ATTACHMENT 3.1-F PAGE 1

Health Home State Plan Amendment

Submission Summary

Transmittal Number:
Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

☑ **The State elects to implement the Health Homes State Plan option under Section 1945 of the Social Security Act.**

Name of Health Homes Program:
MD HHS

State Information

State/Territory name: **Maryland**

Medicaid agency: Office of Health Services

Authorized Submitter and Key Contacts

The authorized submitter contact for this submission package.

Name: Rebecca Frechard

Title: Chief, Behavioral Health Division

Telephone number: (410) 767-1750

Email: rebecca.frechard@maryland.gov

The primary contact for this submission package.

Name: Morgan Cole

Title: Health Policy Analyst

Telephone number: (410) 767-9733

Email: morgan.cole@maryland.gov

The secondary contact for this submission package.

Name: Rebecca Frechard

Title: Chief, Behavioral Health Division

TN# 13-15 APPROVAL DATE: SEP 27 2013 EFFECTIVE DATE: OCT 1 2013
SUPERSEDES TN#: NEW

Telephone number: (410) 767-1750

Email: rebecca.frechard@maryland.gov

The tertiary contact for this submission package.

Name: Susan Tucker

Title: Executive Director, Office of Health Services

Telephone number: (410) 767-1430

Email: Susan.Tucker@maryland.gov

Proposed Effective Date

10/01/2013 (mm/dd/yyyy)

Executive Summary

Summary description including goals and objectives:
Health Homes for individuals with chronic conditions will augment the State's broader efforts to integrate somatic and behavioral health services, as well as aim to improve health outcomes and reduce avoidable hospital encounters. The program will target populations with behavioral health needs who are at high risk for additional chronic conditions, offering them enhanced care coordination and support services from providers with whom they regularly receive care. Health Homes are designed to enhance person-centered care, empowering participants to manage and prevent chronic conditions in order to improve health outcomes, while reducing avoidable hospital encounters. Several provider types are eligible to enroll as Health Homes, including psychiatric rehabilitation programs, mobile treatment service providers, and opioid treatment programs. Health Homes will serve individuals who experience serious persistent mental illness (SPMI), serious emotional disturbance (SED), and those with opioid substance use disorders determined to be at risk for additional chronic conditions. Health Homes will receive a flat per member, per month payment to provide these services, as well as a one-time payment for each individual's initial intake assessment.

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 14732463.00
Second Year	2015	$ 17708115.00

Federal Statute/Regulation Citation

Section 2703 of the ACA

Governor's Office Review

TN# 13-15 APPROVAL DATE: SEP 27 2013 EFFECTIVE DATE: OCT 1 2013
SUPERSEDES TN#: NEW

◉ **No comment.**

○ **Comments received.**
Describe:

○ **No response within 45 days.**

○ **Other.**
Describe:

Submission - Public Notice

Indicate whether public notice was solicited with respect to this submission.

○ **Public notice was not required and comment was not solicited**

○ **Public notice was not required, but comment was solicited**

◉ **Public notice was required, and comment was solicited**

Indicate how public notice was solicited:

☐ **Newspaper Announcement**

☑ **Publication in State's administrative record, in accordance with the administrative procedures requirements.**

Date of Publication:
07/12/2013 (mm/dd/yyyy)

☑ **Email to Electronic Mailing List or Similar Mechanism.**

Date of Email or other electronic notification:
02/18/2013 (mm/dd/yyyy)
Description:
emailed to Behavioral Health Integration listserv, including 800+ stakeholders, as well as emailed to all eligible PRP, MT, and OTP providers.

☑ **Website Notice**

Select the type of website:

☑ Website of the State Medicaid Agency or Responsible Agency

Date of Posting:
02/18/2013 (mm/dd/yyyy)
Website URL:
http://dhmh.maryland.gov/bhd/SitePages/Chronic_Health_Homes.aspx

☐ Website for State Regulations

Date of Posting:

(mm/dd/yyyy)

Website URL:

☐ Other

☑ **Public Hearing or Meeting**

Date	Time	Location
Jun 14, 2012	10:00am-12:00pm	UMBC Tech Center, 1450 S Rolling Rd, Baltimore, MD 21227
Jul 12, 2012	10:00am-12:00pm	UMBC Tech Center, 1450 S Rolling Rd, Baltimore, MD 21227
Aug 9, 2012	10:00am-12:00pm	UMBC Tech Center, 1450 S Rolling Rd, Baltimore, MD 21227

☑ **Other method**

Other	
Name: Stakeholder Webinar Date: 12/05/2012 (mm/dd/yyyy) Description: Webinar held to educate and solicit feedback from providers eligible to become Health Homes, as well as other stakeholders	
Name: Stakeholder Webinar Date: 12/10/2012 (mm/dd/yyyy) Description: Webinar held to educate and solicit feedback from providers eligible to become Health Homes, as well as other stakeholders	

Indicate the key issues raised during the public notice period:(This information is optional)

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service Delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Submission - Tribal Input

☑ **One or more Indian health programs or Urban Indian Organizations furnish health care services in this State.**

☐ **This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**

☑ **The State has solicited advice from Tribal governments prior to submission of this State Plan Amendment.**

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner:

☐ **Indian Tribes**

☐ **Indian Health Programs**

☑ **Urban Indian Organization**

Urban Indian Organizations	

Indicate the key issues raised in Indian consultative activities:

☑ **Access**

Summarize Comments

Discussion centered around the difficulties of reaching the Native American population with behavioral health needs due to cultural, economic, and other barriers.

Summarize Response
Implementation of the Health Home program will include outreach to tribal contacts, as well as a possible emphasis on the use of alternative outreach methods and referral sources to reach the Native American population in Maryland.

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Submission - SAMHSA Consultation

☑ **The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.**

Date of Consultation	
Date of consultation: 01/03/2013 (mm/dd/yyyy)	
Date of consultation: 02/15/2013 (mm/dd/yyyy)	

Health Homes Population Criteria and Enrollment

Population Criteria

The State elects to offer Health Homes services to individuals with:

☐ **Two or more chronic conditions**

Specify the conditions included:

☐ **Mental Health Condition**
☐ **Substance Abuse Disorder**
☐ **Asthma**
☐ **Diabetes**
☐ **Heart Disease**
☐ **BMI over 25**

Other Chronic Conditions	

☑ **One chronic condition and the risk of developing another**

Specify the conditions included:

☐ **Mental Health Condition**
☐ **Substance Abuse Disorder**
☐ **Asthma**
☐ **Diabetes**
☐ **Heart Disease**
☐ **BMI over 25**

Other Chronic Conditions	
Opioid Substance Use Disorder	

Specify the criteria for at risk of developing another chronic condition:
Eligibility criteria based on opioid substance use disorder:
1. The consumer has been diagnosed with an opioid substance use disorder.
2. The consumer must be engaged in opioid maintenance therapy.
3. The consumer is determined to be at risk for additional chronic conditions due to current tobacco, alcohol, or other non-opioid substance use, or a history of tobacco, alcohol, or other non-opioid substance dependence.

☑ **One or more serious and persistent mental health condition**

Specify the criteria for a serious and persistent mental health condition:
Eligibility criteria based on SPMI or SED:
1. The consumer has been diagnosed with SPMI or SED, meeting all relevant medical necessity criteria to receive psychiatric rehabilitation program (PRP) services or mobile treatment services (MTS).
2. The individual must be engaged in services with a PRP or MTS provider.
1. The consumer is not currently receiving either of the following services, considered duplicative of Health Home services:
a. 1915(i) waiver services
b. Targeted Mental Health Case Management

Geographic Limitations

☑ **Health Homes services will be available statewide**

If no, specify the geographic limitations:

○ **By county**

Specify which counties:

○ **By region**

Specify which regions and the make-up of each region:

○ **By city/municipality**

Specify which cities/municipalities:

○ **Other geographic area**

Describe the area(s):

Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the State will use to enroll eligible Medicaid individuals into a Health Home:

◉ **Opt-In to Health Homes provider**

Describe the process used:
Health Homes may enroll an eligible individual to whom they provide PRP, MT, or OTP services, contingent upon participant consent, and in the case of OTP participants, the presence of an identified qualifying risk factor. Health Homes may enroll participants only after they have been enrolled for the provider's applicable PRP, MT, or OTP services, ensuring that all relevant medical necessity criteria has been met to confirm the qualifying diagnosis. Enrollment is complete upon submission of the participant's online eMedicaid intake. Consent will authorize sharing of information between identified service providers, the State, applicable Managed Care Organizations (MCOs) and Administrative Service Organizations (ASOs) for the

purpose of improved care coordination and program evaluation. The Health Home will notify other treatment providers (e.g., primary care providers) of the participant's goals and the types of Health Home services the participant is receiving and encourage participation in care coordination efforts.

The State will use claims data to identify potentially-eligible consumers who could benefit from Health Home services. This includes individuals with a qualifying diagnosis who experience frequent emergency department usage, hospitalization, or increases in level of care. MCOs and the ASO may assist the State in the identification, outreach, and referral of potential participants among their own consumers. Upon obtaining consumer consent, the State, MCO, or ASO will refer individuals to a Health Home near their residence, at which point the Health Home may outreach to the consumer directly. The State will engage additional referral sources to familiarize them with the Health Home's purpose and referral protocols, as well as alert them to opportunities for continued collaboration with Health Home providers. This may include hospitals and emergency departments, public agencies, and school-based health centers.

○ **Automatic Assignment with Opt-Out of Health Homes provider**

Describe the process used:

☐ **The State provides assurance that it will clearly communicate the opt-out option to all individuals assigned to a Health Home under an opt-out process and submit to CMS a copy of any letter or other communication used to inform such individuals of their right to choose.**

○ **Other**

Describe:

☑ **The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**

☑ **The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**

☑ **The State provides assurance that hospitals participating under the State Plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.**

☑ **The State provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each Health Homes enrollee will be claimed. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.**

☑ **The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

Health Homes Providers

Types of Health Homes Providers

☑ **Designated Providers**

Indicate the Health Homes Designated Providers the State includes in its program and the provider qualifications and standards:

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards:

☐ **Rural Health Clinics**

Describe the Provider Qualifications and Standards:

☐ **Community Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Community Mental Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Home Health Agencies**

Describe the Provider Qualifications and Standards:

☑ **Other providers that have been determined by the State and approved by the Secretary to be qualified as a health home provider:**

☐ **Case Management Agencies**

Describe the Provider Qualifications and Standards:

☑ **Community/Behavioral Health Agencies**

Describe the Provider Qualifications and Standards:
Health Homes must be licensed by the Department of Health and Mental Hygiene as a Psychiatric Rehabilitation Program (PRP), a Mobile Treatment Services (MTS) provider or an Opioid Treatment Program (OTP). In addition, providers must:

1) Be enrolled as a Maryland Medicaid Provider;
2) Be accredited by, or in the process of gaining accreditation from, an approved accrediting body offering a Health Home accreditation product.
3) For those agencies working with minors, demonstrate a minimum of 3 years of experience serving children and youth.

☐ **Federally Qualified Health Centers (FQHC)**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Teams of Health Care Professionals**

Indicate the composition of the Health Homes Teams of Health Care Professionals the State includes in its program. For each type of provider indicate the required qualifications and standards:

☐ ***Physicians***

Describe the Provider Qualifications and Standards:

☐ **Nurse Care Coordinators**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Professionals**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Health Teams**

Indicate the composition of the Health Homes Health Team providers the State includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards:

☐ **Medical Specialists**

Describe the Provider Qualifications and Standards:

☐ **Nurses**

Describe the Provider Qualifications and Standards:

☐ **Pharmacists**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Dieticians**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Specialists**

Describe the Provider Qualifications and Standards:

☐ **Doctors of Chiropractic**

Describe the Provider Qualifications and Standards:

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Describe the Provider Qualifications and Standards:

☐ **Physicians' Assistants**

Describe the Provider Qualifications and Standards:

Supports for Health Homes Providers

Describe the methods by which the State will support providers of Health Homes services in addressing the following components:

1. **Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services,**
2. **Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines,**
3. **Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders,**
4. **Coordinate and provide access to mental health and substance abuse services,**

5. **Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care,**
6. **Coordinate and provide access to chronic disease management, including self-management support to individuals and their families,**
7. **Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services,**
8. **Coordinate and provide access to long-term care supports and services,**
9. **Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services:**
10. **Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate:**
11. **Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.**

Description:

To encourage ongoing information-sharing and problem-solving between Health Homes, the Department will offer educational opportunities such as webinars and regional meetings. Additionally, regular communication and feedback between the State and individual Health Homes will facilitate a collaborative and responsive working relationship. The Maryland Department of Health and Mental Hygiene will closely monitor Health Home providers to ensure their services meet Maryland's Health Home standards as well as CMS' Health Home core functional requirements stated above. Oversight activities may include medical chart and care management record review, site audits, and team composition analysis. The State will perform outreach to providers and agencies that may collaborate with Health Homes for the benefit of patients, informing them of the Health Home objectives and role in order to foster these linkages.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.

All Health Homes must maintain staff in the ratios specified below whose time is exclusively dedicated to the planning and delivery of Health Home services.

1) Health Home Director: .5 FTE per 125 Health Home enrollees. Health Homes with less than 125 enrollees may employ 1 FTE individual to serve as both the Nurse Care Manager and Health Home Director, provided that individual is licensed and legally authorized to practice as a registered nurse. Health Homes requiring a Director at a level more than .5 FTE may choose to designate a lead Health Home Director and subsequent additional key management staff to fulfill the Director staffing requirement.

2) Health Home Care Manager: .5 full-time equivalent (FTE) per 125 Health Home enrollees. Among providers with more than 1 FTE Care Manager, the initial 1FTE care manager role must be filled by a nurse, while subsequent staff in this role may be physicians' assistants.

3) Physician or Nurse Practitioner Consultant: 1.5 hours per Health Home enrollee per 12 month period

4) Administrative Support Staff: The State estimates that Administrative Support Staff of approximately .25 FTE per 125 Health Home enrollees will be necessary to effectively implement the Health Home. However, because providers utilize a wide range of care management tools that may lessen the burden of administrative tasks, Health Homes may use their discretion in determining the staffing levels necessary to fulfill the administrative activities of the Health Home.

The staffing ratios specified as "per 125 Health Home enrollees" act as a minimum, requiring providers with less than 125 enrollees to maintain this level regardless of their enrollment. Smaller Health Homes may form a consortium to share Health Home staff and thus costs, although participants will be served at their own provider's location. Creation of such consortiums is contingent upon geographic proximity and State approval of an application addendum detailing the planned collaboration.

Although the aforementioned staffing must be dedicated exclusively to Health Home activities, qualified staff members within the PRP, MT or OTP—such as licensed counselors or nurses—may provide Health Home

services as well. It is expected that all staff members, not only those dedicated exclusively to the Health Home, will be fully informed of the goals of the Health Home and collaborate to serve participants.

Provider Standards

The State's minimum requirements and expectations for Health Homes providers are as follows:
A Health Home serves as the central point for directing person-centered care with the goal of improving patient outcomes while reducing avoidable health care costs. While providers are afforded a degree of flexibility in the design and implementation of their Health Homes, they must meet certain requirements in addition to those delineated above. These standards are detailed below.

Initial Provider Qualifications
1. Health Home providers must be enrolled in the MD Medicaid program as a PRP,OTP, or Mobile Treatment provider and agree to comply with all Medicaid program requirements.

2. Health Home providers must have, or demonstrate their intention to pursue, accreditation from an approved body offering a Health Home accreditation product.

3. Health Home providers must directly provide, or subcontract for the provision of, Health Home services. The Health Home provider remains responsible for all Health Home program requirements, including services performed by the subcontractor.

4. Health Homes providing PRP or MT services to minors must demonstrate a minimum of 3 years of experience providing services to children and youth.

5. Health Homes must ensure a minimum of one Health Home director and one Care Manager are in place before beginning service provision, and must reach all required staffing levels within 30 days of beginning service provision.

6. Health Homes must provide services to all Health Home enrollees, with each individual's care under the direction of a dedicated care manager accountable for ensuring access to medical and behavioral health care services and community social supports as defined in the participant's care plan.

7. Providers must complete an application to the State demonstrating their ability to perform each of the CMS Health Home core functional components (refer to section Support for Providers). Providers must propose a set of systems and protocols, including:
a. processes used to perform these functions;
b. processes and timeframes used to assure service delivery takes place in the described manner; and
c. descriptions of multifaceted Health Home service interventions that will be provided to promote patient engagement, participation in their plan of care, and that ensures patients appropriate access to the continuum of physical and behavioral health care and social services.

8. Health Homes must participate in federal and state-required evaluation activities including documentation of Health Home service delivery as well as clients' health outcomes and social indicators in the eMedicaid online portal.

9. Providers must maintain compliance with all of the terms and conditions as a Health Home provider or will be discontinued as a provider of Health Home services. In the event of any recovery of funds resulting from a provider termination, the FMAP portion of funds recovered will be returned to CMS in accordance with standard protocols.

10. Providers that wish to disenroll as a Health Home must notify the State of their intent with at least 30 days notice prior to discontinuing services. They must inform Health Home participants that they will no longer provide Health Home services, and that these may be obtained elsewhere if the participants wish to transfer their care.

Ongoing Provider Qualifications
Following enrollment, Health Home providers must also:

1. Enroll with Chesapeake Regional Information System for our Patients (CRISP) to receive hospital encounter alerts and access pharmacy data;

2. Convene and document internal Health Home staff meetings every 6 months, at minimum, to plan and implement goals and objectives of practice transformation.

3. Complete a program assessment process every six months confirming that the Health Home meets all staffing and regulatory requirements, and demonstrating a quality improvement plan to address gaps and opportunities for improvement; and

4. Obtain accreditation from an approved accrediting body offering a Health Home accreditation product within 18 months of initiating the accreditation process, or demonstrate significant progress towards this goal.

Health Homes Service Delivery Systems

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Identify the service delivery system(s) that will be used for individuals receiving Health Homes services:

☑ **Fee for Service**
☐ **PCCM**

○ **PCCMs will not be a designated provider or part of a team of health care professionals. The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments.**

○ **The PCCMs will be a designated provider or part of a team of health care professionals.**

The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Requirements for the PCCM participating in a Health Homes as a designated provider or part of a team of health care professionals will be different from those of a regular PCCM.**

If yes, describe how requirements will be different:

☐ **Risk Based Managed Care**

The Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals. Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be affected:

☐ **The current capitation rate will be reduced.**

☐ **The State will impose additional contract requirements on the plans for Health Homes enrollees.**

Provide a summary of the contract language for the additional requirements:

☐ **Other**

Describe:

The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.

Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Homes services.

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

The State intends to include the Health Homes payments in the Health Plan capitation rate.

Yes

☐ **The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:**

- **Any program changes based on the inclusion of Health Homes services in the health plan benefits**
- **Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)**

- **Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)**
- **Any risk adjustments made by plan that may be different than overall risk adjustments**
- **How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM**

☐ **The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services.**

☐ **The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found.**

○ **No**

Indicate which payment methodology the State will use to pay its plans:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Other Service Delivery System:**

Describe if the providers in this other delivery system will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers:

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

Health Homes Payment Methodologies

The State's Health Homes payment methodology will contain the following features:

☑ **Fee for Service**

☑ **Fee for Service Rates based on:**

☐ **Severity of each individual's chronic conditions**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☑ **Other: Describe below.**

Health Homes may receive a one-time reimbursement for the completion of each participants' initial intake and assessment necessary for enrollment into the Health Home. The payment will be the same as the rate paid for monthly services on a per-member basis.

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee-for-service rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

☑ **Per Member, Per Month Rates**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

Health Homes will be paid a PMPM rate based on the employment costs of required Health Home staff, using salary and additional employment cost estimates for each of the required positions and their respective ratios. Payments is contingent upon the Health Home meeting the requirements set forth in the Health Home applications, as determined by the State of Maryland. Failure to meet such requirements is

grounds for payment sanctions or revocation of Home Health status. The State of Maryland will audit Health Homes to confirm adherence to all regulations and requirements.

The Department does not pay for separate billing for services which are included as part of another service. At the end of each month, Health Homes will ensure that all Health Home services and outcomes have been reported into eMedicaid. The provider will then submit a bill within 30 days for all participants that received the minimum Health Home service requirement in the preceding month. The provider may begin billing for a Health Home participant when the intake portion of that individual's eMedicaid file has been completed with the necessary demographics, qualifying diagnoses baseline data, and consent form. The initial intake process itself qualifies as a Health Home service. The ongoing criteria for receiving a monthly PMPM payment is:

1. The individual is identified in the State's Medicaid Management Information System (MMIS) as Medicaid-eligible and authorized to receive PRP, MT, or OTP services;

2. The individual was enrolled as a Health Home member with the Health Home provider in the month for which the provider is submitting a bill for Health Home services; and

3. The individual has received a minimum of two Health Home services in the previous month, which are documented in the eMedicaid system.

The agency's rates were set as of 10/1/2013 and are effective for services on or after that date. The rate will be posted on the Maryland Health Home website at http://dhmh.maryland.gov/bhd/Documents/HealthHomesFeeSchedule.pdf. Except as otherwise noted in the plan, this rate is the same for both governmental and private providers. Attached to the SPA submission is the payment methodology.

☐ **Incentive payment reimbursement**

Provide a comprehensive description of incentive payment policies that the State will use to reimburse in addition to the unit base rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the incentives that will be reimbursed through the methodology, how the supplemental incentive payments are tied to the base rate activities, the criteria used to determine a provider's eligibility to receive the payment, the methodology used to determine the incentive payment amounts, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

☐ **PCCM Managed Care (description included in Service Delivery section)**

☐ **Risk Based Managed Care (description included in Service Delivery section)**

☐ **Alternative models of payment, other than Fee for Service or PM/PM payments (describe below)**

☐ **Tiered Rates based on:**

☐ **Severity of each individual's chronic conditions**

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Rate only reimbursement**

Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.
Recipients of specified waiver services and mental health case management that may be duplicative of Health Home services will not be eligible to enroll in a Health Home. In addition to offering guidance to providers regarding this restriction, the State may periodically examine recipient files to ensure that Health Home participants are not receiving similar services through other Medicaid-funded programs.

☑ **The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule**

☑ **The State provides assurance that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.**

Submission - Categories of Individuals and Populations Provided Health Homes Services

The State will make Health Homes services available to the following categories of Medicaid participants:

☑ **Categorically Needy eligibility groups**

Health Homes Services (1 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive Care Management

Definition:
Health Home staff will collaborate to provide comprehensive care management services with active patient and family participation. The Health Home will coordinate primary and behavioral health care and social services to address the whole-person needs of patients at the individual and population levels. This will include the following:
a. Initial assessment: The Health Home will conduct, or provide a referral to the PCP for, a comprehensive biopsychosocial assessment, if no such assessment has been performed by a licensed physician or nurse practitioner in the preceding 6-month period.
b. Development of Care plan: Using the initial assessment and PCP records as available, the Health Home team will work with the participant to develop an ITP including goals and timeframes, community networks and supports, and optimal clinical outcomes.
c. Delineation of roles: The Health Home will assign each team member clear roles and responsibilities. Participant ITPs will identify the various providers and specialists within and outside the Health Home involved in the consumer's care.
d. Monitoring and reassessment: The Health Home will monitor individual health status and progress towards ITP goals, documenting changes and adjusting care plans as needed, twice annually minimally.
e. Outcomes and Reporting: The Health Home will use the eMedicaid portal and other available HIT tools possibly including EHR, to review and report quality metrics, assessment and survey results, and service utilization in order to evaluate client satisfaction, health status, service delivery, and costs.
f. Population-based Care Management: Providers will monitor population health status and service use to determine adherence to or variance from treatment guidelines. The Health Home will identify and prioritize and population-wide needs and trends, then implement appropriate population-wide treatment guidelines and interventions.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
All Health Homes will have access to the State's online eMedicaid portal, allowing providers to report and review participant intake, assessment, assigned staff, ITP, clinical baselines and data relating to chronic conditions, as well as Health Home services provided, such as referrals made and health promotion activities completed. EMedicaid will generate reports of the aforementioned data at a participant or provider level. Additional access to hospital encounter and pharmacy data through the Chesapeake Regional Information System for Our Patients (CRISP) Electronic Notification System will enable Health Homes to gain a more comprehensive understanding to their participants' care and health status.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Opioid Treatment Program Clinical Supervisors, Licensed Mental Health Professionals, and PRP Rehabilitation Specialists and PRP Direct Support Staff may participate in development of the participant's ITP, as well as ongoing monitoring and reassessment. Clinical Supervisors may also play a role in population-based care management tasks.

☑ **Nurse Care Coordinators**

Description
Nurse Care Coordinators may participate in development of the participant's ITP, as well as ongoing monitoring and reassessment. Nurse Care Coordinators may also play a role in population-based care management tasks.

☑ **Nurses**

Description

Nurses may participate in development of the participant's ITP, as well as ongoing monitoring and reassessment. Nurse Practitioners may perform the initial biopsychosocial assessment of a new Health Home participant, as well as play in role in population-based care management.

☐ **Medical Specialists**

Description

☑ **Physicians**

Description
Physicians may perform the initial biopsychosocial assessment of a new Health Home participant, as well as participate in development and ongoing monitoring and reassessment of the ITP goals. Physicians may also play a role in population-based care management tasks.

☑ **Physicians' Assistants**

Description
Physicians' Assistants may participate in development of the participant's ITP, as well as ongoing monitoring and reassessment.

☐ **Pharmacists**

Description

☑ **Social Workers**

Description
Social Workers may participate in development of the participant's ITP, as well as ongoing monitoring and reassessment.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Health Home Director

Description

The Health Home Director may participate in development of the participant's ITP, as well as ongoing monitoring and reassessment. They may also take part in population-based care management activities.

Care Coordination

Definition:

Care coordination will include implementation of the consumer-centered ITP through appropriate linkages, referrals, coordination and follow-up to needed services and support. Specific activities include: appointment scheduling, referrals and follow-up monitoring, tracking of appropriate screenings and EPDST needs, and communication with other providers and supports. Health Homes serving children will place particular emphasis on coordination with school officials, PCPs, and involved agencies such as DSS.

The Health Home provider will assign each enrollee a Care Manager who will be responsible for coordinating the individuals' care and ensuring implementation of the treatment plan in partnership with the individual and family, as appropriate.

At the population level, the Health Home provider will develop policies and procedures to facilitate collaboration between primary care, specialist, and behavioral health providers, as well as agencies and community-based organizations; and for children, school-based providers. Such policies will clearly define the roles and responsibilities of each in order to ensure timely communication, use of evidence-based referrals, follow-up consultations, and regular case review meetings with all members of the Health Home team. The Health Home will ensure that all regular screenings and immunizations are conducted through coordination with the primary care or other appropriate provider. In addition, members of the Health Home team will meet with area providers to enhance collaboration and integration with regard to the population.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The eMedicaid online portal will allow Health Homes to report and review referrals made to outside providers, social and community resources, and individual and family supports. Access to CRISP hospital encounter alerts will facilitate prompt discharge planning and follow-up. As the State continues to develop eMedicaid's capabilities, claims data may ultimately populate fields in the eMedicaid system, allowing Health Home providers to better track their participant needs, services received, and identify opportunities for improved care coordination.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Appropriate behavioral health professionals or specialists- including Addictions Counselors, OTP Clinical Supervisors, PRP Rehabilitation Specialists, and PRP Direct Support Staff- may provide care coordination services.

☑ **Nurse Care Coordinators**

Description
Nurse Care Coordinators may provide care coordination services.

☑ **Nurses**

Description
Nurses may provide care coordination services.

☐ **Medical Specialists**

Description

☑ **Physicians**

Description
Physicians may provide care coordination services.

☑ **Physicians' Assistants**

Description
Nurse Care Coordinators may provide care coordination services.

☐ **Pharmacists**

Description

☑ **Social Workers**

Description
Social Workers may provide care coordination services.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name
Administrative Support Staff

Description
Administrative Support Staff may provide care coordination services in the form of appointment scheduling and tracking.

Health Promotion

Definition:
Health Promotion services assist patients and families to participate in the implementation of their care plan and place a strong emphasis on skills development for monitoring and management of chronic and other somatic health conditions. Health promotion services will include health education and coaching

specific to an individual's condition(s), development of a self-management goals, medication review and education, and promotion of healthy lifestyle interventions. Such interventions may include, those that encourage substance use and smoking prevention or cessation, improved nutrition, obesity prevention and reduction, and increased physical activity.

Health Homes working with children will emphasize these preventive health initiatives, while actively involving parents and families in the process. This will include identifying conditions for which the child may be at risk due to family, physical, or social factors, and working with the patient and caregivers to address these areas.

At the population level, the Health Home team will use data to: identify and prioritize particular areas of need with regard to health promotion; research best-practice interventions; implement the activities in group and individual settings; evaluate the effectiveness of the interventions; and modify them accordingly.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Health Home providers will use the eMedicaid portal to document, review, and report health promotion services delivered to each enrollee. Additionally, periodic updates to clinical outcomes may be reported in tandem with the related health promotion services delivered—for example, while reporting a discussion regarding physical activity in the eMedicaid portal, the Health Home would note the participant's weight and BMI.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
As appropriate, the following providers may perform or assist with health promotion services: Addictions Counselors, PRP Rehabilitation Specialists, Licensed Mental Health Professionals, OTP Clinical Supervisors and PRP Direct Support Staff.

☑ **Nurse Care Coordinators**

Description
Nurse Care Coordinators may perform health promotion services.

☑ **Nurses**

Description
Nurses may perform health promotion services.

☐ **Medical Specialists**

Description

☑ **Physicians**

Description
Physicians may perform health promotion services.

☑ **Physicians' Assistants**

Description
Physicians' Assistants may perform health promotion services.

☐ **Pharmacists**

Description

☑ **Social Workers**

Description
As appropriate, Social Workers may perform health promotion services.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Health Homes Services (2 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

Definition:
Health Homes will provide services designed to streamline plans of care, reduce hospital admissions, ease the transition to long-term services and supports, interrupt patterns of frequent hospital emergency department use, and ensure timely and proper follow up care. The Health Home will increase consumers' and family members' ability to manage care and live safely in the community, shifting the use of reactive care and treatment to proactive health promotion and self-management.

Transitional care services will vary by age of participants, and may include transitions to or from residential care facilities. Among transitional-age youth, services will address the needs of participants and families as the individuals approach a shift into adult services and programs.

To accomplish these functions, providers will establish a clear protocol for responding to CRISP alerts or notification from any other inpatient facility to facilitate collaboration in treatment, discharge, and safe transitional care. Care Managers will follow up with consumers within two business days post-discharge discharge via home visit, phone call, or scheduling an on-site appointment.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
All Health Homes will be required to enroll with CRISP in order to receive alerts of hospital admissions, discharges, or transfer among their Health Home patient panel. Real-time access to this information will allow Health Home providers to provide prompt coordination and follow-up care. This ability will be augmented by real-time access to pharmacy data that may aid in medication reconciliation.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description

As appropriate, the following providers may deliver or assist in the delivery of comprehensive transitional care services: OTP Clinical Supervisors, Addictions Counselors, Licensed Mental Health Professionals, PRP Rehabilitation Specialists, PRP Direct Support Staff.

☑ **Nurse Care Coordinators**

Description
Nurse Care Managers may provide comprehensive transitional care services.

☑ **Nurses**

Description
Nurses may provide comprehensive transitional care services.

☐ **Medical Specialists**

Description

☑ **Physicians**

Description
Physicians may provide comprehensive transitional care services.

☑ **Physicians' Assistants**

Description
Physicians' Assistants may provide comprehensive transitional care services.

☐ **Pharmacists**

Description

☑ **Social Workers**

Description
Social Workers may provide comprehensive transitional care services.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name
Health Home Directors

Description
Health Home Directors may provide comprehensive transitional care services.

Individual and family support, which includes authorized representatives

Definition:
Services will include advocating for individuals and families; assisting with medication and treatment adherence; identifying resources for individuals and families to support them in attaining their highest level of health and functioning, including transportation to medically-necessary services; improving health literacy; increasing the ability to self-manage care; facilitating participation in the ongoing revision of care/treatment plan; and providing information as appropriate on advance directives and health care power of attorney. Health Homes will additionally connect participants with peer support services, many of which will be offered on-site, as well as referring participants to support groups and self-care programs as appropriate.

At the population level, services will include: collecting and analyzing individual and family needs data; developing individual and family support materials and groups regarding the areas listed above; soliciting community organizations to provide group support to the population; and providing training and technical assistance as needed regarding the special needs of and effective interventions for the population.

The Health Home provider will ensure that all communication and information shared with the enrollee, the enrollee's family and caregivers, as appropriate, is language, literacy and culturally appropriate.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

The eMedicaid tool will allow Health Home providers to document, review, and report individual and family support services delivered, including referrals to outside groups or programs. Using real-time pharmacy data, Health Home providers will be better able to assist individuals in obtaining and adhering to prescription medications.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
As appropriate, the following providers may deliver or assist in the delivery of individual and family support services: OTP Clinical Supervisors, Addictions Counselors, Licensed Mental Health Professionals, PRP Rehabilitation Specialists, and PRP Direct Support Staff.

☑ **Nurse Care Coordinators**

Description
Nurse Care Coordinators may provide individual and family support services.

☑ **Nurses**

Description
Nurses may provide individual and family support services.

☐ **Medical Specialists**

Description

☑ **Physicians**

Description
Physicians may provide individual and family support services.

☑ **Physicians' Assistants**

Description
Physicians' Assistants may provide individual and family support services.

☐ **Pharmacists**

Description

☑ **Social Workers**

Description

Social Workers may provide individual and family support services.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Referral to community and social support services, if relevant

Definition:
The Health Home will identify available community-based resources and actively manage appropriate referrals, access to care, and engagement with other community, social, and school-based supports. Specific services will include: providing assistance for accessing Medical Assistance, disability

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benefits, subsidized or supported housing, personal needs support, peer or family support, and legal services, as appropriate. The Health Home will assist in coordinating these services and following up with consumers post service engagement.

At the population level, the Health Home team will: develop and monitor cooperative agreements with community and social support agencies that establish collaboration, follow-up, and reporting standards; recruit agencies to enter into those collaborative agreements; and provide training and technical assistance as needed regarding the special needs of and effective interventions for the population.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.
Using the eMedicaid online portal, Health Home providers may document, report, and review referrals to community-based resources.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
The following providers may provide referrals to community and social support services: OTP Clinical Supervisors, Addictions Counselors, Licensed Mental Health Professionals, PRP Rehabilitation Specialists, and PRP Direct Support Staff.

☑ **Nurse Care Coordinators**

Description
Nurse Care Coordinators may provide referrals to community and social support services.

☑ **Nurses**

Description
Nurses may provide referrals to community and social support services.

☐ **Medical Specialists**

Description

☑ **Physicians**

Description
Physicians may provide referrals to community and social support services.

☑ **Physicians' Assistants**

Description
Physicians' Assistants may provide referrals to community and social support services.

☐ **Pharmacists**

Description

☑ **Social Workers**

Description
Social Workers may provide referrals to community and social support services.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name
Health Home Director

Description
The Health Home Director may provide referrals to community and social support services.

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:
Referral & Enrollment
Potential Health Home participants may be informed of and referred to a Health Home in their region by a variety of sources. Upon engaging with a potential participant, the Health Home will enroll the individual in the appropriate PRP, MT, or OTP services for which they are eligible, and in the case of OTP patients, identify the qualifying risk factors that place them at risk for additional chronic conditions. The Health Home will then explain the data-sharing elements of the program and obtain consent from the participant. Finally, the provider will create an entry and intake for the participant in the eMedicaid system, effectively enrolling them in the Health Home.

Participation
While participating in the Health Home, an individual will receive a minimum of two Health Home services per month, to be documented in the eMedicaid portal. A Care Manager will monitor their care and health status, and the Health Home team will assist with the provision of Health Home services as necessary. The Health Home will periodically reassess participants, and in doing so determine whether Health Home services are necessary.

Discharge
Discharge from the Health Home will primarily result from incidents such as relocation, incarceration, or loss of eligibility. In such cases, the Health Home provider will follow discharge protocol appropriate to the circumstances. In such cases where an individual 's PRP, MT, or OTP services cease due to stabilization or reaching age 18, they may remain in the Health Home for six months, during which the Health Home provider will emphasize support their transition to the appropriate level of care. Discharge planning may include the development of a discharge plan with referrals to the appropriate services and providers which will continue the individual's care and support. The Health Home provider will report in eMedicaid the discharge of a participant, as well as note the completion of discharge planning.

☑ **Medically Needy eligibility groups**

◉ **All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.**

○ **Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.**

○ **All Medically Needy receive the same services.**

○ **There is more than one benefit structure for Medically Needy eligibility groups.**

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:
Using claims data, the State will track avoidable hospital readmissions by calculating ambulatory care sensitive conditions (ACSC) readmissions per 1000 enrollees. To calculate this rate: (# of readmissions with a primary diagnosis consisting of an Agency of Healthcare Research and Quality (AHRQ) ICD-9 code for ambulatory care sensitive conditions/member months) x 12,000.

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.

To measure cost savings generated by Chronic Health Homes, the State may compare the costs per member per month for participants by Health Home provider and by condition to costs for comparison groups of OTP, MT, and PRP participants enrolled with non-Health Home providers. The State may also compare overall costs between the groups for emergency room utilization, hospitalizations, nursing facility admissions, and pharmacy utilization. In this assessment, the State may review each Chronic Health Home independently for its overall costs and the allocation of its funds amongst services provided to inform future implementation and process modifications.

Describe how the State will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

1.eMedicaid Portal: eMedicaid is a web-based portal accessible to all networks, allowing Health Home providers to record and review of services delivered as well as clinical and social outcomes related to the individuals' chronic conditions. The portal is secure, with Health Homes' access limited to access the records of their own current enrollees. The State will use eMedicaid reports to track enrollment, compliance, and outcomes at the provider and population levels.

2.Chesapeake Regional Information System for our Patients (CRISP): All Health Home providers must enroll with CRISP's Electronic Notification System to receive hospital encounter alerts. This entails an initial upload of the Health Home's patient panel with all necessary demographic information, followed by monthly panel updates, as well as the set up of a direct message inbox and/or an interface with the provider's EHR to receive alerts.

3.Pharmacy Data: CRISP will additionally provide pharmacy data to Health Homes, including all Schedule II-V through the State's Prescription Drug Monitoring Program (PDMP), as well as any prescription drug within the Surescripts network.

4.Electronic Health Records (EHR) and Clinical Management Systems:Qualification as a Health Home provider is in part dependent upon the ability to report detailed performance metrics, measure improvement in care coordination, and gauge clinical outcomes on a provider level. Providers who do not currently use a robust EHR or clinical management system may determine that such a tool is necessary to meet the reporting and care coordination requirements of the Health Home program, as well as to improve their overall care capabilities.

Quality Measurement

☑ **The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.**

☑ **The State provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.**

States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:

Evaluations

☑ **The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.**

Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:

Hospital Admissions

Measure:
Hospital admissions- asthma
Measure Specification, including a description of the numerator and denominator.
Hospital admissions with asthma complications as a primary or secondary diagnosis, per 1000 Health Home participants per month.
Data Sources:
Claims/Encounters
Frequency of Data Collection:
- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Measure:
Hospital admissions- diabetes
Measure Specification, including a description of the numerator and denominator.
Hospital admissions with diabetes-related complications as a primary or secondary diagnosis, per 1000 Health Home participants per month.
Data Sources:
Claims/Encounters
Frequency of Data Collection:
- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ ***Continuously***
- ○ **Other**

Measure:
Hospital admissions- heart disease
Measure Specification, including a description of the numerator and denominator.
Hospital admissions with congestive heart failure and/or heart disease as a primary or secondary diagnosis, per 1000 Health Home participants per month.
Data Sources:
Claims/Encounters
Frequency of Data Collection:
- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Measure:

Hospital admissions- hepatitis C

Measure Specification, including a description of the numerator and denominator.
Hospital admissions with hepatitis C-related complications as a primary or secondary diagnosis, per 1000 Health Home participants per month.
Data Sources:
Claims/Encounters
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Measure:

Hospital admissions- HIV/AIDS

Measure Specification, including a description of the numerator and denominator.
Hospital admissions with HIV/AIDS-related complications as a primary or secondary diagnosis, per 1000 Health Home participants per month.
Data Sources:
Claims/Encounters
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Measure:

Hospital admissions- hypertension

Measure Specification, including a description of the numerator and denominator.
Hospital admissions with hypertension related complications as a secondary diagnosis, per 1000 Health Home participants per month.
Data Sources:
Claims/Encounters
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Measure:

Hospital admissions- kidney disease

Measure Specification, including a description of the numerator and denominator.
Hospital admissions with chronic kidney disease complications as a primary or secondary diagnosis, per 1000 Health Home participants per month.
Data Sources:
Claims/Encounters
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**

- (●) **Annually**
- ( ) **Continuously**
- ( ) **Other**

Measure:

Hospital admissions- mental health

Measure Specification, including a description of the numerator and denominator.
Hospital admissions with mental health conditions as a primary or secondary diagnosis, per 1000 Health Home participants per month.
Data Sources:
Claims/Encounters
Frequency of Data Collection:

- ( ) **Monthly**
- ( ) **Quarterly**
- (●) **Annually**
- ( ) **Continuously**
- ( ) **Other**

Measure:

Hospital admissions- obesity

Measure Specification, including a description of the numerator and denominator.
Hospital admissions with obesity related complications as a secondary diagnosis, per 1000 Health Home participants per month.
Data Sources:
Claims/Encounters
Frequency of Data Collection:

- ( ) **Monthly**
- ( ) **Quarterly**
- (●) **Annually**
- ( ) **Continuously**
- ( ) **Other**

Measure:

Hospital admissions- substance use disorder

Measure Specification, including a description of the numerator and denominator.
Hospital admissions with substance use disorder as a primary or secondary diagnosis, per 1000 Health Home participants per month.
Data Sources:
Claims/Encounters
Frequency of Data Collection:

- ( ) **Monthly**
- ( ) **Quarterly**
- (●) **Annually**
- ( ) **Continuously**
- ( ) **Other**

Measure:

Hospital costs

Measure Specification, including a description of the numerator and denominator.
Hospitalization costs per member per month, aggregated and by Health Home provider.

Data Sources:
Claims/Encounters
Frequency of Data Collection:
- Monthly
- Quarterly
- (•) Annually
- Continuously
- Other

Measure:
Inpatient admissions
Measure Specification, including a description of the numerator and denominator.
Inpatient admissions per 1000 Health Home participants per month, stratified by mental health diagnoses and all other diagnoses.
Data Sources:
Claims/Encounters
Frequency of Data Collection:
- Monthly
- Quarterly
- (•) Annually
- Continuously
- Other

Measure:
Mental health readmissions
Measure Specification, including a description of the numerator and denominator.
Mental health readmissions within 30 days.
Data Sources:
Claims/Encounters
Frequency of Data Collection:
- Monthly
- Quarterly
- (•) Annually
- Continuously
- Other

Measure:
Potentially preventable readmissions
Measure Specification, including a description of the numerator and denominator.
Potentially preventable readmissions within 30 days as a percentage of potentially preventable hospital admissions, stratified by mental health diagnoses and all other diagnoses.
Data Sources:
Claims/Encounters
Frequency of Data Collection:
- Monthly
- Quarterly
- (•) Annually
- Continuously
- Other

Emergency Room Visits

Measure:
Emergency department costs
Measure Specification, including a description of the numerator and denominator.
Emergency Department costs per member per month, aggregated and by HH provider.
Data Sources:
Claims/Encounters
Frequency of Data Collection:
- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Measure:
Emergency department visits- asthma
Measure Specification, including a description of the numerator and denominator.
Asthma ED visit rate per 1000 Health Home participants per month.
Data Sources:
Claims/Encounters
Frequency of Data Collection:
- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Measure:
Emergency department visits- diabetes
Measure Specification, including a description of the numerator and denominator.
Diabetes-related ED visit rate per 1000 Health Home participants per month.
Data Sources:
Claims/Encounters
Frequency of Data Collection:
- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Measure:
Emergency department visits- heart disease
Measure Specification, including a description of the numerator and denominator.
Congestive heart failure and/or heart disease ED visit rate per 1000 Health Home participants per month.
Data Sources:
Claims/Encounters
Frequency of Data Collection:
- ○ **Monthly**
- ○ **Quarterly**

(●) **Annually**
( ) **Continuously**
( ) **Other**

Measure:
Emergency department visits- hepatitis C
Measure Specification, including a description of the numerator and denominator.
Hepatitis C-related ED visit rate per 1000 Health Home participants per month.
Data Sources:
Claims/Encounters
Frequency of Data Collection:
( ) **Monthly**
( ) **Quarterly**
(●) **Annually**
( ) **Continuously**
( ) **Other**

Measure:
Emergency department visits- HIV/AIDS
Measure Specification, including a description of the numerator and denominator.
HIV/AIDS-related ED visit rate per 1000 Health Home participants per month.
Data Sources:
Claims/Encounters
Frequency of Data Collection:
( ) **Monthly**
( ) **Quarterly**
(●) **Annually**
( ) **Continuously**
( ) **Other**

Measure:
Emergency department visits- hypertension
Measure Specification, including a description of the numerator and denominator.
Hypertension related ED visit rate per 1000 Health Home participants per month.
Data Sources:
Claims/Encounters
Frequency of Data Collection:
( ) **Monthly**
( ) **Quarterly**
(●) **Annually**
( ) **Continuously**
( ) **Other**

Measure:
Emergency department visits- kidney disease
Measure Specification, including a description of the numerator and denominator.
Chronic kidney disease ED visit rate per 1000 Health Home participants per month.
Data Sources:
Claims/Encounters
Frequency of Data Collection:

- Monthly
- Quarterly
- Annually
- Continuously
- Other

Measure:

Emergency department visits- obesity

Measure Specification, including a description of the numerator and denominator.
Obesity-related complications ED visit rate per 1000 Health Home participants per month.
Data Sources:
Claims/Encounters
Frequency of Data Collection:

- Monthly
- Quarterly
- Annually
- Continuously
- Other

Measure:

Emergency department visits- substance use

Measure Specification, including a description of the numerator and denominator.
Substance use disorder ED visit rate per 1000 Health Home participants per month.
Data Sources:
Claims/Encounters
Frequency of Data Collection:

- Monthly
- Quarterly
- Annually
- Continuously
- Other

Measure:

Emergency department visits

Measure Specification, including a description of the numerator and denominator.
Emergency Department (ED) visit rate per 1000 Health Home participants per month, stratified by mental health diagnoses and all other diagnoses.
Data Sources:
Claims/Encounters
Frequency of Data Collection:

- Monthly
- Quarterly
- Annually
- Continuously
- Other

Skilled Nursing Facility Admissions

Measure:

Nursing facility admissions

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Measure Specification, including a description of the numerator and denominator. Nursing Facility admission rate per 1000 Health Home participants per month, all facility admissions. Data Sources: Claims/Encounters Frequency of Data Collection: ○ **Monthly** ○ **Quarterly** ◉ **Annually** ○ **Continuously** ○ **Other**
Measure: Nursing facility costs Measure Specification, including a description of the numerator and denominator. Skilled nursing facility costs per member per month, aggregated and by HH provider. Data Sources: Claims/Encounters Frequency of Data Collection: ○ **Monthly** ○ **Quarterly** ◉ **Annually** ○ **Continuously** ○ **Other**

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

Hospital Admission Rates
The State plans to capture hospital admission rates and readmission rates per 1000 Health Home participants per month.
With the aid of state and academic partners, the State will use ED classifications developed by researchers at the New York University Center for Health and Public Service Research to classify the appropriateness of ED care for Health Home participants and compare usage with groups of OMT, MT and PRP participants receiving care non-Health Home PRP, MT and OMT providers. This methodology categorizes emergency visits as follows:

1. Non-emergent: Immediate care was not required within 12 hours based on patient's presenting symptoms, medical history, and vital signs
2. Emergent but primary care treatable: Treatment was required within 12 hours, but it could have been provided effectively in a primary setting (e.g., CAT scan or certain lab tests)
3. Emergent but preventable/avoidable: Emergency care was required, but the condition was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness (e.g., asthma flare-up)
4. Emergent, ED care needed, not preventable/avoidable: Ambulatory care could not have prevented the condition (e.g., trauma or appendicitis)
5. Injury: Injury was the principal diagnosis
6. Alcohol-related: The principal diagnosis was related to alcohol
7. Drug-related: The principal diagnosis was related to drugs
8. Mental health-related: The principal diagnosis was related to mental health
9. Unclassified: The condition was not classified in one of the above categories by the expert panel

The State also may use hospital readmissions data for Health Home participants to determine if care managers are establishing prompt contact with patients and their physicians to coordinate care after hospitalization discharge.

Chronic Disease Management
The State may modify standardized assessment tools using claims data, encounter data, pharmacy data, and qualitative interviews with Health Home administrative staff and providers, to determine implementation of the following components:

1. inclusion of preventive and health promotion services;
2. coordination of care between primary care, specialty providers and community supports;
3. emphasis on collaborative patient decision making and teaching of disease self-management;
4. structuring of care to ensure ongoing monitoring and follow-up care;
5. facilitation of evidence-based practice; and
6. use of clinical information systems to facilitate tracking of care as well as integration between providers.

In addition, the State may conduct comparative evaluations that focus on groups at-risk to incur high costs to determine the success and cost-effectiveness of the Health Homes.

Coordination of Care for Individuals with Chronic Conditions
Using the Chronic Health Homes tool on eMedicaid, the State will monitor Health Home providers to ensure they are coordinating care effectively for participants. The State may assess provision of care coordination services by measuring:

1. the level of contacts made by care managers during and after hospitalization;
2. the frequency of telephonic and/or face-to-face contact with participants after hospitalization discharge;
3. the level of active care management for high-risk participants; and
4. behavioral activity and engagement of high-risk participants in response to care management interventions.

Oversight activities may include, but not be limited to: medical chart and care management record review, site audits, team composition analysis, and review of types and number of contacts.

Assessment of Program Implementation
The State will have the capacity to assess and monitor ongoing performance of the Health Homes program with the aid of claims and encounter data, pharmacy data, the eMedicaid case management tracking tool, and regularly scheduled educational activities and meetings. Through a combination of evaluation data, information from training sessions, feedback from the regional meetings, and information gathered from practice representatives and participants, the State and Health Home providers may identify ineffective practices and implementation challenges and develop potential solutions. The State may assess if Health Homes have developed and implemented a tool to track and monitor recipient encounters with providers and inpatient facilities. The State may also perform evaluations of patient volume levels, the percentage of participants who opt out of Health Home services, achievement of participation goals set by each Health Home provider, and retention rates.

Processes and Lessons Learned
The State may provide training and education opportunities for health home providers, such as webinars, regional meetings, and/or training sessions to foster shared learning, information sharing, and problem solving. These forums may permit discussion of successful and unsuccessful implementation strategies, along with frequent communication, feedback, learning activities, and technical assistance. The State also may monitor Health Home processes by assessing evaluation data, conducting medical chart and care management record reviews, site audits, team composition analysis, and review of types and number of contacts between Health Home case managers and participants.

Assessment of Quality Improvements and Clinical Outcomes
The State requires each Health Home to use eMedicaid to input information related to participants' services and overall health. In addition to assisting the Health Home with coordination of care and case management, the tool tracks data linked to chronic conditions, such as Body Mass Index (BMI), blood pressure, and others. Data collected may inform the individual's plan of care, proper follow-up protocols upon the recipient's hospitalization discharge, health promotion services, and management of chronic conditions.
The State's current HEDIS™ measures for Medicaid-eligible adults that correspond with measures recommended by CMS for Health Home efforts are Ambulatory Care – Sensitive Condition Admission, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, and Controlling High Blood Pressure. The State may opt to evaluate additional HEDIS™ measures for adults that link to overall health promotion, such as Adult BMI Assessment, Medical Assistance with Smoking and Tobacco Use Cessation, Comprehensive Diabetes Care: Hemoglobin A1c Testing and LDL-C Screening, Annual Monitoring for Patients on Persistent Medications, Breast Cancer Screening, Cervical Cancer Screening, Chlamydia Screening in Women Ages 21-24, Postpartum Care Rate, Controlling High Blood

Pressure, and the CAHPS survey to evaluate experience of care. These measures may be obtained using claims data, encounter data, medical chart reviews, survey responses, and pharmacy data. The State also may incorporate Medicare data to evaluate the Health Home's impact on the dual eligible population.
The endpoint evaluation may also identify and assess the number and types of outcomes indicative of poorly managed care of chronic conditions at the patient level. Examples include multiple ED visits, hospital re-admissions, and preventable disease-specific complications.

Estimates of Cost Savings

☑ **The State will use the same method as that described in the Monitoring section.**

If no, describe how cost-savings will be estimated.