

Ohio Medicaid Health Home Informational Forum

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An Applied Approach to
Implementing
CBHC Health Home

Health Home Prerequisites

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Health home is
...thinking out of the box
...a paradigm shift
...transformational

Today's Objective

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- Develop an increased understanding of Ohio's health home model to facilitate provider and local system readiness



And now ... Flexibility and Innovation

4



"I'll be happy to give you innovative thinking. What are the guidelines?"

Health Home Boundaries - “what, not how”

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- Target Population – person-centered focus to meet needs of persons with SPMI
- Providers must meet provider requirements
- Integrated Care Plan – comprehensive
- Payment methodology is consistent but design is flexible to promote innovation
- Geographic Area - health home service will be phased in based on readiness

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

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

SPMI Target Population

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

Health Home Population Criteria: Serious and Persistent Mental Health Condition

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

Health Home Population Criteria: Serious and Persistent Mental Health Condition

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- **Serious and Persistent Mental Illness (SPMI) *cont.***

- **Treatment history criteria**

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

Health Home Population Criteria: Serious and Persistent Mental Health Condition

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- **Serious Mental Illness (SMI) :**

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

Health Home Population Criteria: Serious and Persistent Mental Health Condition

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

Health Home Population Criteria: Serious and Persistent Mental Health Condition

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

Ohio Medicaid Health Home Program Goals

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

The work begins

**Health
Home**



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Medicaid Health Home Service Provider Requirements



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Am I eligible to provide Health Home service?

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- ✓ Must be certified by ODMH as eligible to provide all of the following Medicaid covered community mental health services*:
 - 1) pharmacological management
 - 2) mental health assessment (physician and non-physician)
 - 3) behavioral health counseling and therapy (individual & group)
 - 4) community psychiatric support treatment (individual & group)

**This certification includes achieving accreditation from any of the following national organizations: The Commission on Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or The Council on Accreditation for Children and Family Services.*

Am I eligible to provide Health Home service?, cont.

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✓ Must have the capacity to provide **ALL** health home service components:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care & Follow-up
- Individual and Family Supports
- Referral to Community and Social Support Services
- Use of health information technology to link services

Health Home Service Components

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

Health Home Service Components

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• Care Coordination

- Implementation of individualized treatment plan;
- Assist consumer in obtaining health care, including mental health, substance abuse services and developmental disabilities services, ancillary services and supports;
- Medication management, including medication reconciliation;
- Track tests and referrals and follow-up as necessary;
- Coordinate, facilitate and collaborate with consumer, family, team of health care professionals, providers;
- Develop a crisis management and contingency plan working with the individual, family and significant others;
- Assist consumer in obtaining referrals to community, social and recovery supports, making appointments and validating that the consumer received the service;
- Monitor care plan and the individual's status in relation to his or her care plan goals;
- Reassess the consumer at least once every 90 days to determine if a change is needed in the treatment plan or if there is a change in health status;
- Provide clinical summaries and consumer information along with routine reports of treatment plan compliance to the team of health care professionals, including consumer/family.

Health Home Service Components

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• Health Promotion

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

Health Home Service Components

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

Health Home Service Components

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

Health Home Service Components

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

Am I eligible to provide Health Home service?, cont.

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- ✓ **Must demonstrate integration of physical and behavioral health by receiving one of the following accreditations or certifications within 18 months of becoming a CBHC health home service provider:**
 - CARF's Integrated Physical Health/Behavioral Health Core Program Standards
 - Joint Commissions' Physical Health Standards module
 - National Committee for Quality Assurance Patient Centered Medical Home Recognition (Level 1)
 - Equivalent recognition standards as approved by the State

Am I eligible to provide Health Home service?

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- ✓ CBHCs must establish evidence of integrated primary/behavioral health care services through use of a contract, MOU, or other written agreements approved by the state if they:
 - Do not have an ownership interest in a primary care organization, and;
 - Do not have embedded, onsite or co-located primary care practitioners



Am I eligible to provide Health Home service?, cont.

26

- ✓ Must support delivery of person-centered care by:
 - Expanded, timely access
 - Orientation of the patient to Health Home services
 - Services in a culturally and linguistically appropriate manner
 - A multi-disciplinary team based approach for the delivery of Health Home services through the continual use of an established team of core members defined by the state

Am I eligible to provide Health Home service?, cont.

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- ✓ **Must build a multi-disciplinary health home service team that includes**
 - Health Home Team leader
 - Embedded Primary Care Clinician
 - Care Manager
 - Care Manager Aid

Am I eligible to provide Health Home service?, cont.

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

Am I eligible to provide Health Home service?, cont.

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• Health Home Team Leader Requirements

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

Am I eligible to provide Health Home service?, cont.

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• Embedded Primary Care Clinician Requirements

- Participate in provision of health home services including identification of consumers, assessment of service needs, development of care plan and treatment guidelines, monitoring of health status service use.
- Provide education and consultation to the health home team and other team members regarding best practices and treatment guidelines in screening and management of physical health conditions as well as engage with, and act as a liaison between, the treating primary care provider and the team.
- Meet with care managers individually to review challenging and complex cases as needed.
- Can be any of the following professionals: primary care physicians, pediatricians, gynecologists, obstetricians, Certified Nurse Practitioners with primary care scope of practice and Physician Assistants.
- It is strongly preferred that the embedded primary care clinician also functions as the treating primary care clinician whenever possible and may hold dual roles on the health home team.

Am I eligible to provide Health Home service?, cont.

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• Care Manager Requirements

- Accountable for overall care management and care coordination and be able to both provide and coordinate all of the health home services. A single care management record will be agreed to and shared by all team professionals and case reviews will be conducted on a regular basis.
- Responsible for overall management and coordination of the beneficiary's care plan which will include both medical/behavioral health and social service needs and goals.
- Care managers must have the necessary credentials and skills to be able to conduct comprehensive assessments and treatment planning. The minimum qualifications for the Care Manager include social workers with LSW or LISW, counselors with PC or PCC, Marriage and Family Therapists with MFT or IMFT, RN Nurses (including a 3 year RN degree) with extensive experience working with the SPMI population, and other qualified staff approved by the State.
- Must have formal training as well as practical experience in behavioral health and possess core and specialty competencies and skills in working with SPMI population.
- Must demonstrate either formal training or a strong knowledge base in chronic physical health issues and physical health needs of the SPMI population and must be able to function as a member of an inter-disciplinary team.
- Must be knowledgeable and experienced in community resources and social support services for the SPMI population.

Am I eligible to provide Health Home service?, cont.

32

• Care Manager Aid Requirements

- Assist with care coordination, referral/linkage, follow-up, family/consumer support and health promotion services.
- May be any of the following: LPN nurses, CPST workers with four year degrees or 2 year Associate Degrees, wellness coaches, peer support specialists, certified tobacco treatment specialists, health educators and other qualified workers (e.g., community health workers with Associate Degrees or CPST workers with commensurate experience.)

Am I eligible to provide Health Home service?, cont.

33

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

Am I eligible to provide Health Home service?, cont.

34

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

Am I eligible to provide Health Home service?, cont.

35

- ✓ Must demonstrate development of an integrated care plan that addresses behavioral health care, physical health care, long-term care, and social support needs:
 - State will NOT prescribe the format or contents of the integrated care plan
 - The integrated care plan does not replace the treatment plans for specialty or other providers

Am I eligible to provide Health Home service?, cont.

36

- ✓ Must have the capacity to receive electronic data from a variety of sources to facilitate all components of health home service:
 - Within 12 months, acquire (or adopt) an electronic health record (EHR) product certified by Office of the National Coordinator for Health Information Technology
 - Within 24 months, demonstrate EHR is used to support all health home services, including population management
 - Participate in statewide Health Information Exchange

Am I eligible to provide Health Home service?, cont.

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- ✓ Must maintain a comprehensive and continuous quality improvement program capable of collecting and reporting data on utilization and health outcomes, and the ability to report to the State or its designee
- ✓ Must participate in Medicaid Health Home Learning Communities
- ✓ Must allow the state to conduct site visits related to quality performance

Am I eligible to provide Health Home service?, cont.

38

- ✓ CBHCs must establish relationships with managed care plans:
 - Ensuring all needs of health home members are met
 - Ensuring clear delineation of service delivery responsibilities
 - ALL health home services will be provided by the CBHC Health Home
 - Work with a designated single point of contact assigned by MCP
 - Collaborate with MCP panel providers and clinicians
 - Foster relationships with MCP that encourage bi-directional free flow of data gathering and reporting

Am I eligible to provide Health Home service?, cont.

39

- ✓ To facilitate health home beneficiaries' access to needed services, CBHCs must also establish relationships with:
 - Specialty (including substance abuse) care providers
 - Long-term care providers
 - Hospitals (including emergency departments)
 - Other community providers (e.g., nutritionists, housing, etc.)



**Health
Information
Technology**

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What are the HIT requirements?

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- Within 12 months of receiving designation as a Health Home provider, the CBHC must acquire (or adopt) an electronic health record product that is certified by the Office of the National Coordinator for Health Information Technology.
- Within 24 months of receiving designation as a Health Home provider, the CBHC must demonstrate that the electronic health record is used to support all Health Home services, including population management.
- The CBHC must also participate in any statewide Health Information Exchange.

What are the HIT requirements?

42

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

What are the HIT requirements?

43

• Care Coordination

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

What are the HIT requirements?

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• Health Promotion

- Day One Requirements – The CBHC health home must:
 - ✦ Receive electronically the health utilization profile
 - ✦ Auto-generate letters that notify PCPs of lab values
 - ✦ Develop website that contains wellness and health promotion information, and supports access to services.
 - ✦ Develop audio visual aides to support health promotion
 - ✦ Establish a “tickler” system (e-mail, postcard, phone call) to remind clients to schedule routine exam (dental exam, vision checks, medical test such as lab work, physical exam, mammogram, etc.)
- Future Requirements
 - ✦ The state will continue to build the capacity to exchange data through the HIE.

What are the HIT requirements?

45

- **Comprehensive Transitional Care**
 - Day One Requirements – The CBHC health home must receive electronically:
 - × Health Utilization Profile
 - × Inpatient Admissions – goal is to inform CBHC health home as soon as a hospital admission occurs
 - ODMH Regional Psychiatric Hospital Admission
 - Psychiatric general Hospital Admission
 - General medical admission of an MCP enrollee with a CBHC Health Home
 - General medical admission of an Non-MCP enrollee with a CBHC Health Home
 - Nursing Facilities
 - Children moving in and out of foster care
 - × Hospital ED Visits
 - Future Requirements
 - × The state will continue to build the capacity to exchange data through the HIE.

What are the HIT requirements?

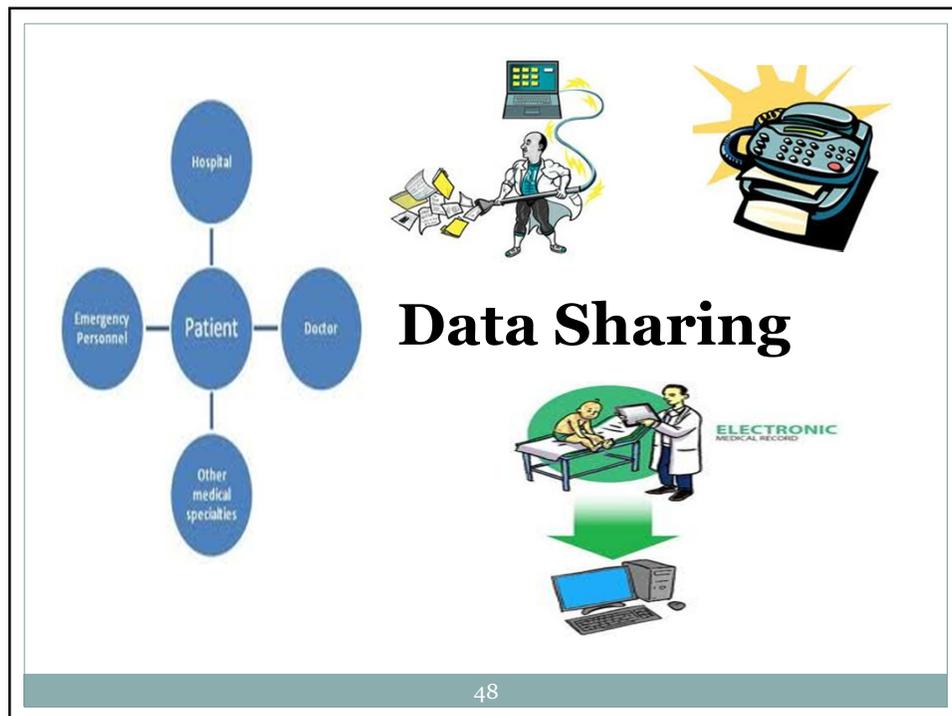
46

- **Individual & Family Support Services**
 - Day One Requirements – The CBHC health home must:
 - × Receive electronically the health utilization profile.
 - × Use YouTube, FaceBook, secure Email and voice mail.
 - × Auto-generate appointment reminder letters for patients and family members.
 - × Establish a “tickler” system (e-mail, postcard, phone call) to remind clients to schedule routine exam (dental exam, vision checks, medical test such as lab work, physical exam, mammogram, etc.).
 - × Establish capacity to develop website that contains wellness and health promotion information, and supports access to services.
 - Future Requirements
 - × The state will continue to build capacity to exchange data through HIE.

What are the HIT requirements?

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



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What Data will be Shared ?

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

What Data will be Shared ?

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Patient Profile

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

What Data will be Shared ?

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

Health Home Performance Measures Requirements



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How will performance be measured?

53

- ODMH/ODJFS have identified 26 performance measures
 - CMS has defined 7 required core measures
 - State has identified an additional 19 measures
- Data sources will be a combination of claims, EMR, vital statistics, survey and potential for on-site reviews



How will performance be measured? cont.

54

Must report chronic disease related data to the state:

- **Improve cardiovascular care**
 - Cholesterol Management (<100 mg-dL; 18-75 years)
 - Controlling High Blood Pressure (Patients with Hypertension <140/90) (18 - 85 years)
- **Improve diabetes care**
 - Cholesterol Management (<100 mg-dL; 18-75 years)
 - Monitoring of A1c Level (< 7.0%; 18-64 years)
- **Improve care for persons with asthma**
 - Use of Appropriate Medications for People with Asthma (5-64)

How will performance be measured? cont.

55

Reporting of chronic disease related data:

- **Cholesterol (LDL) Codes**
 - 3011F Lipid panel (including total cholesterol, HDL-C, triglycerides and calculated LDL-C) results documented and reviewed
 - 3048F Most recent LDL-C less than 100mg/dl
 - 3049F Most recent LDL-C 100 – 129 mg/dl
 - 3050F Most recent LDL-C greater than or equal to 130mg/dl
 - 4013F Statin therapy prescribed or currently being taken
 - 0056F Plan of care to achieve lipid control documented

How will performance be measured? cont.

56

Reporting of chronic disease related data:

- **Blood Pressure Codes**
 - 3074F Most recent systolic blood pressure less than 130mm Hg
 - 3075F Most recent systolic blood pressure 130-139mm Hg
 - 3077F Most recent systolic blood pressure greater than or equal to 140mm Hg
 - 3078F Most recent diastolic blood pressure less than 80mm Hg
 - 3079F Most recent diastolic blood pressure 80-89mm Hg
 - 3080F Most recent diastolic blood pressure greater than or equal to 90mm Hg

How will performance be measured? cont.

57

Reporting of chronic disease related data:

- **Hemoglobin A1c Codes**
 - 3044F Most recent hemoglobin A1c (HbA1c) level less than 7.0%
 - 3045F Most recent hemoglobin A1c (HbA1c) level 7.0-9.0%
 - 3046F Most recent hemoglobin A1c (HbA1c) level greater than 9.0%

How will performance be measured? cont.

58

Improve health outcomes for people with mental illness:

- Follow Up After Hospitalization for Mental Illness, 7-day - visit with MH practitioner (6+ years)*
- Schizophrenia 2: Annual assessment of weight/BMI, glycemic control, lipids
- Screening for Clinical Depression and Follow-up Plan (18 years and older)*
- Bipolar Disorder - Annual assessment of weight/BMI, glycemic control, lipids

*CMS required core measure

How will performance be measured? cont.

59

Reduce substance abuse:

- Initiation and engagement of alcohol and other drug (AOD) dependence treatment- engagement of AOD treatment (13 – 17/18+years/Total)*
- Smoking & Tobacco Use Cessation, Medical assistance
 - Advising smokers and users to quit
 - Discussing cessation medications
 - Discussing cessation strategies (18 years & older)

**CMS required core measure*

How will performance be measured? cont.

60

Reporting of substance abuse data:

- Tobacco Codes
 - 1000F Tobacco use assessed
 - 4000F Tobacco use cessation intervention, counseling
 - 4001F Tobacco use cessation intervention, pharmacologic therapy
 - 4004F Patient screened for tobacco use and received tobacco cessation (intervention, counseling, pharmacotherapy, or both) if identified as a tobacco user
 - 1034F Current tobacco smoker
 - 1035F Current smokeless tobacco user
 - 1036F Current tobacco non-user

How will performance be measured? cont.

61

Improve Preventive Care:

- Percent of Live Births Weighing Less than 2,500 grams
- Prenatal and Postpartum Care - Timeliness of Prenatal Care
- Adult BMI Assessment (18 - 74)*
- Weight Assessment: child/adolescent document weight/BMI (3-17)
- Adolescent Well-Care Visits (12- 21 years)
- Adults' Access to Preventive/Ambulatory Health Services (20 and older)
- Appropriate Treatment for Children with Upper Respiratory Infections (3 mos. - 18)
- Annual Dental Visit (2-21 years) & (> 21 years)

Preventative Care Code

- 3008F Adult and child/adolescent BMI documented

How will performance be measured? cont.

62

Improve Care Coordination:

- Timely Transmission of Transition Record to Healthcare Professional: discharged to home or other facility, w/in 24 hrs of discharge (for IP facility discharges)*
- Medication Reconciliation Post-Discharge (MRP)

**CMS required core measure*

How will performance be measured? cont.

63

Improve Appropriate Utilization/Site of Care:

- Ambulatory Care - Sensitive Condition Admission (under age 75)*
- Inpatient & ED utilization - Mental Health, Substance Abuse, General/Acute
- Plan - All Cause Readmission (18 and older)*

**CMS required core measure*

How will performance be measured? cont.

64

Improve management of behavioral health conditions:

- Client Perception of Care - National Outcome Measure (SPMI Health Home)
- Medication adherence: Medication Possession Ratio (MPR)

Health Home Payment Methodology

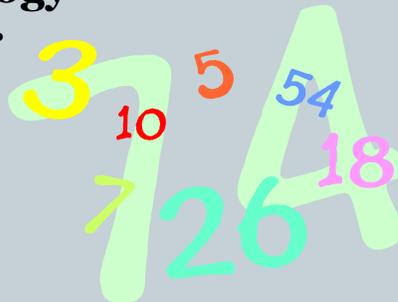
65



What is the payment rate ?

66

**Consistent Methodology
but No single Answer**



Based on ODMH Uniform Cost Principles

What are the cost components?

67

Allowable Costs

- For privately owned and/or operated not-for-profit agencies/programs, allowable costs shall be determined in accordance with 42 CFR 413 and OMB Circular A-122.
- For governmentally owned and/or operated agencies/programs, allowable costs shall be determined in accordance with 42 CFR 413 and OMB Circular A-87.
- For privately owned and/or operated for-profit agencies/programs, allowable costs shall be determined in accordance with 42 CFR 413 and the PRM, Part 1

What are the cost components?

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Unallowable Costs

- For privately owned and/or operated not-for-profit agencies/programs, unallowable costs shall be determined in accordance with 42 CFR 413 and OMB Circular A-122.
- For governmentally owned and/or operated agencies/programs, unallowable costs shall be determined in accordance with 42 CFR 413 and OMB Circular A-87.
- For privately owned and/or operated for-profit agencies/programs, unallowable costs shall be determined in accordance with 42 CFR 413 and the PRM, Part 1

What are the cost components?

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Direct Service Personnel Costs

- Must represent the full salary and benefit cost of those personnel who provide direct services to the clients
- Total paid time includes that time spent in delivering a unit of service as well as the time for that position which may be devoted to paperwork, vacation, meetings, etc.
- Costs include the total time paid for each position minus the value of any time allocated to the provision of clinical supervision, program oversight or administration, or quality assurance by a clinician who has primary or significant responsibility in these areas

What are the cost components?

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Support Service Personnel Costs

- Directly support CBHC health home service components
- Includes the value of any direct care staff time allocated to the provision of clinical supervision, program oversight or administration or quality assurance by a clinician who has primary or significant responsibility in these areas.
- Example: clerical staff dedicated to health home service

What are the cost components?

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Non-personnel costs

- Costs necessary for and allocated to specific direct services
- Examples: weight and height measuring scales, blood pressure cuffs; examination tables;

What are the cost components?

72

Administrative Overhead Costs

- Personnel and non-personnel costs that benefit the agency as a whole and can not be allocated to a specific service or services.
- Examples: electronic health record; personnel costs of the chief financial officer, human resource director, QI, medical director

Let's build a health home rate!



73

What are the health home rate components?

74

- Initially,
 - Cost component weighted at 100%
 - + Pay for Performance component weighted at 0%Total health home rate
- Rate Components will be weighted and adjusted over time as efficiencies and outcomes are realized
- Parameters in place to assure costs and caseload size are within acceptable boundaries

Is this the health home rate?

75

NO - Agency Example

- All data is **fictional**
- Provider specific rate
- This example assumes
 - all UCR supporting worksheets have been accurately completed and in accordance with OAC 5122-26-19
 - FTE is considered 40 hours a week, 52 weeks a year for a total of 2,080 hours

What are the assumptions for hypothetical Rate Setting Scenario?

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TEAM COMPOSITION - GENERAL INFORMATION

- Salary Calculations
 - Salaries based on Ohio Council Annual Salary Survey
 - Fringe factor = 30% of base
 - Total salary = Base salary + fringe factor
- Staffing Ratio
 - Clinician informed caseloads
 - EXAMPLE assumes an average SPMI caseload
 - All assumptions include a 1 FTE to client ratio

How do I project Caseload & Staff Ratios?

77

- Health home must determine caseload based on current and projected SPMI population
- The acuity levels of the SPMI population will drive the staff/client ratios
- Establish staffing ratios within the health home team and within member role based on client's intensity levels (*e.g. low, medium, high*)

Does a team ratio differ from clinician ratio?

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TEAM RATIO



*INDIVIDUAL
CLINICIAN RATIO*

Assumptions:

Caseload: 2,566

Care Mgr Staffing Ratio=1:60 → 2,566/60 = 42.77 FTEs

Care Mgr Aide Staffing Ratio= 1:40 → 2,566/40=64.15 FTEs

42.77 + 64.15 =106.92 FTEs

2,566 clients / 106.92 FTEs = 24

Staffing Ratio = 1:24

Assumptions for hypothetical Rate Setting Scenario, cont.

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Direct Service personnel and staffing ratios

- **Team Leader** – LISW-S
Annual Salary = \$65,000 Staffing Ratio = 1:300
- **Embedded PC Clinician** – Nurse Practitioner w/Rx authority
Annual Salary = \$109,200 Staffing Ratio=1:1,500
- **Care Manager** – Master's LSW,
Annual Salary = \$50,050 Staffing Ratio = 1:60
- **Care Manager Aide**–Bachelor's, CPST
Annual Salary = \$38,870 Staffing Ratio = 1:40

Assumptions, cont.

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- **Support Personnel Costs** - \$55,440
 - e.g. Clerical
- **Non-Personnel Costs** - \$250,000
 - e.g. Supplies, blood pressure cuffs, medical exam tables
- **Administrative Costs** - \$250,800
 - e.g. QI, billing director, medical director, training, medical records staff

For Illustrative Purposes only
CBHC Health Home Payment Rate Methodology - FY 2012
CBHC SED Caseload 1,155

Cost Category	Credentials	Staffing		Annual	
		Ratios	FTEs	Annual Salary	Staffing Cost
Direct Service Personnel					
Health Home Team Leader	LISW	300	3.85	\$ 65,000	\$ 250,250
Embedded Primary Care Clinician	Nurse Practitioner	1,500	0.77	\$ 109,200	\$ 84,084
Care Managers	LSW	60	19.25	\$ 50,050	\$ 963,463
Care Manager Aides	BA Level	40	28.88	\$ 38,870	\$ 1,122,371
Support Personnel					
Clerical		500	2.31	\$ 24,000	\$ 55,440
Non-Personnel					
Supplies, blood pressure cuffs, exam tables					\$ 250,000
Administrative overhead					
QI		5,000	0.23	\$ 50,000	\$ 11,550
Medical Records		1,500	0.77	\$ 32,000	\$ 24,640
CEO		5,000	0.23	\$ 130,000	\$ 30,030
CFO		5,000	0.23	\$ 100,000	\$ 23,100
CIO		5,000	0.23	\$ 100,000	\$ 23,100
Human Resources		5,000	0.23	\$ 100,000	\$ 23,100
Billing staff		1,500	0.77	\$ 32,000	\$ 24,640
Clinical Director		2,000	0.44	\$ 80,000	\$ 35,200
Medical Director		5,000	0.23	\$ 200,000	\$ 46,200
Training		5,000	0.23	\$ 40,000	\$ 9,240
<i>Total Direct and Support Personnel Costs</i>					\$ 2,976,408
<i>Non-Personnel & Administrative overhead</i>					
PMPM Cost Component					\$ 2,976,408

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Rate methodology Key Points

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Cost Summary	
Cost Component	\$ 2,976,408
Performance Component	\$ -
Total Costs	\$ 2,976,408
Monthly Case Rate Calculation	
PMPM Cost	\$ 214.748
PMPM Performance	\$ -
Total PMPM	\$ 214.75
Care Manager & Care Manager Aide Staffing Ratio	
Care manager FTEs	19.25
Care Manager Aide FTEs	28.88
Ratio	24.00

Provider Application Process



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When and how can I apply ?

84

- Providers will utilize existing Medicaid provider number
- Provider led - ODMH will accept applications from any qualified CBHCs who demonstrate they are able to provide the core elements and meet provider standards
- Participation **will not be** limited to only one provider per region

What do I do while I am waiting?

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Implementation/Operational – examples

- Finalize QI forms and system
- Finalize documentation forms
 - Care plan, progress notes, transition plan
 - Review orientation, informed consent form
 - Review policies, procedures
 - Review integration arrangements to meet BH/physical healthcare requirements
- Reconfigure existing staff, teams, hiring & training
- Reconfigure intake process to identify new referrals

What do I do while I am waiting?

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Implementation/Operational examples, cont.

- Work towards meeting long-term information technology requirements
- Work towards meeting phased-in accreditation requirements for integration
- Assure expanded access requirements are met
- Additional tasks as necessary to assure all requirements are met and able to be implemented

State approved CBHC application
to provide health home service!



Implementation efforts begin ...

87

How do I assign clients to the health home?

88

- Submit batch file with key client data to ODJFS
- After initial batch submission, new health home consumers and updates can be entered using the ODJFS web portal
 - Information will be ultimately used to
 - ✦ validate claim payments against date span,
 - ✦ trigger coordination of care with managed care plans, hospitals, other specialty providers, etc.
 - ✦ make health care providers and MCP aware of who is assigned to health home.

How do I transition clients?

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- Develop care plan with the client to demonstrate client's orientation to the health home service
 - Care Plan format must address behavioral health care, physical health care, long-term care, and social support needs



What documentation is required and why?

90

- Progress Note is required:
 - To support the monthly claim;
 - To substantiate medical necessity;
 - To demonstrate accountability that health home services were provided.



How will I get paid?

91

- CBHC health home will get paid by submitting fee-for-service monthly claim (HCPCS code S0281)
- CBHC can bill for health home service for clients on spend-down as soon as spend-down is met and services are rendered
- Units of service is one per month regardless of the number days health home services were provided
- Separate payments will continue for
 - Community Behavioral Health treatment services
 - Other treatment services (e.g., primary care & specialty services) through existing Medicaid payment mechanisms (MCPs or FFS)

What processing edits will be in place?

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- Limited to one claim per client per calendar month across providers(S0281)
- Require SPMI diagnosis code
- Initially, modifiers cannot be used with S0281
- Can be provided to a client enrolled in a MCP
- Rate will be provider specific
- Zero billed charges for CPT 2 codes submitted with S0281 will be required for performance monitoring

Does any other payment change for clients who receive health home services?

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- Medicaid will not pay twice for the delivery of case management services.
- If health home service is being provided simultaneously, claims for the following Medicaid Case Management Services will be denied:
 - ODMH CPST – H0036,
 - ODADAS Case management –H0006,
 - Help Me Grow Targeted Case management

Milestones & Next Steps

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

Timeline and Tasks

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- **May 2012**
 - Collect letters of intent
- **June 2012**
 - Determine region(s)
 - ODJFS files rules
 - State submits SPA to CMS
- **July 2012**
 - ODMH will accept health home applications
- **August 2012**
 - CBHC health homes selected in mid-August

Timeline and Tasks, cont.

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- **September 2012**
 - CBHC health homes identify individuals eligible for health home services
 - Data & utilization profiles out to health homes by 9/30
- **October 2012**
 - State Plan Amendment (SPA) effective October 1st
 - Payment to CBHC health homes
- **January 2013**
 - Learning Communities start

What is the Implementation schedule?

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- CBHC should submit non-binding letter of intent
 - BH/PH Integration Model
 - Team composition
 - Local system readiness
 - Implementation timeframe (month/year)
- ODMH & ODJFS will determine regions and implementation schedule



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

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

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Questions ?

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