Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | DC2017MS0010O | DC-18-0006 | My DC Health Home

Package Header

Package ID	DC2017MS0010O	**SPA ID**	DC-18-0006
Submission Type	Official	**Initial Submission Date**	8/13/2018
Approval Date	2/21/2019	**Effective Date**	N/A
Superseded SPA ID	N/A		

Executive Summary

Summary Description Including Goals and Objectives

The District of Columbia's (DC) Departments of Health Care Finance and Behavioral Health partnered to develop the DC's Health Home (HH) state plan benefit for individuals with serious and persistent mental health illness (SMI). The goals of DC's HH program for individuals with SMI are aligned with those of CMS and are to improve the integration of physical and behavioral health care; lower rates of hospital ED use; reduce avoidable hospital admissions and re-admissions; reduce healthcare costs; improve the experience of care, quality of life and consumer satisfaction; and improve health outcomes. Under DC's approach, the HH is the central point for coordinating patient-centered and population-focused care for both behavioral health and other medical services. To leverage already established relationships between the SMI population and community mental health providers, Core Services Agencies (CSAs) and Freestanding Mental Health Clinics (FSMHC) regulated and certified by DBH will deliver the HH benefit. The HH program enables CSAs and FSMHC to add primary and other physical health-care focused individuals to existing care teams in order to achieve an interdisciplinary team approach that integrates behavioral, primary and acute health services. Medicaid beneficiaries enrolled in the Home and Community-Based Services (HCBS) Waiver for the Elderly and Individuals with Physical Disabilities and Medicaid beneficiaries enrolled in the HCBS Waiver for Persons with Intellectual and Developmental Disabilities are not eligible to participate in the HH program. An individual can only be enrolled in one HH at a time. While enrolled in a HH, an individual can concurrently receive all MHRS with the exception of the Assertive Community Treatment program. Communication and collaboration within HHs and among external health care partners will be supported by DBH's web-based electronic medical record and billing system.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2019	$1248935
Second	2020	$974403

Federal Statute / Regulation Citation

42 USC § 1396w-4

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created

No items available

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Governor's Office Review

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ● Other

Describe As part of the District State Plan Amendment development process, the Mayor's Office is informed of and has the opportunity to provide feedback on all state plan amendment's prior to submission to CMS. Any feedback received from the Mayor's Office is reflected in this submission.

Submission - Public Comment

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

- ○ Public notice was not federally required and comment was not solicited
- ○ Public notice was not federally required, but comment was solicited
- ◉ Public notice was federally required and comment was solicited

Indicate how public comment was solicited:

- ☐ Newspaper Announcement
- ☐ Publication in state's administrative record, in accordance with the administrative procedures requirements — **Date of Publication:** Jan 11, 2019
- ☐ Email to Electronic Mailing List or Similar Mechanism
- ☐ Website Notice
- ☐ Public Hearing or Meeting
- ☐ Other method

Upload copies of public notices and other documents used

Name	Date Created
Health Care Finance Department of 29 DCMR Ch. 8 and Ch. 69 Medicaid Reimbursement for Health Home Services	1/4/2019 11:50 AM EST
22A DCMR Ch. 25 Health Home Certification Standards	1/11/2019 3:15 PM EST

Upload with this application a written summary of public comments received (optional)

Name	Date Created
No items available	

Indicate the key issues raised during the public comment period (optional)

- ☐ Access
- ☐ Quality
- ☐ Cost
- ☐ Payment methodology
- ☐ Eligibility
- ☐ Benefits
- ☐ Service delivery
- ☐ Other issue

Submission - Tribal Input

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Name of Health Homes Program

My DC Health Home

One or more Indian health programs or Urban Indian Organizations furnish health care services in this state

- ○ Yes
- ● No

Submission - Other Comment

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Superseded SPA ID N/A

SAMHSA Consultation

Name of Health Homes Program

My DC Health Home

Date of consultation

4/20/2015

☐ 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.

Health Homes Intro

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	User-Entered		

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 DC Health Home

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) and Department of Behavioral Health (DBH) partnered to develop the DC's Health Home (HH) state plan benefit for individuals with serious and persistent mental health illness (SMI). The goals of DC's HH program for individuals with SMI are aligned with those of CMS and are to improve the integration of physical and behavioral health care; lower rates of hospital ED use; reduce avoidable hospital admissions and re-admissions; reduce healthcare costs; improve the experience of care, quality of life and consumer satisfaction; and improve health outcomes. Under DC's approach, the HH is the central point for coordinating patient-centered and population-focused care for both behavioral health and other medical services. To leverage already established relationships between the SMI population and community mental health providers, Core Services Agencies (CSAs) and Free Standing Mental Health Clinics (FSMHC) will deliver the HH benefit. The HH program will add primary care focused individuals to the existing teams within the CSAs and FSMHC to achieve an interdisciplinary team approach that integrates behavioral, primary and acute health services. An individual can only be enrolled in one HH at a time. While enrolled in a HH, an individual can concurrently receive all MHRS with the exception of the Assertive Community Treatment program. Medicaid beneficiaries enrolled in the Home and Community-Based Services (HCBS) Waiver for the Elderly and Individuals with Physical Disabilities and Medicaid beneficiaries enrolled in the HCBS Waiver for Persons with Intellectual and Developmental Disabilities are not eligible to participate in the HH program. Communication and collaboration within HHs and with external health care partners is supported by DBH's web-based medical record and billing system.

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.

Health Homes Geographic Limitations

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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

Health Homes Population and Enrollment Criteria

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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

Health Homes Population and Enrollment Criteria

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Population Criteria

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

- [ ] Two or more chronic conditions
- [ ] One chronic condition and the risk of developing another
- [ ] One serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition:

Criteria for a serious and persistent mental health condition are defined in D.C. Code § 7-1131.02 (1f) and (24). Individuals eligible for HH services have a diagnosable mental, behavioral, or emotional disorder (including those of biological etiology) which substantially impairs the mental health of the person or is of sufficient duration to meet diagnostic criteria specified within the DSM-5 or its ICD-10-CM equivalent (and subsequent revisions) with the exception of DSM-5 "Z" codes, substance abuse disorders, intellectual disabilities and other developmental disorders, or seizure disorders, unless those exceptions co-occur with another diagnosable mental illness.

Health Homes Population and Enrollment Criteria

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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:

DBH will use an 'Opt-In' method to enroll eligible Medicaid individuals into HHs. DC will leverage existing relationships between CSAs and FSMHC with individuals with severe and persistent mental illness (SMI), and designate CSAs and/or FSMHC, which meet DC's criteria, as HHs. CSAs and FSMHC deliver the majority of community-based mental health services to Medicaid individuals with SMI. The enrollment process is as follows: 1) DC will identify eligible individuals to HHs based on the individual's health status and historical CSA/FSMHC service utilization found in Medicaid claims data; 2) DBH will send a letter to individuals to provide notification of HH eligibility, the individual's assigned HH and the process for choosing another HH if desired; and 3) the HH will engage each individual assigned and provide them information about the benefit and notify them of their right to Opt-in as well as the right withdraw consent to participate in the HH program once enrolled. Individuals with no recent MHRS claims will be attributed to a HH based on the current distribution of SMI individuals to CSAs or FSMHC. Individuals who elect not to receive HH services or withdraw consent to participate in the Benefit once enrolled may do so without jeopardizing their access to other medically necessary services, such as MHRS. Individuals who opt-out will be permitted to receive HH services in the future as long as they continue to meet HH eligibility requirements. Individuals new to Medicaid or newly diagnosed with an SMI will be eligible for this benefit. A protocol for informing new consumers of their eligibility for HH services and their options of service providers is described in the DC Municipal Regulations (DCMR).

Health Homes Providers

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Types of Health Homes Providers

☐ Designated Providers

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

☐ Physicians

☐ Clinical Practices or Clinical Group Practices

☐ Rural Health Clinics

☐ Community Health Centers

☐ Community Mental Health Centers

Describe the Provider Qualifications and Standards

Designated providers of HH services for individuals with SMI shall be CSAs and FSMHC identified by DC to meet the standards of a HH. CSA qualifications are listed in 22-A DCMR § 3400 et seq. To meet the HH standards, CSAs and FSMHC must be adequately staffed by teams of health care professionals. Required staff include: 1) Health Home Director- Master's level education in a health-related field; 2) Primary Care Liaison- nurse practitioner or physician, licensed dietitian or nutritionist, or other clinicians approved by DC; and 3) Nurse Care Manager- nurse with an advanced practice license or a registered nurse with experience in one or more areas of practice relevant to integrated chronic disease care management (i.e. adult health, family nurse practitioner, advanced primary care, other chronic disease specialties). HHs may also supplement a team of healthcare professionals with other types of clinicians or practitioners necessary to address the unique care coordination needs of enrolled consumers. Payment to HHs that elect to use supplemental team members will not receive additional payment and must ensure that required services can be performed within the established health home rate amounts. All clinicians must meet the requirements of Health Occupations and Revisions Act of 1985, and subsequent amendments thereto, and implementing regulations.

☐ Home Health Agencies

☐ Case Management Agencies

☐ Community/Behavioral Health Agencies

☐ Federally Qualified Health Centers (FQHC)

☐ Other (Specify)

☐ Teams of Health Care Professionals

☐ Health Teams

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

Designated providers of HH services to individuals with SMI will be CSAs and FSMHC identified by DC to meet the standards of a HH. Through DC's initial engagement efforts with potential HHs, DC will consider its analysis of HH eligible individuals and their existing relationships with CSAs and FSMHC, then solicit interest from as many CSAs and FSMHC that are interested and capable of meeting requirements to serve as HHs. HHs are responsible for developing working relationships and partnership agreements, as appropriate, with primary care and community based service providers to order to deliver HH services to enrolled individuals. On an ongoing basis, DBH will work collaboratively with DHCF to facilitate relationships between HHs and Medicaid primary care, long term care, acute care and other community and social services providers in order to coordinate services.

Supports for Health Homes Providers

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

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

Description

The HH program is a partnership between DHCF, DBH and providers. DC is committed to providing ongoing technical assistance, training, IT and data support, care management guides, and other assistance necessary to help HHs be successful. To support the launch of the program, DC will provide 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. Post program launch, DC will support HH's continuous quality improvement by fostering shared learning, information sharing and joint problem solving. Ongoing educational opportunities, coaching, and collaborative learning programs provided by DC will support the provision of evidence-based, timely, high-quality HH services that are whole-person focused and that integrate medical and behavioral health, community supports and social services. DC will communicate externally to other agencies, 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. Further HH support is a coordinated HH care plan embedded in DBH's approved integrated electronic medical record system. The HH care plan expands upon data gathered via the treatment planning process, to include 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. DC will maintain a close working relationship with HHs to monitor program implementation, respond to learning needs that emerge, and establish HH performance monitoring activities to ensure HHs' services meet DC's and CMS' individualized and population-focused standards.

Other Health Homes Provider Standards

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 an individual'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 the participants concerned with a person's care to achieve safer, more effective care and improved health outcomes.

At a minimum:
HHs must meet DBH's HH certification standards, as well as expectations for maintaining HH certification through active participation in ongoing HH program training, performance monitoring, reporting, and evaluation. Initial certification standards require a CSA or FSMHC to: 1) Provide a letter expressing interest to acquire HH certification and to continue compliance with Medicaid program requirements as a CSA or FSMHC; and 2) Participate in DC's HH readiness and infrastructure capacity activities, that include reviews of HH team staffing and ability to document and track HH services in DBH's approved integrated electronic medical record system.

As part of maintaining HH certification status, HHs will: 1) Maintain all required HH team staffing and submit reports indicating full time employee status, vacancies and others determined by DC; 2) Participate in CMS and DC-required evaluation activities and DC-sponsored activities that contribute to successful HH service delivery implementation and sustainability, such as a) collaborative leadership and professional development trainings to foster professional competency and best practice development; b) program monitoring and performance reporting, c) and continuous quality improvement activities; 3) Utilize resources made available by DC and through partnerships with external health care partners to conduct care management and care coordination services; 4) Participate in required program assessments, at a frequency determined by DC, to confirm that the HH meets all staffing and regulatory requirements, with an improvement plan in place to address deficiencies; 5) Establish data sharing agreements that are compliant with federal and DC laws and regulations that establish protocols with external health care partners to assure effective coordination and monitoring of HH enrollees' health care services and for efficient transitional care; and 6) ensure that enrolled beneficiaries do not receive services that duplicate Health Home services.

Name	Date Created
No items available	

Health Homes Service Delivery Systems

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

☐ Fee for Service

☐ PCCM

☐ 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

☐ 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

The population of Medicaid individuals eligible to receive HH services includes individuals with SMI enrolled in risk based managed care. DHCF administers the District's Medicaid managed care program, and after competitive procurement, contracts with licensed HMOs to be Medicaid Managed Care Organizations (MCOs). DC projects that the MCO capitation rates will not change as a result of HH implementation. Specific guidance on the collaboration between HHs and MCOs is in the DCMR and MCO contractual language.

Modifications to the current Medicaid MCO contracts will be executed to ensure MCOs and the downstream HHs included within their MCO provider networks truly collaborate in primary care and behavioral health service integration. MCOs will be expected to leverage relationships between the HH and their MCO-enrolled individuals in meeting their contractual population-based service coordination mandates. For individuals enrolled in both a HH and an MCO, the HH and MCO will communicate at a frequency specified by DHCF, DBH, and/or between the HH and MCO, where both parties discuss the types of HH services delivered or that will be delivered to the shared individual. MCOs are expected to refer eligible individuals to an appropriate HH, and the HH should partner with the MCOs, where appropriate, to ensure individuals receive timely access to needed health services.

☐ Other

☐ Other Service Delivery System

Health Homes Payment Methodologies

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Payment Methodology

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

- [ ] Fee for Service
  - [ ] Individual Rates Per Service
  - [ ] Per Member, Per Month Rates
    - [ ] 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
      - [ ] Other

        Describe below

        Indirect and overhead costs necessary to integrate behavioral and physical health needs.
  - [ ] Comprehensive Methodology Included in the Plan
  - [ ] Incentive Payment Reimbursement

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

DC will establish a single per member per month (PMPM) rate for payment of HH services. The rate calculation is based on the salary costs of the required team of health care professionals as well as indirect and overhead costs necessary to integrate behavioral and physical health needs.
DC will review the HH rates annually and re-base as necessary.

- [ ] 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)

Health Homes Payment Methodologies

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Agency Rates

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

Effective Date

Feb 1, 2019

Website where rates are displayed

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

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Rate Development

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 1) Cost data and assumptions that were used to develop the HH rate are attached below. Generally, (care team provider salary and fringe benefits) are divided by (minutes per month divided by average minutes spent with the client per month) to get the cost per patient per month for each care team provider. Overhead costs and expenses are added to this total to get a per member per month rate.
2) Reimbursable units of service include any of the HH services defined in the service definition section of this state plan.
3) a HH provider must bill at least one HH service a month to be eligible for the per member per month payment.
4) Providers shall document in writing and in forms prescribed by DBH a consumer's informed consent to opt-in or withdraw consent to participate in the Benefit once enrolled in the Health Home program. A Comprehensive Care Plan (CCP) is the document that drives the delivery of all services. The CCP shall be the plan that collates all the consumer's services and providers of service in order to reduce any instances of duplication of service, prioritize the consumer's goal(s) and monitor the progress of the goal(s) in the plan. Each Health Home shall utilize the DBH's designated electronic health record for documenting and billing all Health Home services. Health Home providers shall document each Health Home service and activity in the consumer's record in the DBH's designated electronic health record. Any claim for services shall be supported by written documentation which clearly identifies the specific service type rendered, date, duration, and actual time, a.m. or p.m. for both the beginning and ending times, during which the services were rendered, name, title, and credentials of the person who provided the services, setting in which the services were rendered, and confirmation that the services delivered are contained in the consumer's CCP.
5) DC shall review the per member per month rate, at least annually. DC shall review the provider costs (salary, fringe, and overhead) and the time spent delivering HH services to patients when determining the appropriateness of the per member per month rate.

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Assurances

☐ 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

HH service payments will not result in any duplication of payment or services between Medicaid programs, services, or benefits (i.e. managed care, other delivery systems including waivers, any future HH state plan benefits, and other state plan services).

HH services will add to, and not duplicate, the clinical care coordination services provided under the Mental Health Rehabilitative Services (MHRS) and 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, DBH 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 CCP. The HHs and MCOs will be expected to develop protocols for sharing information on care planning and patient care. HH will identify any gaps in service needs for the enrolled individuals regardless of the benefits from which the beneficiaries receive services.

Beneficiaries enrolled in Assertive Community Treatment, the Home and Community-Based Services (HCBS) Waiver for the Elderly and Individuals with Physical Disabilities, the HCBS Waiver for Persons with Intellectual and Developmental Disabilities, or another District Health Homes program are not eligible to participate in Health Homes I. 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 has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☐ 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).

Optional Supporting Material Upload

Name	Date Created
Cost and Assumptions	10/10/2017 2:23 PM EDT

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | DC2017MS0010O | DC-18-0006 | My DC Health Home

Package Header

Package ID	DC2017MS0010O	**SPA ID**	DC-18-0006
Submission Type	Official	**Initial Submission Date**	8/13/2018
Approval Date	2/21/2019	**Effective Date**	2/1/2019
Superseded SPA ID	15-005		

User-Entered

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) services address stages of health and disease to maximize current functionality and prevent individuals from developing additional chronic conditions and complications. As part of CCM Health Homes will use a standardized tool to assess the risks and whole-person service needs of individuals; collect behavioral, primary, acute and long-term care information from health and social service providers [e.g. from existing MHRS Diagnostic Assessments and individual recovery or treatment plans; physical assessments from PCPs; hospital discharge planners; etc.] to facilitate the creation of a person-centered care plan for every enrolled individual, that is updated at set intervals (as detailed in the DCMR) and following an unplanned inpatient stay; and monitor individual's health status and progress toward goals in the care plan documenting changes and adjusting the plan as needed. The care plan is – accessible in DBH's approved integrated electronic medical record system, along with documented activities completed to create and maintain the HH care plan. In addition, Health Homes will use aggregated data to determine levels of consumer engagement, progress toward CCM goals, and adherence to or variance from treatment guidelines. Based on this analysis, Health Homes will prioritize outreach, reminders and notifications to individuals and/or providers. Health Homes will systematically review and report quality metrics, assessment results, and service utilization in order to evaluate health status, service delivery, and consumer satisfaction.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

DBH's approved integrated electronic medical record system will provide integrated patient profiling and risk assessment, charting, care management and administrative functionality for managing service authorizations, payments and reports. All HHs will use DBH's approved integrated electronic medical record system. This system will allow HHs to report and review individual's intake, assessment results, assigned HH team, integrated CCP, clinical baselines and data related to chronic conditions, as well as HH services provided, such as referrals made and health promotion activities completed. Efforts will be made for the DBH approved integrated electronic medical record system to match external sources data such as ambulatory electronic medical records used by federally qualified health centers (FQHC) and primary care provider, hospital information systems, MCO and health information exchanges) to develop reports for Providers to use to stratify populations based on risk factors and to aggregate data. The system will also assist in the development of CCPs, facilitate provider empanelment, determine and assign tasks to HH team members, and create disease management protocols and generate reports.

Additionally, HHs are expected to use data from CRISP, or other HIE services as directed by DC, to receive hospital event alerts (e.g. emergency department visits; hospital admissions, transfers and discharges) that will help HHs create a person-centered CCP.

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

Provider Type	Description
Community Mental Health Centers	Designated providers of HH services for individuals with SMI shall be CSAs and FSMHC identified by DC to meet the standards of a HH. CSA qualifications are listed in 22-A DCMR § 3400 et seq. To meet the HH standards, CSAs and FSMHC must be adequately staffed by teams of health care professionals. Required staff include: 1) Health Home Director- Master's level education in a health-related field; 2) Primary Care Liaison- nurse practitioner or physician, licensed dietitian or nutritionist, or other clinicians approved by DC; and 3) Nurse Care Manager- nurse with an advanced practice license or a registered nurse with experience in one or more areas of practice relevant to integrated chronic disease care management (i.e. adult health, family nurse practitioner, advanced primary care, other chronic disease specialties). HHs may also supplement a team of healthcare professionals with other types of clinicians or practitioners necessary to address the unique care coordination needs of enrolled consumers. All clinicians must meet the requirements of Health Occupations and Revisions Act of 1985, and subsequent amendments thereto, and implementing regulations.

Care Coordination

Definition

Care coordination involves facilitating appropriate linkages, referrals, and coordination of needed services and support. Care coordination may involve, but is not limited to; scheduling appointments and providing telephonic reminders of appointments; telephonic outreach and follow-up to individuals 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 arrangements such as transportation, directions and completion of durable medical equipment requests; assisting in medication reconciliation; obtaining missing records and consultation reports; and participating in hospital and emergency department transition care planning.

Care coordination activities will be documented in DBH's approved integrated electronic medical record system. Health Homes will have partnerships with DC Medicaid Managed Care Organizations, primary care, 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. Health Homes will ensure that screenings appropriate for specific chronic conditions are conducted through coordination with the primary care or other appropriate providers.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

HHs will use DBH's approved integrated electronic medical record system 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 individual's historical service utilization which will allow better tracking of individual'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 DC, to receive hospital event alerts (e.g. emergency department visits; hospital admissions, transfers and discharges) and both generate and receive continuity of care information.

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

Provider Type	Description
Community Mental Health Centers	Designated providers of HH services for individuals with SMI shall be CSAs and FSMHC identified by DC to meet the standards of a HH. CSA qualifications are listed in 22-A DCMR § 3400 et seq. To meet the HH standards, CSAs and FSMHC must be adequately staffed by teams of health care professionals. Required staff include: 1) Health Home Director- Master's level education in a health-related field; 2) Primary Care Liaison- nurse practitioner or physician, licensed dietitian or nutritionist, or other clinicians approved by DC; and 3) Nurse Care Manager- nurse with an advanced practice license or a registered nurse with experience in one or more areas of practice relevant to integrated chronic disease care management (i.e. adult health, family nurse practitioner, advanced primary care, other chronic disease specialties). HHs may also supplement a team of healthcare professionals with other types of clinicians or practitioners necessary to address the unique care coordination needs of enrolled consumers. All clinicians must meet the requirements of Health Occupations and Revisions Act of 1985, and subsequent amendments thereto, and implementing regulations.

Health Promotion

Definition

Health Promotion service involves the provision and facilitation of health education to the individual (family member and or significant other) specific to his/her chronic illness. The service may also involve the use of data to identify and prioritize particular areas of need within the patient population; research best-practice interventions; coordinate or refer individuals to appropriate health promotion activities in group and individual settings; evaluate the effectiveness of the interventions, and plan accordingly. Health promotion also involves ensuring the connection of the individual to peer/recovery supports including self-help/self-management and advocacy groups, to support for improving an individual's social network, and to educational opportunities for the individual about accessing care in appropriate settings.

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

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All HHs will use DBH's approved integrated electronic medical record system to document, review, and report health promotion services delivered to each individual. Additionally, clinical data such as height, weight and BMI will be recorded and reported in DBH's approved integrated electronic medical record system.

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

Provider Type	Description
Community Mental Health Center	Designated providers of HH services for individuals with SMI shall be CSAs iand FSMHC dentified by DC to meet the standards of a HH. CSA qualifications are listed in 22-A DCMR § 3400 et seq. To meet the HH standards, CSAs and FSMHC must be adequately staffed by teams of health care professionals. Required staff include: 1) Health Home Director- Master's level education in a health-related field; 2) Primary Care Liaison- nurse practitioner or physician, licensed dietitian or nutritionist, or other clinicians approved by DC; and 3) Nurse Care Manager- nurse with an advanced practice license or a registered nurse with experience in one or more areas of practice relevant to integrated chronic disease care management (i.e. adult health, family nurse practitioner, advanced primary care, other chronic disease specialties). HHs may also supplement a team of healthcare professionals with other types of clinicians or practitioners necessary to address the unique care coordination needs of enrolled consumers. All clinicians must meet the requirements of Health Occupations and Revisions Act of 1985, and subsequent amendments thereto, and implementing regulations.

Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

Comprehensive transitional care includes the Health Home's efforts to reduce hospital emergency department and inpatient admissions, readmissions and length of stay through planned and coordinated transitions between health care providers and settings. Health Homes will increase individual'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. Health Homes will automatically receive notifications of emergency room visits, admissions, discharges and transfers (ADT) from hospitals through DBH's approved integrated electronic medical record system as part of HHs' enrollment in CRISP, and will coordinate outreach to individuals to ensure appropriate follow-up care after transitions. Health Home's goal is to facilitate in-person outreach when the individual is still in the hospital and make a follow up call to the individual within 48 hours of discharge. They will ensure that appropriate follow up visits are scheduled for individuals with a primary care provider and/or specialist within one week of discharge. Health Homes 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.
As part of consumer contacts during transitions, the HH will: a) review the discharge summary and instructions; b) perform medication reconciliation; c) ensure that follow-up appointments and tests are scheduled and coordinated; d) assess the patient's risk status for readmission to the hospital or other failure to obtain appropriate, community-based care; and e) arrange for follow-up care management, if indicated on the discharge plan.

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 DC, 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, MCOs 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.

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

Provider Type	Description
Community Mental Health Centers	Designated providers of HH services for individuals with SMI shall be CSAs and FSMHC identified by DC to meet the standards of a HH. CSA qualifications are listed in 22-A DCMR § 3400 et seq. To meet the HH standards, CSAs and FSMHC must be adequately staffed by teams of health care professionals. Required staff include: 1) Health Home Director- Master's level education in a health-related field; 2) Primary Care Liaison- nurse practitioner or physician, licensed dietitian or nutritionist, or other clinicians approved by DC; and 3) Nurse Care Manager- nurse with an advanced practice license or a registered nurse with experience in one or more areas of practice relevant to integrated chronic disease care management (i.e. adult health, family nurse practitioner, advanced primary care, other chronic disease specialties). HHs may also supplement a team of healthcare professionals with other types of clinicians or practitioners necessary to address the unique care coordination needs of enrolled consumers. All clinicians must meet the requirements of Health Occupations and Revisions Act of 1985, and subsequent amendments thereto, and implementing regulations.

Individual and Family Support (which includes authorized representatives)

Definition

Individual and family support services include all the ways a HH supports the individual and their support team (including family and authorized representatives) in meeting their range of health needs and accessing community resources ((such as medical transportation and other benefits to which they may be eligible) . The services provide for continuity in relationships between the individual/family with their physician and other health service providers and can include communicating on the individual and family's behalf. These services also assist to further educate the individual in self-management of their identified 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 include referrals to support services that are available in the individual's community and assist with the establishment of and connection to "natural supports." They promote personal independence; empower the consumer to improve their own environment; include the consumer family in the quality improvement process including surveys to capture their experience with HH services; and allow consumers/families access to electronic health record information or other clinical information.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All HHs will use DBH's approved integrated electronic medical record system, to document, review, and report family support services delivered to each individual.

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

Provider Type	Description
Community Mental Health Centers	Designated providers of HH services for individuals with SMI shall be CSAs and FSMHC identified by DC to meet the standards of a HH. CSA qualifications are listed in 22-A DCMR § 3400 et seq. To meet the HH standards, CSAs and FSMHC must be adequately staffed by teams of health care professionals. Required staff include: 1) Health Home Director- Master's level education in a health-related field; 2) Primary Care Liaison- nurse practitioner or physician, licensed dietitian or nutritionist, or other clinicians approved by DC; and 3) Nurse Care Manager- nurse with an advanced practice license or a registered nurse with experience in one or more areas of practice relevant to integrated chronic disease care management (i.e. adult health, family nurse practitioner, advanced primary care, other chronic disease specialties). HHs may also supplement a team of healthcare professionals with other types of clinicians or practitioners necessary to address the unique care coordination needs of enrolled consumers. All clinicians must meet the requirements of Health Occupations and Revisions Act of 1985, and subsequent amendments thereto, and implementing regulations.

Referral to Community and Social Support Services

Definition

Referral to community and social support services provides individuals with referrals to a wide array of support services that will help them overcome access or service barriers, increase self-management skills, and achieve an improvement in overall health as indicated on their comprehensive care plan. Referral to community and social support involves facilitating access to support and assistance for individuals to address medical, behavioral, educational, social and community issues that may impact overall health. The types of community and social support services to which individuals will be referred may include, but are not limited to: wellness programs, including smoking cessation, fitness, and weight loss programs; specialized support groups (e.g. cancer; diabetes support groups; etc.); substance treatment, support groups, recovery coaches, and 12-step programs; housing resources; social integration; financial assistance such as TANF or Social Security; Supplemental Nutrition Assistance Program; employment and educational program or training; legal assistance resources; and faith-based organizations. Health Homes will assist in coordinating the services listed above and following up with individuals after 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.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All HHs use DBH's approved integrated electronic medical record system to document, report and review referrals to community-based resources.

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
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- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description

Provider Type	Description
Community Mental Health Centers	Designated providers of HH services for individuals with SMI shall be CSAs and FSMHC identified by DC to meet the standards of a HH. CSA qualifications are listed in 22-A DCMR § 3400 et seq. To meet the HH standards, CSAs and FSMHC must be adequately staffed by teams of health care professionals. Required staff include: 1) Health Home Director- Master's level education in a health-related field; 2) Primary Care Liaison- nurse practitioner or physician, licensed dietitian or nutritionist, or other clinicians approved by DC; and 3) Nurse Care Manager- nurse with an advanced practice license or a registered nurse with experience in one or more areas of practice relevant to integrated chronic disease care management (i.e. adult health, family nurse practitioner, advanced primary care, other chronic disease specialties). HHs may also supplement a team of healthcare professionals with other types of clinicians or practitioners necessary to address the unique care coordination needs of enrolled consumers. All clinicians must meet the requirements of Health Occupations and Revisions Act of 1985, and subsequent amendments thereto, and implementing regulations.

Health Homes Services

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Package Header

Package ID	DC2017MS0010O	**SPA ID**	DC-18-0006
Submission Type	Official	**Initial Submission Date**	8/13/2018
Approval Date	2/21/2019	**Effective Date**	2/1/2019
Superseded SPA ID	15-005		
	User-Entered		

Health Homes Patient Flow

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

The HH receives a list of eligible individuals already being served by that CSA or FSMHC and makes plans for a Health Home team member or the designated staff to inform and enroll individuals during a planned or newly scheduled encounter via CSA/HH/FSMHC/ASARS provider. Information is provided to inform choice about enrolling into and dis-enrolling from the HH program (i.e. assignment to a HH team, HH services are free, enrollment is optional, not enrolling does not impact current services). After consent and enrollment, the HH gathers health information from individuals' service providers (e.g. MCOs; PCP; CSA/ASARS/FSMHC etc.), conducts health risk screens (e.g. depression; substance abuse; etc.), and ensures that comprehensive health assessment information is gathered and entered into DBH's approved integrated electronic medical record system. The Nurse Care Manager (NCM), consumer, and other health and social service partners (CSA/FSMHC/ASARS) can review/discuss assessment results, health goals and health care priorities. The individual and multi-disciplinary team agrees upon and documents a comprehensive care plan that addresses wellness and self-management goals for social and physical behavioral health conditions. This comprehensive care plan, the established plan, will be accessible in DBH's approved integrated electronic medical record system. The HH team works with an individual's PCP via protocols for disease management and/or facilitating visits or referrals; and links an individual with a PCP if necessary. Daily, the HH team reviews hospital ADT feeds to determine if any individuals used the ER or were admitted to the hospital. Weekly, the HH team uses huddles to monitor individual's progress and plan accordingly for interventions/interactions. Monthly, the NCM reviews updated registries and care plan statuses for all individuals on the HH team's panel and targets planned services accordingly, identifying emerging issues warranting changes and follow-up (e.g. re-assessment, revised/increased levels of activity). Issues flagged include medication management, care compliance, outlier lab values, and progress controlling BMI levels, tobacco use, and metabolic screening values. HH care plans are updated at least every 180 days.

Name	Date Created
DC Patient Flow for HH1_8_2_18	8/2/2018 1:23 PM EDT

Health Homes Monitoring, Quality Measurement and Evaluation

Package Header

Package ID	DC2017MS0010O	**SPA ID**	DC-18-0006
Submission Type	Official	**Initial Submission Date**	8/13/2018
Approval Date	2/21/2019	**Effective Date**	2/1/2019
Superseded SPA ID	15-005		
	User-Entered		

Monitoring

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

DC will use historical claims and encounter data from fiscal years 13 through 15 to establish a baseline and expected trend on medical spending for the eligible HH population. DC will then compare expected trend with actual spending. The delta between expected spending and actual spending will represent cost savings. DC may also compare a cohort of individuals who have enrolled in the HH program with a cohort of similar individuals who are eligible for the program but not enrolled.

DC will also compare costs related to emergency room utilization, hospitalizations, nursing facility admissions, pharmacy utilization, etc. This will enable DC 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). DC 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)

DBH's approved integrated electronic medical record system will serve as the centerpiece of a comprehensive health information technology/exchange (HIT/E) solution for the DC's HH program. This system, which all HHs will be required to use or connect to, will serve as the single platform for capturing, tracking and claiming services provided to enrolled HH individuals including the six core HH services.

DBH will make efforts to integrated their approved electronic medical record systems to be able to populate with information generated via interfaces to entities such as: 1) DC's FQHCs; 2) local hospitals, by leveraging the Encounter Notification Service within the CRISP HIE; 3) DC's MMIS from which periodic feeds of Medicaid claims and encounter data will be generated and uploaded into DBH's approved integrated electronic medical record system; and 4) other administrative systems such as the DC Access System (DCAS), the DC's integrated eligibility determination system.

DBH's approved integrated electronic medical record system will support the following essential HH program functions: 1) Initial screening and health/functional assessment, risk analysis and stratification; 2) Proactive alerts to HHs for – at a minimum - emergency room utilization and inpatient hospitalization; 3) Care plan development enhanced by best practices and real-time intelligence about a patient's status; and 4) Care plan administration where multiple HH staff will be able to access and work off a single care plan in a highly secure system environment.

Health Homes Monitoring, Quality Measurement and Evaluation

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	User-Entered		

Quality Measurement and Evaluation

- [ ] 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

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