum, the community behavioral health center health home will reassess the individual at least once every 90 days. Based on the health assessment, the community behavioral health center health home will assemble a team of health professionals and establish and negotiate roles and responsibilities for each member, including the accountable point of contact. The community behavioral health center health home will develop and continuously update a single, integrated, person-centered care plan that will include prioritized goals and actions with anticipated timeframes for completion and will reflect the individual's preferences. Prior to implementation of the care plan, a communication plan must be developed to ensure that routine information exchange of clinical patient summaries, medication profiles, updates on patient progress toward meeting goals, collaboration, and communication occurs between the team members, providers, and the individual/family.
OREGON	The patient-centered primary care home/health home will identify patients with high-risk environemental or medical factors, including patients with special health care needs, who will benefit from additional care planning. Care management activities may include, but are not limited to, population panel management, defining and following self-management goals, developing goals for preventative and chronic illness care, developing action plans for exacerbations of chronic illnesses and developing end-of-life care plans when appropriate. Patient-centered primary care home services will occur under the direction of licensed health professionals, physicians, physician assistnats, nurse practioners, nurses, social workers, or professional counselors.
RHODE ISLAND	Comprehensive care management services are conducted with high need individuals, their families, and supporters to develop and implement a whole person-oriented treatment plan and monitor the individual's success in engaging in treatment and supports. Comprehensive care management services are carried out through use of a biopsychosocial assessment. A biopsychosocial assessment of each individual's physical and psychological status and social functioning is conducted for each person evaluated for admission to the community mental health organization. A psychiatrist, registered nurse or a licensed and/or Master's prepared mental health professional (consistent with the Rhode Island Rules and Regulations for the Licensing of Behavioral Healthcare Organizations), may conduct assessments. The assessment determines an individual's treatment needs and expectations of the individual served; type and level of treatment to be provided, need for specialized medical or psychological evaluations; need for the participation of the family or other support persons; and identification of the staff person(s) and/or program to provide the treatment. Based on the biopsychological assessment, a goal-oriented, person-centered care plan is developed, implemented, and monitored by a multidisciplinary team in conjunction with the individual served. Any member of the community mental health organization health home team may provide comprehensive care management services; however, Master's level health home team coordinators will serve as the primary practitioners, providing comprehensive care management services.

Care Coordination

MISSOURI

Care coordination is the implementation of the individualized treatment plan (with active client involvement) through appropriate linkages, referrals, coordination, and follow-up to needed services and supports, including referral and linkages to long-term services and supports. Specific activities include, but are not limited to, appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes, and communicating with other providers and clients/family members. Nurse care managers with the assistance of the health home administrative support staff will be responsible for conducting care coordination activities across the health team. The primary responsibility of the nurse care manager is to ensure implementation of the treatment plan for achievement of clinical outcomes consistent with the needs and preferences of the client.

NEW YORK

The health home provider will be accountable for engaging and retaining health home enrollees in care, as well as coordinating and arranging for the provision of services, supporting adherence to treatment recommendations, and monitoring and evaluating the enrollee's needs. The individualized plan of care will identify all the services necessary to meet goals for care management of the enrollee such as prevention, wellness, medical treatment by specialists and behavioral health providers, transition of care from provider to provider, and social and community services, where appropriate. To fulfill the care coordination requirements, the health home provider will assign each individual enrollee one dedicated care manager who is responsible for overall management of the enrollee's plan of care. The enrollee's health home care manager will be clearly identified in the patient record and will have overall responsibility and accountability for coordinating all aspects of the individual's care. The health home provider will be responsible to assure that communication will be fostered between the dedicated care manager and treating clinicians to discuss as needed enrollee's care needs, conflicting treatments, change in condition, etc., which may necessitate treatment change (i.e., written orders and/or prescriptions).

The health home provider will be required to develop and have policies, procedures and accountabilities (contractual agreements) in place, to support and define the roles and responsibilities for effective collaboration between primary care, specialist, behavioral health providers, and community-based organizations. The health home providers policies and procedures will direct and incorporate successful collaboration through use of evidence-based referrals, follow-up consultations, and regular, scheduled case review meetings with all members of the interdisciplinary team. The health home provider will have the option of utilizing technology conferencing tools, including audio, video, and/or web-deployed solutions when security protocols and precautions are in place for protected health information to support care management/coordination activities. The health home provider will be required to develop and utilize a system to track and share patient information and care needs across providers, monitor patient outcomes, and initiate changes in care as necessary to address patient need.

NORTH CAROLINA

Care coordination, a core component of care management, is the implementation of the individualized care plan (developed by the healthcare team with active primary care physician, care manager, and patient and family/caregiver involvement) through appropriate linkages, referrals, coordination, and follow-up to needed services and supports. Specific activities include, but are not limited to, appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes, and communicating with other providers and clients/family members. Care managers or primary care provider team members are responsible for conducting care coordination activities across providers and settings, with their primary responsibility being to ensure implementation of the care plan for achievement of clinical outcomes consistent with the needs and preferences of the client. Care manager care coordination interventions are identified and documented in Content Management Interoperability Services (CMIS).

The mental health integration program aims to improve the screening and treatment of mental health conditions in the primary care setting and enhance the medical care of individuals with behavioral health problems. They are working to implement the National Council for Behavioral Health's four quadrant clinical integration model as the foundation for communication, collaboration, assessment, referral, and clinical management of care. After an initial pilot period,

the model is being implemented statewide, with primary care practices having incorporated behavioral health treatment in the primary care provider office setting while also supporting enhanced referral processes for more complex patients to specialty mental health services and behavioral health care coordination. The central office and networks use psychiatrists to coordinate implementation of the four quadrant model and to identify patients with behavioral and physical health care needs for the primary care providers.

OHIO

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

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

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

OREGON

Care coordination will be an integral part of the health home. Patients will choose and be assigned to a provider/clinic or team to increase continuity with the chosen provider team and to ensure individual responsibility for care coordination functions. A person-centered plan will be develolped based on the patient's needs and desires with at least the following elements: options for accessing care, information on care planning and care coordination, names of other priary care team members, when applicable, and information on ways the patient particpates in this care coordination. Care coordination functions can include, but are not limited to, tracking of ordreed tests and result notification, tracking referrals ordered by its clinicians, inlcuding referral status and whether consultation results have been communicted to patients and clinicians, and direct collaboration or co-management of patients with specitly mental health, substance abuse, and providers of services and supports to peopole with developmental disabilities and people receiving long-term care services and supports. Co-location of behavioral health and primary care is strongly ensouraged. Health home services will occur under the direction of licensed health professionals, physicians, physician assistants, nurse practitioners, nurses, social workers, or professional counselors.

RHODE ISLAND	Care coordination is the implementation of the individualized treatment plan (with active involvement of the individual served) for attainment of the individual's goals and improvement of chronic conditions. Care managers are responsible for conducting care coordination activities across providers and settings. Care coordination involves case management necessary for individuals to access medical, social, vocational, educational, and other individualized supportive services, including, but not limited to, assessing support and service needed to ensure the continuing availability of required services; assistance in accessing necessary healthcare; follow up care and planning for any recommendations; assessment of housing status and providing assistance in accessing and maintaining safe and affordable housing; conducting outreach to family members and significant others in order to maintain an individual's connection to services, and expand social network; assisting in locating and effectively utilizing all necessary community services in the medical, social, legal, and behavioral healthcare areas and ensuring that all services are coordinated; and coordinating with other providers to monitor an individual's health status, medical conditions, medications, and side effects. Care coordination services may be provided by any member of the community mental health organization health home team; however, community psychiatric supportive treatment specialists will be the primary practitioners providing care coordination services.

Health Promotion

MISSOURI	Health promotion services shall minimally consist of providing health education specific to an individual's chronic conditions, development of self-management plans with the individual, education regarding the importance of immunizations and screenings, child physical and emotional development, providing support for improving social networks, and providing health promoting lifestyle interventions, including but not limited to, substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, and increasing physical activity. Health promotion services also help consumers participate in the treatment plan's implementation and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions. The primary care health home director, nurse care manager, behavioral health consultant and appropriate primary care health home administrative support staff will provide health promotion services.
NEW YORK	Health promotion begins for eligible health home enrollees with the commencement of outreach and engagement activities. New York's health home plan for outreach and engagement will require a health home provider to actively engage patients in care by phone, letter, health information technology, and community "inreach" and outreach. Each of these outreach and engagement functions will include aspects of comprehensive care management, care coordination, and referral to community and social support services. All of the activities are built around the notion of linkages to care that address all of the clinical and non-clinical care needs of an individual and of health promotion. The health home provider will support continuity of care and health promotion by developing a treatment relationship with the individual and the interdisciplinary provider's team. The health home provider will promote evidence based wellness and prevention by linking health home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self-help recovery resources, and other services based on individual needs and preferences. Health promotion activities will be utilized to promote patient education and self-management of their chronic condition.
NORTH CAROLINA	Health promotion services help consumers participate in the implementation of their care plan and place a strong emphasis on skills development for management and monitoring of chronic health conditions. It is an integral service provided by primary care providers and and their care teams or Community Care of North Carolina care managers. Most of the quality improvement initiatives conducted by the networks include a health promotion component, which educates primary care providers and their care teams about ways to promote health with their patients an also gives primary care providers easily accessible tools to use with patients. Health promotion services include health education and coaching specific to an individual's chronic conditions, development of self-management plans, education regarding the importance of immunizations and screenings, promoting lifestyle interventions, including, but not limited

	to, substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, and increasing physical activity. These services are provided by Community Care of North Carolina care managers, primary care providers, or their care teams.
OHIO	Health promotion services are intended to equip the individual/family with relevant knowledge and skills that increases understanding of diseases/conditions identified in the assessment, promote self-management, and improve quality of life and daily functioning. This may be accomplished through the following education about wellness and healthy lifestyle choices; provision of, or referrals, to evidence-based wellness programs such as tobacco cessation, weight management, chronic disease management programs, wellness management and recovery, and others, and connections to peer supports. A health promotion focus will be to support and engage the individual and the family in the development, implementation, and monitoring of the care plan. By empowering the individual and promoting self-advocacy, there will be an increased ability to be proactive in the self-management of existing conditions, increase the utilization of preventative services, and accessing care in appropriate settings.
OREGON	The patient-centered primary care home provider will support continuity of care and health promotion through the development of a treatment relationship with the individual, other primary care team members, and community providers. The health home provider will promote the use of evidence-based, culturally sensitive wellness and prevention by linking the enrollee with resources for smoking cessation, diabetes, asthma, self-help resources, and other services based on individual needs and preferences. Health promotion activities will promote consumer/family education and self-management of the chronic conditions. Health home services will occur under the direction of licensed health professionals, physicians, physician assistants, nurse practitioners, nurses, social workers, professional counselors, community health workers, personal health navigators, or peer wellness specialists.
RHODE ISLAND	Health promotion services encourage and support healthy ideas and concepts to motivate individuals to adopt healthy behaviors. The services also enable individuals to self-manage their health. Any professional working within a health home team can provide health promotion services. Health promotion activities place a strong emphasis on self-direction and skills development for monitoring and management of chronic health conditions. These services help individuals take a self-directed approach to health, through the provision of health education. Specific health promotion services may include, but are not limited to, providing or coordinating assistance with promoting individuals' health and ensuring that all personal health goals are included in person-centered care plans; promotion of substance abuse prevention, smoking prevention and cessation, nutritional counseling, obesity reduction, and increased physical activity; providing health education to individuals/family members about chronic conditions; providing prevention education to individuals/family members about health screening and immunizations; providing self-management support and development of self-management plans and/or relapse prevention plans so that individuals can attain personal health goals; and promoting self-direction and skill development in the area of independent administering of medication. Any member of a health home team may provide health promotion services. However, psychiatrists and nurses will be the primary practitioners providing health promotion services.

Comprehensive Transitional Care

MISSOURI	In conducting comprehensive transitional care, a member of the health team provides care coordination services designed to streamline plans of care, reduce hospital admissions, ease the transition to long-term services and supports, and interrupt patterns of frequent hospital emergency department use. The health team member collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing clients' and family members' ability to manage care and live safely in the community, and shift the use of reactive care and treatment to proactive health promotion and self-management.

NEW YORK

Comprehensive transitional care will prevent avoidable readmission after an enrollee's discharge from an inpatient facility (i.e., hospital, rehabilitative, psychiatric, skilled nursing, or treatment facility) and to ensure proper and timely follow-up care. To accomplish this, the health home provider will be required to develop and have a system in place with hospitals and residential/rehabilitation facilities in their network to provide the health home care manager prompt notification of an enrollee's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.

The health home provider will also establish policies and procedures with local practitioners, health facilities, including emergency rooms, hospitals, and residential/rehabilitation settings, providers, and community-based services to ensure coordinated, safe transition in care for its patients who require transfer to/from sites of care. The health home provider will be required to develop and have a systematic follow-up protocol in place to assure timely access to follow-up care post discharge that includes at a minimum receipt of a summary care record from the discharging entity, medication reconciliation, and a plan for timely scheduled appointments at recommended outpatient providers. The health home care manager will be an active participant in all phases of care transition, including discharge planning and follow-up to ensure enrollees received follow-up care and services and re-engagement of patients who have become lost to care.

NORTH CAROLINA

A transition occurs any time a patient moves from one care setting to another or when she/he moves from one area to another within the same care setting. Every hospital admission is assessed for transitional care need using real-time data from multiple sources. Transitional care is initiated, in some cases on the first admission, for patients with chronic conditions at high-risk of readmission and for conditions in which the admission is ambulatory-care sensitive. Networks provide transitional care management to all hospitals in their region. Networks are mandated to maintain active referring relationships with all hospitals to facilitate access to primary care following hospital discharge or emergency department services. Onsite embedded care management is provided through 55 transitional care nurses who work full-time in hospitals with a large volume of admissions for the ABD population. Hospitals with embedded transitional care managers account for 80% of Medicaid ABD inpatient admissions.

The primary role of the care manager in the transitional care process is to facilitate interdisciplinary collaboration among providers during transitions; encourage the primary care physicians, patients, and family/caregivers to play a central and active role in the formation and execution of the care plan; promote self-management skills and direct communication among the patient and caregiver, the primary care physicians, and other care providers; achieve medication reconciliation by consulting with the network pharmacist, hospital, primary care physicians, specialists, patient, and his/her caregiver.

The community care networks connect the primary care provider/medical home to the community. Networks have forged links with all North Carolina hospitals to obtain timely information about their hospitalized patients to support transitions that are more effective. Care managers schedule visits with patients in the hospital and then follow-up with home visits within 3 days of discharge. One of the key functions is to perform medication reconciliation on hospitalized patients that seek to make sense of all the different medications the patients may take (from the medicine cabinet, the primary care physician's list, hospital discharge instructions, specialists and behavioral health providers, over-the-counter meds, etc.). Post-discharge home visits not only support medication reconciliation efforts, but also provide care managers with valuable knowledge about the patients' home environments and support issues.

The primary care provider is informed about an admission by the care manager provision of a copy of the hospital discharge summary, either electronically or by mail, depending on the format available. Transitional care staff update the patient's medical homes about hospitalizations, other prescribed medications, social and environmental concerns, and other agencies providing services such as personal care, home healthcare, and behavioral health support, and make sure that the primary care provider receives discharge summaries. Network pharmacists review medication lists and alert the primary care provider of discrepancies and other findings. Transitional care staff shares information among a variety of local agencies, including behavioral health providers and long-term care support providers.

Transitional care is triggered by access to real-time admission/discharge/transfer data from most hospitals in their respective communities. Additional real-time data is accessed with Thompson-Reuters data or embedded hospital care managers have direct access to hospital census data. These three data sources provide access to real-time data across all hospitals statewide, which is then screened by care managers to determine the need for transitional care services. Post-acute care coordination and medication reconciliation relies on electronic data sources, including the primary care provider problem and medication lists and hospital discharge instructions, and information from face-to-face assessments of transitional care recipients at the hospital bedside by care managers, at the recipient's home and at follow-up appointments at the medical home.

The following types of transition care activities are documented in CMIS and can be used in queries and reports: patient care plan; information gathered during in-person visits or telephonically; transition and support; medication review; medication reconciliation; home visit; percentage of hospitalized patients ca care manager touched in a specified time period; communication gathered from other providers and resources; and needed follow-ups and reminders.

OHIO

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

The care manager will be the accountable team member for providing comprehensive transitional care service, including the development and coordination of a discharge and transition plan. However, other members of the health home team will provide input in the development and assist with the implementation of the discharge and transition plan. The care manager is responsible for exchanging or facilitating exchange of medical records such as the care plan, crisis plan, list of current medications, the most recent psychiatrist note, and any other medical documents necessary to facilitate continuity of care during a crisis, hospitalization, incarceration, or admission to a residential program. The care manager will attend hospital treatment team meetings whenever possible. Qualified health home specialists will assist with physical discharge process, assisting the client with returning home and community and linking the client to follow-up appointments. The care manager will review the discharge records, including after-care plan and medications, update care plan accordingly, coordinate with other team members, including family, psychiatrist, hospital liaison worker, nurse, and pharmacist, and re-engage and re-orient the consumer to community-based care. The team leader will track team clients in crisis, hospitalized, or incarcerated, conduct case reviews, review discharge/transition plans, monitor warm hand-off, and smooth transition of clients back to community.

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

OREGON

The health home will emphasize transitional care by demonstrating either a written agreement and/or procedures in place with its usual hospital providers, local practitioners, health facilities, and community-based services to ensure notification and coordinated, safe transitions, as well as improving the percentage of patients seen or contacted within one week of facility discharges. Health home services will occur under the direction of licensed health professionals, physicians, physician assistants, nurse practitioners, nurses, social workers, professional counselors, community health workers, personal health navigators, or peer wellness specialists.

RHODE ISLAND	Comprehensive transitional care services focus on the transition of individuals from any medical, psychiatric, long-term care, or other out-of-home setting into a community setting. Designated members of the health home team work closely with the individual to transition the individual smoothly back into the community and share information with the discharging organization in order to prevent any gaps in treatment that could result in a re-admission. To facilitate timely and effective transitions from inpatient and long-term settings to the community, all health home providers will maintain collaborative relationships with hospital emergency departments, psychiatric units of local hospitals, long-term care and other applicable settings. In addition, all health home providers will use hospital liaisons to assist in the discharge planning of existing community mental health organization clients and new referrals from inpatient settings to community mental health organizations. Care coordination may also occur when transitioning an individual from a jail/prison setting into the community. Hospital liaisons, community support professionals, and other designated members of the team may provide transitional care services. The team member collaborates with physicians, nurses, social workers, discharge planners, and pharmacists within the hospital setting to ensure that a treatment plan has been developed and works with family members and community providers to ensure that the treatment plan is communicated, adhered to, and modified as appropriate. Any member of the community mental health organization health home team may provide comprehensive transitional care services; however, hospital liaisons will be the primary practitioners providing comprehensive transitional care services.

Individual and Family Support Services

MISSOURI	Individual and family support services activities include, but are not limited to, advocating for individuals and families and assisting with obtaining and adhering to medications and other prescribed treatments. In addition, health team members are responsible for identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services. A primary focus will be increasing health literacy, ability to self-manage their care, and participation in the ongoing revision of their care/treatment plan. For individuals with developmental disorders, the health team will refer to and coordinate with the approved developmental disorders case management entity for services more directly related to habilitation and coordinate with the approved developmental disorders case management entity for services more directly related to a particular healthcare condition.
NEW YORK	The patient's individualized plan of care will reflect and incorporate the patient and family or caregiver preferences; education and support for self-management; self-help recovery; and other resources, as appropriate. The provider will share and make the individualized plan of care assessable to the enrollee, their families, or other caregivers (based on the individual's preferences) by presenting options for accessing the enrollee's clinical information. The health home provider will use peer supports, support groups, and self-care programs to increase patients' and caregivers' knowledge about the individual's disease(s), promote the enrollee's engagement and self-management capabilities, and help the enrollee improve adherence to their prescribed treatment. The provider will discuss and provide the enrollee, the enrollee's family, and caregivers information on advance directives to enable them to make informed end-of-life decisions ahead of time. The health home provider will ensure that all communication and information shared with the enrollee, the enrollee's family, and caregivers is language-, literacy-, and culturally-appropriate so it can be understood.
NORTH CAROLINA	Primary care providers and their care teams, or the case manager, provide individual and family support services activities that include, but are not limited to, advocating for individuals and families and assisting with obtaining and adhering to medications and other prescribed treatments. In addition, health team members are responsible for identifying

	resources for individuals to support them in attaining their highest level of health and functioning with their families and in their community, including transportation to medically necessary services and access to long-term care and support services. Primary care providers have a key role in supporting appropriate referrals. Many network activities are geared toward supporting and educating primary care providers on how to promote access to community services and resources in their role as health home provider. In different practice areas, this guidance takes different forms. For patients in need of long-term care and aging services, Regional networks have each formed a long-term care steering committee to connect network primary care practices to local aging and disabilities resource centers and area agencies on aging. Network clinical directors lead the steering committees. Networks also produce resource manuals for network practices tied to the local and regional continuum of medical, social, and long-term care services. Every resource manual incorporates detailed information regarding local resources. North Carolina received the CMS State Demonstration to Integrate Care for Dual Eligible Individuals Grant, which enables them to plan further improvements in this area. Networks provide detailed protocols regarding effective approaches to supporting recipients with chronic illness with regard to self-management of chronic illness and access to community and medical resources to support improved health and well-being. Care managers develop relationships with recipients and, when possible, their family and social supports through face-to-face and telephone interactions.
OHIO	Individual and family support services include, but are not limited to, providing expanded access and availability of services along with continuity in relationships between the individual/family, provider(s), and the care manager; supporting the delivery of person-centered care; assisting with accessing natural support systems in the community; performing outreach and advocacy for the individual/family to identify and obtain needed resources (e.g., transportation); educating and teaching the individual on self-management techniques; facilitating further development of daily living skills; assisting with obtaining and adhering to medication and other prescribed treatments; providing interventions that address symptoms, and behaviors and assist the health home enrollee in eliminating barriers to seeking or maintaining education, employment, or other meaningful activities related to his or her recovery-oriented goal; providing opportunities for the individual/family to participate in the assessment and care plan development/implementation, including providing access to electronic health records or other clinical information; and making referrals to community/social/recovery supports. Health home services will also be delivered in a manner that takes into account the individual's and family's preferences and is culturally and linguistically appropriate. Individuals and their families will be integral to the quality improvement process by providing feedback on experience/satisfaction of care through surveys or by participating in patient/family advisory councils.
OREGON	The health home will have processes for patients and family education, health promotion and prevention, self-management supports, and information and assistance obtaining available non-healthcare community resources, services, and supports. The person-centered plan will reflect the client and family/caregiver preferences for education, recovery, and self-management. Peer supports, support groups, and self-care programs will be used to increase the client and caregiver's knowledge about the client's disease. Health home services will occur under the direction of licensed health professionals, physicians, physician assistants, nurse practitioners, nurses, social works, professional counselors, community health workers, personal health navigators, or peer wellness specialists.
RHODE ISLAND	Community support professionals and other members of the health team provide individual and family support services to reduce barriers to individuals' care coordination, increase skills and engagement, and improve health outcomes. Individual and family support services may include, but are not limited to, providing assistance in accessing needed self-help and peer support services; advocacy for individuals and families; helping individuals identify and develop social support networks; assistance with medication and treatment management and adherence; identifying resources that will help individuals and their families reduce barriers to their highest level of health and success; and connecting individuals and their family members to peer advocacy groups, wellness centers, NAMI, and family psycho-educational programs. Individual and family support services may be provided by any member of the health home team; however, CPST specialists will be the primary practitioners providing individual and family support services.

Referral to Community and Social Support Services

MISSOURI	Referral to community and social support services, including long-term services and supports, involves providing assistance for clients to obtain and maintain eligibility for healthcare, disability benefits, housing, personal need, and legal services, as examples. For individuals with developmental disorders, the health team will refer to and coordinate with the approved developmental disorder case management entity for this service.
NEW YORK	The health home provider will identify available community-based resources and actively manage appropriate referrals, access to care, engagement with other community and social supports, coordinate services, and follow-up post engagement with services. To accomplish this, the health home provider will develop policies, procedures, and accountabilities (through contractual agreements) to support effective collaboration with community-based resources, that clearly define the roles and responsibilities of the participants. The plan of care will include community-based and other social support services, appropriate and ancillary healthcare services that address and respond to the patient's needs and preferences, and contribute to achieving the patient's goals.
NORTH CAROLINA	Community care works holistically. It requires network providers, with care management support, to attend not only to the delivery of physical health service, but also to social, mental, and to community issues that may affect health and medical care. Care management recognizes the social and environmental factors that affect population health. As part of the care management approach, the health home works to increase access to appropriate community and social support services and to use and organize community resources. Care managers are knowledgeable bout local agencies and resources and share this knowledge with network providers by providing resource manuals containing relevant contact information for an array of community and social support services.
OHIO	The health home will offer and/or arrange for onsite and offsite community and social support services through effective collaborations with social service agencies and community partners. The health home will identify and provide referrals to community, social, or recovery support services such as maintaining eligibility for benefits, obtaining legal assistance, and housing. The health home will assist the consumer in making appointments; validate the service was received; and complete any follow up as necessary. Care managers will be responsible for identifying non-clinical services and needs that require referrals to community and social supports during the comprehensive assessment with input from individual and family and other team members. However, qualified health home specialists will largely initiate referrals to community resources and social supports, assist with the completion of paperwork, ensure that needed services, resources, and supports are acquired and provide status reports and updates to the team. The team leader will monitor the team's referral process for community and social supports identify/compile community resources and assist with complex cases. The methods of health home services delivery will consist of service delivery to the beneficiary and may include other individuals who will assist in the beneficiary's treatment; service delivery may be face-to-face, by telephone, and/or by video conferencing; and service delivery may be in individual, family, or group format; service delivery is not-site specific and the health home services should be provided in locations and settings that meet the needs of the health home beneficiary.
OREGON	The health home will demonstrative processes and capacity for referral to community and social support services such as patient and family education, health promotion and prevention, and self-management support efforts, including available community resources. Care coordination functions will include the use of the person-centered plan to manage such referrals and monitor follow-up, as necessary. Health home services will occur under the direction of licensed health professionals, physicians, physician assistants, nurse practitioners, nurses, social workers, professional counselors, community health workers, personal health navigators, or peer wellness specialists.

RHODE ISLAND

Referral to community and social support services provide individuals with referrals to a wide array of support services that will help individuals overcome access or service barriers, increase self-management skills, and improve overall health. Referral to community and social support involves facilitating access to support and assistance for individuals to address medical, behavioral, educational, social, and community issues that may affect overall health. The types of community and social support services to which individuals will be referred may include, but are not limited to, primary care providers and specialists; wellness programs, including smoking cessation, fitness, weight loss programs, and yoga; specialized support groups (e.g., cancer or diabetes support groups); substance treatment links in addition to treatment-supporting recovery with links to support groups, recovery coaches, and 12-step; housing; social integration (e.g., NAMI support groups, MHCA OASIS, Alive Program, and/or recovery center; assistance with the identification and attainment of other benefits; Supplemental Nutrition Assistance Program (SNAP); connection with the Office of Rehabilitation Service, as well as the internal community mental health organization team to help the person develop work/education goals and then identify programs/jobs; assisting the person in their social integration and social skill building; faith-based organizations; access to employment and educational program or training; referral to community and social support services may be provided by any member of the health home team; however, CPST specialists will be the primary practitioners providing referrals to community and social support services.

APPENDIX B – CMS CORE HEALTH HOME QUALITY MEASURES

NQF #	Measure Title	Measure Description	Numerator/Denominator	Alignment with Other CMS Programs
N/A	1. **Adult BMI Assessment**	Percentage of members 18-74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year	**NUMERATOR DESCRIPTION** BMI documented during the measurement year or the year prior to the measurement year **DENOMINATOR DESCRIPTION** Members 18-74 of age who had an outpatient visit	Medicaid Adult Core Set, HEDIS
N/A	2. **Ambulatory Care-Sensitive Condition Admission**	Age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population under age 75 years	**NUMERATOR DESCRIPTION** Total number of acute care hospitalizations for ambulatory care-sensitive conditions for those under age 75 years **DENOMINATOR DESCRIPTION** Total mid-year population under age 75	
648	3. **Care Transition—Transition Record Transmitted to Healthcare Professional**	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other care site for whom a transition record was transmitted to the facility, primary physician, or other healthcare professional designated for follow-up care within 24 hours of discharge.	**NUMERATOR DESCRIPTION** Patients for whom a transition record was transmitted to the facility, primary physician, or other healthcare professional designated for follow-up care within 24 hours of discharge **DENOMINATOR DESCRIPTION** All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care	Medicaid Adult Core set
0576	4. **Follow-Up After Hospitalization for Mental Illness**	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.	**NUMERATOR DESCRIPTION** An outpatient visit, intensive outpatient encounter, or partial hospitalization (refer to Table FUH-C in the original measure documentation for codes to identify visits) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge **DENOMINATOR DESCRIPTION** Members 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December of the measurement year	Children's Core Set, Medicaid Adult Core Set, HEDIS

NQF #	Measure Title	Measure Description	Numerator/Denominator	Alignment with Other CMS Programs
1768	**5. Plan – All Cause Readmission**	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	**NUMERATOR DESCRIPTION** Count the number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination **DENOMINATOR DESCRIPTION** Count the number of Index Hospital Stays for each age, gender, and total combination	Adult Core set, HEDIS
0418	**6. Screening for Clinical Depression and Follow-up Plan**	Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool and follow-up documented	**NUMERATOR DESCRIPTION** Total number of patients from the denominator who have follow-up documentation **DENOMINATOR DESCRIPTION** All patients 18 years and older screened for clinical depression using a standardized tool	PQRS, CMS QIP, Medicare Shared Savings Program, Medicaid Adult Core set, Meaningful Use 2
0004	**7. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**	Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received the following: > Initiation of AOD treatment. > Engagement of AOD treatment.	**NUMERATOR DESCRIPTION** Initiation of AOD dependence treatment: Members with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis. Engagement of AOD treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations with any AOD diagnosis within 30 days after the date of the initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers to be counted. **DENOMINATOR DESCRIPTION** Members 13 years of age and older as of December 31 of the measurement year with a new episode of AOD during the intake period, reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators.	Meaningful Use 1 and 2, Medicaid Adult Core set, HEDIS
0018	**8. Controlling High Blood Pressure**	The percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.	**NUMERATOR DESCRIPTION** The number of patients in the denominator whose most recent, representative BP is adequately controlled during the measurement year. For a member's BP to be controlled, both the systolic and diastolic BP must be <140/90mm Hg. **DENOMINATOR DESCRIPTION** Patients 18-85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the first six months of the measurement year.	Million Hearts, Medicaid Adult Core set, Meaningful Use 2, ACO Measure

ENDNOTES

1. For a recent review, see Scott D, Happell B., "The high prevalence of poor physical health and unhealthy lifestyle behaviors in individuals with severe mental illness. Issues in Mental Health Nursing 2011;32(9):589-97
2. The Best Practices in Schizophrenia Treatment (BEST) Center of the Northeastern Ohio Medical University and the Health Foundation of Greater Cincinnati commissioned Health Management Associates to conduct a study documenting the business case for integrated physical and behavioral healthcare. The final report is available at www.neomed.edu/academics/bestcenter/integratingprimaryandmentalhealthcare.
3. Substance Abuse and Mental Health Services Administration. (2010). *Mental Health and Substance Abuse Services in Medicaid, 2003:* Charts and State Tables. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration at http://store.samhsa.gov/shin/content//SMA10-4608/SMA10-4608.pdf.
4. World Health Organization. (2011). Global Status Report on Alcohol and Health. Available at: www.who.int/substance_abuse/publications/global_alcohol_report/msbgsruprofiles.pdf
5. The Patient Protection and Affordable Care Act (PPACA, P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA, P.L. 111-152), is collectively referred to in this paper as the Affordable Care Act of 2010.
6. Parks, J., Svendsen, D., Singer, P. and Foti, M.E. Morbidity and Mortality in People with Serious Mental Illness. National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council Technical Report, October 2006.
7. NIDA (National Institute on Drug Abuse) www.drugabuse.gov/publications/drugfacts/drug-related-hospital-emergency-room-visits
8. Centers for Medicare and Medicaid Services, Overview of Mental Health Services. www.cms.hhs.gov/MHS
9. Frank, R., Conti, R and Goldman, H., *Mental Health Policy and Psychotropic Drugs*. The Milbank Quarterly, Vol. 83, No. 2, 2005 (pp. 271-298).
10. Ibid.
11. Ibid.
12. Assumes all states adopt the Medicaid expansion. Estimate drops to 11 million with the expectation that not all states will adopt the expansion.
13. Hyde, P. "What You Need To Know About Health Reform What the Affordable Care Act Offers." SAMHSA News September/October 2010, Volume 18, Number 5 available at www.samhsa.gov/samhsanewsletter/Volume_18_Number_5/SeptemberOctober2010.pdf.
14. See www.neomed.edu/academics/bestcenter/integratingprimaryandmentalhealthcare.
15. Ambulatory Care Sensitive Conditions (ACSC) are medical conditions for which physicians broadly concur that a substantial proportion of cases should not advance to the point where hospitalization is needed if they are treated in a timely fashion with adequate primary care and managed properly on an outpatient basis. Examples include asthma and diabetes.
16. Federal Medical Assistance Percentages (FMAP) are the percentage rates used to determine the matching funds rate allocated annually to states for Medicaid.
17. Missouri and Rhode Island each have two separate SPAs with focuses on different chronic conditions, so as of now there are nine approved SPAs in seven states.
18. CMS will soon migrate these resources to the Medicaid.gov.
19. State Medicaid agencies may request CMS approval to access federal matching funds to offset state expenses incurred in the planning and design of health home services.
20. See www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Eligibility.html for a discussion on current Medicaid eligibility requirements.
21. Community health teams operate through an interdisciplinary model that can include home visits, and they include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractic, licensed complementary and alternative medical practitioners, and physician assistants. See Section 3502 of the ACA (in the Social Security Act § 1945(h)(5) and (6)), as added by Section 2703 of the ACA.
22. Health Management Associates, Overview of the Medicaid Health Home Care Coordination Benefit, National Council Live Webinar, June 7, 2011 available at www.thenationalcouncil.org/galleries/resources-services%20files/HMA%20June%202011%20Webinar.pdf.
23. "Building Medical Homes: Lessons From Eight States With Emerging Programs", Neva Kaye, Jason Buxbaum, and Mary Takach, National Academy for State Health Policy for the Commonwealth Fund, December 2011.
24. "Health Home Considerations for a Medicaid Managed Care Delivery System: Avoiding Duplication of Services and Payments." (February 2012). Integrated Care Resource Center. Available at www.chcs.org/usr_doc/HH_Managed_Care_Options_Matrix_020312_.pdf.
25. The National Council for Behavioral Health offers trainings that support both the provider who is newly providing whole health services and the consumer who needs support in understanding the impact of primary care on their behavioral health needs and developing whole health goals that will improve their quality of life.
26. Missouri Medical Model Data Lab, Health Home Services Forms
27. New York State Health Home SPA for Individuals with Chronic Behavioral and Medical Health Conditions
28. North Carolina Health Home SPA for individuals with chronic conditions
29. Oregon's state plan for patient-centered primary care homes for individuals with chronic conditions
30. Rhode Island health home state plan amendment for serious mental illness
31. Draft 2703 Health Homes Quality Reporting Guidance issued by CMS to states involved in Health Home State Plan discussions.
32. Draft 2703 Health Homes Quality Reporting Guidance issued by CMS to states involved in Health Home State Plan discussions. Official quality measurement guidance is expected from CMS in 2013.
33. A patient registry is intended to facilitate the delivery of health home services and stratify populations by risk and aggregate data from external sources (e.g., electronic medical records, hospital admit/discharge systems, shared info from other partner health organizations). The registry will also assist in development of care plans, facilitate provider empanelment, and determine tasks to be completed by members of health care teams, create disease management protocols and generate reports. The patient care registry will support care coordination and identify individuals who require telephonic support or reminders based on embedded protocols, provide templates for risk assessment and patient surveys, identify outstanding care items and provide medication lists. The registry will also create education materials and tools to support health promotion.

ENDNOTES

34. www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-%E2%80%93PM-Adult-Health-Care-Quality-Measures.html
35. "Meaningful use" means providers need to show, and states need to confirm, that certified electronic health record technology is used in ways that can be measured in both quality and in quantity. Also, see www.medicaidhitechta.org/ResourcebrLibrary/MeaningfulUse.aspx.
36. See description of Missouri's Medicaid Community Psych Rehab services at http://manuals.momed.com/collections/collection_cpr/Community_Psych_Rehab_Section13.pdf.
37. See Targeted Case Management and Health Homes on the New York Department of Health website at www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/targ_case_mgmt.
38. See Rhode Island's Community Mental Health Provider Reference Handbook at www.bhddh.ri.gov/bhservices/pdf/MedicaidProviderReferenceBook.pdf.
39. Health Management Associates, Accountable Care in the Safety Net, November 2010. Available at www.healthmanagement.com/files/FINAL_Accountable_Care_in_the_Safety_Net.pdf.
40. Section 3022 of the Affordable Care Act or Section 1899 of the Social Security Act
41. In a 2007 report entitled, *Integrating Publicly Funded Physical and Behavioral Health Services: A Description of Selected Initiatives,* Health Management Associates found that one of the most frequently cited barriers to integration was the lack of payment for care/case management and care coordination. The report is available at www.rwjf.org/pr/product.jsp?id=19271.