

Health Home State Plan Amendment

Submission Summary

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

Name of Health Homes Program: Care Management for Beneficiaries with Chronic Conditions

State Information

State/Territory name: District of Columbia

Medicaid Agency: District of Columbia Department of Health Care Finance

Authorized Submitter and Key Contacts

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Proposed Effective Date: 4/1/2017

Executive Summary

Summary description including goals and objectives: The District of Columbia's (DC) Department of Health Care Finance (DHCF) developed DC's Health Home (HH) state plan benefit for beneficiaries with chronic conditions. The goals of DHCF's HH program for beneficiaries with chronic conditions are to improve the integration of medical and behavioral health, community supports and social services; to lower rates of avoidable emergency department (ED) use; to reduce preventable hospital admissions and re-admissions; to reduce healthcare costs; to improve the experience of care, quality of life and beneficiary satisfaction; and to improve health outcomes. Under DHCF's approach, the HH will be the central point for coordinating patient-centered and population-focused care for beneficiaries with multiple chronic conditions. HH providers will be embedded in the primary care setting to effectively manage the full breadth of beneficiary needs. A beneficiary can only be enrolled and receive HH services from one HH at a time. DHCF will ensure payments to HH providers do not duplicate payments for comparable services financed by Medicaid. HH services will be consistent with, but not limited to, those set forth under 42 C.F.R. § 440.169.

Federal Budget Impact

Federal Fiscal Year		Amount
First Year	2017	
Second Year	2018	

Federal Statute/Regulation Citation

Governor's Office Review

No Comment

Comments received:

No response within 45 days.

Other:

Submission – Public Notice

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

- Public notice was not required and comment was not solicited
- Public notice was not required, but comment was solicited
- Public notice was required, and comment was solicited

Indicate how public notice was solicited:

- Newspaper Announcement

Name:

Date of Publication:

Locations Covered:

- Publication in State's administrative record, in accordance with the administrative procedures requirements

Date of Publication 9/30/2016

- Email to Electronic Mailing List or Similar Mechanism.

Date of Email or other electronic notification:

Description:

- Website Notice

Select the type of website:

- Website of the State Medicaid Agency or Responsible Agency

Date of Posting:

Website URL: <http://dhcf.dc.gov>

- Website for State Regulations

Date of Posting:

Website URL:

- Other Website

Type:

Date of Posting:

URL:

Public Hearing or Meeting

Date: 10/15/2015

Time: 3:00 pm – 4:30 pm

Location: 441 4th Street NW, Washington, DC 20001

Date: 10/28/2015

Time: 3:00 pm – 4:30 pm

Location: 441 4th Street NW, Washington, DC 20001

Date: 11/12/2015

Time: 3:00 pm – 4:30 pm

Location: 441 4th Street NW, Washington, DC 20001

Date: 11/23/2015

Time: 3:00 pm – 4:30 pm

Location: 441 4th Street NW, Washington, DC 20001

Date: 12/9/2015

Time: 3:00 pm – 4:30 pm

Location: 441 4th Street NW, Washington, DC 20001

Date: 1/12/2016

Time: 3:00 pm – 4:30 pm

Location: 441 4th Street NW, Washington, DC 20001

Date: 1/20/2016

Time: 3:00 pm – 4:30 pm

Location: 441 4th Street NW, Washington, DC 20001

Date: 2/3/2016

Time: 3:00 pm – 4:30 pm

Location: 441 4th Street NW, Washington, DC 20001

Date: 3/2/2016

Time: 3:00 pm – 4:30 pm

Location: 441 4th Street NW, Washington, DC 20001

Date: 4/25/2016

Time: 3:00 pm – 4:30 pm

Location: 441 4th Street NW, Washington, DC 20001

Other Method

Name:

Date:

Description:

Submission – SAMHSA Consultation

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

Date of consultation: 06/09/2016

Health Homes Population Criteria and Enrollment

Population Criteria

Three or more chronic conditions.

Specify the conditions included:

Mental Health Condition (Depression; Personality Disorders)

Substance Use Disorder

Asthma (+Chronic Obstructive Pulmonary Disease (COPD))

Diabetes

Heart Disease (Congestive Heart Failure (CHF); Conduction Disorders/Cardiac Dysrhythmias;
Myocardial Infarction; Pulmonary Heart Disease)

Body Mass Index (BMI) over 25 (Morbid Obesity only)

Other Chronic Conditions

Cerebrovascular Disease; Chronic Renal Failure (On Dialysis); Hepatitis; HIV; Hyperlipidemia;
Hypertension; Malignancies; Paralysis; Peripheral Atherosclerosis; Sickle Cell Anemia

Geographic Limitations

Health Homes services will be available statewide

Enrollment of Participants

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

Opt-In to Health Homes provider

Describe the process used:

Automatic Assignment with Opt-Out of Health Homes provider

Describe the process used:

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

DHCF is implementing an opt-out method to enroll eligible Medicaid beneficiaries into HHs. Under this methodology, eligible beneficiaries will be auto-assigned based on past experience with HH providers, using up to a two year look back of Medicaid claims. If a beneficiary does not have a prior relationship with a HH provider, the beneficiary will be auto-assigned based on geography and/or provider capacity. Once a beneficiary is assigned to a HH, DHCF will communicate information about the HH program to the beneficiary, including the beneficiary's rights under the opt-out process. Specifically, DHCF will send a letter to the eligible beneficiary to notify the beneficiary of HH eligibility, provide information on the beneficiary's assigned HH, and explain the beneficiary's rights to choose another HH if desired or to opt-out of the program, as well as the processes through which the beneficiary may exercise these rights. DHCF will also communicate information about the HH program to HH and non-HH providers with past experience with the beneficiary to help ensure the beneficiary is receiving consistent information from their network of providers. Additional information and protocols for informing beneficiaries of their eligibility for HH services and their option of service providers will be described in the DC Municipal Regulations (DCMR).

Other

Describe:

- The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**
- The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Home services.**
- The State provides assurance that hospitals participating under the State Plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.**
- The State provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each Health Homes enrollee will be claimed. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.**
- The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

Health Homes Providers

Types of Health Home Providers

Designated Providers

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

Clinical Practices and Clinical Group Practices

The HH team of health care professionals will be embedded in the primary care setting to effectively manage the full breadth of beneficiary needs.

Each HH beneficiary will be attributed to a designated clinical practice or clinical group practice that will serve as his/her HH. In addition to the scope of services normally delivered by the clinical practice or clinical group practice, this entity will construct an interdisciplinary team to deliver HH services. Specific HH services will include: assessing the HH beneficiary to develop a comprehensive care plan; managing chronic illnesses; coordinating specialty care and referrals to social, community, and long-term care supports; providing comprehensive care management; and twenty-four (24) hour, seven (7) day a week access to clinical advice. HH providers will be paid a per member per month (PMPM) fee for HH services. A risk adjustment tool will stratify the population into two acuity cohorts: Group 1 (lower risk) and Group 2 (higher risk), with a higher PMPM fee for HH services delivered to beneficiaries in Group 2.

Each HH team must be adequately staffed by health care professionals that, at a minimum, are capable of providing specific functions to meet Federal and District HH standards, and must be comprised of practitioners (or comparable practitioners approved by DHCF) who fill the following roles for each acuity group of HH beneficiaries:

Group 1, Lower Acuity: 1) HH Director- Master's level education in a health-related field; 2) Nurse Care Manager- nurse with an advanced practice license or Bachelor of Nursing with appropriate care management experience; and 3) Peer Navigator – a trained health educator capable of linking beneficiaries with the health and social services they need to achieve wellness; and

Group 2, Higher Acuity: 1) HH Director- Master's level education in a health-related field; 2) Nurse Care Manager- nurse with an advanced practice license or a Bachelor of Nursing with appropriate care management experience; 3) Peer Navigator – a trained health educator capable of linking beneficiaries with the health and social services they need to achieve wellness, 4) Care Coordinator- a Bachelor-level social worker or an individual with a Bachelor's degree in a health-related field with training in a health care, human services field or equivalent experience; and 5) Clinical Pharmacist – a Doctor of Pharmacy with education and training in direct patient care environments, including medical centers, clinics, and other health care settings.

HH team members must meet all applicable licensure and certification requirements of the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.* (2012 Repl. & 2015 Supp.)) and attendant regulations contained in Title 17 of the DCMR.

The minimum ratio for each required HH staff member to HH beneficiary will be listed in the DCMR. DHCF will establish a process to allow HHs to request approval to utilize an alternative comparable staffing model. Finally, HHs are encouraged to add additional roles to HH teams that reflect the needs of their empaneled members (e.g. dietician).

Federally Qualified Health Center (FQHC)

The HH team of health care professionals will be embedded in the primary care setting to effectively manage the full breadth of beneficiary needs.

Each HH beneficiary will be attributed to a designated FQHC that will serve as his/her HH. In addition to the scope of services delivered as a primary care provider (e.g. acute and preventive care), the FQHC will construct an interdisciplinary team to deliver HH services. Specific HH services will include: assessing the HH beneficiary to develop a comprehensive care plan; managing chronic illnesses; coordinating specialty care and referrals to social, community, and long-term care supports; providing comprehensive care management; and twenty-four (24) hour, seven (7) day a week access to clinical advice. HH providers will be paid a PMPM fee for HH services. A risk adjustment tool will stratify the population into two acuity cohorts: Group 1 (lower risk) and Group 2 (higher risk), with a higher PMPM fee for HH services delivered to beneficiaries in Group 2.

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Official Code §§ 3-1201.01 *et seq.* (2012 Repl. & 2015 Supp.)) and attendant regulations contained in Title 17 of the DCMR.

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Supports for Health Home Providers

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

- 1. Provide quality-driven, cost-effective, culturally appropriate, and person-and family-centered Health Homes services,**
- 2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines,**
- 3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders,**
- 4. Coordinate and provide access to mental health and substance abuse services,**
- 5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participations in discharge planning and facilitation transfer from a pediatric to an adult system of health care,**
- 6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families,**
- 7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services,**
- 8. Coordinate and provide access to long-term care supports and services,**
- 9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and Non-clinical health-care related needs and services,**
- 10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provider feedback to practices, as feasible and appropriate,**
- 11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.**

Description: The HH program is a provider-facing program overseen by DHCF. DHCF is committed to, directly or indirectly, provide technical assistance with, but not limited to IT and data support (e.g. CRISP HIE) and care management to aide in the success of the HHs. The types of assistance may include: a) training to support HHs' development and implementation of electronic information infrastructure, culturally appropriate HH care plans, policies and practices, and ability to conduct

data analytics and financial modeling; b) continuous quality improvement by fostering shared learning, information sharing and joint problem solving through periodic meetings and other means to facilitate an open dialogue; and c) educational opportunities, coaching, and collaborative learning programs to support the provision of evidence-based, timely, and high-quality HH services that are whole-person focused and that integrate medical and behavioral health, transitional care, community supports and social services.

DHCF will communicate externally to other agencies, health care providers, and community stakeholders to facilitate HH referrals and the collaborative engagement of those entities with HHs as they coordinate the delivery of health care services. HHs will have access to real-time hospital and ER use alerts of their enrolled beneficiaries through CRISP, and further support via a coordinated HH care plan embedded in their certified electronic health record (EHR) technology. The HH care plan includes primary, acute and long term health care information to achieve an individualized, comprehensive approach for health care treatment and self-management. It will also serve as a source of information for monitoring and evaluation purposes. DHCF will work collaboratively with HHs to monitor program implementation, respond to learning needs that emerge, and establish HH performance monitoring activities to ensure HHs' services meet District and federal individualized and population-focused standards.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services.

Designated providers of HH services for beneficiaries with chronic conditions will be Clinical Practices, Clinical Group Practices or FQHCs identified by DHCF to meet the standards of a HH. The Clinical Practices, Clinical Group Practices or FQHCs will lead a team of health care professionals who deliver HH services to HH beneficiaries. Additionally, the Clinical Practices, Clinical Group Practices or FQHCs are responsible for developing working relationships and partnership agreements, as appropriate, with managed care organizations (MCOs), other community-based service providers, hospitals and other health-related entities that deliver services to their enrolled beneficiaries in order to adequately deliver HH services. HHs will use their certified EHR technology to facilitate the delivery of the six (6) core HH services, and will use their EHRs to capture and track services provided to enrolled HH beneficiaries.

Provider Standards

The State's minimum requirements and expectations for Health Home providers are as follows:

HHs will operate under a "whole-person" approach to care within a culture of continuous quality improvement that looks at a HH beneficiary's full array of clinical and non-clinical health care needs and services and social needs and services. HHs will deliberately organize culturally appropriate, person-centered care activities and share information among all practitioners directly involved with a person's care to achieve safer, more effective care and improved health outcomes. The below standards were developed with input from a variety of stakeholders including primary care physicians, FQHCs, hospitals, clinics, and housing providers. Representatives from DC's Departments of Health, Behavioral Health, and Human Services, DC's Health Information Exchange Policy Board, and DC's Interagency Council for

Homelessness also participated in the development of these standards. The standards set the foundation for assuring that HH beneficiaries receive appropriate, and timely access to medical, behavioral, and social services in a coordinated and integrated manner.

A. Eligibility Standards: In order to be eligible to serve as a HH provider in the DC Medicaid program, entities must, at minimum:

1. Be enrolled as a DC Medicaid provider;
2. Not have current or pending exclusions, suspensions, or debarment from any District or federal health care program; and
3. Maintain compliance with the Enrollment and Maintenance Standards in Sections B and C, as outlined below.

B. Enrollment Standards: In order to be enrolled as a HH provider in the DC Medicaid program, entities must apply to become a HH provider. DHCF will review the application based on the following enrollment standards:

1. Having NCQA Patient-Centered Medical Home (PCMH) Level 2 recognition (or future corresponding NCQA PCMH equivalent level recognition) or proof of beginning the NCQA PCMH application process.
2. Using certified EHR technology to create and execute a person-centered care plan for each beneficiary based on HH assessments, hospital data and information gathered from other external health care providers.
3. Providing 24/7 access to clinical advice, including culturally appropriate translation and interpretation services for beneficiaries with limited English proficiency;
4. Demonstrating sufficient core team member capacity to serve eligible beneficiaries including, at a minimum, qualified practitioners to fill the following roles for each acuity group of HH beneficiaries: Group 1, Lower Acuity: HH Director, Nurse Care Manager, and Peer Navigator; and Group 2, Higher Acuity: HH Director, Nurse Care Manager, Peer Navigator, Care Coordinator, and Clinical Pharmacist. DHCF will establish protocols for HH providers to report program changes in order to maintain compliance with Section A, B, and C.
5. Demonstrating ability to deliver core HH services, as well as document the processes used to perform the following functions:
 - a. Providing quality-driven, cost-effective, culturally appropriate, and person-and family-centered HH services;

- b. Coordinating and providing access to high-quality health care services informed by evidence-based clinical practice guidelines;
 - c. Coordinating and providing access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
 - d. Coordinating and providing access to mental health and substance abuse services;
 - e. Coordinating and providing access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up and inpatient to other settings, such as participations in discharge planning and facilitation transfer from a pediatric to an adult system of health care;
 - f. Coordinating and providing access to long-term care supports and services;
 - g. Developing a person-centered care plan for each beneficiary that coordinates and integrates all of his or her clinical and non-clinical healthcare related needs and services; and
 - h. Establishing a continuous quality improvement program.
6. Demonstrating that the HH will be able to directly provide, or subcontract for the provision of, HH services. The HH remains responsible for all HH program requirements, including services provided by the subcontractor.
7. Developing a plan to establish and maintain communication protocols with external health care partners, including legally compliant data sharing agreements, to assure effective coordination and monitoring of beneficiaries' health care services and for efficient transitional care; and
8. Enrolling or demonstrating enrollment in CRISP to receive hospital and ER alerts for enrolled beneficiaries.
- C. Maintenance Standards:** In order to maintain enrollment as a HH provider in the DC Medicaid program, entities must:
- 1. Participate in activities supporting the successful implementation and sustainability of HH services. Activities may include, but are not limited to: trainings to foster professional competency and best practice development related to person-centered planning, chronic disease self-management, and other topics; continuous quality improvement tasks, monitoring and performance reporting; and CMS and DHCF-required evaluations.
 - 2. Maintain compliance with the Eligibility and Enrollment Standards identified in Sections A and B, as outlined above. DHCF will establish protocols for HH providers to report program changes in order to maintain compliance with Sections A and B, as outlined above.

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

Fee for Service

The population of Medicaid beneficiaries eligible to receive HH services includes beneficiaries with chronic conditions enrolled in Medicaid under the fee-for-service system. DHCF administers the District's Medicaid fee-for-service system and will reimburse all HH providers directly for HH services delivered to beneficiaries in the fee-for-service population.

 Risk Based Managed Care

The population of Medicaid beneficiaries eligible to receive HH services includes beneficiaries with chronic conditions enrolled in risk-based managed care. DHCF administers the District's Medicaid managed care program, and, after competitive procurement, contracts with licensed managed care entities to be Medicaid MCOs.

DHCF will reimburse all HH providers directly for HH services delivered to beneficiaries in the MCO population. MCO capitation rates will not change as a result of HH implementation. At a set frequency stated in the DCMR and Medicaid MCO contracts, DHCF will forward a report to each MCO that: 1) lists enrollees eligible for the HH program, including enrollees currently attributed to a HH; and 2) lists enrolled HH providers. DHCF will establish a process to allow MCOs to refer eligible enrollees to HHs for services. With guidance from DHCF, each MCO will develop a Memorandum of Agreement (MOA) with each HH delivering services to its enrollees. The MOA will detail how both entities will partner to deliver services to beneficiaries enrolled in the MCO's case management program and a HH, as well as how both entities will partner to deliver services to beneficiaries not enrolled in the MCO's case management program. Specific guidance on the collaboration requirements between HHs and MCOs will be in the DCMR and MCO contractual language.

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

The current capitation rate will be reduced.

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

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

Modifications to the current Medicaid MCO contracts will be executed to ensure MCOs and the downstream HHs included within their MCO provider networks implement functional collaboration in primary, acute, behavioral health, and long-term services and supports integration. MCOs will be expected to leverage relationships between the HH and their MCO-enrolled beneficiaries in meeting their contractual population-based service coordination mandates. For beneficiaries enrolled in both a HH and an MCO, the HH and MCO will establish a Memorandum of Agreement (MOA) that sets the communication frequency and protocol for: 1) identifying beneficiaries receiving services from both entities; 2) developing a joint care plan or aligning individual care plans for each shared

beneficiary, and clear division of labor for the provision of care coordination and case management services, reflected in each entity's respective care plan for each shared beneficiary; 3) outlines types of HH services delivered or that will be delivered to the shared beneficiary; 4) flagging each other on new information necessary for coordinating services, such as failure to pick up medication, recent housing status, new community-based supports, and others; and 5) establishing audit and program monitoring arrangements. This MOA will specify the point of contact for each entity. MCOs are expected to follow DHCF's established process to link eligible beneficiaries to an appropriate HH.

Other:

Health Home Payment Methodologies

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

Fee for Service

Fee for Service Rates based on:

Severity of each individual's chronic conditions

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

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

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

Other: Describe

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

Per Member, Per Month Rates

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee-for-service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and

other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

DHCF will use two (2) per member per month (PMPM) rates to reimburse for HH services that differ based on the assessed acuity of the Medicaid beneficiary. DHCF developed these rates by analyzing FY 2014 and 2015 Medicaid claims data to identify the most common chronic conditions associated with more frequent ER use and/or hospital admissions. Through the analysis, DHCF identified the top sixteen (16) chronic conditions, which include: mental health conditions (depression, personality disorders); substance use disorders; asthma (+COPD); diabetes; heart disease (CHF, conduction disorders/cardiac dysrhythmias, myocardial infarction, pulmonary heart disease); BMI over 25 (morbid obesity only); cerebrovascular disease; chronic renal failure [on dialysis]; hepatitis; HIV; hyperlipidemia; hypertension; malignancies; paralysis; peripheral atherosclerosis; and sickle cell anemia. DHCF will utilize a risk adjustment tool to determine the risk for future hospital utilization, and target and stratify the population into two acuity cohorts: Group 1 (lower risk) and Group 2 (higher risk). The methodology will be used to place the higher risk beneficiaries in Group 2 and the remainder of eligible beneficiaries in Group 1.

The two (2) resulting rates are based on the DHCF HH staffing model and reflect the average expected service intensity for those receiving HH services, and will be set in accordance with Section 1902(a)(30)(A) of the Social Security Act (42 U.S.C. § 1396a(a)(30)(A)). DHCF will pay a higher PMPM rate for beneficiaries in Group 2 (higher acuity) due to a higher expected need for HH services and requisite staff. The base PMPM rates for both Group 1 (lower acuity) and Group 2 (higher acuity) account for the regionally adjusted salaries for the required HH staff (including fringe costs) and is adjusted based on staffing ratios per acuity group. Two (2) payment enhancements are added on top of both base rates: 1) to reflect overhead or administrative costs; and 2) to support HH providers in meeting the health information technology requirements. The payment methodology and rates will be further outlined in the DCMR. DHCF will review the HH rates annually and re-base as necessary.

In order to receive the first PMPM payment for an eligible HH beneficiary, a HH provider must inform the HH beneficiary about available HH services, receive the beneficiary's consent to receive HH services, and begin the development of a care plan. The development of the care plan will follow standards for Comprehensive Care Management described below. HH providers must deliver at least one (1) HH service within the calendar month to the eligible HH beneficiary in order to receive a PMPM that month. For beneficiaries in Group 1, the HH service does not need to be delivered in-person for the provider to be eligible for the PMPM payment. For beneficiaries in Group 2, at least one (1) HH service needs to be delivered in-person for the provider to be eligible for the PMPM payment.

HH rates will be made available on the DHCF fee schedule at <https://www.dc-medicaid.com/dcwebportal/home>.

Incentive payment reimbursement

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

DHCF plans to implement a pay-for-performance component that provides incentive payments to HH providers for achieving quality/performance benchmarks. DHCF will ensure the methodology used to calculate and disburse incentive payments is consistent with the HH program goals of efficiency, economy and quality.

In only the first quarter of the first year of the program, HH providers will be eligible for a one time incentive payment to support the development of care plans (as described in the definition of Comprehensive Care Management) for HH beneficiaries.. Further guidance on the incentive payment will be outlined in the DCMR.

HH providers will also be eligible to receive an annual pay-for-performance bonus payment, no sooner than the last quarter of the second full Fiscal Year after the effective date of the program. HH provider performance will be evaluated by process, efficiency, and outcome categories. DHCF will inform HH providers prior to the start of each Fiscal Year the target performance for each measure category, based on an analysis of prior performance. HH providers will be subject to a percentage withhold of their PMPM, no sooner than the first quarter of the second full Fiscal Year after the effective date of the program. The HH provider must achieve the target performance for each measure in the category to achieve the incentive payment for that category. Subject to available funding, HH providers may earn an incentive payment higher than the amount withheld. Further guidance on the pay-for-performance component will be outlined in the DCMR.

Explain how the State will ensure Non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.

DHCF will ensure that HH service payments will not duplicate payment for Medicaid-funded services offered through another method (i.e. managed care, 1915(c) waivers, any future HH state plan benefits, and other state plan services). DHCF will utilize the DCMR, provider guidance materials, and MOAs to clarify roles of providers offering similar services to promote a complementary system of services that advances whole-person care and ensures non-duplication of payment or services. In

instances of known duplication, DHCF will leverage its Medicaid Management Information System (MMIS) to systematically restrict duplicative provider payments. Programs with services similar to HH and DHCF's strategy to address them are outlined below.

DC has two 1915(c) waivers, the Elderly and Persons with Physical Disabilities (EPD) Waiver and the Individuals with Intellectual and Developmental Disabilities (IDD) Waiver. Both waivers provide Medicaid-reimbursable case management services. Currently, EPD case managers receive reimbursement to develop and execute a person-centered care plan for beneficiaries enrolled in the EPD Waiver program. Functions provided by EPD case managers also include assessments to determine unmet needs related to waiver services, planning of services provided under the waiver, submission of requests for the authorization of waiver services, and monitoring of service provision. Similarly, IDD service coordinators currently receive reimbursement to coordinate and facilitate the provision of quality services and supports, review the implementation and delivery of services and supports identified in the Individual Support Plan (ISP), take corrective action as necessary, assist with problem solving, and advocate for the person and his/her family. To prevent duplication of services, DHCF will establish a process to ensure beneficiaries receiving case management services from the EPD or IDD waiver will not concurrently receive HH services.

HH services will add to, and not duplicate, the clinical care coordination services provided under the Adult Substance Abuse Rehabilitative Services (ASARS) Medicaid State Plan benefit, where clinical coordinators focus on ways to ensure care plans include services that address a beneficiary's substance use disorder. To prevent duplication of services, DHCF will establish a process to ensure HH providers coordinate and collaborate with the ASARS providers and leverage their work in order to advance the "whole-person" approach to care and supports the beneficiary's full array of clinical and non-clinical health care needs.

HHs will partner with DC Medicaid MCOs through MOAs containing clearly defined roles and responsibilities for each party. Additional guidance will be supplied to HHs and MCOs in the DCMR and MCO contracts in order to avoid duplicative efforts and to ensure timely communication, care transition planning, use of evidence-based referrals, and follow-up consultations with appropriate health service providers. HHs will include the MCO, as appropriate, when creating or updating the HH care plan. The HHs and MCOs will be expected to develop protocols for sharing information on care planning and patient care. HHs will identify any gaps in service needs for HH enrolled beneficiaries regardless of the programs from which the beneficiaries receive services.

When applicable to a particular HH provider that is otherwise reimbursed for providing care management or coordination services, DHCF will prevent duplicative payments by furnishing a differential payment to that provider, reducing payment by the amount of the duplicative service. Additionally, a beneficiary may not be enrolled in more than one HH in a given month.

DHCF does not cover targeted case management services under 1915(g). As such, there is no risk of duplication of payment for targeted case management services.

The State provides assurances that all governmental and private providers are reimbursed according to the same rate schedule.

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

Submission – Categories of Individuals and Populations Provided Health Homes Services

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

Categorically Needy eligibility groups

Service Definitions

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

Comprehensive Care Management

Definition:

Comprehensive care management (CCM) is the creation, documentation, execution, and updating of a person-centered plan of care. CCM services address stages of health and disease to maximize current functionality and prevent beneficiaries from developing additional chronic conditions and complications. These services include, but are not limited to conducting a comprehensive biopsychosocial needs assessment to determine the risks and whole-person service needs and lead the HH team through the collection of behavioral, primary, acute and long-term care information from all health and social service providers (e.g. from existing MHRS Diagnostic Assessments and individual service plans; physical assessments from other PCPs; hospital discharge planners; etc.) to create a person-centered, continuous, and integrated HH care plan for every enrolled beneficiary. HHs will use a strengths-based approach in developing the HH care plan that identifies the positive attributes of the beneficiary, which includes assessing his/her strengths and preferences health and social services, and end of life planning. Each HH team will update the care plan for each empaneled beneficiary at set intervals (as detailed in the DCMR), whenever there has been a significant change in condition, and following an unplanned inpatient stay. The HH team will monitor the beneficiary’s health status, engage the beneficiary in HH services and their own care, and progress toward goals in the care plan documenting changes and adjusting the plan as needed. The HH care plan is created and updated in the HH’s certified EHR technology, along with documented activities completed to create and maintain the HH care plan. Many activities of this HH component may be provided by any HH team member, but are driven by protocols and guidelines developed by the Nurse Care Manager or comparable health care professional.

Describe how Health information technology will be used to link this service in a comprehensive approach across the care continuum All HH provides will be required to utilize a certified EHR

technology which will allow providers to report and review an HH beneficiary’s intake, assessment results, assigned HH team, integrated HH care plans, clinical baselines and data related to chronic conditions, as well as HH services provided, such as referrals made and health promotion activities completed. HHs will be responsible for establishing an informed consent process, including a process for obtaining consent to share patient data across the HH provider continuum. Additionally:

- HHs will be required to utilize CRISP, or other HIE services as directed by DHCF, to receive hospital event alerts (e.g. emergency department visits; hospital admissions, transfers and discharges) that will help HHs create a person-centered HH care plan.
- HHs may have access to a Dynamic Patient Care Profile tool currently being developed through CMS Implementation Advanced Planning Document (IAPD) funding support. The tool will be an “on-demand” document made available to Meaningful Use Eligible Providers (EP) and Eligible Hospitals (EH), in addition to members of their care team, that would display an aggregation of critical data (both clinical and administrative) for a selected patient.
- HHs may have access to Electronic Clinical Quality Measurement Tool and Dashboard, an electronic clinical quality measurement (eCQM) tool to route inbound Continuity of Care documents (CCD) (as outlined in 2015 Edition Health Information Technology Certification Criteria, 2015 Edition Base Electronic Health Record Definition, and ONC Health IT Certification Program Modifications or subsequent releases) from eligible Medicaid hospitals and practices to support required quality calculations and reporting; develop a population-level dashboard accessible by EPs and EHs for patient panel management.
- HHs may have access to an Analytical Patient Population Dashboard, also being developed with support from IAPD funds to enable EPs and EHs to perform panel-level analysis on their associated patient populations
- HHs are expected to share structured data utilizing Consolidated Clinical Document Architecture (C-CDA) (as outlined in 2015 Edition Health Information Technology Certification Criteria, 2015 Edition Base Electronic Health Record Definition, and ONC Health IT Certification Program Modifications or subsequent releases) or other certified data exchange standards to a designated HIE entity(ies) in the District.

Scope of benefit/service

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

Other (specify): FQHCs; Clinical Practices and Clinical Group Practices

Care Coordination

Definition: Care coordination is the implementation of the HH care plan through appropriate linkages, referrals, coordination and follow-up to needed services and support. Care coordination includes, but is not limited to:

- appointment scheduling and providing telephonic reminders of appointments;
- assisting the beneficiary in navigating health, behavioral health, and social services systems, including housing as needed;

- community-based outreach and follow-up, including face-to-face contact with beneficiaries in settings in which they reside, which may include shelters, streets or other locations for unsheltered persons;
- telephonic outreach and follow-up to beneficiaries who do not require face-to-face contact;
- ensuring that all regular screenings are conducted through coordination with the primary care or other appropriate providers;
- assisting with medication reconciliation;
- assisting with arrangements such as transportation, directions and completion of durable medical equipment requests;
- obtaining missing records and consultation reports;
- encouraging the beneficiary's decision-making and continued participation in HH care plan;
- participating in hospital and emergency department transition care;
- documentation in the certified EHR technology; and
- Ensuring that beneficiary is connected to and maintains eligibility for any public benefits to which the beneficiary may be entitled, including Medicaid

HHs will have partnerships with DC Medicaid MCOs, primary care providers, specialists, and behavioral health providers, as well as community based organizations. Within these partnerships, the roles and responsibilities for each party will be clearly defined, and guided by the DCMR, in order to avoid duplicative efforts, and to ensure timely communication, use of evidence-based referrals, and follow-up consultations. HHs will ensure that screenings appropriate for specific chronic conditions are conducted through coordination with the appropriate providers.

Care coordination services may be provided by any member of the Health Home team, but are driven by protocols and guidelines developed by the Nurse Care Manager or comparable health care professional, in collaboration with any other appropriate health care professional (e.g. the beneficiary's mental health and substance use disorder (SUD) practitioners).

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum: HHs will use their certified EHR technology to report and review referrals made to outside providers, social and community resources and individual and family supports. Through this system, HHs will have access to each beneficiary's historical service utilization which will allow better tracking of the beneficiary's needs, services received, and the identification of opportunities for improved care coordination.

To enable critical information exchange, all HHs will utilize CRISP, or other HIE services as directed by DHCF, to receive hospital event alerts (e.g. emergency department visits; hospital admissions, transfers and discharges) and both generate and receive continuity of care information. Additionally, HHs may be able to benefit from the historical information (updated in near real-time) through the Dynamic Patient Care Profile and the capabilities in the Analytical Patient Population Dashboard to inform the care coordination services delivered.

Scope of benefit/service

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

Other (specify): FQHCs; Clinical Practices and Clinical Group Practices

Health Promotion

Definition: Health promotion is the provision of health education to the beneficiary (and family member/significant other when appropriate) specific to his/her chronic conditions or needs as identified in his/her HH care plan. This service includes, but is not limited to, assistance with medication reconciliation and provides assistance for the beneficiary to develop a self-management plan, self-monitoring and management skills and promotion of a healthy lifestyle and wellness (e.g. substance abuse prevention; smoking prevention and cessation; nutrition counseling; increasing physical activity; etc.). Health promotion may also involve connecting the beneficiary with peer/recovery supports including self-help/self-management and advocacy groups, providing support for improving a beneficiary's social network, and educating the beneficiary about accessing care in appropriate settings. Health promotion may also involve the assessment of the beneficiary's understanding of their health conditions and motivation to engage in self-management, and using coaching and evidence-based practices such as motivational interviewing to enhance understanding and motivation to achieve health and social goals. HH team members will document the results of health promotion activities (e.g. beneficiary requesting additional nutrition counseling; beneficiary selecting a date to quit smoking; successful linkage with a community-based support group) in the beneficiary's care plan, and ensure health promotion activities align with the beneficiary's stated health and social goals.

Each HH will use data to identify and prioritize particular areas of need with regard to health promotion; research best-practice interventions; implement the activities in group and individual settings; evaluate the effectiveness of the interventions, and modify them accordingly.

Health promotion services may be provided by any member of the Health Home team, but are driven by protocols and guidelines developed by the Nurse Care Manager or comparable health care professional in collaboration with the provider's mental health and substance use disorder (SUD) practitioners.

Describe how Health information technology will be used to link this service in a comprehensive approach across the care continuum: All HHs will use their certified EHR technology to document, review, and report health promotion services delivered to each beneficiary. Additionally, clinical data such as height, weight and BMI will be recorded and reported in the certified EHR technology. Additionally, structured data shared through C-CDAs or C-CDA equivalent approaches and the capabilities of the Analytical Patient Population Dashboard holds the potential to support health promotion activities of HH providers.

Scope of benefit/service

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

Other (specify): FQHCs; Clinical Practices and Clinical Group Practices

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

Definition: Comprehensive transitional care is the planned coordination of transitions between health care providers and settings in order to reduce hospital emergency department and inpatient admissions, readmissions and length of stay. An aim of comprehensive transitional care is to increase the beneficiary's and family members' ability to manage care and live safely in the community, shifting the use of reactive or emergency care and treatment to proactive health promotion and self-management. HHs will automatically receive notifications of emergency room visits, admissions, discharges and transfers (ADT) from hospitals as part of HHs' enrollment in CRISP, and will contact hospitals from which notifications are received to ensure appropriate follow-up care after transitions. HHs will conduct in-person outreach prior to discharge or up to twenty-four (24) hours after discharge to support transition from inpatient to other care settings. They will schedule visits for beneficiaries with a primary care provider and/or specialist within one (1) week of discharge. HHs will have a clear protocol for responding to ADT alerts from hospitals or any other inpatient facility to facilitate collaboration in treatment, discharge, and safe transitional care. Services as part of beneficiary contacts during transitions include but are not limited to: a) reviewing the discharge summary and instructions; b) performing medication reconciliation; c) ensuring that follow-up appointments and tests are scheduled and coordinated; d) assessing the patient's risk status for readmission to the hospital or other failure to obtain appropriate, community-based care; e) arranging for follow-up care management, if indicated in the discharge plan; and f) planning appropriate care/place to stay post-discharge, including facilitating linkages to temporary or permanent housing and arranging transportation as needed for transitional care and follow-up medical appointments. This HH component is provided primarily by the Nurse Care Manager and Care Coordinator or comparable provider.

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

To enable critical information exchange, all HHs will enroll with CRISP, or other HIE services as directed by DHCF, to receive hospital event alerts (e.g. emergency department visits; hospital admissions, transfers and discharges) and both generate and receive continuity of care information. MCOs also receive hospital alerts through CRISP. To the extent that hospitals and other inpatient settings have care transition programs, HHs are expected to coordinate with hospital discharge planners to prevent duplication of services and to ensure that all essential functions of an effective care transition have been performed. Additionally, HHs may benefit from the historical information (updated in near real-time) through the Dynamic Patient Care Profile, structured data shared through C-CDAs or C-CDA equivalent approaches, and the capabilities in the Analytical Patient Population Dashboard to inform transitional care efforts.

Scope of benefit/service

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

Other (specify): FQHCs; Clinical Practices and Clinical Group Practices

Individual and family support services, which includes authorized representatives

Definition: Individual and family support services are activities that help the beneficiary and their support team (including family and authorized representatives) in identifying and meeting their range of biopsychosocial needs and accessing resources. These services include, but are not limited to, medical transportation, language interpretation, appropriate literacy materials, housing assistance, and any other needed services. The services provide for continuity in relationships between the beneficiary/family with their physician and other health service providers and can include communicating on the beneficiary and family's behalf. These services may also educate the beneficiary in self-management of their chronic conditions, provide opportunities for the family to participate in assessment and care treatment plan development, and ensure that HH services are delivered in a manner that is culturally and linguistically appropriate. Additionally, these services may include referrals to support services and to facilitate linkages that are available in the beneficiary's community and assist with the establishment of and connection to "natural supports." These services may promote personal independence, assist and support the beneficiary in stressor situations, empower the beneficiary to improve their own environment, include the beneficiary's family in the quality improvement process including surveys to capture their experience with HH services, and allow beneficiaries/families access to electronic health record information or other clinical information. Where appropriate, the HH will develop family support materials and services, including creating family support groups.

This HH component is provided by any member of the HH team, but will be primarily facilitated by the Care Coordinator or comparable provider, in line with the beneficiary's care plan, and driven by protocols and guidelines developed by the Nurse Care Manager or comparable provider.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum: All HHs will use their certified EHR technology, to document, review, and report family support services delivered to each beneficiary. Additionally, HHs may benefit from the historical information (updated in near real-time) through the Dynamic Patient Care Profile and the capabilities in the Analytical Patient Population Dashboard to inform individual and family support efforts.

Scope of benefit/service

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

Other (specify): FQHCs; Clinical Practices and Clinical Group Practices

Referral to community and social support services, if relevant

Definition: Referral to community and social support services is the process of connecting HH beneficiaries to a wide array of support services that will help them overcome access or service barriers, increase self-management skills, and achieve overall health. These services include, but are not limited to, facilitating access to support and assistance for beneficiaries to address medical, behavioral, educational, economic, social and community issues that may impact overall health. For persons experiencing homelessness, this support may include individual housing transition services, as described in the June 26, 2015 Center for Medicaid & CHIP Services (CMCS) Informational Bulletin. The types of community and social support services to which beneficiaries will be referred may include, but are not limited to: a) wellness programs, including smoking cessation, fitness,

weight loss programs; b) specialized support groups (e.g. cancer; diabetes support groups; etc.); c) substance treatment, support groups, recovery coaches, and 12-step programs; d) housing resources, including additional housing and tenancy sustaining services; e) social integration; f) financial assistance such as Temporary Cash Assistance for Needy Families (TANF) or Social Security; g) Supplemental Nutrition Assistance Program; h) employment and educational program or training; i) legal assistance resources; j) faith-based organizations; and k) child care. HHs will assist in coordinating the services listed above, facilitating linkages and helping address barriers to accessing services, and following up with beneficiaries to ensure that needed services have been received. The HH will develop and monitor cooperative agreements with community and social support agencies in order to establish collaboration, follow-up, and reporting standards and provide training and technical assistance as needed regarding the special needs of the population.

This HH component is provided by any member of the HH team, but will be primarily facilitated by the Care Coordinator, in line with the beneficiary's care plan, and driven by protocols and guidelines developed by the Nurse Care Manager or comparable provider.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum: All HHs will use certified EHR technology to document, report and review referrals to community-based resources. Additionally, HHs may benefit from the historical information (updated in near real-time) through the Dynamic Patient Care Profile.

Scope of benefit/service

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

Other (specify): FQHCs; Clinical Practices and Clinical Group Practices

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:

An eligible HH beneficiary will receive written notice from DHCF about being auto-assigned to a HH. This notice will include information about the HH program, including the beneficiary's rights under the opt-out process (i.e. assignment to a HH team, HH services are free, enrollment is optional, not enrolling does not impact current services). This notice will be supplemented by HH provider outreach, which will be initiated once DHCF communicates information about the HH program to HH and non-HH providers with past experience with the beneficiary. This notice is to help ensure the beneficiary is receiving consistent information from their network of providers. Subsequently, the beneficiary can anticipate outreach from the HH provider that will include an informed consent process. The provider must document the beneficiary's written informed consent to participate in the HH program, which the beneficiary may provide during a planned or newly scheduled visit. At that visit, the beneficiary should expect to participate in an assessment to inform the development of a comprehensive care plan. As part of this process, the beneficiary should also anticipate that the

HH provider will gather health information from the beneficiary's other healthcare providers (e.g. MCOs; specialists; etc.) and conduct health risk screens (e.g. depression; substance abuse; etc.). The beneficiary should also anticipate that the Nurse Care Manager (NCM) or comparable provider and will review/discuss assessment results, health goals and health care priorities with the beneficiary during the visit. The beneficiary and multi-disciplinary HH team will agree upon and document a comprehensive HH care plan that addresses wellness and self-management goals for any assessed needs. Subsequently, the beneficiary can expect the HH team to deliver HH services that enable the beneficiary to meet the goals outlined in the care plan. Moving forward, the beneficiary should expect the HH team to work with their primary care provider and other providers as necessary; and to be linked with any additional providers if necessary. The beneficiary will be monitored daily by the HH team through reviews of hospital ADT feeds to determine if the beneficiary used the ER or was admitted to the hospital. The beneficiary will be monitored weekly by the HH team through case rounds to track progress and plan accordingly for interventions/interactions based on patient acuity and need. The beneficiary will be monitored quarterly through reviews of updated registries and care plan statuses conducted by the NCM. If the NCM identifies emerging issues warranting changes, the beneficiary should anticipate follow-up (e.g. re-assessment, revised/increased levels of activity). Beneficiary issues that may trigger additional levels of activity include, but are not limited to, medication management, care compliance, outlier lab values, and progress controlling BMI levels, tobacco use, and metabolic screening values. The beneficiary should anticipate their HH care plan being updated at least every three hundred sixty-five (365) days or when there is a significant change in their condition.

Medically Needy eligibility groups

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

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:

In line with the technical specifications for the core HH measures, DHCF will collect all-cause thirty (30) day readmissions for all beneficiaries enrolled in the HH program, using DHCF claims data.

Data are reported in the following categories:

- Denominator: Count of Index Hospital Stays (IHS)
- Numerator: Count of 30-Day Readmissions

DHCF will calculate and report this measure in alignment with NCQA HEDIS specifications per CMS mandated Health Home measure.

While claims data will be an important source of information related to hospital admissions and readmissions, the time lag of this data is not ideal for real time management of patient care. For that reason, a connection to CRISP will be made available to provide real-time admissions, discharge and transfer feeds from participating hospitals.

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

DHCF will use historical claims and encounter data from Fiscal Years 2014 through 2016 to establish a baseline and expected trend on medical spending for the eligible HH population. DHCF will then compare expected spending with actual spending. The difference between expected spending and actual spending will represent cost savings. DHCF may also compare a cohort of beneficiaries who have enrolled in the HH program with a cohort of similar beneficiaries who are eligible for the program but not enrolled.

DHCF will also compare costs related to services or utilization including, but not limited to, emergency room utilization, hospitalizations, nursing facility admissions, and pharmacy utilization. This will enable DHCF to understand the overall impact of the program, not just on total spending, but on whether utilization reflects the types of services expected for a given patient (pharmacy, primary care, substance abuse treatment, etc.) or is found in areas that could still indicate poor care coordination (like ER and hospital inpatient). DHCF will analyze each HH for its overall impact on total cost of care and health care utilization, and then compare their performance to other HHs in DC to inform future policy decisions and ways to promote continuous quality improvement.

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

All HH providers will be required to utilize certified EHR technology which will allow providers to report and review a beneficiary's intake, assessment results, assigned HH team, integrated HH care plans, clinical baselines and data related to chronic conditions, as well as HH services provided, such as referrals made and health promotion activities completed. Additionally, HHs are expected to use data from CRISP, or other HIE services as directed by DHCF, to receive hospital event alerts (e.g. emergency department visits; hospital admissions, transfers and discharges) that will help HHs create a person-centered HH care plan. The HHs will also have access to Dynamic Patient Care Profile tool currently being developed through CMS IAPD funding support. The tool will be an "on-demand" document made available to Meaningful Use EPs and EHs, in addition to members of their care team, that would display an aggregation of critical data (both clinical and administrative) for a selected patient. The HHs will have access to Electronic Clinical Quality Measurement Tool and Dashboard, an electronic clinical quality measurement (eCQM) tool to route inbound CCDs from eligible Medicaid hospitals and practices to support required quality calculations and reporting; develop a population-level dashboard accessible by EPs and EHs for patient panel management. The HHs will also have access to an Analytical Patient Population Dashboard, also being developed with support from IAPD funds to enable EPs and EHs to perform panel-level analysis on their associated patient populations. Finally, all HHs will be required to share C-CDA or C-CDA equivalent structured data to one of the designated HIE entities in the District.

Quality Measurement

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

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

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

Evaluations

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

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

Hospital Admissions

Measure: Plan All-Cause Readmissions Rate

Measure Specifications, including a description of the numerator and denominator.

DHCF will calculate the percentage of acute inpatient (i.e., index hospital) stays during the measurement year that were followed by an acute readmission for any diagnosis within thirty (30) days and the predicted probability of an acute readmission for Health Home beneficiaries age eighteen (18) and older.

Denominator: The eligible population

Numerator: At least one acute readmission for any diagnosis within 30 days of the index discharge date.

DHCF will calculate and report this measure as outlined in the CMS Health Home measure specifications.

Data Sources: Administrative Data - MMIS claims and encounter data

Frequency of Data Collection:

- Monthly
- Quarterly
- Annually
- Continuously
- Other Daily

Measure: Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite

Measure Specifications, including a description of the numerator and denominator.

DC will calculate the number of hospital admissions for ambulatory care sensitive chronic conditions per 1,000 HH beneficiaries age 18 and older. This measure includes adult hospital admissions for diabetes with short- and long-term complications; uncontrolled diabetes without complications; diabetes with lower-extremity amputation; chronic obstructive pulmonary disease; asthma; hypertension; heart failure; or angina without a cardiac procedure.

Denominator: The eligible population enrolled in a HH program during the measurement year.

Numerator: Of the eligible population, the numerator will include discharges for patients who meet the inclusion and exclusion rules for the numerator in any of the following Prevention Quality Indicators (PQIs):

- PQI 1: Diabetes Short-Term Complications Admission

- PQI 3: Diabetes Long-Term Complications Admission
- PQI 5: COPD or Asthma in Older Adults Admission
- PQI 7: Hypertension Admission
- PQI 8: Heart Failure Admission
- PQI 13: Angina without Procedure Admission
- PQI 14: Uncontrolled Diabetes Admission
- PQI 15: Asthma in Younger Adults Admission
- PQI 16: Lower-Extremity Amputations Among Patients with Diabetes

Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator.

This measure will be reported in as outlined in the CMS Health Home measure specifications.

Data Sources: Administrative Data - MMIS claims and encounter data

Frequency of Data Collection:

- Monthly
- Quarterly
- Annually
- Continuously
- Other Daily

Measure: Inpatient Utilization

Measure Specifications, including a description of the numerator and denominator.

DC will calculate the rate of acute inpatient care and services (total, maternity, mental health, surgery, and medicine) per 1,000 beneficiary months among HH beneficiaries.

Denominator: Number of enrollee months

Numerator: Inpatient utilization and by discharge date, rather than by admission date, and including all discharges that occurred during the measurement year.

The measure will be reported in as outlined in the CMS Health Home measure specifications.

Data Sources: Administrative Data - MMIS claims and encounter data

Frequency of Data Collection:

- Monthly
- Quarterly
- Annually
- Continuously
- Other Daily

Emergency Room Visits

Measure: Ambulatory Care – Emergency Department Visits

Measure Specifications, including a description of the numerator and denominator.

Rate of emergency department (ED) visits per 1,000 enrollee months among Health Home enrollees.

Denominator: Number of enrollee months

Numerator: Number of ED visits

The measure will be reported in as outlined in the CMS Health Home measure specifications.

Data Sources: Administrative Data - MMIS claims and encounter data.

Frequency of Data Collection:

- Monthly
- Quarterly
- Annually
- Continuously
- Other

Skilled Nursing Facility Admissions

Measure: Nursing Facility Utilization

Measure Specifications, including a description of the numerator and denominator.

The number of admissions to a nursing facility from the community that result in a short-term (less than 101 days) or long-term stay (greater than or equal to 101 days) during the measurement year per 1,000 enrollee months.

Denominator: 1,000 Enrollee Months

Numerator: Count of Short Term and Long Term Admissions

The measure will be reported in as outlined in the CMS Health Home measure specifications.

Data Sources: Administrative Data - MMIS claims and encounter data.

Frequency of Data Collection:

- Monthly
- Quarterly
- Annually
- Continuously
- Other

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

Hospital Admission Rates: Hospital admissions are collected through claims data for admits provided under fee-for-service and through encounter data for admits provided under risk based managed care. The outline performance measures along with two additional data points around low acuity non-emergent emergency rooms visits and potentially preventable admissions will be used to evaluate hospital admission rates.

Chronic Disease Management: A comprehensive person-centered care plan will be developed for each HH beneficiary. DHCF's evaluation will include outcome measurement using nationally recognized performance measures in alignment with DHCF's agency-wide care coordination/case management strategy. The metrics will include data collected from administrative data as well as hybrid data as appropriate.

Coordination of Care for Individuals with Chronic Conditions: Chronic disease management data is collected through administrative claims/encounter data, NCM assessments, HH payment records, and HH encounter data verifying services received by beneficiaries (e.g., primary care, mental health, SUD treatment, mental health services, prescriptions, etc.). This data is obtained through DHCF's MMIS payment system. NCM notes and assessments provide evidence of interaction and referrals and will be evaluated at time of monitoring. DHCF will monitor health home performance by reviewing a sample of care plans in accordance with requirements outlined in the DCMR.

Assessment of Program Implementation: The DC HH program, at a minimum, will monitor:

- Rate of active beneficiary participation;
- Rate of timely completed assessments;

- Rate of timely completed care plans;
- Frequency of and type of services provided to HH beneficiaries; and
- HH services delivered in accordance with the type, scope, amount, frequency, and duration outlined in the care plan.

Processes and Lessons Learned: DHCF will implement quality and process improvement programs that will track performance and provide oversight and assistance to ensure providers are implementing a continuous quality improvement strategy. Participation and adherence to DHCF’s quality strategy, policies, procedures, and any future DHCF quality initiative will be required of HH beneficiaries.

Assessment of Quality Improvements and Clinical Outcomes: DHCF will collect the “Core Set of Health Care Quality Measures for Medicaid Health Home Programs,” found at: <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/health-home-core-set-manual.pdf>. DHCF may add additional metrics beyond those required by CMS for the HH program.

Estimates of Cost Savings

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

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