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Health Homes Intro

MEDICAID - Health Homes - My Health GPS - DC - 2016

CMS-10434 OMB 0938-1188

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Submission Type Official - Review 1

Approval Date 2/6/2017

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Initial Submission Date 11/10/2016

Effective Date 7/1/2017

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Program Authority

+/-

1945 of the Social Security Act

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

Name of Health Homes Program My Health GPS

Executive Summary

+/-

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

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.

General Assurances

+/-

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

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

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

☑ The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.

☑ 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.

☑ The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

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Health Homes Population and Enrollment Criteria

MEDICAID - Health Homes - My Health GPS - DC - 2016

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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 (Mandatory and Options for Coverage) Eligibility Groups

☑ Medically Needy Eligibility Groups

Mandatory Medically Needy

☑ Medically Needy Pregnant Women

☑ Medically Needy Children under Age 18

Optional Medically Needy (select the groups included in the population)

Families and Adults

☑ Medically Needy Children Age 18 through 20

☑ Medically Needy Parents and Other Caretaker Relatives

Aged, Blind and Disabled

☑ Medically Needy Aged, Blind or Disabled

☑ Medically Needy Blind or Disabled Individuals Eligible in 1973

Population Criteria

+/-

The state elects to offer Health Homes services to individuals with

☑ Two or more chronic conditions

Specify the conditions included

☑ Mental Health Condition

☑ Substance Use Disorder

☑ Asthma

☑ Diabetes

☑ Heart Disease

☐ BMI over 25

☑ Other (specify)

Name	Description
Chronic Obstructive Pulmonary Disease	N/A
Cerebrovascular Disease	N/A
Chronic Renal Failure	On dialysis
Hepatitis	N/A
Human Immunodeficiency Virus	N/A
Hyperlipidemia	N/A
Hypertension	N/A
Malignancies	N/A
Paralysis	N/A
Peripheral Atherosclerosis	N/A
Sickle Cell Anemia	N/A
Morbid Obesity	BMI over 35

1-12 of 12

☐ One chronic condition and the risk of developing another

☐ One serious and persistent mental health condition

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

◉ Referral and assignment to Health Homes provider with opt-out

○ Other (describe)

Describe the process used

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).

☑ The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Homes benefit or to change Health Homes providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individuals of the Health Homes benefit and their rights to choose or change Health Homes providers or to elect not to receive the benefit

Name	Date Created	Type
HH2 Bene NotificationLtr (2)JB 2016 .09.07	10/28/2016 4:46 PM EDT	PDF

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Health Homes Geographic Limitations

MEDICAID - Health Homes - My Health GPS - DC - 2016

CMS-10434 OMB 0938-1188

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Superseded SPA ID	N/A		

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- (•) Health Homes services will be available statewide
- ( ) Health Homes services will be limited to the following geographic areas
- ( ) Health Homes services will be provided in a geographic phased-in approach

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Health Homes Services

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Service Definitions

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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 providers 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 service

The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists
- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☐ Nurses
- ☐ Medical Specialists
- ☐ Physicians
- ☐ Physician's Assistants
- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☑ Other (specify)

Provider Type	Description
FQHCs; Clinical Practices and Clinical Group Practices	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.

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 service

The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists
- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☐ Nurses
- ☐ Medical Specialists
- ☐ Physicians
- ☐ Physician's Assistants
- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☑ Other (specify)

Provider Type	Description
FQHCs; Clinical Practices and Clinical Group Practices	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).

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 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

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 service

The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists
- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☐ Nurses
- ☐ Medical Specialists
- ☐ Physicians

- ☐ Physician's Assistants
- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☑ Other (specify)

Provider Type	Description
FQHCs; Clinical Practices and Clinical Group Practices	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 beneficiary's mental health and substance use disorder (SUD) practitioners.

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 service

The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists
- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☐ Nurses
- ☐ Medical Specialists
- ☐ Physicians
- ☐ Physician's Assistants
- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists

☑ Other (specify)

Provider Type	Description
FQHCs; Clinical Practices and Clinical Group Practices	This HH component is provided primarily by the Nurse Care Manager and Care Coordinator or comparable provider.

Individual and Family Support (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 development of the person-centered plan of care, 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 service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

☐ Nurse Practitioner

☐ Nurse Care Coordinators

☐ Nurses

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☑ Other (specify)

Provider Type	Description
FQHCs; Clinical Practices and Clinical Group Practices	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.

Referral to Community and Social Support Services

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 service

The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists
- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☐ Nurses
- ☐ Medical Specialists
- ☐ Physicians
- ☐ Physician's Assistants
- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☑ Other (specify)

Provider Type	Description
FQHCs; Clinical Practices and Clinical Group Practices	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.

Health Homes Patient Flow

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Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment 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.

Name	Date Created	Type
DC Patient Flow for SPA docx	10/28/2016 5:33 PM EDT	

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Health Homes Providers

MEDICAID - Health Homes - My Health GPS - DC - 2016

CMS-10434 OMB 0938-1188

Not Started | In Progress | Complete

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Package ID DC2016MH0001O

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Initial Submission Date 11/10/2016

Effective Date 7/1/2017

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Types of Health Homes Providers

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☑ Designated Providers

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

☐ Physicians

☑ Clinical Practices or Clinical Group Practices

Describe the Provider Qualifications and Standards

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).

☐ Rural Health Clinics

☐ Community Health Centers

☐ Community Mental Health Centers

☐ Home Health Agencies

☐ Case Management Agencies

☐ Community/Behavioral Health Agencies

☑ Federally Qualified Health Centers (FQHC)

Describe the Provider Qualifications and Standards

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.
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 a 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).

☐ Other (Specify)

☐ Teams of Health Care Professionals

☐ Health Teams

Provider Infrastructure

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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.

Supports for Health Homes Providers

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

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

Description

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 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.

Other Health Homes Provider Standards

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The state's requirements and expectations for Health Homes 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.

Name	Date Created	Type
No items available		

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Records / Submission Packages

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Health Homes Service Delivery Systems

MEDICAID - Health Homes - My Health GPS - DC - 2016

CMS-10434 OMB 0938-1188

Not Started | In Progress | Complete

Package Header

Package ID DC2016MH0001O

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Approval Date 2/6/2017

Superseded SPA ID N/A

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Initial Submission Date 11/10/2016

Effective Date 7/1/2017

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

- [x] Fee for Service
- [ ] PCCM
- [x] Risk Based Managed Care

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

- ( ) Yes
- (•) No

Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be avoided

- [ ] The current capitation rate will be reduced
- [x] 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

☐ Other Service Delivery System

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Health Homes Payment Methodologies

MEDICAID - Health Homes - My Health GPS - DC - 2016

CMS-10434 OMB 0938-1188

Not Started | In Progress | Complete

Package Header

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Payment Methodology

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

- [x] Fee for Service
  - [ ] Individual Rates Per Service
  - [x] Per Member, Per Month Rates
    - [x] Fee for Service Rates based on
      - [x] Severity of each individual's chronic conditions
      - [x] Capabilities of the team of health care professionals, designated provider, or health team
      - [ ] Other
  - [ ] Comprehensive Methodology Included in the Plan
  - [x] Incentive Payment Reimbursement
    - [x] Fee for Service Rates based on
      - [ ] Severity of each individual's chronic conditions
      - [ ] Capabilities of the team of health care professionals, designated provider, or health team
      - [x] Other

Describe below

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. 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, available at: www.dcregs.dc.gov, with an effective date of July 1, 2017.

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

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. Providers will submit claims via MMIS using a specific procedure code for health home services. Additionally, providers will be required to utilize a modifier on the procedure code that itemizes which of the health home services was delivered.

Any claim for program services shall be supported by written documentation in the EHR and the DCMR will provide clear instructions on minimum documentation requirements. All claims for health home services will be subject to regular audits to ensure that Medicaid payments made to health home providers are consistent with efficiency, economy and quality of care, and made in accordance with federal and District conditions of payment.

Information on the PMPM rates will be made available through the DCMR, available at: www.dcregs.dc.gov, with an effective date of July 1, 2017.

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

☐ PCCM (description included in Service Delivery section)

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

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

Agency Rates

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Describe the rates used

○ FFS Rates included in plan
● Comprehensive methodology included in plan
○ The agency rates are set as of the following date and are effective for services provided on or after that date

Rate Development

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Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates
2. Please identify the reimbursable unit(s) of service
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
4. Please describe the state's standards and process required for service documentation, and
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
   - the frequency with which the state will review the rates, and
   - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description

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. Providers will submit claims via MMIS using a specific procedure code for health home services. Additionally, providers will be required to utilize a modifier on the procedure code that itemizes which of the health home services was delivered.

Any claim for program services shall be supported by written documentation in the EHR and the DCMR will provide clear instructions on minimum documentation requirements. All claims for health home services will be subject to regular audits to ensure that Medicaid payments made to health home providers are consistent with efficiency, economy and quality of care, and made in accordance with federal and District conditions of payment.

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

Assurances

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☑ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved

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 meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), 1902(a)(30)(A), and 1903 with respect to non-payment for provider-preventable conditions.

☑ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☑ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

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Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID - Health Homes - My Health GPS - DC - 2016

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Monitoring

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Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates

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 may 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 may 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 may 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 and Evaluation

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☑ The state provides assurance 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

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

☑ The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report

Go to HHQM Reports

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