ACKNOWLEDGEMENTS

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SAMHSA-HRSA CENTER FOR INTEGRATED HEALTH SOLUTIONS

The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings. CIHS is the first “national home” for information, experts, and other resources dedicated to bidirectional integration of behavioral health and primary care.

Jointly funded by the Substance Use and Mental Health Services Administration and the Health Resources and Services Administration, and run by the National Council for Behavioral Health, CIHS provides training and technical assistance to community behavioral health organizations that received SAMHSA Primary and Behavioral Health Care Integration grants, as well as to community health centers and other primary care and behavioral health organizations.

CIHS’ wide array of training and technical assistance helps improve the effectiveness, efficiency, and sustainability of integrated services, which ultimately improves the health and wellness of individuals living with behavioral health disorders.

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SUMMARY

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

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

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

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

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

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

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

BACKGROUND

Across the country, publicly funded primary care, acute care, and behavioral health care safety-net services operate as parallel systems, often with limited connection or interaction. The consequences of this fragmentation are significant. Research shows that individuals with serious mental illnesses die decades earlier than the general population, in part because of limited access to quality primary care (e.g., 60% of premature deaths for people with schizophrenia can be attributed to preventable or treatable medical conditions). Because of limited access to quality primary care, many individuals with mental illness rely on emergency departments as a primary source of care, which results in avoidable expense and poor continuity in treatment of chronic medical and behavioral issues. The National Institute on Drug Abuse examined substance use disorders’ impact on hospital emergency department use. In
2009, there were nearly 4.6 million drug-related hospital emergency department visits, of which 45% (2.07 million) were a consequence of drug abuse. The total number of drug-related emergency department visits increased 81% between 2004 (627,291) and 2009 (1,244,679). Emergency department visits due to non-medical use of pharmaceuticals increased by 98.4% during that same period.\footnote{7}

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

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

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

- Represented about 10% of total Medicaid beneficiaries and accounted for 26% of total Medicaid expenditures in 2010.
- Suffered co-occurring chronic physical health conditions (i.e., heart disease, hypertension, diabetes, chronic respiratory conditions, dental disease) at rates higher than other adult Medicaid beneficiaries without serious mental illnesses.
- Experienced more than twice as many hospitalizations for certain ambulatory care-sensitive conditions\footnote{15} than adults without a serious mental illness.
- Underwent double the number of emergency department visits for asthma than adults without a serious mental illness.

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

OVERARCHING HEALTH HOME POLICY AND CONSIDERATIONS

Overview of Health Homes

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

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

A core purpose of Medicaid health homes is coverage for individuals with chronic health conditions of care coordination through well-defined services supporting whole person care. Health home services complement traditional medical, behavioral, and other services, but are not to supplant healthcare treatment services. States have considerable flexibility in defining target populations, service compo-
nents, and payment methodologies for health home services. The scope and limits of these flexibilities are described below. As of July 2013, twelve states — Alabama, Idaho, Iowa, Maine, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island, Washington, and Wisconsin — have approved state plan amendments (SPAs) to establish health home services. Several states have submitted additional health home SPAs under review by CMS.

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

CMS Guidance

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

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

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

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

Geographic and Implementation Flexibility

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

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

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

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

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

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

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

- States hoping to foster comprehensive changes to primary care practice leverage a number of high volume chronic physical illnesses, in some cases supplemented by mental illness and substance use disorders. States taking this approach include Missouri in its primary care SPA, North Carolina, Iowa, Oregon, and New York. This approach will lead to a relatively high percentage of Medicaid beneficiaries eligible for health homes.

- States seeking to enhance care at mental health provider organizations have modeled clinical eligibility criteria on existing definitions of mental illness used by the state in its definition of eligibility for community behavioral health treatment. These states want health homes to change practice standards for community mental health and/or substance use treatment providers — both to strengthen behavioral healthcare care management and to foster integration of physical and behavioral healthcare. States taking this approach include Missouri in its Community Mental Health Center SPA, Rhode Island in its Community Mental Health Organization SPA, and Ohio.

- States wanting to create more coordinated, systemic response to opiate and other addictions plan to implement a hub and spoke health home approach for eligible beneficiaries. Vermont currently seeks CMS approval for a multipayer patient-centered medical home and a community treatment provider effort designed to integrated health systems for addictions treatment by expanding capacity of methadone treatment and supporting the provision of medication assisted treatment (MAT) through community health teams. By leveraging and more effectively coordinating existing primary care and addictions resources, Vermont plans to achieve greater savings, particularly in corrections and child welfare systems.

- States can focus on care management delivered through a specific provider type, define patient eligibility more narrowly, and tie eligibility standards for services to those providers. For example, one of Rhode Island's SPAs focused on patients at Comprehensive, Evaluation, Diagnosis, Assessment, Referral, Re-evaluation (CEDARR) Family Centers, who specialize in serving children and youth.

Provider Infrastructure

The health homes statutory language identifies three potential categories of health home providers: designated providers, a team of healthcare professionals, or a community health team. Of these, only the “community health team category” has a statutory definition that prescribes a specific staffing/provider model, leaving states considerable flexibility to define the “designated provider” and “team of healthcare professionals” categories. States with approved or pending SPAs have included primary care providers, community mental health centers, acute care managed care organizations, managed behavioral health organizations, and specialized providers for children with special healthcare needs as designated providers. This last example, from one of Rhode Island’s two health home programs, demonstrates that although states may not formally limit beneficiary eligibility based on age or eligibility category, they may limit participation to providers who focus on specific age groups.
There are important overlaps and distinctions between the health home state plan option and the concept of medical home. The National Academy for State Health Policy defines medical homes as follows: "A medical home is defined as an enhanced model of primary care that offers whole-person, comprehensive, ongoing, and coordinated patient- and family-centered care. Public payers, especially Medicaid, have been leaders in these efforts, with the hopes of preventing illness, reducing wasteful fragmentation, and averting the need for costly emergency department visits, hospitalizations, and institutionalizations." Both medical homes and Medicaid health homes emphasize the need for one provider responsible for comprehensive care management. However, the primary care medical home focuses on primary care physician practices as the locus of care. As noted above, other provider types or managed care organizations can serve as Medicaid health homes. In addition, health homes are directed strictly at Medicaid beneficiaries, while many medical home initiatives have been multipayer or not sponsored by insurers at all. The health home option focuses on individuals with chronic conditions, while primary care medical homes seek broad practice transformation across an entire primary care panel.

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

**Health Home Services**

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

1. Comprehensive care management
2. Care coordination
3. Health promotion
4. Comprehensive transitional care
5. Individual and family support
6. Referral to community and support services
The health homes statute further indicates that states should document the “use of health information technology to link services.” These six service components, together with the health IT linkage component, require that states have the capacity to manage a continuum of specialty and primary care health services and, at least, coordinate long-term care services and other supports. There has been significant diversity in how states employed these terms, with some states explicitly defining a health home to incorporate a continuum of care and others focusing on the health IT linkage component. Appendix A contains partial service descriptions from selected states with approved SPAs.

8. Controlling High Blood Pressure

The percentage of patients 13-85 years of age who had a diagnosis of hypertension and were taking antihypertensive medication whose blood pressure (BP) was adequately controlled during the measurement year. For a median BP to be reported, both the systolic and diastolic BP must be <140/90 mmHg.

DENOMINATOR DESCRIPTION: Members 13 years of age and older as of December 31 of the measurement year with a new episode of AOD during the intake period, reported in two age stratafications (13-17 and 18+ years). Denominator may occur on multiple occasions, in which case a whole person count is reported.

NUMERATOR DESCRIPTION: Count the number of index hospital stays with HEDIS readmission for any diagnosis that were followed by an acute readmission within 30 days after the date of the initiation encounter (inclusive). Multiple encounters for a single hospital stay are counted.

The Affordable Care Act also specifically references measurement of skilled nursing facility utilization as a measure to document the quality of care. In New York, this measure includes coordination of skilled nursing facility discharges and transitions, as well as coordination with home and community-based long-term supports and services. New York has required health homes to be networks that include both hospitals and skilled nursing facilities and ensure that transitions are meaningful and linkages with hospitals and to facilitate effective communication and care continuity in preparation for hospital discharge.

Notably, care management and care coordination are already a significant part of community mental health treatment; although the term is broad and interpreting it can vary significantly across states. However, according to the November 16, 2010 state Medicaid director letter, “States will be expected to develop a health home model of care coordination that allows for a whole-person approach to care looks at all the needs of the person and does not compartmentalize aspects of the person, his or her health, or his or her well-being. We expect providers of health home services to use a person-centered planning approach to identifying needed services and supports, providing care and linkages to care that address all of the clinical and non-clinical needs of an individual.”

HEALTH PROMOTION addresses member education, primary prevention, and wellness activities such as smoking cessation. Additionally, even if a state includes only chronic medical conditions for beneficiaries to be eligible for health home services, providers must screen for depression and substance use. Each state has its own definition of the six health home service components. Notably, states focusing on individuals with chronic conditions and their family members. New York is the first state to request an additional measure of personal engagement of a whole person.

COMPREHENSIVE TRANSITIONAL CARE stresses the expansion of the health home services to include coordination of skilled nursing facility discharges and transitions, as well as coordination with home and community-based long-term supports and services. New York has required health homes to be networks that include both hospitals and skilled nursing facilities and ensure that transitions are meaningful and linkages with hospitals and to facilitate effective communication and care continuity in preparation for hospital discharge.
behavioral healthcare managers, placing a particular emphasis on transitional care and emergency department diversion capacity for individuals with serious behavioral conditions and complex chronic illnesses. Additionally, the Affordable Care Act requires that hospital emergency departments identify individuals in need of health home services. As an example, North Carolina’s Community Care program, a single-source vendor for health home care management operating through 14 regional networks and a statewide care management agency, embedded nurse care managers in hospitals around the state to support transitional care and management functions.

**INDIVIDUAL AND FAMILY SUPPORT SERVICES**

In addition to transitional care, the program focuses on providing education and care management supports to the beneficiary and his or her family. This strategy includes facilitating the delivery of person-centered care and performing outreach and advocacy activities aimed at achieving positive outcomes and increasing access to services. In providing such services, often by using peers, behavioral health providers emphasize the importance of prescription medication adherence, and the development of crisis and relapse prevention plans. While primary care practices have similarly engaged in chronic illness management and related support services, efforts have typically been less formal and more focused on traditional medical services. CMS has indicated that states should stress and address these issues in their service descriptions. The health home will coordinate long-term services and supports to improve the quality of care and help states incorporate this information, as no particular category references long-term services and supports by name and many of the initial states have chosen to do so under “referral to community and support services.”

**Provider Standards**

States have taken a variety of approaches to defining provider standards. New York maintains a list of target health homes to a specific provider type, standards correspond to that provider definition. Other states may have relevant national certification programs such as the National Committee for Quality Assurance (NCQA). New York’s Community Care program implementation of patient-centered medical homes has the option to develop state-specific certification structures or to employ one of the national patient-centered medical homes recognition programs, or a combination of both.

All health homes must meet a core set of measures to demonstrate good performance. These measures specify that a community provider will interact with hospitals. CMS requires states to assure health homes’ capacity to provide care. The provider standards section in the state plan must be able to accept hospital and emergency department referrals as part of their SPA. This capacity is especially critical for states focusing on populations with serious mental illness.

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

States seeking to drive practice changes in the mental health system must also consider how additional health provider standards will interact with existing state systems and how they fit within the scope of federal requirements. To maximize the enhanced federal funds available two years, those states converting some existing mental healthcare to health home services will want to consider the timing of the SPA’s effective dates and capacity to meet new health homes standards and requirements.
Health Home Goals and Quality Measures

In the fall of 2011, CMS began requiring health home core quality measures, while allowing states flexibility to define additional measures around the state’s goals. States should propose quality measures that relate to the health home program’s stated goals. Quality measures can be constructed as part of a program that addresses multiple areas of intervention. If a state does not propose a measure, CMS requires that the state provide a description of why not. Each measure should be consistent, if possible, with measures included in Healthy People 2020 or as part of an existing national measure set. States should propose measures that are relevant to the health home program’s stated goals. They should consider the types of quality measures that have been validated or used by other states, as well as other national priorities and programs.

Provider Payment

The reimbursement methodology section of CMS’s online health homes SPA template is designed to feed into Section 4.19B (payment for services) of the Medicaid State Plan Amendment (SPA). States are required to describe their methodology for determining payments in the program’s core quality measures, but they are not required to submit the rate cells to CMS as a document accompanying the SPA. Rate development can be actuarial and tied to anticipated service volumes relative to member acuity, but must be paid in connection with the rendering of a Medicaid allowed health home service.

Reimbursement formulas should have to do with the expected provider staffing levels and non-staff costs for the anticipated enrolled populations. Many states’ patient-centered medical home demonstrations have used a Medicaid primary care case management payment model in which the primary care manager receives monthly allotments not based upon the volume of furnished services. These documents provide detail of states’ options in structuring payment in managed care organization-based health homes.

An important aspect of health homes is the ability to move beyond payments for individual service encounters. Although the statute referenced per member per month (PMPM) payments, it explicitly allows other payment models. Therefore, states have flexibility regarding the structure of payments. Payment can be tied to the provider’s capabilities to handle different levels of complexity or severity. For example, New York uses a claims-based grouper to assign PMPM reimbursement based on the acuity or severity of the member’s chronic conditions or by the provider’s capabilities to handle different levels of complexity or severity. Reimbursement does not have to be limited to fee-for-service arrangements. Alternatively, most initial health home states have used program-level data to support rates. These states have used expected provider staffing levels and non-staff costs for the anticipated enrolled populations.

Patient Enrollment

States have several options for enrollment.

- **MANDATORY ENROLLMENT:** In general, health homes must be voluntary programs that the Medicaid beneficiary agrees to outpatient encounter with a diagnosis of HN during the first six months of the measurement year.
join. However, CMS indicated that it would consider state applications for a 1915(b) Freedom of Choice Waiver to implement a mandatory health homes program. As of this writing, no states with submitted SPAs are pursuing one of the voluntary approaches described below.

### Relationship to Existing Care Management Programs

CMS has emphasized that health homes should be responsible for all of their enrollee’s care management and care coordination. CMS has also emphasized that Medicaid managed care delivery systems must also be responsible for enrollees’ care management and care coordination, which means that Medicaid is not permitted to pay twice for the same services. (See the technical assistance resource Health Home Considerations for a Medicaid Managed Care Delivery System: Avoiding Duplication of Services and Payments.) Given that many recipients of health home services may also receive care managed through managed care plans, community-based waivers, or primary care case management programs, states will need to work out the process for opting out of receiving care management and care coordination services from the assigned health home provider.

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

Historically, the process of enrollment and assignment to a health home provider was completed via U.S. Mail or other methods of communication. States have found it necessary to evaluate health home programs and enrollment models and describe individuals’ choice in selecting a health home as follows. States will need to provide a description of health home services, and describe the process for individuals to opt-out of receiving care management services from the assigned health home provider.

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

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</tr>
<tr>
<td>AOD diagnosis within 30 days after the date of hospital admission</td>
<td>% of patients aged 18+ years with a new episode of AOD treatment</td>
</tr>
</tbody>
</table>
New York and North Carolina both use health homes in part to streamline and integrate existing case/care management programs. In New York, targeted case management providers focusing on mental illness are linked in provider networks with hospitals and primary care providers through a competitive request for proposal (RFP) process that required applicants to build integrated networks. North Carolina is implementing health homes to help bring multiple, previously fragmented case/care management programs under its established Community Care program. North Carolina is also developing a strong operation that fosters integration between behavioral health and primary care and is its individualized behavioral health waiver to support multiple care coordination strategies. Oregon and Missouri mandate participation in health homes to improve care coordination capacity as part of a practice transformation process.

### Team Composition

Health homes offer community mental health providers the opportunity to provide services in an integrated manner. This will require a cultural shift for those providers that have not integrated physical and behavioral health approaches through strategies such as provider co-location. While a multidisciplinary team approach to treatment is the standard for many community health programs, the emphasis on care coordination, information sharing, and treatment goals on the same interdisciplinary team expands the team concept. Recognizing the need to incorporate non-traditional members such as community health workers, peers, patient advocates, and medical assistants, staff will need training on developing an effective integrated service delivery system and on communicating with additional team members who utilize different approaches. In addition, consumers with a mental health or substance use disorder will need education on the importance of primary care for behavioral health conditions and how to access preventive medical care and self-care behaviors.

Education for staff and clients must focus on the pivotal role of primary care for behavioral health conditions and work toward recovery. Integrating substance use and mental health services requires an emphasis on an integrated approach to care and the need to include primary care within the health home model. Missouri's Department of Mental Health has introduced a brief intervention, and referral to treatment (SBIRT) for all patients, not just health home enrollees. Since the primary care providers had limited experience in SBIRT, the Missouri Department of Mental Health awarded $30,000 in SAMHSA SBIRT grants to providers to support their efforts.

A challenge for all health home team members will be the development of systems that allow routine and open sharing of information. The use of an electronic health record and patient registry will become basic requirements for the effective sharing of treatment plans and care.

### Staffing of Health Homes

The staffing of health homes varies from state to state. While some states require professionals comprising the health home team, goals of the provision due to the emphasis on an integrated approach to care and the need to include primary care within the health home model. All team members must meet basic requirements for the effective sharing of treatment plans and care.

As of October 2012, seven states have approved health home SPAs. Core team members may include community health center staff, case managers, nurses, medical assistants, and behavioral health providers. Person-centered goal setting has also been a cornerstone of community behavioral health treatment planning. The health home model will require that the team members meet the goals for behavioral health.

### Screening for Tobacco Use

#### 1. Smoking Status
- **Numerator Description**: Number of members who were screened for smoking status (in person or by survey).
- **Denominator Description**: Total number of members who were eligible for the smoking status screening.

#### 2. Tobacco Dependence Level
- **Numerator Description**: Number of members with tobacco dependence.
- **Denominator Description**: Total number of members who were eligible for the tobacco dependence level screening.

#### 3. Initiation of Tobacco Dependence Treatment
- **Numerator Description**: Number of members who initiated a treatment for tobacco dependence.
- **Denominator Description**: Total number of members who were eligible for the initiation of treatment for tobacco dependence.

#### 4. Follow-up Tobacco Dependence Treatment
- **Numerator Description**: Number of members who received follow-up treatment for tobacco dependence.
- **Denominator Description**: Total number of members who were eligible for the follow-up treatment for tobacco dependence.

### Blood Pressure Screening

#### 5. Blood Pressure Screening
- **Numerator Description**: Number of members who were screened for blood pressure.
- **Denominator Description**: Total number of members who were eligible for the blood pressure screening.

### Other Drug Use

#### 6. Initiation of Other Drug Use Treatment
- **Numerator Description**: Number of members who initiated a treatment for other drug use.
- **Denominator Description**: Total number of members who were eligible for the initiation of treatment for other drug use.

#### 7. Follow-up Other Drug Use Treatment
- **Numerator Description**: Number of members who received follow-up treatment for other drug use.
- **Denominator Description**: Total number of members who were eligible for the follow-up treatment for other drug use.

### Depression and Suicidality

#### 8. Screening for Depression and Suicidality
- **Numerator Description**: Number of members who were screened for depression and suicidality.
- **Denominator Description**: Total number of members who were eligible for the screening for depression and suicidality.

#### 9. Initiation of Depression and Suicidality Treatment
- **Numerator Description**: Number of members who initiated a treatment for depression and suicidality.
- **Denominator Description**: Total number of members who were eligible for the initiation of treatment for depression and suicidality.

#### 10. Follow-up Depression and Suicidality Treatment
- **Numerator Description**: Number of members who received follow-up treatment for depression and suicidality.
- **Denominator Description**: Total number of members who were eligible for the follow-up treatment for depression and suicidality.

### Outcome Measures

- **Follow-up Plan**: Engagement of AOD treatment: Initiation of AOD treatment and two or more inpatient admissions, or any hospitalization for a drug or alcohol related admission within 120 days of discharge or intensive outpatient treatment

### Quality Indicators

- **Program, Medicaid Adult Core set, HEDIS 1 and 2**
- **Meaningful Use, PQRS, CMS, Adult Core set, HEDIS 1 and 2**
- **Million Hearts, Medicaid Adult Core set, HEDIS 1 and 2**
- **ACO Measure, Medicaid Adult Core set, HEDIS 1 and 2**
- **ACO Measure, Medicaid Adult Core set, HEDIS 1 and 2**

### Goal Setting

Goal setting has also been a cornerstone of community behavioral health treatment planning. The health home model will require that all team members meet the goals for behavioral health.
Mary care physician consultant, and administrative support staff. Optional team member may include the individuals treating primary care physician, treating psychiatrist, and mental health case manager, as well as a nutritionist/dietician, pharmacist, peer recovery specialist, grade school personnel or other representative, as appropriate to meet the client's needs.26

New York’s health homes use multidisciplinary teams of medical, mental health, substance use disorder treatment providers, social workers, nutritionists, and other care coordinators in the care of patients who receive medical, behavioral, and social services in accordance with a single plan of care. Optional team members may include nutritionists/dieticians, pharmacists, community health workers, and outreach workers such as peer specialists and other representatives, as appropriate to meet the enrollee’s needs (e.g., housing representatives, employment).

North Carolina’s team of health homes is interdisciplinary and includes primary care physicians, specialist physicians, psychiatric nurses, community health workers, and outreach workers such as peer specialists and other representatives, as appropriate to meet the enrollee’s needs. Care management staff are housed in regional networks and a statewide agency. Both are contracted by a single state vendor, Community Care of North Carolina, which is funded through MMNM payments for Medicaid beneficiaries. Regional care management staff includes nurses, social workers, and pharmacists.28

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

Oregon’s team of health homes is interdisciplinary and includes primary care physicians, specialist physicians, psychiatric nurses, community health workers, and outreach workers such as peer specialists and other representatives, as appropriate to meet the enrollee’s needs. Care management staff are housed in regional networks and a statewide agency. Both are contracted by a single state vendor, Community Care of North Carolina, which is funded through MMNM payments for Medicaid beneficiaries. Regional care management staff includes nurses, social workers, and pharmacists.28

Rhode Island’s community mental health organization health home team consists of, at a minimum, of a Master’s-level team coordinator (central coordinator for health home services), a psychiatrist, a registered nurse, a Master’s-level clinician, a community psychiatric support team, a primary care collaborative, and a peer specialist.

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

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

**Positions Funded by Health Home Payments in Four States**

**Missouri**

- Health Home Director/Coordinator
- Nurse
- Primary Care Clinician/Consultant
- Psychiatrist or Other Mental Health Professional

**Rhode Island**

- Health Home Director/Coordinator
- Care Manager (including Peer Support Specialist)
- Primary Care Clinician/Consultant
- Psychiatrist or Other Mental Health Professional

**New York**

- Health Home Director/Coordinator
- Nurse
- Primary Care Clinician/Consultant
- Psychiatrist or Other Mental Health Professional

**Ohio**

- Health Home Director/Coordinator
- Nurse
- Primary Care Clinician/Consultant
- Substance Use Disorder Specialist

*Note: X indicates presence of the position.*

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**Definitions:**

- **Health Home:** A model of care that integrates primary care, behavioral health, and social services for Medicaid beneficiaries.
- **Team of Healthcare Professionals:** Includes physicians, nurses, social workers, pharmacists, and other specialists.
- **Missouri**

- **Blood Pressure:** Percentage of patients aged 13 years and older who had at least one recorded blood pressure (BP) reading, with BP controlled (<140/90 mm Hg) during the measurement year. The denominator includes all patients aged 13 years and older who had at least one recorded BP reading during the measurement year.

- **Depression and Follow-up Plan:** Percentage of patients aged 13 years and older who had a diagnosis of depression and had a follow-up plan documented in the medical record within 30 days of the diagnosis.

- **Engagement of AOD Treatment:** Percentage of patients aged 13 years and older who had an episode of alcohol or other drug (AOD) treatment, with the treatment initiated within 14 days of the diagnosis.

- **Readmission:** Percentage of patients aged 13 years and older who were readmitted within 30 days of discharge from inpatient care, with the readmission occurring for any diagnosis.

- **Substance Use Disorder Specialist:** A trained professional who focuses on substance use disorders and provides treatment and support services.

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**Notes:**

- **Medicaid Adult Core set, Meaningful Use 2:** Measures are reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators.

- **Medicaid Adult Core set, Meaningful Use 1 and 2:** Measures are reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators.

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**References:**

26. Substance Use Disorder Specialist.
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28. Primary Care Clinician/Consultant.
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QUALITY MEASUREMENT AND HEALTH HOMES

Background

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

The joint federal-state nature of the Medicaid program means that the development of quality measures for health homes involves both federal designation of national measures and state-specific measures subject to federal review. CMS has also required states to set quality standards within their managed care plans that can include health home measures. Health plans are responsible for implementing, monitoring, and reporting on the quality indicators chosen by the states, with state oversight. States have almost universally designated health plans as a sector for use with care coordination efforts.

The Affordable Care Act explicitly broadens the scope of public programs to include improving health, promoting prevention and wellness, and enhancing the patient experience, while also reducing the cost of care. Health home statutory language mandates quality measurement; programs funded under the Affordable Care Act include the enhanced payment for care coordination services associated with health homes, must collect and report quality indicators, and appropriate management of the most common chronic illnesses. Currently, there are no quality measures of care or outcomes for all conditions, services, or populations. Notably, few measures exist for mental health and substance abuse treatment services.

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Measuring Quality in Health Homes

In draft guidance, CMS directs states developing health homes to include two types of quality measures: a core required set of quality indicators and a set of state-specific measures that reflect the program’s population. Together, these data will help CMS understand if health homes improve the health of the populations they serve.
CMS has further divided the types of quality measures they wish to receive into three categories:

1. **CLINICAL OUTCOME**: Measures that assess beneficiaries’ health status and related healthcare utilization (e.g., reduced hospital admissions and readmissions, reduced hospital emergency department visits, improved adherence to psychotropic medications). At least one measure should be a clinical measure that measures the effectiveness of the care that has been delivered to the patient. Examples of measures which might be used to describe whether the state is meeting its goal may include:
    - Controlling High Blood Pressure
    - Controlling High Blood Pressure
    - Adult Body Mass Index (BMI) Assessment
    - Screening for Clinical Depression and Follow-Up Plan

2. **EXPERIENCE OF CARE**: Measures that assess the patient’s experience in the delivery of care such as completed needs assessment, care planning, a developed care plan, and regular receipt of services provided. Each approved health home SPA contains the specific measures states have chosen to verify each of the required health home services and measure achievement of the goal. The list of measures to be undertaken by each state is extensive and includes both existing data sources and outcomes identified by the information contained in the use of electronic medical records.

3. **QUALITY OF CARE**: Measures that evaluate the processes used in the delivery of care such as completed needs assessment, care planning, a developed care plan, and regular receipt of services provided. These measures will then supplement the required national core measures currently being finalized by CMS. CMS recommends eight health home core measures to assess individual level clinical outcomes and care processes.

CMS Health Home Core Quality Measures

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

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

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

**State Specific Health Home Goals and Measures**

CMS asks states to define goals for their health home services model in each of the three domains of quality of care, experience, and achievement of care goals. For example, in its guidance, CMS sets a goal to “reduce emergency department visits by 10% for health home enrollees with a diagnosis of mental illness.” Exemplars of measures that might be used to assess whether the state is meeting its goal may include, but are not limited to:

- **CLINICAL OUTCOMES**: Percentage of hospital emergency department visits for mental illness with the expectation that the patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the measurement year.
- **QUALITY OF CARE**: Percentage of health home enrollees receiving care after an emergency care visit in the past 6 months.
Missouri, New York, Ohio, Oregon, and Rhode Island identify individuals with mental illnesses or substance use disorders as eligible health home populations. Health home goals included in selected approved SPAs relevant to these populations are included in Table 3.

### STATE GOALS OF APPROVED HEALTH HOME SPAS

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

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

**MEASURE:** Percent of patients 18-75 years of age with diabetes.

**NUMERATOR:** For a given 90-day period, number of patients with diabetes in a health home registry and a documented Hba1c test in the previous 12 months.

**DENOMINATOR:** For a 90-day period, number of patients with diabetes in health home registry and having a documented Hba1c test in the previous 12 months.

**SOURCE:** Missouri community mental health centers are required to utilize a disease registry within the health home program to track patients with diabetes and other chronic diseases. Patients with diabetes can be identified through claims and crosschecked with the disease registry to assess compliance with treatment standards.

To track patient experience, Rhode Island plans to use an existing survey: the Outcomes Evaluation Instrument (OEI). Other states may choose to use the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS). While expensive to administer, states are turning to existing quality measures to assess achievement of the state level goals. For example, Missouri intends to examine the health home’s impact on adults with diabetes by using the HEDIS measures.

### Challenges of Collecting and Reporting Health Home Quality Measures

In 2010, a panel convened under CMS’ auspices to identify a larger set of measures (as directed by the Affordable Care Act) and receive stakeholder feedback on a selection of measures. Despite this challenge, CMS is committed to the goal of improving the quality of care over time. CMS asks states to work with providers to phase in implementation within a one-year timeline.

1. **Feasibility of implementing the core set on the SPA’s effective date.**
2. **Implementation barriers.**
3. **Interim proxy measures can be reported to CMS when the state is unable to implement measures on the SPAs effective date and works with providers to phase in implementation within a one-year timeline.**
To date, states have identified the following challenges:

1. Not all claims will be in the same data system because of multiple healthcare payers, especially when Medicare pays for some services and Medicaid for others. For example, knowing if a patient gets follow-up care within 48 hours of a hospital discharge requires linking the Medicare hospital claim, the Medicare patient claim, or looking for evidence on a phone call to the patient. Although CMS demonstrations are facilitating this, several states have access to claims that were followed by an acute readmission for any diagnosis within 30 days. Some states are starting to use data that had been in the replacement system that does not follow a patient through inpatient stays.

2. States similarly have information coordination challenges between Medicaid and managed care agencies because different IT systems pay for different services. Some individuals receive behavioral health services often include members of managed care health plans. Since records are not available to sign with fee for service claims, Medicaid managed care encounter data has generated an increasing number of claims because of the numerous entities involved in its collection and production. Use of encounter data may require time-consuming analysis and improvement before it can be considered reliable.

3. Most states do not use electronic medical records to generate claims, nor do they use electronic medical records to handle claims. In the last several years, it has been a laborious process to route charts to extract clinical information such as, for example, BMI.

4. Electronic health records could be programmed to facilitate quality data collection, though those currently in the field would not necessarily include the CMS core performance measures or any state-developed measures. Retrospecting data may be a viable option.

5. Not all claims generate a claim, particularly care provided under a grant or contract. A number of states still use contracts rather than claims systems to capture mental and behavioral health services measured in terms of encounters that do not align with fee for service claims. Medicaid managed care encounter data has generated an increasing number of claims because of the numerous entities involved in its collection and production. Use of encounter data may require time-consuming analysis and improvement before it can be considered reliable.

6. Screening for Clinical Depression and Other Disruptive Behaviors.

   - **Numerator Description:** Total number of patients from the denominator who did not in-state submit a new episode of AOD treatment.
   - **Denominator Description:** Total number of patients from the denominator.

   Development of Affordable Care Act-required data systems, greater incorporation of electronic health records, and ongoing dialogue between CMS and states will likely continue to overcome these challenges. As more providers adopt electronic health records and process measures improve, the field will yield more reliable results.

7. Initiative and Engagement of AOD Treatment.

   - **Numerator Description:** Engagement of AOD treatment.
   - **Denominator Description:** Total number of patients from the denominator.

   Use of encounter data may require time-consuming analysis and improvement before it can be considered reliable.

8. Controlling High Blood Pressure for members 18 years of age and older, the number of acute inpatient stays with HEDIS Core set, Meaningful Use 2, Medicare Adult Core set, PQRS, CMS.

   - **Numerator Description:** Members 13 years of age and older as of December 31 of the measurement year with a new episode of AOD during the intake period, total technology (FH) measurements (31 days at 18 years), and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators.
   - **Denominator Description:** Members 13 years of age and older as of December 31 of the measurement year.

**USE OF HEALTH INFORMATION TECHNOLOGY IN HEALTH HOMES**

**Background**

Historically, states and providers focused their investments in information technology (IT) on systems that streamlined operations and improved the administrative processes of healthcare — from practice management systems that improved clinician and staff productivity and ensured accurate billing — to Medicaid Management Information Systems (MMIS) used by state Medicaid agencies to process claims for services provided. Over the past decade — and particularly in the last several years as spurred by enactment of the Affordable Care Act — states and providers have focused investments in information technology (IT) on systems that are intended to improve the practice of medicine.

These IT products and services (e.g., electronic medical records) enable the collaboration and sharing of health information among all entities responsible for an individual’s care. These IT solutions facilitate communication among providers, improve the quality of care, and reduce the risk of preventable medical errors, saving lives and significantly reducing costs to the healthcare system. To date, states have identified the following challenges:

1. Not all claims will be in the same data system because of multiple healthcare payers, especially when Medicare pays for some services and Medicaid for others. For example, knowing if a patient gets follow-up care within 48 hours of a hospital discharge requires linking the Medicare hospital claim, the Medicare patient claim, or looking for evidence on a phone call to the patient. Although CMS demonstrations are facilitating this, several states have access to claims that were followed by an acute readmission for any diagnosis within 30 days. Some states are starting to use data that had been in the replacement system that does not follow a patient through inpatient stays.

2. States similarly have information coordination challenges between Medicaid and managed care agencies because different IT systems pay for different services. Some individuals receive behavioral health services often include members of managed care health plans. Since records are not available to sign with fee for service claims, Medicaid managed care encounter data has generated an increasing number of claims because of the numerous entities involved in its collection and production. Use of encounter data may require time-consuming analysis and improvement before it can be considered reliable.

3. Most states do not use electronic medical records to generate claims, nor do they use electronic medical records to handle claims. In the last several years, it has been a laborious process to route charts to extract clinical information such as, for example, BMI.

4. Electronic health records could be programmed to facilitate quality data collection, though those currently in the field would not necessarily include the CMS core performance measures or any state-developed measures. Retrospecting data may be a viable option.

5. Not all claims generate a claim, particularly care provided under a grant or contract. A number of states still use contracts rather than claims systems to capture mental and behavioral health services measured in terms of encounters that do not align with fee for service claims. Medicaid managed care encounter data has generated an increasing number of claims because of the numerous entities involved in its collection and production. Use of encounter data may require time-consuming analysis and improvement before it can be considered reliable.

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   - **Denominator Description:** Members 13 years of age and older as of December 31 of the measurement year.
about care and services is crucial. When properly deployed, HIT solutions linking multiple providers under HIE can empower providers by enhancing their triage and diagnostic capabilities and by enabling continuous, integrated care management and monitoring.

Although the federal government does not mandate the use of HIT solutions in health home services, HIT adoption has been strongly encouraged through various efforts. These include financial incentives, grants and/or decision support systems to manage beneficiaries' demographic and clinical information, facilitate provider payment, and monitor service utilization, the U.S. Department of Health and Human Services encourages states — at least as a starting point — to utilize those systems to measure provider performance. By using meaningful use metrics and demonstrating meaningful use of IT solutions to justify financial incentives.

HIT to Support Care Coordination and Management

Providers, including those in states with approved Medicaid health home SPAs, fall within a wide spectrum of HIT adoption. In some instances, health home providers use HIT systems that plug into the state or statewide HIT entity. In some cases states are supporting these efforts by providing electronic health record systems, registries, and data as well as support in implementing these tools. For framing and illustration purposes, the following examples present two states implementing health home initiatives that fall at opposite spectrum: Missouri uses CyberAccess, a web-based EMR that captures Medicaid claims data for the state's Medicaid program (MO HealthNet) and is accessible to enrolled Medicaid providers, including community mental health centers, primary care practices, and schools. The tool is a HIPAA-compliant portal that can be used for:

- Download paid claims data submitted for an enrollee by any provider (e.g., drug claims, diagnosis codes, CPT codes).
- View the dates and the providers of hospital emergency department stays.
- Identify clinical issues that affect an enrollee's care and obtain best practice information.
- Prospectively examine specific preferred drug lists and clinical algorithms to facilitate a prescription for an individual enrollee and determine if a prescription meets the requirements for Medicaid payment.
- Electronically request drug prior authorizations or clinical edit overrides.
- Identify approved or denied prescription drug prior authorizations or clinical edit overrides or medical pre-certifications previously issued and transmit a prescription electronically to the enrollee's pharmacy of choice.
- Pre-certifications for inpatient services, diagnostic service and durable medical equipment electronically requested pre-certifications.
- Review laboratory and clinical trial data.
- Examine and exclude all patients with a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year.
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When Health IT and Health Information Exchange applications combine, the synergy has the potential to fundamentally transform healthcare delivery and management, particularly in service delivery models such as Medicaid health homes where care coordination, access to information, and timely decision support about care and services is crucial.
With its functionality and the rich data set contained within, CyberAccess gives providers access to a wealth of information in a timely, secure manner.

The state also maintains an initial and concurrent authorization tool on length of stay that requires hospitals to notify MO HealthNet (via accessing the online tool through a computer) within 24 hours of a new inpatient admission of a Medicaid enrollee. The state also provides guidance on diagnosis, condition, and treatment for inpatient authorization. The state also promotes the use of tools for monitoring utilization and quality improvement for inpatient admissions, and also monitors trends in the use of inpatient services. The state is also beginning to develop tools for monitoring utilization and quality improvement for outpatient services, and is also exploring the use of tools for monitoring utilization and quality improvement for ambulatory services.

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Finally, to encourage health home enrollees in managing their care and improving their health, CyberAccess offers personal health management tools. These tools include reminders and produces exception reports for consideration in care planning. Providers are expected to routinely access a behavioral health pharmacy management system to identify problematic prescribing patterns.

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

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

Missouri’s community mental health organization health home programs will use utilization profiles from the state — for the Medicaid fee-for-service population provided by the two Medicaid managed care organizations operating in the state — to monitor inpatient and outpatient behavioral health visits. Providers are expected to make sure that patients are being referred to appropriate services and that the care plan is being followed.

The state also maintains an initial and concurrent authorization tool on length of stay that requires hospitals to notify MO HealthNet (via accessing the online tool through a computer) within 24 hours of a new inpatient admission of a Medicaid enrollee. The state also promotes the use of tools for monitoring utilization and quality improvement for inpatient admissions, and also monitors trends in the use of inpatient services. The state is also beginning to develop tools for monitoring utilization and quality improvement for outpatient services, and is also exploring the use of tools for monitoring utilization and quality improvement for ambulatory services.

Finally, to encourage health home enrollees in managing their care and improving their health, CyberAccess offers personal health management tools. These tools include reminders and produces exception reports for consideration in care planning. Providers are expected to routinely access a behavioral health pharmacy management system to identify problematic prescribing patterns.

These features of Missouri’s health home IT structure position the state as a model for how HIT solutions can deploy in support of health home initiatives.
REIMBURSEMENT AND RATE SETTING FOR HEALTH HOME SERVICES

Background

A key provision under the health home model is that payment is for services rather than a specific provider. States and service providers favor PMPM as it allows for better control over reimbursement rates and avoids the burden of documentation. Implementing this method requires the costs of such non-reimbursable services. As a result, there is a need to ensure that the payment framework is in place to support the health home service. This includes non-reimbursable services such as care coordination, referrals to community and social services, and the coordination of care for individuals moving from one SPA to another.

Feedback to States about Establishing Health Home Payments

CMS requires states to ensure that health home service payments will not duplicate or under-reimburse other payments. This includes duplication among beneficiaries who receive services from multiple providers. To prevent this, states must ensure that enhanced FMAP payments do not occur for a single beneficiary at more than one SPA.

Non-Duplication among Beneficiaries

As discussed earlier in this report, states must ensure that enhanced FMAP payments of 90% federal match do not occur for a single beneficiary for more than eight consecutive quarters. States with multiple SPAs and different start dates must consider this requirement. To achieve this, states may consider tracking each individual participating in a Medicaid health home project and ensuring that enhanced match for the individual moving from one SPA to another is only provided for the initial geographic region.

This structure presents important considerations for states considering multiple SPAs with different start dates. For states that plan a phase-in based on geography, or based on when providers will be ready to participate, there is always the option of covering different phases (i.e., different target groups, providers, or geographical areas) in each SPA. In one SPA, the state may consider covering the first six months of the measurement year with a focus on pre-adolescents, while another SPA focuses on young adults. This allows the state to maximize the benefits of the enhanced match through multiple SPAs against the administrative difficulty and budgetary impact of tracking and excluding individuals from any claiming of enhanced match in a later SPA.

Since Missouri is the only state that has implemented an enhanced FMAP payment for health home services, it is considered a leader in this area. Other states may consider adopting this approach, but they must be with different providers to be eligible for multiple health home service population or could be included as part of an initial regional implementation of health home services.
Non-Duplication of Services

Since Medicaid health home services could be similar to covered services under an existing state plan benefit, states will also have to assure CMS that the benefit will not duplicate existing services. States may seek to structure health homes alongside managed care services to ensure non-duplication in a brief, Health Home Considerations for administration of the benefit.

Establishing Health Home Payment Rates

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

- MISSOURI: “The delivery design and payment methodology will not result in any duplication of payment between health homes and managed care. ’All AOD diagnoses are denoted, and there will be no duplication of payment for health home services.”

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

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

- OREGON: “Payments for case management or targeted case management services under the plan do not duplicate payments with Home and Community Based Services.”

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

Payment Approach: Creating New Rates for Teams of Healthcare Professionals

Missouri built the community model tool and follow-up documented program, Medicaid Adult Core set, Meaningful Use 2. New York: The delivery design and payment methodology will not result in any duplication of payment between health homes and managed care. “All AOD diagnoses are denoted, and there will be no duplication of payment for health home services.”

Establishing Health Home Payment Rates

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

Missouri built the community model tool and follow-up documented program, Medicaid Adult Core set, Meaningful Use 2.
Rather than build the PMPM rate for the Medicaid Adult Core set to consist of team members who deliver existing Medicaid services (as captured through uniform cost reports, for example), Missouri opted to establish a new rate-setting methodology. Missouri’s health home team continues to provide reimbursement for community support services under its fee-for-service benefit and does not include community support as part of the health home PMPM rate.

### MISSOURI’S HEALTH HOME TEAM MEMBERS AND RATE-SETTING

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

### Blood Pressure (BP) Control

- **Meaningful Use 2**  
  - **ACO Measure**  
  - **Denominator Description**  
  - **Numerator Description**  
  - **ACO Measure**

Blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year. For a member’s BP to be considered controlled, both the systolic and diastolic BP must be <140/90 mm Hg. If a patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the first six months of the measurement year.
Payment Approach: Converting Existing Services to Health Home Services

Both New York and Rhode Island opted to convert existing case management services to health homes. New York is collecting data on its statewide initiative and is implementing targeted programs to designated health homes. Rhode Island’s programs provide similar comprehensive case management and community supports to address the complex needs of their clients. Rhode Island converted community psychiatric supportive treatment (CPST) programs to health homes in order to help meet the extensive care coordination and support services to a health home program and imposes additional requirements to ensure that the service meets federal coverage requirements. Rhode Island developed its monthly case rate based on personnel costs of individual team members, the team composition, and the overall estimated caseload to yield a single statewide average case rate. The rate also reflects operating and support costs.

Payment Approach: Performance-Incentive Payments

In addition to paying for staffing and allowable services costs, many states use health home service payments to reward providers for achieving performance improvement. Missouri intends to help health home providers address a number of components (e.g., providing access to evidence-based services, coordinating access to prevention and health promotion services, establishing continuous quality improvement programs). Missouri’s health home providers participate in a number of learning activities supported with either state or private foundation funding.

Additional State Costs

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

- **STATE COSTS OF ADMINISTERING AND MONITORING THE BENEFIT**: This includes the cost of any additional (or backfilled) staff necessary to oversee delivery of health home services, develop program rules, conduct site visits, or monitor program compliance. CMS allows states to include overhead cost necessary to provide this service, but does not allow separate payment for start-up or infrastructure cost. CMS does not permit payment to help make providers qualified to render health home services.

- **STATE COSTS TO SUPPORT PRACTICE TRANSFORMATION**: This includes the costs associated with the development, implementation, and maintenance of the practice transformation program. Missouri’s health home providers participate in a number of learning activities supported with either state or private foundation funding.

- **EVALUATION AND REPORTING**: CMS requires states to agree to participate in the federal evaluation of health home services. In addition, states may need to provide data to state agencies, presumably those that track quality and process measures for reporting.

Many of the costs may be claimed as indirect costs and others will need to be calculated with CMS to determine what Medicaid reimbursement is available.
OTHER CONSIDERATIONS

Integrated Care for Medicare/Medicaid Eligibles

Under other new Affordable Care Act opportunities, several states plan to integrate services and payments for individuals dually eligible for Medicare and Medicaid. The most effective integrated care approaches for these Medicare/Medicaid eligibles (MMEs) are similar to health home goals (e.g., improving care management and care transitions, integrating data for more effective care coordination and service delivery).

Since health home services may not be implemented statewide, some states have developed models that are intended to address the needs of MMEs through other mechanisms. Some states plan to integrate health home services with Medicaid-only beneficiaries. Other states, such as Michigan, propose to preserve existing managed behavioral health frameworks that use regional Medicaid managed care organizations to manage care for MMEs. A key question for states will concern whether implementing an integrated care model is feasible within their health care system is whether to support singular initiatives to coordinate care (i.e., Medicaid and Medicare only) and decide to address the needs of MMEs through other mechanisms (e.g., integrated Medicare and Medicaid funding) to achieve improvement in outcomes for all MMEs, including among individuals with serious mental health conditions.

Some states propose to implement a single entity responsible for coordinating medical, behavioral, long-term care, and prescription drug services. The Medicaid-only MME has not been recognized as a priority for many managed behavioral health services for MMEs. Other states, such as Michigan and California, have implemented health home services for MMEs and have developed models that are intended to address the needs of MMEs through other mechanisms. States are eager to receive guidance since their focus for the Medicaid safety net population. An important question states will confront is whether implementing an accountable care organization will be feasible within their health care system.

Accountable Care Organizations

Numerous states are also involved in planning or supporting efforts to develop Accountable Care Organizations (ACOs). ACOs have emerged as critical redesigns of delivery systems in order to expand coverage and encourage providers to organize jointly to provide a full continuum of care and commit to improving quality while controlling cost. These providers are then rewarded for success.

Accountable care organizations have emerged as critical redesigns of delivery systems in order to provide a full continuum of care and commit to improving quality while controlling cost. These providers are then rewarded for success.
CONCLUSION

Medicaid health homes provide care coordination and communication across providers. While enhanced funding may lead many states to view health homes as a meaningful pursuit, that alone should not be the reason for coverage of the services. Careful selection and planning should be devoted to planning the appropriate structure based on the unique circumstances of each state, the target population’s care needs, and the existing provider infrastructure.

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

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

» What percentage of the total Medicaid population do individuals with serious mental health conditions represent?

» What percentage of total Medicaid costs do individuals with serious mental health conditions constitute?

» What percentage of total Medicaid community mental health spending is attributable to MMES?

» What are the cost drivers among individuals with serious mental health conditions (e.g., pharmacy, hospital emergency department visits, hospital inpatient services, specialty behavioral health services, and co-morbidities)?

» What physical health conditions most frequently occur among individuals with serious mental health conditions?

» How does total Medicaid cost and utilization of individuals with serious mental health conditions compare with the cost and utilization of individuals without serious mental health conditions?

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

0018 8. Controlling High Blood Pressure

The percentage of patients 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

NUMERATOR DESCRIPTION

- Number of patients with a diagnosis of HTN who had their blood pressure controlled within 30 days of the diagnosis during the measurement year.

DENOMINATOR DESCRIPTION

- Number of patients with a diagnosis of HTN who had their blood pressure measured during the measurement year.
APPENDIX A – SELECTED STATES’ HEALTH HOME SERVICE DESCRIPTIONS

Comprehensive Care Management

### MISSOURI

5. Plan — All For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute hospital stay within 30 days of discharge.

**DESCRIPTION**

Comprehensive care management services are conducted by the nurse care manager, primary care physician consultant, the health home support staff and health home director with the participation of other team members and involve the individual’s medical and behavioral health needs. The individualized care plan will be developed and enhanced based on the information obtained from a comprehensive health risk assessment used to identify the individual’s physical, mental health, chemical dependency, and social service needs, as applicable. The care plan will include an individualized care plan with goals and interventions that will produce this effect must also be included in the plan of care.

The care manager will be required to make sure that the individual (or their guardian) plays a central and active part in the development and execution of their plan of care and that they are in agreement with the goals, interventions, and time frames contained in the plan. Family members and other supports involved in the patient’s care should be identified and included in the plan and execution of care.

The care plan must also include outreach and engagement activities, which will support engaging the patient in their own care and promote continuity of care. In addition, the plan of care will include intermittent reassessment of the individual’s needs and goals and clearly identify the patient’s progress in meeting goals.

### NEW YORK

6. Screening for Depression and Depression Care Management Plan — All for member age 18 years and older screened for Clinical Depression using a standardized tool and follow-up documented

**DESCRIPTION**

Meaningful use in 2015 requires inclusion of depression screening and care management. Individualized care plans will be required to identify the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager, and other providers directly involved in the individual’s care. The individual’s care plan must also identify continuity networks and supports that will be utilized to address their needs.

The care plan must also include outreach and engagement activities, which will support engaging the patient in their own care and promote continuity of care. In addition, the plan of care will include intermittent reassessment of the individual’s needs and goals and clearly identify the patient’s progress in meeting goals. Changes in the plan of care will be based on changes in patient need.

### NORTH CAROLINA

8. Blood Pressure: Systolic Blood Pressure in the 18-55 age group — All for members 13 years of age and older as of December 31 of the measurement year with a new episode of AOD during the intake period.

**DESCRIPTION**

Comprehensive care management involves active participation of the care manager, patient, and family/caregivers. It includes patient identification and comprehensive assessment obtained through direct referrals, mining administrative claims data (e.g., risk stratification), screenings and assessments, and chart review for intervention processes that identify gaps in care; developing an individualized care plan; monitoring the patient’s progress in meeting goals; adjusting care plans as needed. The care team uses quality metrics, assessment, survey results, and utilization of services to monitor and evaluate the impact of interventions.

**NUMERATOR DESCRIPTION**

Count the number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination of high-risk patient admission cluster.

**DENOMINATOR DESCRIPTION**

Count the number of enrollees with a diagnosis of hypertensive (HTN) status, service delivery, and costs.

**DENOMINATOR DESCRIPTION**

Members 13 years of age and older as of December 31 of the measurement year with a new episode of AOD during the intake period.

**DENOMINATOR DESCRIPTION**

The number of patients in the denominator whose medical and behavioral health services, rehabilitative, long-term care, and other service needs are as applicable. The care plan will include an individualized care plan with goals and interventions that will produce this effect must also be included in the plan of care.

The care manager will be required to make sure that the individual (or their guardian) plays a central and active part in the development and execution of their plan of care and that they are in agreement with the goals, interventions, and time frames contained in the plan. Family members and other supports involved in the patient’s care should be identified and included in the plan and execution of care.

The care plan must also include outreach and engagement activities, which will support engaging the patient in their own care and promote continuity of care. In addition, the plan of care will include intermittent reassessment of the individual’s needs and goals and clearly identify the patient’s progress in meeting goals. Changes in the plan of care will be based on changes in patient need.

**DENOMINATOR DESCRIPTION**

Patients 18-85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the first six months of the measurement year.
Comprehensive care management begins with the identification of individuals who are potentially eligible to receive health home services. The community behavioral health center health home will be responsible for identifying individuals with severe and persistent mental illness who are currently affiliated with the health home site. Individuals living in metropolitan areas, and some rural areas, may assess eligibility and be admitted to a health home site. Based on the biopsychological assessment, a goal-oriented, person-centered care plan is developed, implemented, and monitored by a multidisciplinary team in conjunction with the individual served. Any member of the community mental health organization health team may provide comprehensive care management services; however, Master’s level health home team coordinators will serve as the primary practitioners, providing comprehensive care management services.

The community behavioral health center health home will identify patients with high-risk environmental or medical factors, including patients with special health care needs, who are potential candidates for comprehensive care management. Care management activities may include, but are not limited to, determining individual care needs, developing and following self-management goals, developing goals for prevention of acute and chronic illnesses, developing action plans for exacerbations of chronic illnesses and developing end-of-life care plans when appropriate. Patient-centered primary care home services will occur under the direction of licensed health professionals, physicians, physician assistants, nurses, social workers, or professional counselors.

**Comprehensive Care Management**

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<td>1768</td>
<td>5. Plan — All members of a health home should be identified through education and the provision of an informal care plan. A health home is responsible for identifying potential candidates for comprehensive care management and connecting them to a community behavioral health center health home to begin the comprehensive care management process. The next step is for the community behavioral health center to engage the eligible individual and his/her family by explaining the benefits of health home services and the right to opt-out of health home services.</td>
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| 0418    | 6. Screening for 

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| 004     | RHODE ISLAND 

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| 004     | OREGON
Care Coordination

Care coordination is the implementation of the individualized treatment plan (with active client involvement) through appropriate linkages, referrals, coordination, and follow-up monitoring and supports, including but not limited to, ongoing patient education, management of transitions, and referrals to long-term services and supports. Specific activities include, but are not limited to, appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes, and communicating with gender and total combinations of other providers and clients/family members. Care managers with the assistance of the health home administrative support staff will be responsible for overseeing care coordination activities across provider settings, including their primary responsibility to ensure implementation of the care plan for achievement of clinical outcomes consistent with the needs and preferences of the client. Care managers coordinate interventions are identified and documented in Content Management Interoperability Services (CMIS).

The mental health integration program aims to improve the screening and treatment of mental health conditions in the primary care setting and enhance the medical care of individuals with behavioral health problems. They are working to implement the National Council for Behavioral Health's four quadrant clinical integration model as the foundation for communication, collaboration, assessment, referrals, and the coordination and clinical management of care. After an initial pilot period, specific activities include, but are not limited to, ongoing patient education, management of transitions, and referrals to long-term services and supports.
the model is being implemented statewide, with primary care practices having incorporated behavioral health treatment in the primary care provider office setting while also supporting enhanced referral processes for more complex patients to specialty mental health services and behavioral health care coordination. The central office and networks use psychiatrists to coordinate implementation of the four quadrant model and to identify patients with behavioral and physical health care needs for the primary care providers.

### OHIO

Care coordination requires participation of all health home team members in implementation of the care plan, the care manager will have the lead care coordinator role across all providers. The embedded primary care coordinator will have a lead role for the organization of all care planning, collaboration with the treating physical care clinic to clarify patient treatment needs as appropriate. The team leader will be responsible for developing communication and coordination protocols for use with external and internal providers. The team leader will also serve as the universal point of contact and care coordinator for all consumers on the team and serve as back up for the care manager. The embedded health home specialty care coordination pad

### OREGON

Care coordination is the implementation of the single, integrated care plan. With a person-centered focus, the community behavioral health center will coordinate and direct the coordination. Communication, and coordination functions for the individual to demonstrate positive outcomes in the care plan and achieve optimal health outcomes. This includes, but is not limited to assisting the consumer in obtaining healthcare (i.e., primary and specialty medical care, mental health, substance abuse services, developmental disabilities services, long-term services and supports, and ancillary services and supports); performing care coordination and communication protocols for use with external and internal providers. The team leader will also serve as the universal point of contact and care coordinator for all consumers on the team and serve as back up for the care manager. The embedded health home specialty care coordination pad

### Proposal

**Numerator Description**

- **Readmission**
  - The number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination.

- **Percentage of patients 18-85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the measurement year.**

- **Meaningful Use 2**
  - The percentage of adult patients with a new episode of AOD treatment that was followed by an acute readmission. Count the number of Index Hospital Stays for each patient, gender, and total combination that were followed by an acute readmission.

- **Clinical Depression**
  - All patients 18 years and older screened for clinical depression using a standardized tool.

- **PQRS, CMS Adult Core set, Meaningful Use 2**
  - The percentage of adult patients with a new episode of AOD treatment that was followed by an acute readmission. Count the number of Index Hospital Stays for each patient, gender, and total combination that were followed by an acute readmission.

- **Blood Pressure**

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<td>Health Promotion</td>
<td>DENOMINATOR DESCRIPTION</td>
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<tr>
<td>RHODE ISLAND</td>
<td>All patients 18 years and older screened for depression using a standardized tool who have follow-up documentation</td>
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<tr>
<td>NEW YORK</td>
<td>Health promotion services begin for eligible health home enrollees with the commencement of outreach and engagement activities. New York’s health home plan for outreach and engagement will require a health home provider to actively engage patients in care by phone, letter, health information technology, and community “inreach” and outreach. Each of these outreach and engagement functions will include aspects of comprehensive care management, care coordination, and referral to community and social support services.</td>
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### Numerator and Denominator Definitions

#### Missouri 2017

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<tr>
<td>Adult Core set, HEDIS</td>
<td>Medicaid Adult Core set, Mean</td>
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<tr>
<td>Medicare Shared Savings Program, Medicaid</td>
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<td>OIP, CMS</td>
<td>Use 2</td>
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#### North Carolina 2019

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5. Plan — All of the services listed are provided by primary care providers and their care teams, excluding care managers and other community care managers. The services include prevention of AOD dependence, tobacco use prevention, smoking cessation, and providing health promoting lifestyle interventions, including but not limited to, substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, and increasing physical activity.

6. Screening for Clinical Depression and coordination services | Percentage of patients aged 18 years and older screened using a standardized tool for depression by the health home administrative support staff will provide health promotion services. | CQI, CMS | CQI, CMS | CQI, CMS |

7. Initiation and Follow-up for AOD Treatment | Percentage of adolescents and young adults aged 13 years and older screened for AOD treatment, who have follow-up documentation | CQI, CMS | CQI, CMS | CQI, CMS |

8. Controlling High Blood Pressure | The percentage of patients 18-85 years of age who had a diagnosis of hypertension (HTN) and whose diastolic blood pressure (DBP) was adequately controlled (DBP ≤90 mmHg) in their first six months of care, measuring the total number of patients in the denominator whose Medicaid Adult Core set, HEDIS, or Medicare Shared Savings Program, CMS paid for their care. | CQI, CMS | CQI, CMS | CQI, CMS |
OHIO
Health promotion services are intended to equip the individual/family with relevant knowledge and skills that increases understanding of diseases/conditions identified in the assessment, promote self-management, and improve quality of life and daily functioning. This may be accomplished through the following education about wellness and healthy lifestyle choices; provision of, or referrals, to evidence-based wellness programs such as tobacco cessation, weight management, chronic disease management programs, wellness management and recovery, and others, and connections to peer supports. A health promotion focus will be to support and engage the individual and the family in the development, implementation, and monitoring of the care plan. By empowering the individual and promoting self-advocacy, there will be an increased ability to be proactive in the self-management of existing conditions, increase the utilization of preventative services, and accessing care in appropriate settings.

OREGON
The patient-centered primary care home provider will support continuity of care and health promotion through the development of a treatment relationship with the individual, other primary care team members, and community providers. The health home provider will promote the use of evidence-based, culturally sensitive wellness and prevention by linking the enrollee with resources for smoking cessation, diabetes, asthma, self-help resources, and other services based on individual needs and preferences. Health promotion activities will promote consumer/family education and self-management of the chronic conditions. Health home services will occur under the direction of licensed health professionals, physicians, physician assistants, nurse practitioners, nurses, social workers, professional counselors, community health workers, personal health navigators, or peer wellness specialists.

RHODE ISLAND
Health promotion services encourage and support healthy ideas and concepts to motivate individuals to adopt healthy behaviors. The services also enable individuals to self-manage their health. Any professional working within a health home team can provide health promotion services. Health promotion activities place a strong emphasis on self-direction and skills development for monitoring and management of chronic health conditions. These services help individuals take a self-directed approach to health, through the provision of health education. Specific health promotion services may include, but are not limited to, providing or coordinating assistance with promoting individuals’ health and ensuring that all personal health goals are included in person-centered care plans; promotion of substance abuse prevention, smoking prevention and cessation, nutritional counseling, obesity reduction, and increased physical activity; providing health education to individuals/family members about chronic conditions; providing prevention education to individuals/family members about health screening and immunizations; providing self-management support and development of self-management plans and/or relapse prevention plans so that individuals can attain personal health goals; and promoting self-direction and skill development in the area of independent administering of medication. Any member of a health home team may provide health promotion services. However, psychiatrists and nurses will be the primary practitioners providing health promotion services.

Comprehensive Transitional Care
MISSOURI
In conducting comprehensive transitional care, a member of the health team provides care coordination services designed to streamline plans of care, reduce hospital admissions, ease the transition to long-term services and supports, and interrupt patterns of frequent hospital emergency department use. The health team member collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing clients’ and family members’ ability to manage care and live safely in the community, and shift the use of reactive care and treatment to proactive health promotion and self-management.
Comprehensive transitional care will prevent avoidable readmission after an enrollee’s discharge from an inpatient facility (i.e., hospital, rehabilitative, psychiatric, skilled nursing, or treatment facility) and to ensure proper and timely follow-up care. To accomplish this, the health home provider will be required to develop and have a system in place with hospitals and residential/rehabilitation facilities in their network to provide the health home care manager prompt notification of an enrollee’s admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.

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

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

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

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

The primary care provider is informed about an admission by the care manager provision of a copy of the hospital discharge summary, either electronically or by mail, depending on the format available. Transitional care staff update the patient’s medical homes about hospitalizations, other prescribed medications, social and environmental concerns, and other agencies providing services such as personal care, home healthcare, and behavioral health support, and make sure that the primary care provider receives discharge summaries. Network pharmacists review medication lists and alert the primary care provider of discrepancies and other findings. Transitional care staff shares information among a variety of local agencies, including behavioral health providers and long-term care support providers.
Transitional care is triggered by access to real-time admission/discharge/transfer data from most hospitals in their respective communities. Additional real-time data is accessed with Thompson-Reuters data or embedded hospital care managers have direct access to hospital census data. These three data sources provide access to real-time data across all hospitals statewide, which is then screened by care managers to determine the need for transitional care services. Post-acute care coordination and medication reconciliation relies on electronic data sources, including the primary care provider problem and medication lists and hospital discharge instructions, and information from face-to-face assessments of transitional care recipients at the hospital bedside by care managers, at the recipient’s home and at follow-up appointments at the medical home.

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

**OHIO**

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

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

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

**OREGON**

The health home will emphasize transitional care by demonstrating either a written agreement and/or procedures in place with its usual hospital providers, local practitioners, health facilities, and community-based services to ensure notification and coordinated, safe transitions, as well as improving the percentage of patients seen or contacted within one week of facility discharges. Health home services will occur under the direction of licensed health professionals, physicians, physician assistants, nurse practitioners, nurses, social workers, professional counselors, community health workers, personal health navigators, or peer wellness specialists.
Comprehensive transitional care services focus on the transition of individuals from any medical, psychiatric, long-term care, or other out-of-home setting into a community setting. Designated members of the health home team work closely with the individual to transition the individual smoothly back into the community and share information with the discharging organization in order to prevent any gaps in treatment that could result in a re-admission. To facilitate timely and effective transitions from inpatient and long-term settings to the community, all health home providers will maintain collaborative relationships with hospital emergency departments, psychiatric units of local hospitals, long-term care and other applicable settings. In addition, all health home providers will use hospital liaisons to assist in the discharge planning of existing community mental health organization clients and new referrals from inpatient settings to community mental health organizations. Care coordination may also occur when transitioning an individual from a jail/prison setting into the community. Hospital liaisons, community support professionals, and other designated members of the team may provide transitional care services. The team member collaborates with physicians, nurses, social workers, discharge planners, and pharmacists within the hospital setting to ensure that a treatment plan has been developed and works with family members and community providers to ensure that the treatment plan is communicated, adhered to, and modified as appropriate. Any member of the community mental health organization health home team may provide comprehensive transitional care services; however, hospital liaisons will be the primary practitioners providing comprehensive transitional care services.

Individual and Family Support Services

**MISSOURI**
Individual and family support services activities include, but are not limited to, advocating for individuals and families and assisting with obtaining and adhering to medications and other prescribed treatments. In addition, health team members are responsible for identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services. A primary focus will be increasing health literacy, ability to self-manage their care, and participation in the ongoing revision of their care/treatment plan. For individuals with developmental disorders, the health team will refer to and coordinate with the approved developmental disorders case management entity for services more directly related to habilitation and coordinate with the approved developmental disorders case management entity for services more directly related to a particular healthcare condition.

**NEW YORK**
The patient’s individualized plan of care will reflect and incorporate the patient and family or caregiver preferences; education and support for self-management; self-help recovery; and other resources, as appropriate. The provider will share and make the individualized plan of care assessable to the enrollee, their families, or other caregivers (based on the individual’s preferences) by presenting options for accessing the enrollee’s clinical information.

The health home provider will use peer supports, support groups, and self-care programs to increase patients’ and caregivers’ knowledge about the individual’s disease(s), promote the enrollee’s engagement and self-management capabilities, and help the enrollee improve adherence to their prescribed treatment. The provider will discuss and provide the enrollee, the enrollee’s family, and caregivers information on advance directives to enable them to make informed end-of-life decisions ahead of time. The health home provider will ensure that all communication and information shared with the enrollee, the enrollee’s family, and caregivers is language-, literacy-, and culturally-appropriate so it can be understood.

**NORTH CAROLINA**
Primary care providers and their care teams, or the case manager, provide individual and family support services activities that include, but are not limited to, advocating for individuals and families and assisting with obtaining and adhering to medications and other prescribed treatments. In addition, health team members are responsible for identifying...
resources for individuals to support them in attaining their highest level of health and functioning with their families and in their community, including transportation to medically necessary services and access to long-term care and support services. Primary care providers have a key role in supporting appropriate referrals. Many network activities are geared toward supporting and educating primary care providers on how to promote access to community services and resources for individuals in their role as health home provider. In different practice areas, this guidance takes different forms. For example, the need for longitudinal care planning and the need for coordination of care across the spectrum of health-related services. The number of long-term care support services that can be accessed through health home services, for example, is determined by the specific needs of each individual and their families. The health home will identify and prioritize the specific services that are most likely to be effective for reducing barriers to individuals' care coordination, increasing skills and engagement, and improving health outcomes. The health home will have processes for patients and family education, health promotion and prevention, self-management, and social supports through face-to-face and telephone interactions.

**OHIO**

Individual and family support services include, but are not limited to, providing expanded access and availability of services along with continuity in relationships between the individual/family, provider(s), and the care manager; education and training on care planning; assistance with mental health and substance use disorder treatment and support; resource linkage; social work and self-help and peer support services; advocacy for individuals and families; helping individuals identify and develop social support networks; assistance with medication and treatment management and adherence; identifying and activating resources that will help individuals and their families reduce barriers to their highest level of health and success; and connecting individuals and their families to peer advocacy organizations such as NAMI and family psycho-educational programs. Individual and family support services may be provided by any member of the health home team; however, CPST specialists will be the primary practitioners providing this support in this area. Networks provide detailed protocols regarding the services to supporting recipients with chronic illness with regard to self-management and their potential to support improved health and well-being. Care managers develop relationships with community and, when possible, family and social supports through face-to-face and telephone interactions.

**OREGON**

The health home will have processes for patients and family education, health promotion and prevention, self-management supports, and information and assistance obtaining available non-healthcare community resources, services, and supports. The person-centered plan will reflect the individual and their family’s preferences and is cultural and recovery-oriented. Peer supports, support groups, and self-care programs will be used to increase the client and family’s engagement in the care management process and the care coordination process. Health home services will be provided under the direction of licensed health professionals, physicians, physician assistants, nurses practitioners, nurses, social workers, professional counselors, community health workers, personal health navigators, or peer wellness specialists.

**RHODE ISLAND**

Community support professionals and other members of the health team provide individual and family support services to reduce barriers to individual and family care coordination. The number of patients who have been identified as needing individual and family support services may include, but are not limited to, providing assistance in accessing needed self-help and peer support. The individual’s identifiers and the individual’s individual(s) identify and develop social support networks, assistance with medication and treatment management and adherence; identifying and activating resources that will help individuals and their families reduce barriers to their highest level of health and success; and connecting individuals and their families to peer advocacy organizations such as NAMI and family psycho-educational programs. Individual and family support services may be provided by any member of the health home team; however, CPST specialists will be the primary practitioners providing this support in this area. Networks provide detailed protocols regarding the services to supporting recipients with chronic illness with regard to self-management and their potential to support improved health and well-being. Care managers develop relationships with community and, when possible, family and social supports through face-to-face and telephone interactions.

**DENOMINATOR DESCRIPTION**

- Medicaid Adult Core set, Meaningful Use 2
- Adults 18-85

**NUMERATOR DESCRIPTION**

- All patients 18 years and older screened for depression using a standardized tool
- Adults 18-85

**DENOMINATOR DESCRIPTION**

- Readmission for any diagnosis within 30 days
- Patients 18-85 years of age who had a diagnosis of hyperbaric oxygen therapy (HBO) during the measurement year.

**NUMERATOR DESCRIPTION**

- Number of patients from the denominator with initiation of AOD treatment
- Adults 18-85

**DENOMINATOR DESCRIPTION**

- Count the number of Index Hospital Stays for each age, gender, and total combination
- Adults 18-85

**NUMERATOR DESCRIPTION**

- Blood Pressure (BP) was adequately controlled during the measurement year
- Adults 18-85

**DENOMINATOR DESCRIPTION**

- Patients 18-85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the measurement period
- Adults 18-85
Referral to Community and Social Support Services

MISSOURI

Referral to community and social support services, including long-term services and supports, involves providing assistance for clients to obtain and maintain eligibility for social security disability benefits, housing, personal needs, and other services, as appropriate. Referral to community and social supports, coordinate services, and follow-up post engagement with services. To accomplish this, the health home provider will develop policies, procedures, and accountability (through contractual agreements) to support effective collaboration with community-based resources.

NEW YORK

The health home provider will identify available community-based resources and actively manage appropriate referrals, access to care, engagement with other community and social supports, coordinate services, and follow-up post engagement with services. To accomplish this, the health home provider will develop policies, procedures, and accountability (through contractual agreements) to support effective collaboration with community-based resources.

NORTH CAROLINA

Community care works holistically. It requires network providers with care management support, to attend not only to the delivery of physical health services, but also to social, emotional, and psychological issues that may affect health and medical care. Care management recognizes the social and environmental factors that affect population health. As part of the care management approach, the health home works to increase access to appropriate community and social support services and to use and organize community resources. Care managers are knowledgeable about local agencies and resources and share this knowledge with network providers by providing resource manuals containing relevant information on an array of community and social support services.

OHIO

The health home will offer and/or arrange for onsite and offsite community and social support services through effective collaborations with formal health service agencies and community partners. The health home will identify and provide referrals to community, social, or recovery support services and to use and organize community resources. Care managers are knowledgeable about local agencies and resources and share this knowledge with network providers by providing resource manuals containing relevant information on an array of community and social support services.

OREGON

The health home will implement processes and capacity to refer to community and social support services. The number of patients in the denominator who have a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year. This denominator excludes the first six months of the measurement year.
Referral to community and social support services provide individuals with referrals to a wide array of support services that will help individuals overcome access or service barriers, increase self-management skills, and improve overall health. Referral to community and social support involves facilitating access to support and assistance for individuals to address medical, behavioral, educational, social, and community issues that may affect overall health. The types of community and social support services to which individuals will be referred may include, but are not limited to, primary care providers and specialists, wellness programs, including smoking cessation, fitness, weight loss programs, and yoga; specialized community settings (e.g., cancer or diabetes support groups); assistance treatment links in addition to treatment-supportive services (e.g., NAMI support groups, MHCA OASIS, Alive Program, and recovery center); and, assistance with the identification and attainment of other services, including the connection with the Office of Rehabilitation Service, as well as the internal community mental health organization team to help the person develop work/education goals and paid programs/jobs. The types of support services provided may be provided by any member of the health home team; however, CPST specialists will be the primary practitioners providing referrals to community and social support services.
## APPENDIX B – CMS Core Health Home Quality Measures

<table>
<thead>
<tr>
<th>Measure Title</th>
<th>Measure Description</th>
<th>Numerator/ Denominator Description</th>
<th>Alignment with Other CMS Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N/A</strong></td>
<td><strong>1. Adult BMI Assessment</strong></td>
<td>Percentage of members 18-74 years of age who had an outpatient visit and who had a BMI documented within 30 days of the visit and the predicted probability of an acute readmission.</td>
<td>Medicaid Adult Core Set, QIP, Medicare</td>
</tr>
<tr>
<td><strong>0418</strong></td>
<td><strong>6. Screening for Depression</strong></td>
<td>Percentage of patients aged 18 years and older who had a follow-up visit with a certified or registered nurse or a licensed practical nurse within 30 days of the index visit.</td>
<td>PQRS, CMS, QIP, Medicare</td>
</tr>
<tr>
<td><strong>N/A</strong></td>
<td><strong>2. Ambulatory Care Sensitive Condition Admission</strong></td>
<td>Depression and Other Drug Use related to the admission of an inpatient facility, or a partial hospitalization.</td>
<td>Shared Savings Program, Medicaid Adult Core Set, Meaningful Use 1 and 2, Medicaid Adult Core Set, Medicare Adult Core Set, HEDIS</td>
</tr>
<tr>
<td><strong>648</strong></td>
<td><strong>3. Alcohol and Other Drug Treatment Record Transmission to Healthcare Professional</strong></td>
<td>The percentage of members 18-74 years of age who had a diagnosis of hypertension (HTN) and whose most recent, representative BP is adequately controlled (&lt;140/90) during the measurement year.</td>
<td>Million Hearts, Medicaid Adult Core Set, Meaningful Use 2, ACO Measure</td>
</tr>
<tr>
<td><strong>0576</strong></td>
<td><strong>4. Follow-Up After Hospitalization for Mental Illness</strong></td>
<td>The percentage of patients 18-85 years of age who had a diagnosis of a mental health disorder and who had an outpatient visit within 30 days of the discharge of a mental health admission.</td>
<td>SAMHSA-HRSA Center for Integrated Health Solutions</td>
</tr>
<tr>
<td><strong>0018</strong></td>
<td><strong>8. Controlling High Blood Pressure</strong></td>
<td>The percentage of patients 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (&lt;140/90) during the measurement year.</td>
<td>SAMHSA-HRSA Center for Integrated Health Solutions</td>
</tr>
<tr>
<td>NQF #</td>
<td>Measure Title</td>
<td>Measure Description</td>
<td>Numerator/Denominator</td>
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</tr>
<tr>
<td>1768</td>
<td>5. Plan — All Cause Readmission</td>
<td>For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.</td>
<td>NUMERATOR DESCRIPTION Count the number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination. DENOMINATOR DESCRIPTION Count the number of Index Hospital Stays for each age, gender, and total combination.</td>
</tr>
<tr>
<td>0418</td>
<td>6. Screening for Clinical Depression and Follow-up Plan</td>
<td>Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool and follow-up documented</td>
<td>NUMERATOR DESCRIPTION Total number of patients from the denominator who have follow-up documentation. DENOMINATOR DESCRIPTION All patients 18 years and older screened for clinical depression using a standardized tool.</td>
</tr>
<tr>
<td>0004</td>
<td>7. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</td>
<td>Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received the following: &gt; Initiation of AOD treatment. &gt; Engagement of AOD treatment.</td>
<td>NUMERATOR DESCRIPTION Initiation of AOD dependence treatment: Members with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis. Engagement of AOD treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations with any AOD diagnosis within 30 days after the date of the initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers to be counted. DENOMINATOR DESCRIPTION Members 13 years of age and older as of December 31 of the measurement year with a new episode of AOD during the intake period, reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators.</td>
</tr>
<tr>
<td>0018</td>
<td>8. Controlling High Blood Pressure</td>
<td>The percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (&lt;140/90) during the measurement year.</td>
<td>NUMERATOR DESCRIPTION The number of patients in the denominator whose most recent, representative BP is adequately controlled during the measurement year. For a member’s BP to be controlled, both the systolic and diastolic BP must be &lt;140/90mm Hg. DENOMINATOR DESCRIPTION Patients 18–85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the first six months of the measurement year.</td>
</tr>
</tbody>
</table>
ENDNOTES

1. For a recent review, see Scott D, Happell B. “The high prevalence of poor physical health and unhealthy lifestyle behaviors in individuals with severe mental illness. Issues in Mental Health Nursing 2011;32(9):589-97

2. The Best Practices in Schizophrenia Treatment (BEST) Center of the Northeastern Ohio Medical University and the Health Foundation of Greater Cincinnati commissioned Health Management Associates to conduct a study documenting the business case for integrated physical and behavioral healthcare. The final report is available at www.neomed.edu/academics/bestcenter/integratingprimaryandmentalhealthcare.


5. The Patient Protection and Affordable Care Act (PPACA, P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA, P.L. 111-152), is collectively referred to in this paper as the Affordable Care Act of 2010.


10. Ibid.

11. Ibid.

12. Assumes all states adopt the Medicaid expansion. Estimate drops to 11 million with the expectation that not all states will adopt the expansion.


14. See www.neomed.edu/academics/bestcenter/integratingprimaryandmentalhealthcare.

15. Ambulatory Care Sensitive Conditions (ACSC) are medical conditions for which physicians broadly concur that a substantial proportion of cases should not advance to the point where hospitalization is needed if they are treated in a timely fashion with adequate primary care and managed properly on an outpatient basis. Examples include asthma and diabetes.

16. Federal Medical Assistance Percentages (FMAP) are the percentage rates used to determine the matching funds rate allocated annually to states for Medicaid.

17. Missouri and Rhode Island each have two separate SPAs with focuses on different chronic conditions, so as of now there are nine approved SPAs in seven states.

18. CMS will soon migrate these resources to the Medicaid.gov.

19. State Medicaid agencies may request CMS approval to access federal matching funds to offset state expenses incurred in the planning and design of health home services.

20. See www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Eligibility.html for a discussion on current Medicaid eligibility requirements.

21. Community health teams operate through an interdisciplinary model that can include home visits, and they include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractic, licensed complementary and alternative medical practitioners, and physician assistants. See Section 3502 of the ACA (in the Social Security Act § 1945(h)(5) and (6)), as added by Section 2703 of the ACA.


25. The National Council for Behavioral Health offers trainings that support both the provider who is newly providing whole health services and the consumer who needs support in understanding the impact of primary care on their behavioral health needs and developing whole health goals that will improve their quality of life.

26. Missouri Medical Model Data Lab, Health Home Services Forms

27. New York State Health Home SPA for Individuals with Chronic Behavioral and Medical Health Conditions

28. North Carolina Health Home SPA for individuals with chronic conditions

29. Oregon's state plan for patient-centered primary care homes for individuals with chronic conditions

30. Rhode Island health home state plan amendment for serious mental illness

31. Draft 2703 Health Homes Quality Reporting Guidance issued by CMS to states involved in Health Home State Plan discussions.

32. Draft 2703 Health Homes Quality Reporting Guidance issued by CMS to states involved in Health Home State Plan discussions. Official quality measurement guidance is expected from CMS in 2013.

33. A patient registry is intended to facilitate the delivery of health home services and stratify populations by risk and aggregate data from external sources (e.g., electronic medical records, hospital admit/discharge systems, shared info from other partner health organizations). The registry will also assist in the development of care plans, facilitate provider empanelment, and determine tasks to be completed by members of health care teams, create disease management protocols and generate reports. The patient care registry will support care coordination and identify individuals who require telephonic support or reminders based on embedded protocols, provide templates for risk assessment and patient surveys, identify outstanding care items and provide medication lists. The registry will also create education materials and tools to support health promotion.
ENDNOTES

34. www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-%E2%80%93PM-Adult-Health-Care-Quality-Measures.html

35. “Meaningful use” means providers need to show, and states need to confirm, that certified electronic health record technology is used in ways that can be measured in both quality and in quantity. Also, see www.medicaidhitechta.org/Resources/library/MeaningfulUse.aspx.


40. Section 3022 of the Affordable Care Act or Section 1899 of the Social Security Act

41. In a 2007 report entitled, Integrating Publicly Funded Physical and Behavioral Health Services: A Description of Selected Initiatives, Health Management Associates found that one of the most frequently cited barriers to integration was the lack of payment for care/case management and care coordination. The report is available at www.rwjf.org/pr/product.jsp?id=19271.