Exploring Medicaid Health Homes

Designing Tailored Behavioral Health Homes for Adults and Children: Approaches from New Jersey and Oklahoma

August 6, 2015; 3:00 – 4:00PM (ET)

For audio, dial: 1-877-888-4314; Attendee code: 500314

An audio archive will be posted on http://www.medicaid.gov

For more information or technical assistance in developing health homes, visit http://www.Medicaid.gov.

Questions?

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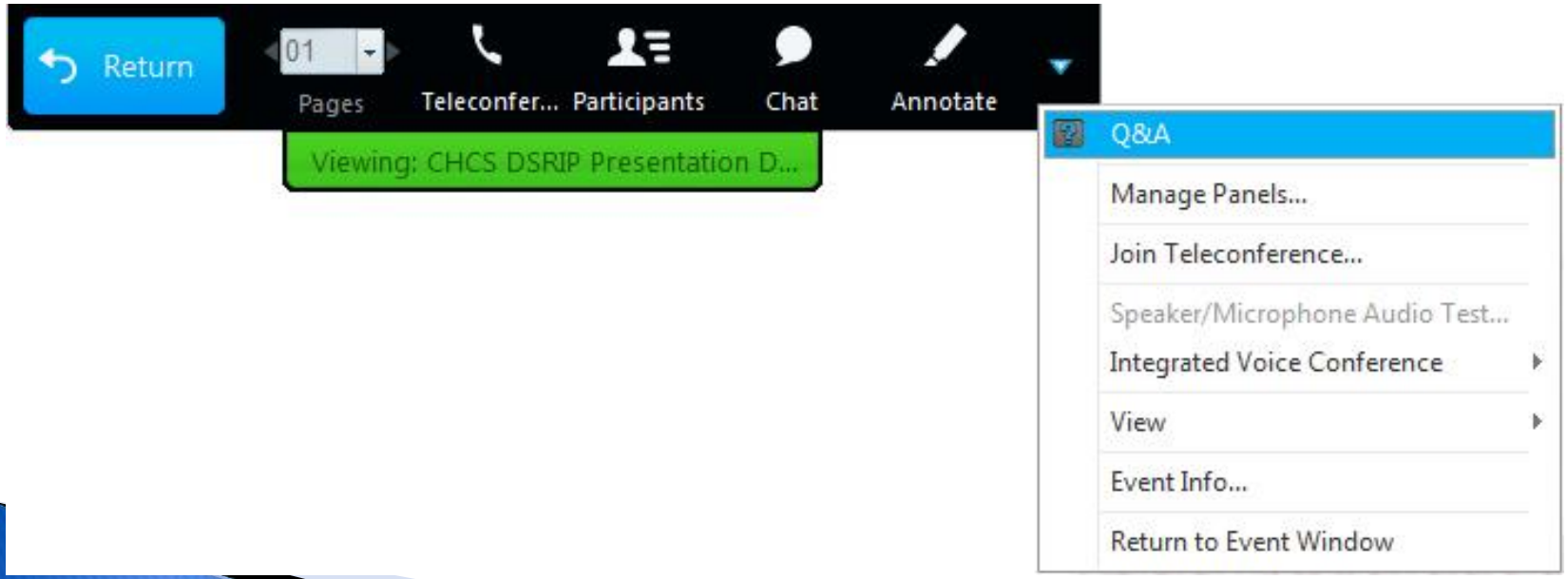
Answers to questions that cannot be addressed due to time constraints will be shared after the webinar.

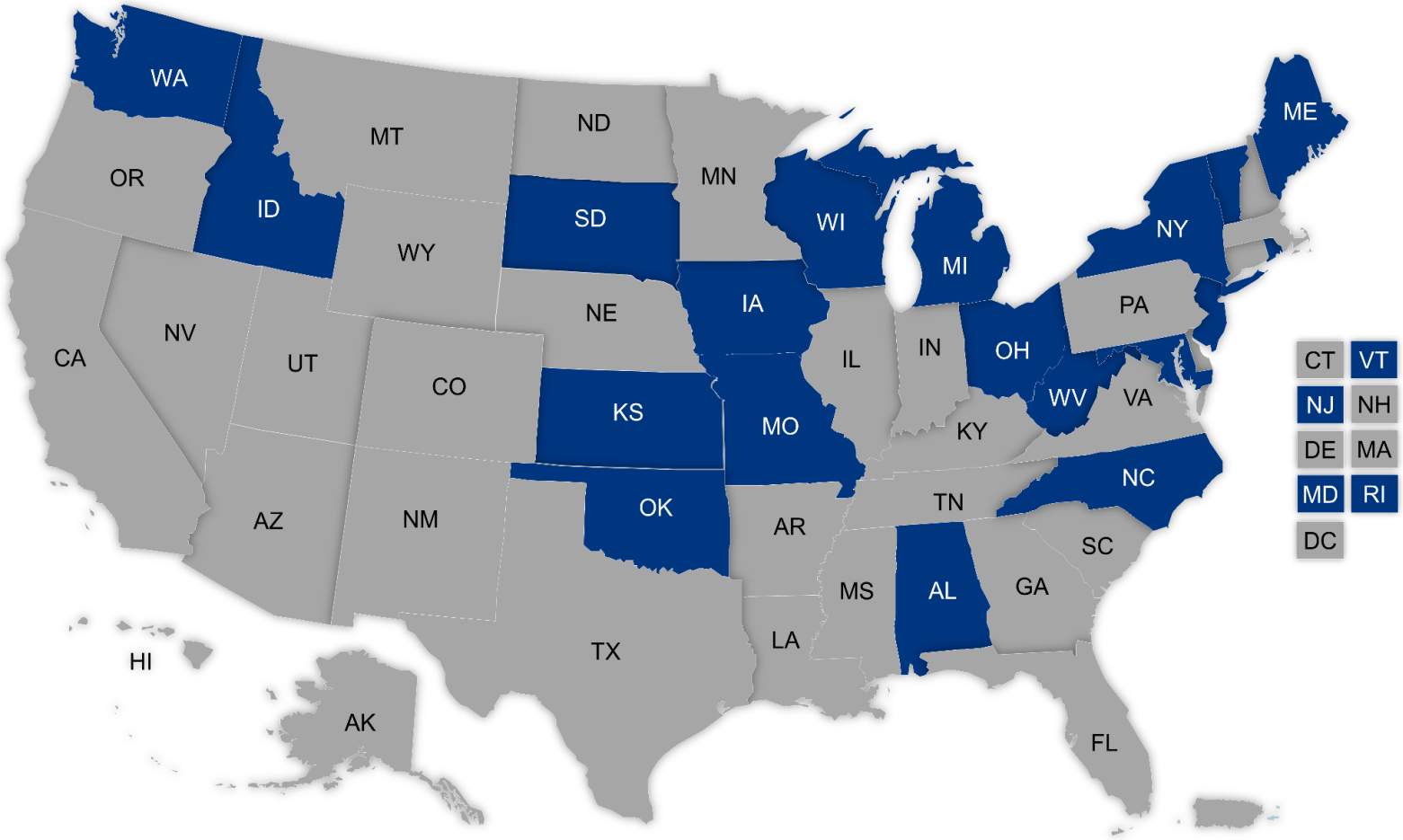


Health Home Information Resource Center

- Established by CMS to help states develop health home models for beneficiaries with complex needs
- Technical assistance includes:
  - One-on-one technical support to states
  - Group discussions and Webinars
  - Online library of hands-on tools and resources, available at:

    http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html

State Health Home Activity



States with Approved Health Home SPAs (number of approved health home models)	Alabama, Idaho, Iowa (2), Kansas, Maine (2), Maryland, Michigan, Missouri (2), New Jersey (2), New York, North Carolina, Ohio, Oklahoma (2), Rhode Island (3), South Dakota, Vermont, Washington, West Virginia, Wisconsin

Presenters

Oklahoma Department of Mental Health and Substance Abuse Services

- Traylor Rains-Sims, Director, Policy & Planning
- Malissa McEntire, Manager of Integrated Care
- Tracy Leeper, Decision Support Policy Analyst

New Jersey Division of Mental Health and Addiction Services, NJ Department of Human Services

- Vicki Fresolone, Chief of Care Management
- Jeff Carrick, Program Specialist

New Jersey Division of Children's System of Care Department of Children and Families

- Ruby Goyal-Carkeek, Deputy Director

SOONERCARE Health Homes

Oklahoma Health Homes

Oklahoma Department of Mental Health and Substance Abuse Services

A strategy to build a system of care to improve health, enhance access and quality and control costs for members with SMI or SED.

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Manager of Integrated Care

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Director, Policy & Planning

Tracy Leeper, M.S.
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Oklahoma Department of Mental Health and Substance Abuse Services

Oklahoma

Oklahoma SPA

- Adult Health Home SPA
- Children Health Home SPA
  - Two SPAs because of differing provider requirements and rate structures for each model
  - Began initial dialogue with CMS in 2010 & began technical assistance process
  - Formally submitted SPA October 2014, approved February 2015, and effective January 2015

Oklahoma State Plan Amendment

The health home option is intended to create health care delivery approaches that facilitate access to and coordination of physical and behavioral health (mental health and substance use) care and community-based social services and supports for both children and adults with chronic conditions.

Adult

- High (ACT)
- Moderate

Child

- High (WRAP)
- Moderate

Health Home Teams

Adult Team

- Health Home Director
- Nurse Care Manager
- Consulting PCP
- Psychiatric Consultant
- Case Manager/Care Coordinator
- Wellness Coach/Peer Support Specialist
- Hospital Liaison/Health Home Specialist
- LBHP (PACT only)

Children Team

- Health Home Director
- Nurse Care Manager
- Consulting PCP
- Psychiatric Consultant
- Case Manager/Care Coordinator
- Family Support Provider
- Youth/Peer Support Specialist
- Children's Health Home Specialist

Adult Health Home: High

- Based on the Assertive Community Treatment (ACT) model
- Intended for the most chronically ill, and highest cost consumers (i.e., adults who require ≥ eight hours of health home services per month)
- Eligibility criteria:
  - Client Assessment Record (CAR) score = Level 4 (uniform assessment tool); and
  - History of ≥ 2 hospitalizations and/or admissions to community-based structured crisis care over the past 24 months, with at least three (3) of the following:
    - Persistent or recurrent severe affective, psychotic or suicidal symptoms;
    - Coexisting substance abuse disorder greater than six (6) months;
    - High risk of or criminal justice involvement over the past 24 months;
    - Homeless, imminent risk of being homeless or residing in substandard or unsafe housing:
    - Residing in supported housing but clinically assessed to be able to live in a more independent living situation if intensive services are provided; or requiring supported housing if more intensive service are not available;
    - Inability to participate in traditional office-based services or evidence that they required a more assertive and frequent non-office based service in order to meet their clinical needs; or
    - Inability to consistently perform the range of practical daily living tasks required for basic adult functioning in the community.
- Consumers receive a minimum of 3 contacts per week, with a least 1 face-to-face contact per week
- Team caseload = 100
- Rate – $453.96 PMPM

Adult Health Home: Moderate

- Intended for individuals whose behavioral health needs have stabilized and have transitioned to a lower level of care
- Eligibility criteria:
  - CAR score < Level 4
  - Co-morbid physical health conditions exist or have potential to develop
- Consumers receive a minimum of 1 contact per month, with an average of at least 1 hour of health home services per month
- Team caseload up to 500
- Rates
  - Urban – $127.35 PMPM
  - Rural – $146.76 PMPM

Child Health Home: High

- Individuals that meet the medical necessity criteria for Wraparound® services
- Service needs must require the involvement of multiple components within the system of care
- Eligibility criteria:
  - CAR score ≥ Level 4 and a clinician-rated Ohio scale shows significant clinical impairment, and at least one of the following conditions:
    - Hospitalization within the past three months;
    - Multiple hospitalizations, ED use and/or crisis center admissions;
    - Intensive array of services are in place, including case management, therapy, medication management, and family support services, at a minimum;
    - Chronic physical health condition, such as diabetes or asthma;
    - Child was in the custody of OKDHS or OJA within the past six months; or
    - High risk of out of home/out of community placement.
- Consumer receives a minimum of 12 hours of service contact per month, including a minimum of weekly face-to-face services
- Team caseload up to 100
- Rates
  - Urban - $864.82 PMPM
  - Rural - $1,009.60 PMPM

Children Health Home: Moderate

- Individuals require extensive system coordination and more significant engagement by behavioral health providers and at least one other child-serving agency
- Service coordination is important to maintain the child or adolescent in the community
- Eligibility criteria:
  - CAR score typically = Level 3
- Consumer receives a minimum of 5 hours of service contact per month, including a minimum of weekly face-to-face services
- Team caseload of up to 500
- Rates
  - Urban - $297.08 PMPM
  - Rural - $345.35 PMPM

Health Home Provider Readiness Reviews

- **Readiness Tools**
  - **Site Review:** location-specific (physical facility) readiness
    - Locations not currently certified
    - Locations (although certified) not previously provided medication services but will now provide those in array of health home services
    - *All other locations will verify by attestation that they are in continued compliance with facility, health, and safety standards as documented in most recent certification review*
  - **Desk Review:** qualitative update on status of operations and preparations to initiate services
    - Health homes will respond to items listed in Desk Review tool and electronically submit responses to Oklahoma Department of Mental Health & Substance Abuse Services (ODMHSAS)
    - Process for response explained in notice to providers

Upon verification that all items on both tools have been sufficiently addressed, ODMHSAS will notify providers they are deemed "ready"

Oklahoma Health Home Certification

- ODMHSAS is the designated state authority for certifying facility-based behavioral health service providers in Oklahoma
- ODMHSAS created formal certification standards and criteria for health homes within state administrative code. This process assures ODMHSAS of the ability to monitor health homes for continued compliance with State Plan Requirements
- The standards address items such as:
  - Target population & client admission/discharge requirements
  - Health home structure and team composition
  - Individual provider requirements
  - Required services, with an emphasis on integration and coordination of care

Oklahoma Health Homes Enrollment

- SoonerCare members with a qualifying SMI/SED designation who had an existing relationship with the health home agency were attributed to the provider's health home panel. During the "engagement" process, members were provided the following:
  - a brief description of health home services
  - a description of individuals' options to choose another health home
  - a process to opt out of enrollment in a health home
  - encouragement to continue any existing relationship with their primary care provider (PCP)

- To accommodate the additional effort that goes into up-front patient engagement, providers are reimbursed a monthly Engagement Fee of $53.98 for these activities. This fee is only payable for three months in any year.

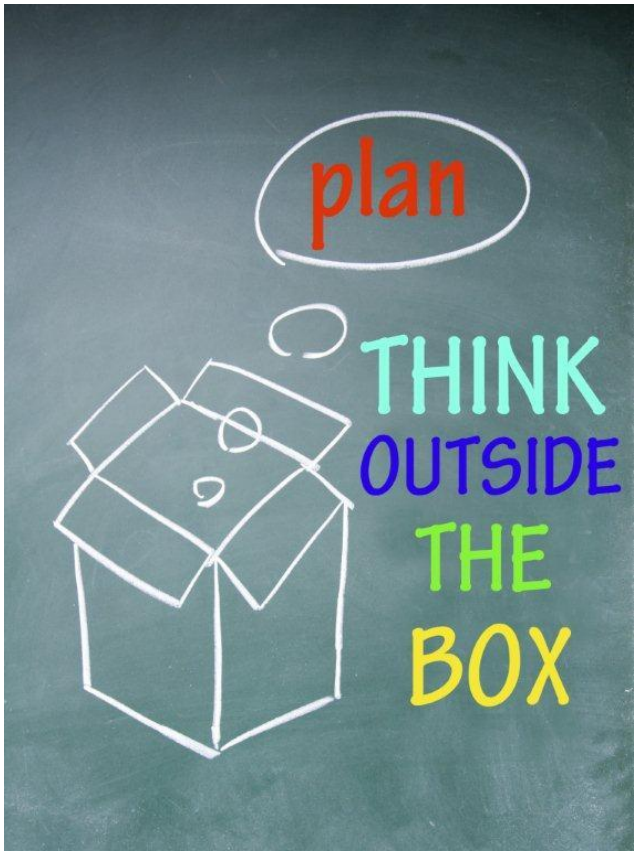
Provider Billing & Reporting

- The health home rates are fee-for-service with corresponding HCPCS codes that are only payable after the provider submits a claim demonstrating they have met the monthly service requirements. While they are only payable once a month, they are not capitated.
- In order to prevent duplication, a table of non-payable service codes was created in the state's MMIS (i.e. case management, family support, care coordination).
- "Shadow Reporting" - Along with the health home HCPCS reimbursement code, providers are required to report all services provided to the client in that month using non-payable service codes that the state has identified for use. We feel this is crucial from a data collection/reporting standpoint.

Oklahoma Health Homes

- 22 providers awarded contracts through RFP process
- Over 100 locations statewide
- Began providing services February 2015
- As of July 2015, 10,000 consumers are receiving services
  - Approximately 6,000 adults
  - Approximately 4,000 children

Provider Technical Assistance



- Oklahoma Health Home Learning Collaborative
  - Providers, stakeholders, Medicaid authority
  - Meet 1-2 times monthly
- National Council on Behavioral Health
  - Case to Care Management
  - Health Home Consultation Day
- University of Oklahoma School of Community Medicine, Department of Psychiatry and Medical Informatics
  - Erik Vanderlip, MD MPH
- ODMHSAS Trainings
  - WRAP 101
  - Family Support Providers
  - Peer Support Providers
  - WellPower
  - Wellness Coach

Lessons Learned

Important Considerations

- Primary internal team
  - Planning team
    - Meet regularly
    - Team decisions
  - Fully integrated team
    - Doctor
    - Nurse
- Communicating with providers
- Engage primary care
- Preparing for change

Cautions

- Information overload
- Document control
- Getting into the weeds
- Losing site of the vision

References

Oklahoma Department of Mental Health & Substance Abuse Services Health Home Page
http://www.ok.gov/odmhsas/Mental_Health/Oklahoma_Health_Homes/index.html

Oklahoma Department of Mental Health & Substance Abuse Services Administrative Rules
http://www.ok.gov/odmhsas/Additional_Information/Provider_Certification/ODMHSAS_Administrative_Rules/Administrative_Rules_That_Are_Currently_In_Effect.html

Oklahoma Healthcare Authority Health Home Page
http://okhca.org/providers.aspx?id=16525&terms=health%20home

Thank You!

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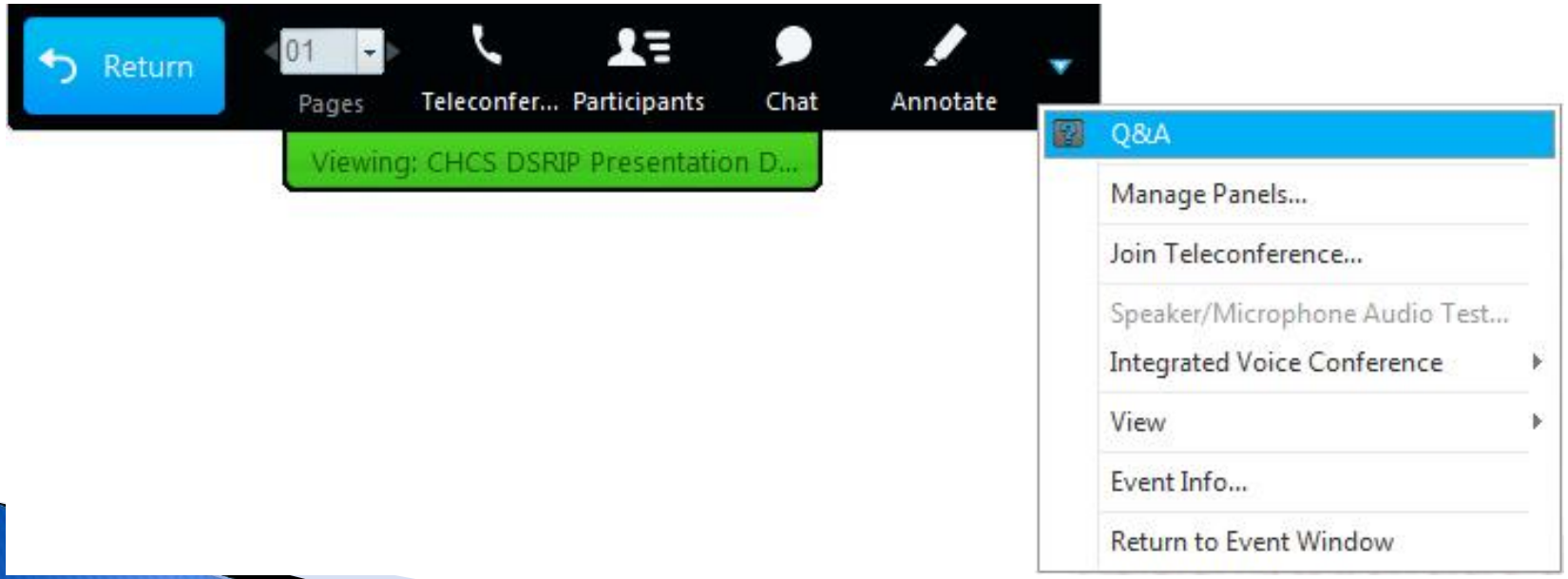

New Jersey Health Home Models

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Division of Children's System of Care

Jeff Carrick
Division of Mental Health and Addiction Services

Behavioral Health Home Delivery

- Children and adults differ in their behavioral health home design
- SPAs are different but were submitted simultaneously
- NJ Department of Children and Families (DCF) and Department of Human Services (DHS) worked closely on design, SPA submission and the system development

Co-Morbidity in Children and Adults

Cost Driver	Children	Adults
Behavioral Health	↑	
Physical Health		↑

Co-Morbidity is not as high in children as in adults

- 1/3 of children with behavioral health have chronic conditions
- 2/3 of adults with mental illness have chronic conditions

Behavioral Health Homes: Children

What it is:

- Care management organizations (CMOs) are the designated behavioral health home for Children in NJ
- Enhancement to the Child Family Team to bring medical expertise to the table

What it is not:

- A physical site

Children-Care Management Entity as Health Home

- CMOs are agencies that provide care coordination and wraparound care planning for children and their families with the most complex needs and are responsible for facilitating access to a full range of treatment and support services

- They facilitate and work within **child-family teams** to develop individualized plans of care

- Responsible for facilitating access to a full range of treatment and support services

Child Family Team (CFT)

A team of family members, professionals, and significant community residents identified by the family and organized by the care management organization to design and oversee implementation of the Individual Service Plan.

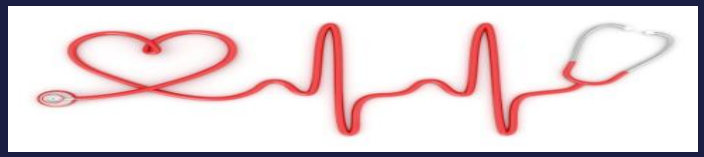
CFT members should include, but are not limited to, the following individuals:

- Child/Youth/Young Adult
- Parent(s)/Legal Guardian
- Care Management Organization
- Natural supports as identified and selected by youth and family members
- Treating Providers (in-home, out-of-home, etc.)
- Educational Professionals
- Probation Officer (if applicable)
- Child Protection & Permanency (CP&P)
  (if applicable)

Children-Care Management Entity as Health Home

- The behavioral health home team has a core of CMO staff with additional medical expertise and support to provide holistic, integrated and coordinated care for children who have qualifying chronic medical conditions

- The additional behavioral health home staffing include:
  - Nurse manager, required by NJ to be credentialed, at minimum, as a registered nurse
  - Health and wellness educator (ex. nutritionist)-bachelor's level in related field with applicable experience



Children- Health Home Supports

- Family Support Organizations (FSOs) are also an integral partner to CMO-involved children and their families

- Relationships with providers, connections with school through educational partnerships, positions CMOs well to collaborate effectively at a local level

Behavioral Health Homes: Adults

- Eligible providers
  - Licensed mental health agencies
  - Completion of a learning community
  - Certified by the Department of Human Services
  - Accredited within 2 years
  - Co-located within 3 years

Adults: The Health Home Team

- Required:
  - Nurse Care Manager (RN or APN)
  - Care Coordinator (LSW, LPN)
  - Health and wellness educator (preferably a peer)
  - Psychiatric and primary care consultation

- Two additional team members:

Nutritionist	Hospital Liaison
Peer Support Staff	Diabetes Educator
Pharmacist	Exercise Specialist
Case Managers	Dietician
Holistic Healer	Additional Nurse or Social Worker
Others as approved by DMHAS	

Adults: Health Home Intensity

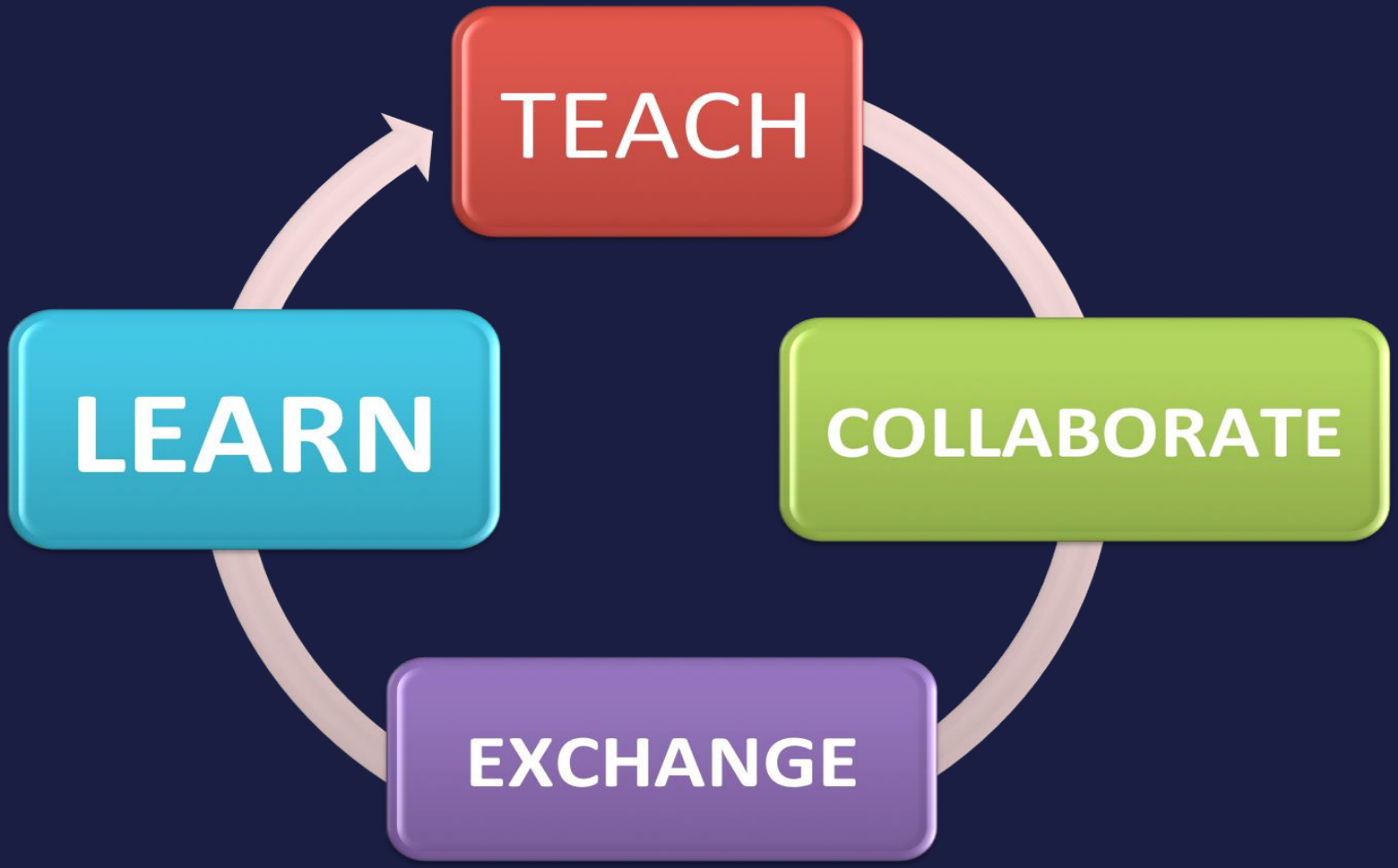
- Engagement/outreach (3 months):
  - Outreach
  - Engage
  - Assess
  - Begin care plan
- Active (24 months):
  - Provision of all health home services
  - Focus on self management, community connection and support system
- Maintenance (indefinite as needed):
  - More able to self manage with fewer interventions

Flow through service designed to increase self management capability

Adults: Consumer Level of Service Evaluation (C.L.O.S.E.)

- DHS-developed tool to guide intensity of care determination
- Influenced by several different evidence-based measures and informed by provider feedback
- Determines a consumer's needs across three dimensions; self-care functioning, co-morbidity, and engagement and recovery status
- Conducted at enrollment and every six (6) months thereafter or for cause

Jointly Preparing the System
Behavioral Health Home Learning Community



Children: Qualifying Criteria

- Children with SED will qualify. SED will be defined to include serious emotional disturbance, co-occurring developmental disability and mental illness, co-occurring mental health and substance use, or DD eligible (per NJ Statute 10:196) with symptomology of SED.
- Among children meeting the above criteria, NJ will target behavioral health home services to those individuals who could benefit from the enhanced model of integrated behavioral/medical coordination that the behavioral health home model provides. This targeting will be based on a set of defined medical necessity criteria which will enumerate eligible medical comorbidities that must be present alongside the targeted conditions listed above. Medical necessity criteria will be determined and reviewed on an ongoing basis by the State and consistently applied by its qualified behavioral health home providers.

Children: Enrollment Process

- The Contracted System Administrator (CSA) will continue to screen and prior authorize children for CMO service eligibility

- Families can opt in or opt out of health home services at the CMO
  - If a child/family opts out of the behavioral health home services, they will continue to receive the CMO's services
  - If they opt in to the behavioral health home, child/family will receive all of the services of the CMO plus the additional behavioral health home services

Adults: Qualifying Criteria

- Individuals with SMI who are at risk of high utilization
  - SMI defined by DHS
  - Used CDPS to determine risk status
    - List of qualifying DX on the DHS website

Adults: Enrollment Process

- Opt in process
- Eligible consumers will receive a letter from Medicaid notifying them of their eligibility
- They can also be self referred, referred by another provider or engaged by the behavioral health home provider
- They will be screened for eligibility at the behavioral health home provider site

Becoming Focused on Whole Health

- Everyone on the team pays attention to body/mind connection
- We look for interconnections (asthma and anxiety, diabetes and depression)
- We use skills in behavioral planning to support self/family management and health behavior change
- The “down stream” work of the health home is paramount
- Wellness is everyone’s work!

Statewide Rollout – By County

SFY 2015	SFY 2016	SFY 2017-2019
Bergen	Cape May	TBD
Mercer	Atlantic	
	Monmouth	

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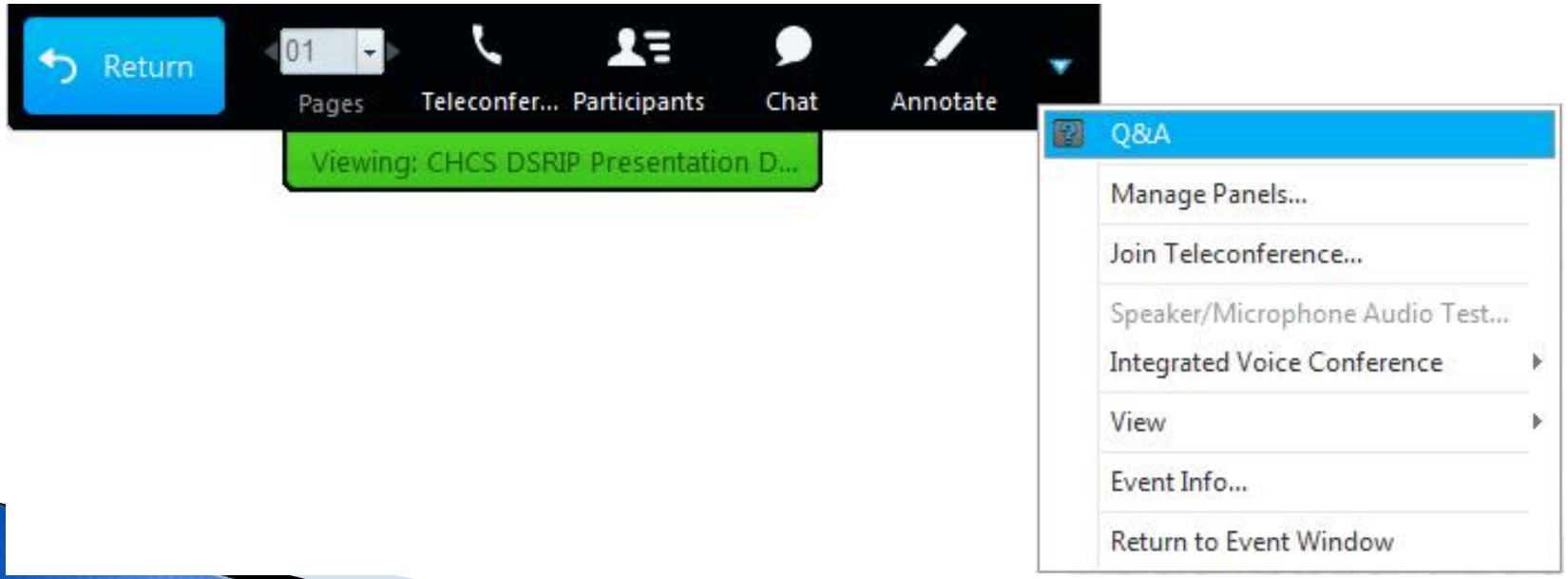

For More Information

- Download practical resources to improve the quality and cost-effectiveness of Medicaid services.
- Subscribe to e-mail updates to learn about new programs and resources.
- Learn about cutting-edge efforts to improve care for Medicaid's highest-need, highest-cost beneficiaries.

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