Department of Behavioral Health

TRANSMITTAL LETTER

SUBJECT Medicaid Health Homes for Adults with Serious Mental Illnesses		
POLICY NUMBER **DBH Manual 1000.5**	**DATE** JAN 13 2016	**TL#** 295

Purpose. The purpose of this policy manual is to provide information about requirements related to services, provider participation, and payment and system requirements necessary for the Health Home Benefit for Medicaid eligible adults with serious mental illnesses.

Note: This manual is a 'living' document, and will continue to be refined and updated as Health Home providers and the District discover best practices and lessons-learned in implementing, monitoring and evaluating the Health Home benefit. Changes will be announced through the Department of Behavioral Health (DBH) Providers Bulletin at: www.dbh.dc.gov or http://DBH1.dc.gov/publications-list

Applicability. Applies to all DBH Core Service Agencies (CSAs) certified as Health Homes pursuant to 22 DCMR A25, Health Home Certification Standards. The Health Home Program is an optional service under the District of Columbia Medicaid State Plan.

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate Behavioral Health Authority (BHA) offices.

Effective Date. This policy is effective for implementation immediately.

Superseded Policy. None.

Distribution. This policy will be posted on the DBH web site at www.dbh.dc.gov under Policies and Rules. Applicable entities are required to ensure that affected staff is familiar with the contents of this policy.

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Director, DBH

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Medicaid Health Home Benefit

For Adults with Serious Mental Illnesses

Operational Guidance

December 2015

The purpose of this document is to provide information related to services, provider participation, and payment and system requirements necessary for the implementation of the Health Home Benefit for Medicaid eligible adults with serious mental illnesses.

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INTRODUCTION

The Health Home Benefit Initiative is a service delivery model that focuses on providing individualized, person-centered and recovery-oriented case management and care coordination.

A Health Home is the central point for coordinating, collaborating and ensuring communication amongst all relevant parties engaged in the delivery of each consumer's care. The Health Home is responsible for achieving the District of Columbia's Triple Aim Goals:

1. Improving the individual experience of assessing and receiving care;
2. Improving the health of its population; and
3. Reducing the per capita costs of care.

Specifically, a Health Home is responsible for:

- Preventing avoidable hospital admissions and readmissions;
- Preventing unnecessary emergency room visits;
- Providing timely transitional follow-up; and
- Decreasing the overall Medicaid cost for the consumers in the District who have serious mental illnesses (SMI).

DC Medicaid Health Home Benefits

Service Area
District-wide

Eligible Providers
CSA's that meet DC's Health Home certification requirements

Target Population
Medicaid consumers with an SMI Diagnosis

Opt-In Method
Consumers must "Opt-In" to the Health Home program, confirmed by a signed Health Home Consent document

Reimbursement Method
Per Member, Per Month Rate

Information Technology Tools
Health Homes must document all Health Homes care plan services and activities delivered in DBH's electronic health record and billing system called iCAMS

This manual is the policy document for the Health Home Benefit. It is a 'living' document, and will continue to be refined and updated as Health Home providers and the District discover best practices and lessons-learned in implementing, monitoring and evaluating the Health Home benefit.

It is the intent of the Health Home Benefit to address the consumer's primary health care needs, hence any service(s) or part of a service provided to a Health Home enrollee that overlaps with MHRS must be provided under the Health Home Benefit and billed under the Per Member Per Month methodology.

BACKGROUND

Evidence exists pointing to dramatic disparities in health outcomes among individuals with serious mental illnesses (SMI). Specifically, in October 2006, the National Association of State Mental Health Program Directors (NASMHPD) issued a report entitled: *Morbidity and Mortality in People with Serious Mental Illness.* This report indicates that individuals who have a serious mental illness die on average, twenty-five (25) years earlier than the general population[1]. The report also concluded that eighty-eight percent (88%) of the deaths and eighty-three (83%) of the premature years of life lost among people with SMI are due to illnesses which are preventable if treated earlier[2]. Finally, and equally important, the report also suggests that a lack of coordination between the primary care and mental health systems of care significantly contribute to the premature deaths and the overall poor health status of individuals with serious mental illnesses.[3]

In response, the District of Columbia Departments of Health Care Finance (DHCF) and Behavioral Health (DBH), referred to throughout this document as "the District" or "DC" unless otherwise noted, partnered to develop a Medicaid Health Home benefit[4] for the District's Medicaid consumers that have a SMI diagnosis and are at-risk for fragmented uncoordinated care from multiple health providers and systems.

A Health Home is the central point for coordinating, collaborating and ensuring communication among all relevant parties engaged in the delivery of each consumer's care. The overall goal of DC's Medicaid Health Home benefit is to leverage the existing services delivered by DC's public mental health provider agencies, called Core Services Agencies (CSA), to build a more

[1] http://www.nasmhpd.org/docs/publications/MdCdocs/Mortality%20and%20Morbidity%20Final%20Report%208.8.08.pdf
[2] http://www.nasmhpd.org/docs/Webinars$20ppts/finalMorbidtyandMobilityAugust2013.pdf
[3] The terms consumers, beneficiary, individuals, and individuals or persons with serious mental are used interchangeably throughout this document

[4] Authority for states (District) to implement a Medicaid Health Home benefit is included in Section 1945 of the Social Security Act. The Health Home is an option offered to States through Section 2703 of what is commonly known as the Affordable Care Act of 2010 (ACA). The ACA consists of the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, and the Health Care and Education Reconciliation Act (Pub. L. 111-152), enacted on March 30, 2010.

systematic, person-centered approach to coordinating and integrating the full array of primary health, behavioral health, acute care, long term care services and supports, and social services to reduce preventable hospitalizations and avoidable emergency room visits. The ultimate goal is to improve overall health outcomes of DC residents with SMI.

The framework of the DC Medicaid Health Home benefit is documented in the District's Health Home State Plan Amendment (SPA)[5], and further defined in the supporting DC Health Home regulations[6]. The purpose of this DC Medicaid Health Home Benefit Operations Guidance Manual is to provide the specific details of the Health Home benefit that providers need to operationalize their service delivery strategies.

In developing the Health Home benefit, the District analyzed Medicaid claims and encounter data to understand the health status, relevant health risks and characteristics of the SMI population and sub-populations. The District formulated its Health Home benefit using the results of this analysis and by studying models for population health management being instituted by states, health systems, and established Medicaid Health Home Benefit Programs being operated around the country. The ensuing benefit is the District's approach to the Health Home model. It reflects the Medicaid data analysis results, current infrastructure of the District's CSAs, existing Medicaid Mental Health Rehabilitative Services (MHRS), and the federal government's Medicaid Health Home requirements.

DC HEALTH HOME BENEFIT OVERVIEW

The Health Home service delivery model encompasses a person-centered, comprehensive approach to addressing consumer's goals for recovery and improvement of behavioral health, physical health, acute care, and social needs. The Health Home team will collaborate with the consumer's physical and behavioral health providers, social services network, and other health data sources such as the consumer provided information, laboratory and radiology results, to develop a Comprehensive Health Assessment (CHA). [7] This CHA will inform the Health Home Comprehensive Care Plan (CCP) of services to be delivered to the consumer.

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[5] A copy of the District's Health Home SPA can be found at on the DHCF webpage, www.dhcf.dc.gov.

[6] 22-A DCMR § 3400

[7] http://www.nasmhpd.org/docs/publications/MdCdocs/Mortality%20and%20Morbidity%20Final%20Report%208.8.08.pdf
JAMA Psychiatry, Online Oct 28, 2015: Premature Mortality in Adults with Schizophrenia in the US
Osborn et al JAMA Psych 2015 72(2): 143-51 Primrose Study
http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201400446
http://psychiatryonline.org/doi/full/10.1176/appi.books.9781615370009.lr10#u2014-10-09T120727.115-0400d1e4625

STATUTORY AND REGULATORY AUTHORITY

Patient Protection and Affordable Care Act

Authority for states and the District of Columbia to implement a Medicaid Health Home benefit is included in Section 1945 of the Social Security Act. The Health Home benefit is an option offered to States through Section 2703 of what is commonly known as the Affordable Care Act of 2010 (ACA). The ACA consists of the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, and the Health Care and Education Reconciliation Act (Pub. L. 111-152) enacted on March 30, 2010.

District of Columbia Administrative Rules

A Health Home shall be a Mental Health Rehabilitative Service Core Service Agency certified in accordance with D.C. Municipal Regulations (DCMR) Title 22A Chapter 34, and DCMR Title 22A Chapter 25, Health Home Certification Standards.

HEALTH HOME BENEFIT FRAMEWORK

The District's Health Home Benefit focuses on the integration of health care and care coordination among health care providers and the consumer's community services and support network. The goal is to reduce avoidable, high cost interventions and increasing the use of appropriate, timely interventions, along with improved self-care management. Health Home services are provided by an interdisciplinary team of primary and behavioral health professionals in conjunction with the consumer and others as identified by the consumer. The Health Home uses a team-based, person-centered approach, where staff collectively uses their skills and knowledge, to ensure that culturally and linguistically competent evidence-based services and supports are employed to address the overall health and wellness of each consumer. Each consumer should be actively involved with the Health Home team in setting goals and participating in his/her care planning. Consumer's voice and choice should drive service needs to be addressed within the written CCP.

SERVICE AREA

Implementation of Health Home services will be District-wide.

CONSUMER ELIGIBILITY

To receive Health Home services, an individual must:

- Be enrolled in the District's Medicaid program;

- Be 18 years of age or order;
- Have a serious mental illness diagnosis as defined in D.C. Code § 7-1131.02 (1f) and (24);
- Agree to participate in the District's Medicaid Health Home Benefit by signing the DBH consent form;
- Be enrolled in a CSA; and
- Not be enrolled in Assertive Community Treatment (ACT).

Individuals eligible for Health Home services may or may not have a co-existing chronic physical condition. DBH will provide each Health Home with a list of eligible consumers assigned to their agency. The list will include the name, Medicaid number and acuity level of the individual as determined by the District. Acuity level will be based upon the individual's service utilization, health conditions and healthcare cost. This list will be periodically updated.

HEALTH HOME STAFF

Health Homes use a team-based approach to deliver the six (6) required services further described below. The team includes a Health Home Director, Primary Care Liaison, a Nurse Care Manager and Care Coordinators. Staff currently employed by the CSA, as "Community Support Workers" may be re-assigned to the Health Home as "Care Coordinators" under the Health Home Benefit. The Health Home may add additional staff to the team (e.g. pharmacist; dietician) to meet the consumer's needs. Health Homes may also use resources provided under the benefit to invest in technology or other supports to effectively assist the consumers. The Health Home staff may be qualified to provided MHRS; however, any service or part of a service under Health Homes that overlaps with MHRS should be provided by the Health Home staff and billed under the Health Home Benefit.

Health Home staff must be knowledgeable about chronic physical health care conditions common among the SMI population within the District and proactively plan to address these conditions. This includes working collaboratively with primary care, specialists, hospitals and other community providers.

Table 1 below describes the roles, functions, and minimum credentials of required Health Home team members.

Table 1 **Roles and Responsibilities of Health Home Staff**

Team Member Role	Minimum Credentials	High-Level Description of Functions
Health Home Director *(Can be existing staff performing new role.)*	Master's level education in a health-related field	• Oversees the daily operation of the Health Home team and facilitates regular ongoing Health Home team meetings with the Primary Care Liaison, Nurse Care Managers and others as appropriate to oversee and foster effective population health management activities and outcomes; • Champions and instructs team members on Health Home services, practice guidelines and comprehensive person-centered care planning with special attention to health and wellness; • Builds partnerships, agreements with primary care and other community based providers to facilitate development of effective team-based care; • Oversees development of agency-specific Health Home policies, protocols and processes to align with evolving standards and evidence based practices; • Monitors and maintains the Health Home's compliance with all applicable federal and DC laws, rules and regulations; and • Champions Health Home practice transformation and comprehensive person-centered care with special attention to health and wellness; • Oversees hospital admission/discharge planning, including medication reconciliation with the assistance of Nurse Care Managers, and assures all hospital alerts are promptly acted upon by the Health Home team.
Nurse Care Manager *(Most likely to be new staff performing a new role.)*	Professional (Registered) Nurse with an advanced practice certification or combination of experience and qualifications in one or more areas of practice relevant to integrated physical and behavioral chronic disease care management (i.e. adult health, family nurse practitioner, advanced primary care, other chronic disease specialties)	• Champions healthy lifestyle changes; • Assists Health Home Director in developing and enhancing wellness initiatives; • Participates as a member and/or leads a Health Home team ; • Coordinates physical care management and care coordination relationships with external healthcare providers; • Receives, identifies and follows-up treatment and medication alerts; • Consults with the Health Home team about identified health conditions of consumers and provides educational training on chronic disease states, prevention, treatment, medications and healthy living; • Makes initial contact with hospitals regarding client admission, conducts a medication reconciliation with input from the consumers primary care physician; • Tracks and assures required assessment and screenings, including a health screening and metabolic screening are complete for each assigned consumer; • Leads development and implementation of an integrated-person-centered care planning process related to physical health care needs of assigned

Team Member Role	Minimum Credentials	High-Level Description of Functions
		consumer; • Conducts assessments of the consumer's health needs; • Provides educational training on chronic physical disease states and treatment protocols; • Identifies and assist with the implementation of self-management protocols for use by consumers; • Conduct at a minimum of once every 180 days for each consumer, a medication review and reconciliation • Approves the Comprehensive Care Plan • Documents all consumer-related activities in iCAMS
Primary Care Liaison *(Most likely to be new staff performing a new role.)*	Advanced Practice Nurse (Nurse Practitioner), or physician with experience and expertise in applying evidence based guidelines to provide primary care for individuals with chronic conditions and complex co-morbidities	• Champions practice transformation and comprehensive person-centered care with special attention to health and wellness; • Works with Health Home Director, Nurse Care Manager(s) , Psychiatrist and other behavioral health staff to monitor utilization and outcomes for consumers as well as the entire Health Home consumer population; • Advises and helps develops protocols to assure that consumers receive care consistent with appropriate physical and behavioral health standards; • Consults with Nurse Care Managers, Care Coordinators and psychiatrists, as appropriate, regarding specific health and wellness concerns of individual consumers; • Assists with fostering agreements and processes for coordination of care with community and hospital medical providers; • Participates in team meetings with the Health Home Director, Nurse Care Manager and others as appropriate. • Documents consumer related activities in iCAMS
Care Coordinator *(Most likely to be existing staff performing both new and existing roles)*	Have a Bachelor's degree in a health or public health-related field with training in a care coordinator role or equivalent experience skills and aptitudes to meet functional requirements of the Health Home Care Coordinator role.	• Care Coordinators provide the full array of community support services which includes, but is not limited to assisting individuals in care to develop self-management and daily living skills, increasing social support skills. • Coordinates services intended to support individuals with SMI and other physical conditions; • Communicates directly with consumers and family members and others regarding the individual's health status and service needs with the consumer's consent • Assists with the provision of health promotion activities according to Health Home protocols and processes; • Coordinates appointment scheduling and provides telephonic reminders of appointments; • Conducts periodic telephonic outreach and follow-up to low-risk Health Home members who do not require face to face contact; • Conducts screening activities as part of team-based

Team Member Role	Minimum Credentials	High-Level Description of Functions
		protocols and processes and monitors to ensure that all regular screenings are completed and recorded, in coordination with the primary care or other appropriate providers; • Assists the Nurse Care Manager in medication reconciliation; • Assists with arrangements such as transportation, directions and completion of durable medical equipment requests; • Obtains missing records and consultation reports; • Participates in hospital and emergency department transition care; and • Documents consumer related activities in iCAMS

Staff Vacancies

The Health Home Director, Nurse Care Manager and Primary Care Liaison must be filled within sixty (60) days of becoming vacant. If one or more of these positions remain vacant for sixty one (61) days or more, the provider must cease billing the Health Home benefit for all assigned consumers. The Health Home must notify DBH accordingly. Billing can resume with DBH approval once replacement staff are hired.

Supervision

The Care Coordinators must be supervised regarding the provision of mental health services in accordance with DBH Policy 710.3A Standards in Supervision of Community-Based Mental Health and Substance Use Disorder Treatment Services. The Health Home shall also comply with any discipline-specific supervision requirements in the Department of Health's professional licensing regulations. In addition, the Nurse Care Manager must supervise the Care Coordinators on all matters pertaining to physical health conditions and services. The supervision process shall be outlined in the Health Home written policies.

The Nurse Care Manager can be administratively supervised by individual other than a nurse. The nurse practice can only be supervised by a nurse.

OPT-IN, TRANSFERS AND OPT-OUT OF THE HEALTH HOME BENEFIT

OPT-IN

The District uses an 'Opt-In' method to enroll eligible Medicaid individuals into the Health Home Benefit. The District will leverage existing relationships between CSAs and

individuals with (SMI) to provide outreach and information to consumers regarding their eligibility for this service. The CSAs that also provide Health Home services will continue to report to Access Help Line their availability to admit new consumers for MHRS and the Health Home Benefit.

In order to be officially enrolled in the Health Home Benefit, the following must occur:

1. The consumer must sign the DBH consent form(s); and
2. The Health Home Team must empanel (assign a consumer) to a Nurse Care Manager and Health Home Team. This information must be documented in iCAMS

Once enrolled in the CSA for MHRS, the CSA can orient the consumer to Health Home services and assist the consumer with enrolling into the Health Home. When multiple providers are simultaneously providing services it is imperative that all providers have access to the Health Home CCP therefore the Health Home consumer's iCAMS profile will be open to DBH approved iCAMS users that are currently providing a service to this consumer.

Access to the Health Home Benefit

There are different ways a consumer can enter the Health Home Benefit. Regardless of how the consumer enters the Benefit the Opt-In process is the same for all consumers. The consumer can be:

- **For an Internal Consumers That May or May not Receives MHRS, and For Consumers That Only Receive Community Supports Services**
    - Refers to the consumer enrolled in a CSA that is interested in participating in the Health Home Benefit and decides to Opt-In to the Health Home Benefit;
    - The Health Home Team can orient the consumer to the Benefit and complete the Opt-In process.
        - Documentation required would be:
            - MHRS
                1. LOCUS
                2. D&A- signed by AQP and QP
                3. Monthly note- Can be completed as one of the Health Home Service notes, if it meets Chapter 34 standards

for a monthly progress referenced in MHRS Bulletin Number 47 from September 16, 2008.

4. IRP- the latest version will be incorporated into the Health Home Comprehensive Care plan

- Health Home

1. Comprehensive Health Assessment- will satisfy Health Homes and MHRS (D&A) if the AQP and RN Care manager signs the document
2. Comprehensive Care Plan- will satisfy Health Homes and MHRS(IRP) if the AQP and RN Care manager signs the document
3. Health Home Service note
    - Comprehensive Care Management
    - Care Coordination
    - Health Promotion
    - Individual and Family Support
    - Referral to Community and Social Support
    - Comprehensive Transitional

If the Health Home Service note meets the MHRS monthly progress note requirements, then the note will satisfy Health Homes and MHRS (Monthly Progress Note) referenced in MHRS Bulletin Number 47 from September 16, 2008

4. Annual note

- **For an External Consumer**
    - Refers to the consumer not associated with a CSA that is interested in participating in the Health Home Benefit offered by that particular CSA. The consumer contacts Access Help Line:
        - Access Help Line completes their standard intake process and notifies the consumer of the Health Home Providers that they made their selection;

- The selected CSA, if open for admissions, will be forwarded the consumer admission request to be initiated;
- The Health Home Director assuring the orientation of the consumer to the Health Home Benefit completes the Opt-In process.
- Documentation required would be:
    - MHRS
        1. LOCUS
        2. D&A- signed by AQP and QP
        3. Monthly note- Can be completed as one of the Health Home Service notes, if it meets Chapter 34 standards for a monthly progress
        4. IRP- the latest version will be incorporated into the Health Home Comprehensive Care plan
    - Health Home
        1. Comprehensive Health Assessment- will satisfy Health Homes and MHRS (D&A) if the AQP and RN Care manager signs the document
        2. Comprehensive Care Plan- will satisfy Health Homes and MHRS(IRP) if the AQP and RN Care manager signs the document
        3. Health Home Service note
            - Comprehensive Care Management
            - Care Coordination
            - Health Promotion
            - Individual and Family Support
            - Referral to Community and Social Support
            - Comprehensive Transitional

        If the Health Home Service note meets the MHRS monthly progress note requirements, then the note will satisfy Health Homes and MHRS (Monthly Progress Note)

        4. Annual note

- **A Transferring Consumer**
  - Refers to the consumer that has opted-in to the Health Home Benefit and no longer wants to participate in the Health Home Benefit plan with assigned provider. Upon notification from the consumer, the Health Home provider will refer the consumer to Access Help Line to begin the transfer process.
  - Access Help Line will assist the consumer in identifying a new Health Home. The transfer will be initiated, as long as:
    - The selected Provider is available to take new enrollees;
    - The consumer selects the new Health Home provider. If the selected provider is not open for new enrollees the consumer will be informed accordingly, and will be asked to make another selection, in order to initiate the requested transfer;
  - Once an available Health Home has been selected an alert will be sent to the sending and receiving Health Homes and MCO, if applicable, of the pending transfer and the two Health Homes must coordinate the transfer to the consumer.
  - Follow the requirements for an internal consumer above.

Billing Attestation

The billing attestation is the billable service, in iCAMS, for the Health Homes Benefit. This service must be the scheduled for all Health Home consumers on the first of each month. The Health Home Team should monitor the service delivery via reports to ensure that the acuity criterion has been met prior to submitting billing for the consumer. After verification, by the Health Home Team, that the requirements have been met, the billing attestation should be signed and submitted for billing. The iCAMs system will be able to identify when the criteria has been met for each acuity level and deny any submissions that have not met the acuity requirement of services.

Please reference DBH Policy 1000.2A, MHRS Provider Authorization and Billing Manual for guidance on time-frames to submit billing. In addition, the billing claims and supporting notes should be complete and accurate as per DBH Policy 911.1- Claims Audit dated November 9, 2010. A Health Home that submits a claim for reimbursement certifies that the service meets the requirements of DCMR Title 22A Chapter 25, Health Home Certification Standards.

Health Home Director

The Health Home Director is responsible for:

a. Assuring that beginning January 2016 and every three months thereafter that an informational forum regarding the Health Home Benefit is held, for consumers, at the principal site of the CSA. All attendees should sign a dated sign-in sheet. The sheet should be maintained by the Health Home Director.
b. Assuring the Health Home team follows the iCAMS enrollment process for consumers that are interested in opting-in to the Health Home Benefit including:
    - Obtaining Consents
    - Assigning Program
    - Assigning Benefit
    - Assigning Nurse care manager and team
    - Assuring the scheduling and completion of the billing attestation

Health Home billing may begin January 1, 2016, once the Opt-In process has been completed in iCAMS. If this consumer also participates in a MCO an alert will be sent to that MCO to begin the coordination of care.

OPT-OUT

Voluntary Opt-Out

Receiving MRHS or CSA Services

Consumers may decide to Opt-Out of Health Home services. Consumers may do so without jeopardizing their access to medically necessary MHRS or other available mental health services and supports. Individuals who Opt-Out or do not elect to Opt-In in the Health Home benefit may make the decision to receive Health Home services at any time in the future as long as they continue to meet DC's Health Home eligibility requirements. The Consumer must sign the Health Home Opt- Out Consent form. Each Health Home will need to develop a policy to guide the process if the consumer refuses to sign the Opt-Out consent. Consumers that only received Community Support Services prior to Opting –In to Health Homes would be included in this group.

Receiving No MHRS or CSA Services

Consumers that are enrolled in the Health Home Benefit and received no other CSA services and decide to Opt- out would need to sign the Health Homes Opt-Out consent as well as following the DBH Disenrollment Policy 525.2 to be dis-enrolled from the CSA

Involuntary Opt-Out

If a Health Home is unable to locate a Health Home consumer or unable to keep them engaged with the Health Home benefit the Health Home may involuntarily Opt-Out the consumer from the Health Homes Benefit and move their services back to MHRS. All efforts should be made prior to this decision is made. Documentation of the challenges should be documented as well as following by the Health Home provider:

1. Ten (10) or more attempts over a two (2) month period to locate the consumer;
2. Call all known contacts, including health care network providers for the consumer in attempt to locate the consumer;
3. Send a letter to the consumer notifying them of the end date of their Health Home services. The Provider should give at least 30 days notification, in the letter, to the consumer prior to involuntarily opting them out of the Benefit. The letter should include:
    a. Purpose of the letter;
    b. Outline all the attempts and mechanisms of attempts made to locate the consumer;
    c. Date that the consumer will be voluntarily opted-out of the Benefit;
    d. Give the consumer information on how they can continue in the Health Home Benefit;
    e. Notify the consumer of the new services (MHRS) they are eligible to receive and a contact number for them to call to schedule an appointment; and
    f. Carbon copy (CC) the Provider network on the letter.
4. On day 31 the consumer can be removed as a Health Home consumer;
5. Coordination with the MHRS provider should be completed with a plan for post- Health Home services;
6. The Nurse Care Manager and Primary Care Liaisons will cosign the Opt-Out Consent and document in iCAMS that the consumer has been involuntarily Opted-Out of the Health Home Benefit.
7. The letter should be uploaded in iCAMS and available for review by DBH, if requested.

Any consumer status changes, whether it health related or disposition should be communicated timely to consumer provider network. This notification will foster care and transitional care coordination.

Again, if the consumer is not receiving MHRS or other services from the CSA then the consumer would need to Opt-out of Health Homes and also dis-enrolled from the CSA. The involuntary Opt-Out process should assist in meeting some of the DBH standard for dis-enrollment

DESCRIPTION OF HEALTH HOME SERVICES

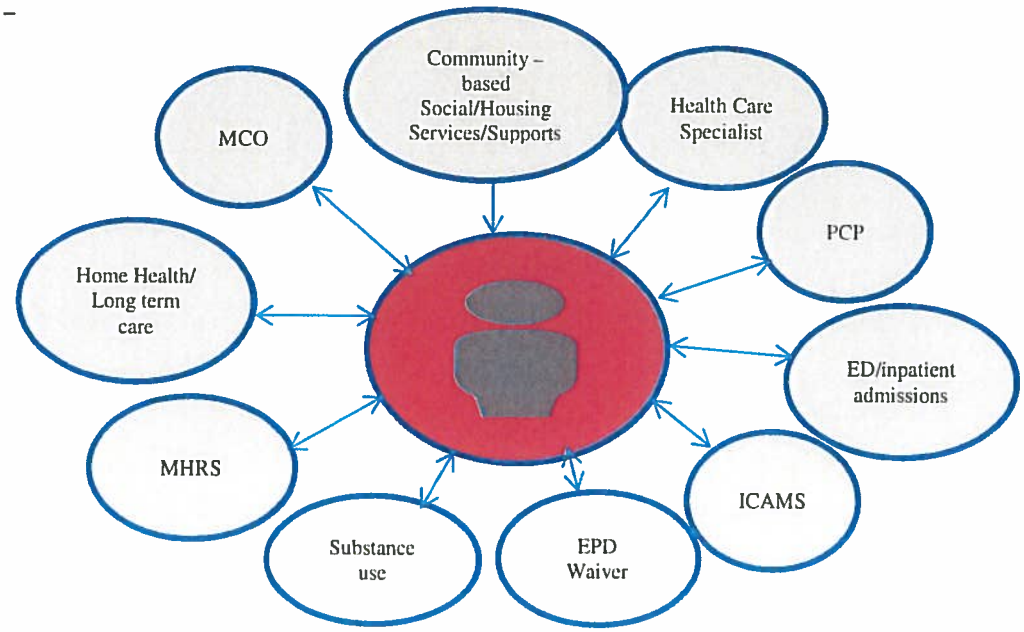
Health Homes encompass a comprehensive approach to addressing consumers' goals for recovery and improvement of behavioral, social and physical health needs. Health Homes will attend to consumer's holistic health needs, whether or not the Health Home directly delivers all of the health care services needed by an individual. The Health Home is therefore accountable for assuring that consumers' health care and social support needs are identified and that consumers are linked to the appropriate providers and services systems.

In order to ensure the provision of holistic care, Health Homes must:

- Develop a care plan for each consumer that coordinates and integrates all clinical and non-clinical services and supports required to address the person's health-related needs.
- Use Health Information Technology (HIT) to link services, facilitate communication between and among providers, the individual, and caregivers, and provide feedback to external health care partners.
- Establish a continuous quality improvement program, and collect and report data that support the evaluation of Health Homes' effectiveness.

The figure below provides an example of the various components of the health and social supports systems that interface when addressing needs of adults with serious mental illness. In this example the role of the Health Home is to ensure that consumer accesses needed care and services from appropriate sources. The Health Home is represented in red. The figure illustrates information sharing and coordination of services on behalf of the consumer.

Figure 1 –



A Health Home must provide the following services:

1. Comprehensive care management;
2. Care coordination and health promotion;
3. Health promotion;
4. Comprehensive transitional care from inpatient to other settings, including follow up;
5. Individual and family support, which includes authorized representatives; and;
6. Referral to community and social support services, if relevant.

In addition to the above services, a Health Home certified by DBH must use the Integrated Care Applications Management System (iCAMS) as the core component of their comprehensive health information technology exchange (HIE) activities. There will be no exceptions. (See Appendix A)

COMPREHENSIVE CARE MANAGEMENT

Health Home staff will collaborate with each other and external partners to provide comprehensive care management services to address each consumer's health conditions and well-being. The goal is to maximize health status, functionality, and prevent the development of chronic health conditions.

Comprehensive care management consists of:

1. Conducting systematic, planned activities to ensure that all consumers of the Health Home are appropriately assessed to identify, stratify and address health risks;

2. Monitoring ongoing progress and health status of all consumers of the Health Home and taking appropriate actions to address identified service needs;
3. Identifying and using recognized health risk assessment and planning processes and tools, including appropriate screening instruments by Health Home Teams;
4. Development of a Comprehensive Care Plan, in partnership with each consumer, that includes:
    - The results of a Comprehensive Health Assessment, IRP and other data from the consumers health care team;
    - Individualized goals agreed upon by the consumer and identified by the comprehensive assessment with time-frames and strategies for addressing each; and
    - The delineation of the specific roles and responsibilities of the members of the Health Home Team who are assisting the consumer in achieving his/her goals.
5. Development of care management protocols that are relevant to the population of Health Home consumers that include:
    - Evidence- based practices for assisting the consumers in achieving his/her goals; and
    - Evidence-base clinical protocols for managing and monitoring specific health conditions.
6. Development and use of programs and approaches including:
    - Self- management and illness recovery supports and practices;
    - Community and natural supports systems as identified by the consumers; and
    - Development and implementation of health promotion campaigns.
7. Development of partnerships with providers and other community-based entities external to the Health Home in order to facilitate shared protocols for care management and coordination and timely communication and effective responses to each consumer's physical and behavioral health needs;
8. Use of DBH's iCAMs to:

- Document any unplanned event (i.e., hospitalization, development of a new medical condition, change in medication or community living status); and
- Document and monitor service delivery. Documentation includes progress notes with status updates on achieving the stated goals of the consumers.

Development and dissemination of reports to include but not limited to consumer's satisfaction, population and individual health status, service utilization, cost and link how the data and information will be used to assist the individual consumer in meeting their goals and or improve their quality of life

The Health Home will also be responsible for keeping the entire enrolled population of consumers as healthy as possible by minimizing the overall need for expensive and unavoidable health care services such as emergency department visits and hospitalizations. Services will focus on individualized health care prevention strategies, early intervention, chronic care management as well as the use of group-based health promotion activities and campaigns.

Comprehensive care management services are driven by protocols and guidelines developed by the Health Homes Registered Nurse Care Manager and/or Primary Care Liaison in collaboration with the consumer, Health Home team members, health practitioners, community providers and individual's identified by the consumer as his/her natural support system.

CARE COORDINATION

Care Coordination is the implementation of the consumer's person-centered goals and objectives as articulated in the Comprehensive Care Plan through appropriate linkages, referrals, coordination and follow-up. Care Coordination may involve but is not limited to:

1. Scheduling appointments;
2. Appointment reminders;
3. Outreach and follow-up with consumers;
4. Ensuring that all health screenings and medical procedures are performed;
5. Assisting RN Care Manager with medication reconciliation;
6. Assisting with making arrangements for transportation;
7. Facilitating the individual's ability to obtain medical supplies and durable medical equipment;

8. Obtaining records and reports;
9. Participating in transitional care;
10. Documenting service provision in the Comprehensive Care Plan;
11. Participating in the development and implementation of a consumer's Comprehensive Care Plan;
12. Providing individualized mental health interventions to assist the person receiving care to develop interpersonal and community coping skills, including adapting to home, school, and work environments; and
13. Helping consumers to increase social support skills and networks that ameliorate life stresses resulting from mental illness or emotional disturbance to enable and maintain independent living.

Care Coordination services are provided by Care Coordinators whose activities are driven by protocols and guidelines developed by the Health Homes' Registered Nurse Care Manager or Primary Care Liaison, in collaboration with the consumer, Health Home team members, health practitioners, community providers and individual's identified by the consumer as his/her natural support system.

HEALTH PROMOTION

Health Promotion Services involves the provision of health education to consumers and as appropriate, each consumer's family member (s) and others involved in the consumer care. This service may include but is not limited to:

1. Providing consumer education to help the consumer with self-monitoring and health management related to each consumer's identified particular chronic care conditions, Health promotion activities should also address issues related to healthy lifestyles and wellness. For example, nutrition, substance abuse prevention, smoking prevention and cessation and physical activity;
2. Assisting with medication reconciliation;
3. Developing and implementing health promotion campaigns;
4. Connecting consumers with peer and recovery supports including self-help, self-management and advocacy groups.

5. Providing mental health education, support and consultation to consumer's families and support system, which is directed toward the well-being and benefit of the consumer; and
6. Assisting the consumer in symptom self-monitoring and self-management to identify and minimize the negative effects of psychiatric symptoms, which interfere with the consumer's daily living, financial management, personal development, school and/or work performance.

Health Promotion services are primarily provided by Care Coordinators whose activities are driven by protocols and guidelines developed by the Registered Nurse Care Manager or Primary Care Liaison, in collaboration with the consumer, Health Home team members, health practitioners, community providers and individual's identified by the consumer as his/her natural support system.

COMPREHENSIVE TRANSITIONAL CARE

Comprehensive Transitional Care is a set of actions designed to ensure the coordination and continuity of health care as consumers transfer between different locations or different levels of care. Comprehensive Transitional Care includes assistance with discharge planning from inpatient settings. It includes:

1. Contacting the consumer within forty-eight (48) hours of the completed transition;
2. Outreach to the consumer to ensure appropriate follow-up after transitions;
3. Scheduling follow-up visits for the consumer with the appropriate health and community-based service providers after the completed transition;
4. Developing strategies and supportive mental health intervention to avoid out-of-home placement for adults and build- stronger family support skills and knowledge of the person's strengths and limitations; and
5. Developing and implementing mental health re-lapse- prevention strategies and plans.

Comprehensive Transitional Care Services are primarily provided by Care Coordinators whose activities are driven by protocols and guidelines developed by the Health Homes' Registered Nurse Care Manager or Primary Care Liaison, in collaboration with the consumer, Health Home team members, health practitioners, community providers and individual's identified by the consumer as his/her natural support system.

INDIVIDUAL AND FAMILY SUPPORT SERVICES

Individual and Family Support Services include providing:

1. Assistance and support for the consumer in stressor situations;
2. Mental health education, support and consultation to consumer's families and their support system, which is directed toward the well-being and benefit of the consumer;
3. Mental health relapse prevention strategies and plans;
4. Activities that facilitate the continuity in relationships between consumer/family with physician and care manager;
5. Advocacy on a consumer's behalf to identify and obtain needed resources such as medical transportation and other benefits for which they may be eligible;
6. Consumer education on how to self-manage their chronic health condition;
7. Opportunities for the family to participate in a consumer's assessment and care treatment plan development;
8. Delivery of culturally and linguistically appropriate services; and
9. Efforts that promote personal independence and empower the consumer to improve their own environment and health. This may include engagement with a consumer's family in identifying solutions to improve a consumer's health and environment and helping consumers and their families with the consumer's authorization to access the consumer's health record information or other clinical information.

The Health Home provider will collect and analyze data to determine health trends and provide directly or with the help of others culturally and linguistically appropriate information, training and technical assistance to consumers regarding their identified needs.

Individual and Family Support services are primarily provided by Care Coordinators whose activities are driven by protocols and guidelines developed by the Registered Nurse Care Manager or Primary Care Liaison, in collaboration with the consumer, Health Home team members, health practitioners, community providers and individual's identified by the consumer as his/her natural support system.

REFERRAL TO COMMUNITY AND SOCIAL SUPPORT SERVICES

Referral to Community and Social Support Services includes the provision of referrals to a wide array of support services that will help individuals overcome access or service barriers, increase self-management skills and achieve overall health. Specifically, this activity 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:

1. Wellness programs, including smoking cessation, fitness, weight loss programs;
2. Specialized support groups (i.e. cancer, diabetes support groups);
3. Substance use recovery support groups ;
4. Housing resources;
5. Supplemental Nutrition Assistance Program;
6. Legal assistance resources;
7. Faith-based organizations; and
8. Access to employment and educational program or training.

Referral to Community and Social Support Services are primarily provided by the Care Coordinator but may be provided by any member of the Health Home team. This process driven by protocols and guidelines developed by the Registered Nurse Care Manager or Primary Care Liaison in collaboration with the consumer Health Home team members, health practitioners, community providers and individual's identified by the consumer as his/her natural support system.

CLARIFYING MHRS SERVICES AND HEALTH HOME SERVICES

MENTAL HEALTH REHABILITATION SERVICES (MHRS)

MHRS is a rehabilitative service designed to improve mental illness by ameliorating conditions and restoring an individual to his or her maximum functioning level. Consumers receiving Health Home services shall remain eligible for receiving MHRS. Providers will be held accountable for adhering to the requirements of Chapter 34, MHRS Provider Certification Standards of Title 22-A. when providing MHRS services.

COMMUNITY SUPPORT AND HEALTH HOME SERVICES

For consumers enrolled in Health Homes, MHRS Community Support Services are now embedded under the Health Home service components. As such, a Health Home cannot bill for MHRS Community Support Services.

ASSERTIVE COMMUNITY TREATEMENT (ACT)

Health home enrollees cannot receive ACT services.

PAYMENT

Non-Community Support MHRS shall be billed as a fee for service (See Chapter 25, specifically 2515.2).

Health Homes Services shall be billed as a per-member per-month (See Chapter 25, specifically 2515.3).

DOCUMENTATION

Documenting thoroughly and accurately is very important to ensure that any claims for services will pass an audit. iCAMS is the official clinical record for a Health Home recipient. Health Home providers shall document each Health Home service in iCAMS and ensure that the MHRS activities are in the consumer's iCAMS record. Any claim for services shall be supported by written documentation which clearly identifies the following:

(a) The specific service type rendered;

(b) The date, duration, and actual time, a.m. or p.m. (beginning and ending), during which the services were rendered;

(c) Name, title, and credentials of the person who provided the services;

(d) The setting in which the services were rendered;

(e) Confirmation that the services delivered are contained in the consumer's CCP;

(f) Identification of any further actions required for the consumer's wellbeing raised as a result of the service provided;

(g) A description of each encounter or service by the Health Home team member which is sufficient to document that the service was provided in accordance with this chapter; and

(h) Dated and authenticated entries, with their authors identified, which are legible and concise, including the printed name and the signature of the person rendering the service, diagnosis and clinical impression recorded in the terminology of the International Statistical Classification of Diseases and Related Health Problems -- ICD-10 CM or subsequent revisions, and the service provided.

No Health Home provider shall be reimbursed for a claim for services that does not meet the above requirements or is not documented in accordance with this section.

When a consumer is enrolled in a Health Home document requirements continue to follow the MHRS regulations.

- LOCUS
- Diagnostic and Assessment
- Monthly Note

Other Health Home-specific documents include

- Opt-In consent
- Billing Attestation

- Comprehensive Health Assessment
- Comprehensive Care Plan
- Health Home Service Visit notes
    - If the service was performed by someone outside of the Heath Home Team, that has been assigned temporarily to the consumer, the note will need to be co-signed by the Nurse Care manager
- Health Home Annual note
    - Referenced in the Health Home Work flow, specifically, Step 6- Reassessment and Revisions to the Comprehensive Care Plan of this manual

HEALTH HOMES AND MEDICAID MANAGED CARE ORGANIZATIONS

Medicaid consumers with SMI, whether enrolled in Medicaid Managed Care Organization (MCO) or not, are eligible to receive Health Home services. Community Support Services are reimbursed on a fee-for-service payment basis and are carve-outs of the Medicaid health plan contracts. Thus, the implementation of the Medicaid Health Home benefit will not affect current MCO capitation rates. Health Homes and the MCOs will both be responsible for delivering care coordination services to individuals enrolled with both entities. About 30% of the Medicaid population, currently enrolled in MCOs, is eligible to receive Health Home services. Most of the providers that will become Health Homes are already included within the MCOs' provider networks. Similar to the collaborative relationship the health plans have now with other health service providers, Health Homes and MCOs are required to share updates on the mutual consumers and their care plan. Additionally, the Health Home team and MCO will collaborate on the development of any care plans created and this collaboration will be documented in the CCP.

HEALTH HOMES AND ELDERLY PERSONS WITH DISABILITIES (EPD) WAIVER

EPD Waiver Case Management Agencies will be paid per member per month (PMPM) rate to develop and execute a person-centered care plan for individuals enrolled in the EPD Waiver Program. Functions provided by EPD Waiver Case Management Agencies include assessments to determine unmet needs related to Medicaid waiver services and non-Medicaid waiver-like services available in the community; developing services provided that include those under the waiver and those outside the waiver; submission of requests for the authorization of waiver services; and monitoring of service provisions. These services are

very similar to those provided by Health Homes. Thus, individuals enrolled in the EPD Waiver who are eligible for and elect to enroll in a Health Home will receive all of their case management services through a Health Home. Health Homes that elect to serve EPD Waiver enrolled individuals must enroll in DC's Medicaid program as a EPD Waiver Case Management Agency, and comply with the case management requirements outlined in 42 C.F.R. §§ 441.301(c)(1)-(3), which will require additional training and coordination with EPD Waiver approved providers including, Home Health agencies. Health Homes providing case management to EPD Waiver consumers will only be able to bill for Health Home services and will not be able to bill for EPD Waiver case management services.

DATA ANALYSIS

UNDERSTANDING THE ELIGIBLE HEALTH HOME POPULATION

Using Medicaid claims and encounters data (pulled by date of service), the District identified prevalent chronic health care diagnoses and service utilization[7] patterns of individuals with SMI. The population of individuals with SMI was then segmented into two care management groups based upon whether individuals have high or low care management needs. The most prevalent physical health care conditions associated with DC SMI population are delineated below:

CHRONIC CONDITIONS

CHRONIC CONDITIONS

Based on analysis of claims data the following diagnoses were prevalent amongst DC's Medicaid consumers with SMI. Care management and care coordinating services, as described in this document, can most likely result in reductions in avoidable high cost and/or unnecessary care. It is important to note that the data set used by the District includes information related to a person's primary mental health diagnosis and physical health care conditions. Health Homes have access to these data which can be used to support their health risk assessment, acuity level and comprehensive profile of health home consumers.

Type 2 Diabetes

Sugar is one of the body's significant sources of energy/fuel. In order for the body to use sugar efficiently the body must produce optimal amounts of a hormone called insulin. The presence of insulin allows the sugar, that's in the body, to enter the cells and begin to produce energy/fuel. Type- 2 diabetes[8] is diagnosed when the body does not produce enough insulin or when the body has built immunity to the effects of insulin that the body has produced. Obesity is one of the lifestyle characteristics or choices that where Type 2 diabetes can be found. This disease can be managed with a healthy diet, weight loss and medications, if the disease does not respond to lifestyle changes.

Congestive Heart Failure

The heart is the organ that acts as the body's pump to circulate oxygenated blood from the heart to the body and un-oxygenated blood back to the heart to be re-oxygenated by the lungs. Congestive heart failure [9]is the failure of heart to pump the blood effectively through the body. Due to the ineffectiveness of the heart (pump) the circulation is compromised and can cause increase pressure in the blood vessels. Increased pressure in the vessels will force the fluid out of the blood vessel and leak the fluid into the nearby tissues causing edema or swelling. Heart failure can affect the right or left side of the heart. If the right side of the heart is affected, swelling in the lower extremities can be seen. If the left side of the heart is affected, fluid may collect in the lungs and manifest as shortness of breath.

Seizure Disorders

A seizure[10] is the result of rapid electrical activity in the brain that can stem from a number of health conditions. There are various types of seizures and their presentation differs. The various types of seizures include: general, absent, myoclonic, colonic, tonic and atonic. In each of the types the presentations of the seizures may vary from staring, loss of consciousness, rhythmic or sporadic jerks, muscle stiffness or flaccid muscles.

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8 "http://www.diabetes.org/diabetes-basics/type-2/?loc=util-header_type2

9 http://www.heart.org/HEARTORG/Conditions/HeartFailure/Heart-Failure_UCM_002019_SubHomePage.jsp

10 http://www.mayoclinic.org/diseases-conditions/epilepsy/symptoms-causes/dxc-20117207

Cirrhosis

The liver is essential for survival and has many different functions for the body. The liver assist in metabolizing alcohol and some drugs assist in digestion of food, produce clotting factors for the blood to help the body's blood clot efficiently, regulate the sugar, fat and protein in the bloodstream. Cirrhosis[11] is the actual scarring of the liver. This scarring will damage the liver and decrease its functionality. Cirrhosis can be caused by several different conditions. Two known causes of cirrhosis are excessive alcohol and an autoimmune disease.

Coronary Artery Disease (CAD), Peripheral Vascular Disease (PVD)

Arteries are the blood vessels that carry the oxygenated blood from the heart and to the entire body. In CAD[12] and PVD the arteries become harden by the deposits of plaque in the blood vessels. This hardening of the arteries is called atherosclerosis. The increase in plaque and the decrease elasticity of the vessel compromises the ability of vessels to transport the needed oxygenate blood to the organs. The absence of oxygen-filled blood will cause damage to the body's organs including the heart. When atherosclerosis occurs in the heart and brain the condition is called CAD, when the condition occurs in another other vessel outside the heart and brain it is called PVD.

Lung Disease

The lungs are responsible to oxygenate the blood in order to keep the body's organs viable. The lungs exchange carbon dioxide and oxygen from the blood and force the oxygen into the blood stream to be carried by the arteries throughout the body. Lung disease[13] is a general term for several different lung disease such; asthma, influenza, chronic obstructive pulmonary disease (COPD) and cancer. In each of these disorders the lung tissue is compromised from the proper exchange and delivery of oxygen by increase fluid, scarring or inflammation.

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11 11http://gi.org/

12 http://www.heart.org/HEARTORG/search/searchResults.jsp?_dyncharset=ISO-8859-1&_dynSessConf=3814696991992109 68&q=CAD

13 http://www.lung.org/lung-health-and-diseases

DESCRIPTIONS OF THE CARE MANAGEMENT GROUPS

Criteria were developed to assign individuals to a High Acuity Care Management Group or a Low Acuity Care Management Group based upon their physical and psychiatric conditions and service utilization. A description of each of these acuity bands is presented below.

If an eligible consumer is interested in enrolling into the Health Home Benefit and does not have an assigned acuity level in iCAMS, the consumer must begin services in the low acuity group. Once the acuity level has been verified through the Medicaid claims data, the acuity level may be changed, if warranted and applicable. An acuity change request must be submitted to DBH through iCAMS.

HIGH ACUITY CARE MANAGEMENT GROUP

The High Acuity Care Management Group (HCA) includes consumers with SMI who had at least 1 hospital inpatient visit (psych or non-psych) and who were diagnosed as having any of the following conditions: cancer, coronary artery disease (CAD), peripheral vascular disease (PVD), congestive heart failure (CHF), cirrhosis, complicated diabetes mellitus (DM), HIV, lung disease, multiple sclerosis (MS), quadriplegia, rheumatoid arthritis (RA), or a seizure disorder. Individuals were also assigned to the HCA if they had one inpatient psychiatric hospital visit or two inpatient non-psychiatric visits but did not have a diagnosis of one of the chronic physical health conditions. The HCA group does not include those individuals with serious mental illness who receive ACT. ACT consumers are not eligible for the Health Home benefit.

LOW ACUITY CARE MANAGEMENT GROUP

The Low Acuity Care Management Group (LACM) includes all of the remaining consumers with serious mental illness currently enrolled in the public behavioral health system that are not assigned to the High Acuity Management group and are not enrolled in ACT services.

Acuity levels have been used to set payment rates and service requirements. However, Health Home providers are expected to develop a CCP that includes a description of the level of care coordination required for each Health Home consumer. The District's approved comprehensive health assessment tool will be used to assist providers in developing CCP for consumers.

Table 2 **Acuity Determination**

High Acuity	One (1) hospital inpatient visit (psych or non- psych) and a diagnosis of one of the chronic illnesses
OR	
High Acuity	One (1) Inpatient psychiatric hospital visit
OR	
High Acuity	Two (2) inpatient non-psych admissions and does not have any of the chronic illnesses
AND	
Low Acuity	All other SMI not assigned to the High Acuity

Acuity Change

All acuity levels remain in place for one (1) year. A request for acuity change should be completed and submitted to DBH via iCAMS when there is major consumer status change. The request must be supported with documentation.

All acuity changes submitted by 25th of the month, if approved by DBH, will be effective on the first day of the following month. Any request submitted after the 25th of the month, when approved will be effective the month thereafter. DBH will review all Acuity change request and complete reviews as outlined in this section.

RATE METHODOLOGY AND PAYMENT OF THE HEALTH HOME RATE

RATE DEVELOPMENT

Health Homes are paid a per-member per-month (PMPM) rate based upon the acuity level assigned to each enrolled individual. The PMPM rates are based on the following:

1. Costs related to the new Health Home team staffing requirements which includes:
   (a) Salaries (plus fringe) of Health Home team members: Health Home Director ($104,125); Nurse Care Manager ($99,231); and Primary Care Liaison ($140,140)[14];

[14] Select DC Providers.

(b) Total health home full-time employees (FTEs) required for each 300 consumers [Note: FTEs can be scaled down to meet the number of enrolled Health Home consumers on the team. FTEs are presented as ratios.]

Administrative fee: Providers will receive a Health Home administrative rate of $15.38 for each consumer. This is to cover the overhead and other administrative costs associated with the operation and administration of Health Home services (i.e., data analytics capacity, refinements to electronic health records, reporting to DBH).

The rate considers the hours of services Health Homes are expected to provide to consumers at each of the two acuity levels. This calculation is based upon historical Medicaid claims data for the average number of hours of MHRS Community Support services received for by high and low acuity consumers and the cost of the additional care management services needed to integrate behavioral and physical service delivery. The Health Home PMPM rate for the consumers in the High Acuity Care Management Group is $481.00; the Health Home PMPM rate for consumers in the Low Acuity Care Management Group is $349.00. The higher rate allocated for consumers in the High Acuity group reflects the higher level of care to be provided to this population.

Only one Health Home can be paid the PMPM rate in a single month therefore consumers, which wish to transfer to another HH, as much as possible, should be transferred by the first day of the next month. If the servicing HH has not provided or billed for any services for the consumer during the month, the two health homes can decide together the best time to transfer services.

- Salary.com, Salary search based on care manager with 2-4 years' experience and RN degree (accessed June 24, 2014).
- Bureau of Labor Statistics, Occupational Employment and Wages, May 2013: Registered Nurses (accessed June 24, 2014)
- Center for Medicare and Medicaid Services (CMS), "Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Medicare Part B for CY2014," CMS-1600-P (July 2013) at Attachment D (CY2014 GCPI Public Use File).
- Survey Participants were: Whitman walker Health, Unity Health.
- Bureau of Labor Statistics, "News Release: Employment Projections, 2012-2022" at Table 4 (Dec. 2013).
- Salary.com, Salary search based on nurse practitioner with 5 years' experience (accessed June 24, 2014). Bureau of Labor Statistics, Occupational Employment and Wages, May 2013: Nurse Practitioners (accessed June 24, 2014)

The Health Homes may deliver multiple services at a single visit, if that strategy works for the consumer, and is patient-centered. Each service delivered must be documented discretely and appropriately in iCAMS. Different from fee-for-service, the Health Home benefit is reimbursed PMPM, therefore there is no maximum limit in the number of services that can be provided nor or a time requirement to be spent on each service. The number and types of services should be dictated by the consumer's needs. Any service or parts of a service that may overlap MHRS and Health Homes should be provided and billed under the Health Home Benefit. For example, a Nurse Care Manager is a member of the Health Home team and is also a qualified practitioner for Medication Somatic services under MHRS, Chapter 34. A Nurse Care Manager that assists a Health Home enrollee with medication reconciliation will treat that service as part of the Health Home benefit and Per Member Per Month payment and will not separately bill MHRS. Only those MHRS services that do not fall under the Health Home benefit will be separately billed.

Table 3 **Procedure Codes**

Care Mgmt. Group	Procedure Code	Modifier	PMPM Rate
High	S0281	U1	$481.00
Low	S0281	U2	$349.00

DC will review rates annually and re-calculate them as necessary. To receive the monthly payment for High Acuity individuals, Health Homes must provide and document in iCAMS at least two comprehensive care management (CCM) services (comprised of assessment/screening; care plan development; care plan review; or transition care) and at least two other Health Home encounters, one must be being face-to-face, with no duration requirement.

Low Acuity individuals must receive at least one CCM service and one other Health Home service, with no face-to-face requirement, that is documented in iCAMS.

All services must be documented accurately in iCAMS. The high and low acuity payment thresholds should not be assumed to be all the provider can provided to a consumer in each of the acuity levels. The PMPM allows for flexibility in the number of services provided. The thresholds are the minimum number of services that that meet the requirement for

payment, the consumer should receive services based on their needs and CCP. Health Homes will be held accountable for achieving the outcome measures described later in this Manual. Every effort needs to be made to provide the appropriate number and type of service needed by each consumer so these outcomes are met.

Table 4 Encounter Requirements Based on Acuity Level

High Acuity	Document in iCAMS: Two (2) Comprehensive Care Management Services and Two (2) other Health Home encounters with one (1) that must be a face to face with no duration requirement.
Low Acuity	Document in iCAMS: One (1) Comprehensive Care Management Service and One (1) other Health Home encounter with no face to face requirement.

DOCUMENTATION OF CARE MANAGEMENT SERVICES

DOCUMENTATION

Providers shall retain all records relating to cost, work performed and supporting documentation for claims submitted to DBH. The Health Home providers will make available these records to DBH and other authorized agents of the District of Columbia governments for audit purposes for six(6) years or until all audits are completed, which every is longer.

iCAMS is the official clinical record for a Health Home recipient. Health Home providers shall document each Health Home service in iCAMS and ensure that the MHRS activities are in the consumer's iCAMS record. Providers may document all services (Health Home and MHRS) in iCAMS. This information is already in the system for fully iCAMS integrated Providers. For partially integrated providers (PIP):

The short term plan would be for the providers to upload, from their system, a monthly report that would encompass all the service notes and procedures for each of their Health Home consumers for each month into iCAMS.

Labeling uploaded file

When uploading the file, the Health Homes should use the following labeling format in iCAMS:

- "MHRS.the name of the service.date" such as "MHRS.daytreatment.01-01-2016" or "MHRS.counseling.2-1-2017".

- If a provider is able to consolidate the month's notes into one document then they would follow this labeling format:
    - "MHRS. Month Year" for example,"MHRS.January 2016"

The Long term plan/goal will be for iCAMS to refine the Continuity Care Document (CCD) process. This CCD would pull data and the service notes from the PIP's MHRS system and populate that information into the appropriate fields in iCAMS. DBH will send out a bulletin when this plan is available for Providers to use. Until that time Providers must use the short term plan process to incorporate the MHRS into iCAMS.

Table 5 **Health Home Documentation**

Document	Due	Who can complete/Approve
LOCUS	Upon admission into the CSA	Follow Chapter 34 standards
D&A (The D&A can also be completed and signed in the Comprehensive Health Assessment component)	Upon admission into the CSA and annually, thereafter	Follow Chapter 34 standards
Opt-In Consent	Once the consumer agrees to enroll into Health Homes	Health Home Team or CSA designee
Billing Attestation	Scheduled the first day of each month and completed for billing submission once the acuity-number and types of services have been completed.	Health Home Director or designee c
Health Home Comprehensive Health Assessment (The D&A can be signed within this document)	Must be completed within 45 days of Opting-In to the Health Home Benefit and annually, thereafter	Health Home Team can complete If the D&A will live in the Behavioral Assessment component, then it must be signed by AQP and the RN Care Manager
Health Home Comprehensive Care Plan (The MHRS IRP is rolled into this plan therefore MHRS standards must be followed for approving signatures)	Must be completed within 45 days of Opting-In to the Health Home Benefit and must be reviewed and/or revised every 180 days	Health Home Team can complete An AQP and the RN Care Manager are the approving practitioners
Annual note	At the year anniversary of the Opting-In	Health Home Team

All Health Home services must be documented in iCAMS. A list of the required services and examples of each is reflected on the chart below.

Table 6 **List of Health Homes Services**

Health Home Services	Service Examples
Comprehensive Care Management	Assessment of health risk and identification of level of care; Identification of service needs and construction of a comprehensive care plan addressing physical and behavioral health chronic conditions, current health status, and goals for improvement; Construction of standardized, evidence-based protocols and clinical pathways for mental health, physical health, social, employment, and economic needs; Monitoring of the individual and population health status and service use; Development and dissemination of reports on satisfaction, health status, cost and quality to guide Health Home service delivery and design; Development of partnerships with physical health care providers and community-based entities in order to facilitate the sharing of information and timely responses to each consumer's needs; and Assignment of different care management roles to members of the Health Home Team;
Care Coordination	Developing strategies and supportive mental health intervention for avoiding out-of-home placement and building stronger family support skills and knowledge of the consumer's strengths and limitations; Providing telephonic reminders of appointments; Providing telephonic consults and outreach; Communicating with family members; Identifying outstanding items on consumer visit summaries such as referrals, immunization, self-management goal support and health education needs; Assisting RN Care Manager with medication reconciliation; Making appointments; Providing consumer education materials; Assisting with arrangements such as transportation, directions and completion of durable medical equipment requests;

	Making appointments; Providing consumer education materials; Assisting with arrangements such as transportation, directions and completion of durable medical equipment requests; Obtaining missing records and consultation reports; and Participating in hospital and emergency room (ER) transition care.
Comprehensive Transitional Care	Contact with the consumer within forty-eight (48) hours of the completed transition; Outreach to consumer to ensure appropriate follow-up after transitions; Ensuring visits for consumer with the appropriate health and community-based service providers following the completed transition; Developing strategies and supportive mental health interventions that reduce the risk for or prevent out-of-home placements for adults and builds stronger family support skills and knowledge of the adult's strengths and limitations; and Developing mental health relapse prevention and illness management strategies and plans.
Health Promotion	Providing consumer education and development of self-monitoring and health management related to consumer's particular chronic conditions as well as in connection with healthy lifestyle and wellness, for example, nutrition, substance abuse prevention, smoking prevention and cessation and physical activity; Assisting with medication reconciliation; Developing and implementing health promotion campaigns; and Connecting consumer with peer and recovery supports including self-help and self-management and advocacy groups. Mental health education, support and consultation to consumer's families and their support system, which is directed exclusively to the well-being and benefit of the consumer; Assisting the consumer in symptom self-monitoring and self-management for the identification and minimization of the negative effects of psychiatric symptoms, which interfere with the consumer's daily living, financial management, personal development, or school or work performance.
Individual and Family Support Services	Assistance and support for the consumer in stressor situations; Mental health education, support and consultation to consumer's families and their support system, which is directed exclusively to the well-being and benefit of the

	consumer; Developing mental health relapse prevention and illness management strategies and plans; Activities that facilitate the continuity in relationships between consumer/family with physician and care manager; Advocacy on a consumer's behalf to identify and obtain needed resources such as medical transportation and other benefits for which they may be eligible; Consumer education on how to self-manage their chronic condition; Providing opportunities for the family to participate in a consumer's assessment and care treatment plan development; Efforts that ensure that health home services are delivered in a manner that is culturally and linguistically appropriate for the consumer; and Efforts that promote personal independence and empower the consumer to improve their own environment and health. This may include engagement with a consumer's family in identifying solutions to improve a consumer's health and environment and helping consumer and their families with the consumer's authorization to access the consumer's health record information or other clinical information.
Referral To Community and Social Support Services	Wellness programs, including smoking cessation, fitness, weight loss programs; Specialized support groups (i.e. cancer, diabetes support groups); Substance use recovery support groups ; Housing resources; Supplemental Nutrition Assistance Program; Legal assistance resources; Faith-based organizations; and Access to employment and educational program or training.
Other Essential Components for Health Homes Service Deliver	
Comprehensive Health Assessment	Active participation and partnership with the consumer; A comprehensive physical health, behavioral health and socioeconomic assessment that is required to be completed at least annually; All Health Home team members may participate in development of CHA . The AQP and Nurse Care Manager as the approving authority for the CCP. Must be completed within 45 days of signing the Opt-In consent Is a Comprehensive Care Management service
Comprehensive Care Plan	Active participation and partnership with the consumer; The consumer's goals as identified by the comprehensive assessment and the timeframes and strategies for addressing each;

	The delineation of the specific roles and responsibilities of the members of the Health Home Team who are assisting the consumers in achieving his/her goals; and All Health Home team members may participate in development of CCP All parties involved in the development of the CCP should be named. The signature of consumer is required along with the AQP and Nurse Care Manager as the approving authority for the CCP. Must be completed within 45 days of signing the Opt-In consent. Must be reviewed and updated minimally every 180 days. Is a Comprehensive Care Management service

Unusual Events

Any unusual event should comport with DBH Policy 480.1C, Reporting Major Unusual Incidents (MUIs) and Unusual Incidents (UIs) dated October 21, 2010.

MHRS Consumers

A consumer that receives both MHRS services must still meet the requirements of MHRS. The required documents, signatures and timelines are all applicable to the MHRS. The Behavioral Assessment component of the CHA is the same document as the MHRS Diagnostic and Assessment (D&A) tool. Although there may be a D&A in the CSA's EMR system, the Health Homes must ensure that the Behavioral Assessment is entered (typed) into the Health Home CHA.. If the Health Home Team has staff that meet the criteria of an AQP and QP, from the MHRS regulations, then the Behavioral Health component that is documented, in the Health Home CHA, can be signed by the Health Home AQP and QP staff and satisfy both the MHRS and the Health Homes regulations, and will eliminate ongoing duplication of work.

INTEGRATED CARE MANAGEMENT SYSTEM (iCAMS)

The District's Integrated Care Management System (iCAMS) plays a vital role in helping Health Homes and the District document, monitor and report on levels of utilization, justification for the type and level of interventions provided, if and how interventions are being carried out, and the status of client progress in meeting identified health goals.

Health Homes will use iCAMS as a tool to deliver the six-core Health Home services described above. iCAMS is the platform for capturing, tracking and submitting claims for services provided to enrolled consumers. This electronic health record, billing and claims system will be eventually

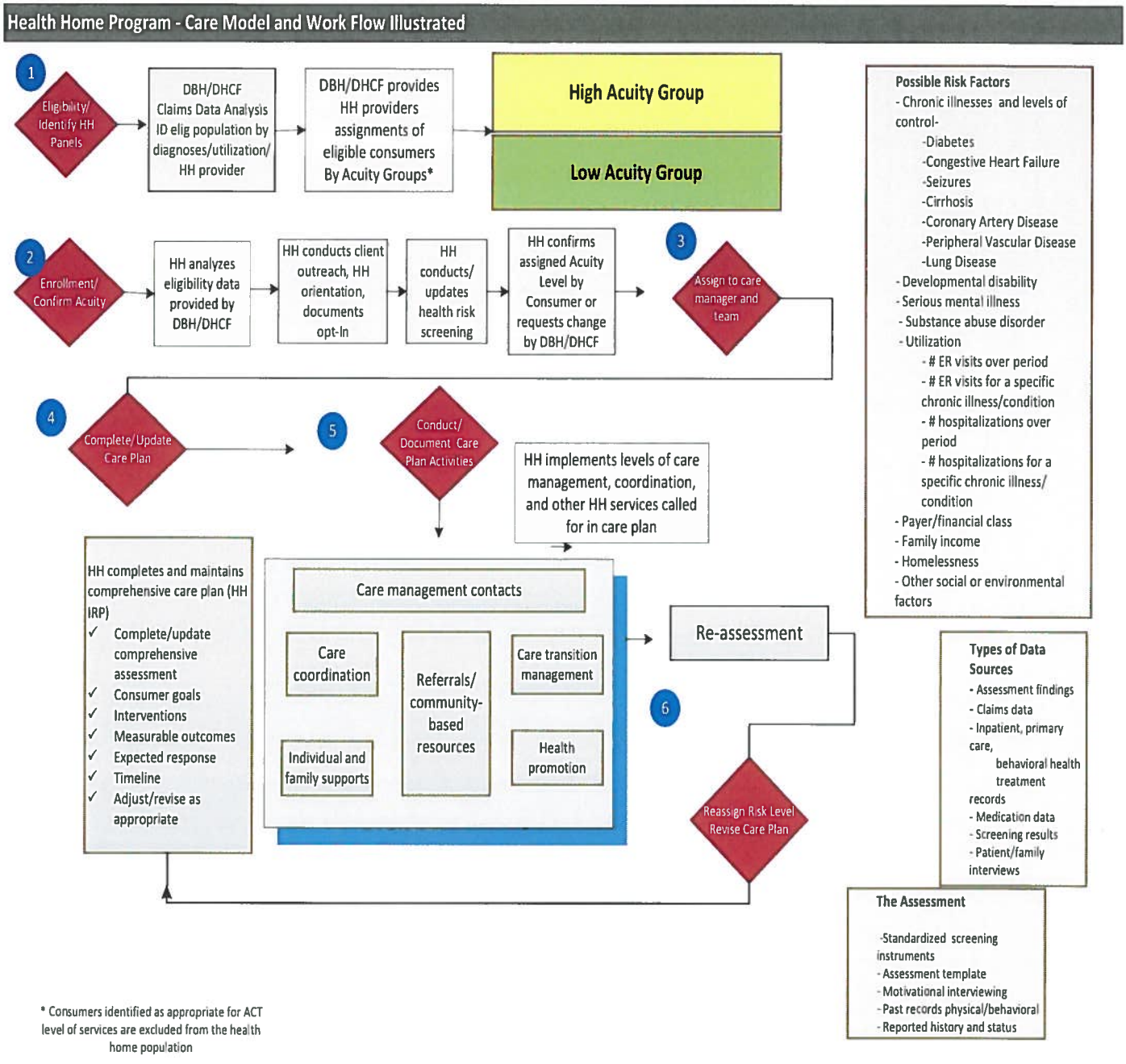
populated with information generated from other health information systems and community service providers such as: 1) DC's Federal Qualified Health Centers; 2) local hospitals, by leveraging the Encounter Notification Service within the Chesapeake Required Information System for our Patients Health Information Exchange (CRISP) 3) DC's Medical Management Information System from which periodic feeds of Medicaid claims and encounter data will be generated and uploaded into iCAMS; and 4) other administrative systems such as the DC Access System (DCAS), the DC's integrated eligibility determination system.

WORK FLOW AND OPERATIONAL STEPS

WORKFLOW DIAGRAM

The operational steps described in this section correspond to the Health Home Care Model – Work Flow diagram presented below (Figure 3). The steps illustrate how CSAs serving as Health Homes must integrate use of HIT and HIE in their practice to address the core functions required for comprehensive care management.

Figure 2 Health Home Care Model and Work Flow Chart



* Consumers identified as appropriate for ACT level of services are excluded from the health home population

STEP 1.

ELIGIBILITY – DATA ANALYSIS TO IDENTIFY AND PROFILE HEALTH HOME PANELS

The District will make an initial determination of health home eligibility through an analysis of claims data. All consumers ages 18 years of age or older will be eligible for the Health Homes benefit. Consumers with a diagnosis of serious mental illness will be categorized as either high or low acuity consumers based upon their service utilization. Consumers requiring Assertive Care Treatment level of care will not be eligible for Health Homes.

One of the core objectives of a Health Home is providing highly individualized care management and care coordination to consumers with complex conditions that may not be well-controlled and result in multiple hospital inpatient admissions or emergency room visits. Medicaid eligibility files will be made available to Health Home providers so that they can affirm the acuity level assigned by the District for eligible consumers. Health Home providers will be required to develop procedures for routinely reviewing the eligibility files and using the data to adjust care management plans to address consumer's needs. This information will also be used to identify focus areas for health promotion and prevention activities across panels.

Task Plan to Complete Data Analyses and Develop Profiles for Health Home Panels			
	Taken by	**Action**	**Pathway**
1.1	DHCF/ DBH	• DHCF/DBH generates and makes eligibility file available to each Health Home (HH) provider grouped by High and Low Acuity based on claims/encounter data, sorted by condition, utilization and last CSA provider seen.	DHCF to iCAMs
1.2	DHCF/ DBH	• Eligibility/Opt-In file will be refreshed periodically by the District	DHCF to iCAMs
1.3	HH	• Establish written process for reviewing updated eligibility/Opt-In data to identify changes in status. • Identify new consumer's eligible for the Health Home benefit that should be contacted to determine whether they would like to participate in the initiative. • Review data to determine if a request should be made to obtain changes in acuity status.	HH to iCAMs

TARGETED OUTREACH, OPT-IN, ASSESSMENT OF CARE MANAGEMENT SERVICE LEVELS

Once a Health Home has a list of eligible consumers, it must conduct additional data analysis to further understand the consumer's health status and utilization patterns. Consumers must be contacted to determine their interest in receiving the Health Home benefit. The Health Home staff will meet with the consumers to provide them with an orientation to the Health Home benefit. The staff will describe the range of services that are available, the role and responsibilities of the staff and their responsibility to engage in self-management and wellness activities to improve their health status. They will be informed of their right to decline services at any time and that this will not impact their ability to receive the full range of behavioral health services and supports available through the DBH. Each person must affirm their agreement to be enrolled in the service in writing.

As outlined in Chapter 25 (2512.2-2512.4), the Health Home will be required to conduct an annual Comprehensive Health Assessment (CHA),) which is a physical, behavioral health and social, housing and community support assessment, which must be completed within 45 days of consumer's signing of the Health Home consent form. The Health Home should explore whether the person has experienced any past or recent stressors or traumatic events that might impact their health status and acuity level designation. The assessment shall include information from the MHRS IRP, health screenings, and an evaluation of medical, behavioral, and social determinants (e.g., housing, transportation, economic conditions, and family/caregiver circumstances).

The findings of this assessment should be used in concert with medical and other Medicaid claims information available in iCAMs to develop the individualized comprehensive care plan. Billing for HH services can begin upon the consumer signing of the consent form. Although the CCP and the CHA are due within 45 days of this date of signing the consent, HH services may begin immediately. The due date of the CCP and CHA is independent of the MHRS requirement. Any MHRS must follow Chapter 34 requirements.

The CCP should clearly delineate (1) the services provided, (2) who will provide the services (3) frequency of the services to be provided and (4) the expected outcomes of the interventions.

Task Plan to Enroll/ Opt-In Members, Conduct Screening and Assessments to Determine Care Management Needs			
	Taken by	**Action**	**Pathway**
2.1	HH	• Eligibility file will be reviewed to create a preliminary profile of HH eligible consumers and to further stratify risks among acuity levels. • Analyzes acuity level data provided to Health Home • Sorts consumers by acuity level and service needs based on identified health risk factors.	• HH Provider reviews information in iCAMs • MHRS assessments, physical health care information, treatment plans, and service utilization data • Establish case load configurations for Health Home teams
2.2	DBH	Provides consumer information on Health Home during orientation session; obtain consumer's consent.	DBH to HH providers HH provider develops internal Opt-In policies/procedures and workflows
2.3	HH provider	Develops and documents strategy to engage assigned consumers. This includes: • A description of the method of contact. • Identification of who is responsible for making contact with the consumers. • Written description of the workflow and documentation to be completed. • Assure: Assuring the Health Home team follows the iCAMS enrollment process for consumers that are interested in Opting-In to the Health Home Benefit including: -Consent signing -Assigning Program -Assigning Benefit -Assigning Nurse care manager and team -Assuring the scheduling and completion of the billing attestation	HH to internal case management system and/or HH to iCAMs HH protocols, work flows to HH teams
2.4	HH Provider	Contacts assigned consumers to: • Provide an orientation to the Health Home benefit. Confirm the consumer's choice to Opt-In. • Conduct health risk screenings/assessment. • Schedule follow up appointment for additional assessments/in-person visits as appropriate.	HH to care management and scheduling software iCAMs: • Mail, in-person contacts • Health risk screenings and assessments conducted • Consent form signed by consumer

ASSIGNMENT OF EACH CONSUMER TO A NURSE CARE MANAGER AND CARE TEAM

Team based care is a key dimension of the Health Home model. Each Health Home consumer must be linked to a Nurse Care Manager who is a part of the Health Home Team. The Nurse Care Manager is an essential member of the team and is responsible for ensuring that on-going care management and care coordination services are delivered to each consumer. He/she will assign consumers to Care Coordinators that serve as a liaison to physical health providers. Team assignments may be determined based upon levels of acuity or other key health care characteristics of each consumer. Assignments should be noted in the consumer's care plan.

Each Health Home must institute internal protocols for assigning consumers to a Nurse Care Manager and Health Home Team, determining which team members will perform key roles, and monitoring team capacity and accountability for the provision of Health Home services.

Assignment of Individual Consumers to an RN Care Manager and Care Team			
	Taken by	**Action**	**Pathway**
3.1	HH Provider	• Assigns consumers to a team and nurse care manager based on acuity levels, other characteristics and relevant factors; and team case mix/capacity • Signs the CHA.(AQP must sign if the D&A is included in the CHA). • Signs the CCP with a AQP	HH will document the following data in iCAMs: RN care manager and team members assigned to an consumer, including peer support partners Primary care provider Other providers required to implement the care plan (e.g. nutritionist)
3.2	HH Provider	Health Home Director/Nurse Care Manager(s) track consumer status and monitor team assignments to determine: • Targeted high risk consumers care coordination needs. • Ongoing changes in risk status and the strategies employed to address identified issues	HH will document information in iCAMs to generate management reports

DEVELOP AND MAINTAIN COMPREHENSIVE CARE PLAN

The Health Home provider must develop a CCP utilizing the DBH template which contains required data elements and related forms. The template will be available in iCAMs. The care plan shall include the following:

- Person-centered health and wellness goals as identified by the consumer's needs;
- Interventions that are designed to address the consumer's acuity level, unique characteristics and service needs;
- Expected outcomes and milestones;
- Include information from the most recent IRP, if applicable
- Include all services the consumer is receiving and from whom
- Timelines for achieving goals; and the
- Person (s) responsible for assisting the consumer to achieve goals.

The care plan shall be reviewed at a minimum of every 180 days or when the consumer's level of care needs change. The approved qualified practitioner and Nurse Care Manager must sign off on the initial CCP and all subsequent CCP updates.

Screening and assessment data derived from the following sources, along with qualitative data collected from the consumer and his/her significant others should be used to develop the CCP plan goals. This includes:

- Physical and mental healthcare screenings and assessments, should be reviewed and updated annually;
    - Consider consumer's beliefs, values, and cultural norms
- Substance use screenings and assessments;
- Medical record review; and
    - Consider MCO and other outside provider information
- Review of the person's current diagnosis and behavioral health treatment plan.
    - Consider MCO and other outside provider information

Examples of the screening tools and assessments that may be used to support goal development can be found in the chart below:

Develop and Maintain Comprehensive Care Plan			
	Taken by	**Action**	**Pathway**
4.1	HH Provider	Team members obtain information on the physical health, behavioral health, social status and other service-related needs to develop the comprehensive care plan.	HH reviews data in iCAMs HH obtains information from consumer and others and document this information in iCAMs HH conducts appropriate screenings and assessments and documents results in iCAMs
4.2	HH Provider	HH conducts appropriate screenings/ assessments that include but not be limited to: o Depression PHQ 9 o Level of Care LOCUS o Global Appraisal of Individual Needs (GAINS-SS) • Obtain information from consumer on of diagnoses, treatment, and current health status • Conduct medication reconciliation to assure medications are appropriate for identified health and behavioral health conditions • Identify consumer's goals for health promotion • Identify consumer's o Physical health needs and goals o Behavioral health needs and goals o Financial needs and goals o Family and community supports need and goals o Frequency of HH contacts and services to be provided	HH documents consumers' needs HH documents health data
4.3	HH Provider	HH Primary Care Liaison consults as appropriate with the consumers primary care and behavioral health practitioners as well as community support network for information and strategies pertaining to the care management/care coordination services	HH documents recommended treatment protocols based upon input from collateral contacts in consumer's care plan HH in collaboration with the consumer prioritize needs and established health and wellness goals
4.4	HH Provider	HH completes the comprehensive care plan • HH obtains consumers' signature on completed plan	HH documents data in iCAMs • Generate copy for consumers
4.5	HH Provider	Share CCP with the consumer's health care providers such as MCOs, primary care providers, FQHCs, etc.	MCOs and other authorized parties access CCP via iCAMs

PROVIDE HEALTH HOME SERVICES AS OUTLINED IN CARE PLAN

The Health Home benefit is designed to provide care management and care coordination services to individuals that Opt-In to the service. The Health Home team documents activities undertaken to achieve the goals of the CCP, progress made in achieving the goals, opportunities and challenges encountered and outcomes. The CCP is a nimble document that guides service delivery. It should be reviewed at least monthly and as needed with the consumer and modified as their health status and service needs change over time. Progress notes should be maintained in the person's electronic health record to document goal achievement, unforeseen changes in status do to traumatic events or other issues and adjustments to the strategies employed to achieve goals.

Provide Comprehensive Health Home Services as Outlined in the Care Plan			
	Taken by	Action	Pathway
5.1	HH Provider	HH implements CCP and documents frequency and type of contacts	HH documents activities in iCAMs
5.2	HH Provider	HH convenes team meetings, monitor and assist consumers' in achieving stated goals • Designated team members generates care coordination/progress reports for assigned consumers • Progress reports and changes in stated goals and strategies are developed with consumer input.	HH documents case management and care coordination services in iCAMs
5.3	HH Provider	HH develops and implements transitional care coordination protocols • Designated team members are assigned responsibility for responding to alerts/notifications received from iCAMs • Nurse care manager institutes contact with hospitals, CPEP or other in-patient or emergency service providers as appropriate o Designated team member and nurse care manager review records and institute transitional care planning o Review discharge information o Schedule follow up and conduct a reassessment of member o Updates CCP	HH documents transitional care activities in iCAMs
5.4	HH Provider	HH provides ongoing case management and care coordination services to each consumer	HH documents activities in iCAMs

RE-ASSESSMENT AND REVISIONS TO COMPREHENSIVE CARE PLAN

Health Home providers must revise/update the CCP at least every 180-days and the CHA must be completed annually. The CCP should be revised whenever warranted by a change in a Health Home consumer's condition as evidenced by a care level transition i.e. moving between ambulatory and in-patient care, if the consumer decides to Opt-Out, or whenever there is a change in condition that affects the consumer's acuity level or ability to achieve his/her stated goals.

Additionally, at least annually the Health Home must conduct a retrospective review (Annual Note) to determine the degree to which the individualized strategies implemented to support the CCP have resulted in improvements in the consumer's health status and overall well-being. Improvements on the CMS Health Home Core Quality Measures and District of Columbia Health Home Quality Measures (Appendix C) as well as areas in which there has been a decline in health status shall be documented in the electronic health record. In addition, improvements made by the person to self-manage his/her illnesses shall also be noted.

Monitoring and Re-Assessment of Comprehensive Care Plan			
	Taken by	**Action**	**Pathway**
6.1	HH Provider	HH conducts re-assessment of CCP of each consumer at least once every 180 days or when the consumer's health status or circumstances change • iCAMs alert triggers 180 day assessment due date • Team members updates the BH/ PH assessment and the CCP with the consumer • AQP and RN Care Manager are the approving practitioners	HH documents care plan updates and the results of the retrospective review in iCAMs
6.2	HH Provider	HH monitors the consumers' s progress in achieving stated goals • Designated team leaders (RN care manager, Health Home Director, Primary Care liaison) convenes team on a routine basis to review goals and progress of each consumer • Health Home Director monitors overall HH team performance through an annual retro review to assess the progress o Consumers' goal achievement o Consumers' satisfaction with services received from the HH o Compliance with Quality Measures o Compliance with federal and District rules and regulation o Adherence to evidence based guidelines/clinical pathways	HH documents consumers' progress iCAMs

Measuring Health Home Quality

The success of the HH Initiative will be determined by each HH's ability to achieve outcomes as measured by the CMS and DBH Health Home Core Quality Measures.

See Appendix C *Health Home Quality Measures and Specifications* for additional details about measure descriptions, source, numerator, and denominator.

Table 5 Required CMS Health Home Quality Measures

Health Home Quality Metrics	
No.	**Measure**
1.	Adult BMI Assessment
2.	Ambulatory Care Sensitive Condition Admission
3.	Care Transition – Transition Record Transmitted to Healthcare Professional
4.	Follow-Up After Hospitalization for Mental Illness
5.	Plan – All Cause Readmission
6.	Screening for Clinical Depression and Follow-Up Plan
7.	Blood Pressure Screening
8.	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Table 6 District-Specific Health Home Quality Measures –

Health Home Quality Metrics For Reporting	
No.	**Measure**
9	Prevention Quality Indicators Inpatient Utilization
10.	Emergency Department Utilization
11.	Tobacco Cessation Screening
12.	Tobacco Cessation
13.	Comprehensive Care Plan
14.	Individuals With Regular Physical Health Exams/Checkups
15.	Consumers Satisfaction

APPENDICES

APPENDIX A:

USE OF HEALTH INFORMATION TECHNOLOGY AND HEALTH INFORMATION EXCHANGE IN HEALTH HOME SERVICES

The Integrated Care Applications Management System

The Integrated Care Applications Management System (iCAMs) is the Internet Technology (IT) solution developed for DBH by Credible Wireless. It will serve as the core component of a comprehensive health information technology/exchange (HIT/E) for the District's Health Home Benefit Initiative. iCAMS is the official clinical record for the Health Home enrollees and all Health Home providers will be required to use iCAMs as the single platform for authorizing HH services, receiving electronic health information, and documenting the provision of HH services to consumers. Data contained in iCAMs will also be used to evaluate the HH Benefit Initiative.

iCAMs will contain some of the data which is necessary for the HH to develop a comprehensive plan. Other sources of data include, but is not limited to, information from the consumer or his/her significant others. Providers will be able to obtain updates on the physical and behavioral health status of consumers and other relevant information such as housing, financial and social engagement through this system.

iCAMs will be populated with consumer's information, such as the initial and periodic health status updates and risk assessments, through systems interfaces to entities such as:

- The District's FQHCs, most of which utilize their own electronic health record solution;
- The District's hospitals, by leveraging the Encounter Notification Service available from health information exchanges;
- The District's Medicaid Management Information Systems (MMIS). Medicaid encounter data will be generated and uploaded from this source into iCAMs;
- Other administrative systems such as District of Columbia Access System (DCAS), which is the District's integrated Medicaid eligibility determination system and Web Infrastructure for Treatment Services (WITS), the system used to track delivery of SAMHSA-funded substance abuse services by authorized providers; and laboratories that analyze clinical tests prescribed by health care practitioners.
- iCAMs will support the following essential Health Home functions:

- Initial screening and health/functional assessment, risk analysis and stratification;
- CCP development and revision ; and
- Notification when a consumer visits an emergency room is hospitalized or misses a scheduled appointment through its alert function.

Chesapeake Regional Information System for Our Patient (CRISP)

Access to real time information regarding consumer hospital admissions, discharges and transfer activity (ADT) is critical for Health Home Providers, in order to coordinate the care of consumers. CRISP is a system that provides electronic notification of these ADT activities. iCAMS will be conduit that Health Home providers will receive the CRISP data feeds. iCAMS will provide CRISP with updated demographic information on a monthly basis and CRISP will provided daily feeds to iCAMS. iCAMS will upload the CRISP data into the consumes profile daily and a notification of the alert will be sent to the Health Home provider to notify them that CRISP data is available for a consumer.

ATTACHMENT #1 HEALTH HOME QUALITY MEASURES

There are eight (8) Core Health Home quality measures that CMS requires all state Health Home Benefits to use in order to monitor and evaluate their Benefit[15]. The District has also identified seven (7) local measures that will augment the federally mandated data set. The two charts below list CMS' Core Health Home and the District's Quality Measures.

[15]The Health Home Core Quality Measures are derived from and align with: (a) the mandatory quality measure reporting requirements included within section 401 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA); (b) the voluntary quality measure reporting requirements within section 2701 of the Affordable Care Act; and (c) the mandatory quality measure reporting requirements within section 3502 of the Affordable Care Act. The purpose of the core set is to assess individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes specific to the provision of health home services.

Centers for Medicare and Medicaid Required Health Home Core Quality Measures				
Topic	**Measure**	**Numerator/Denominator**	**Likely Data Source**	**Minimum Frequency for Monitoring**
1. Adult BMI Assessment	Percentage of individuals 18-74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year	**Numerator Description** Body mass index documented during the measurement year or the year prior to the measurement year **Denominator Description** Members 18-74 of age who had an outpatient visit	Medicaid Claims/ Medical Record	Yearly
2. Ambulatory Care-Sensitive Condition Admission	Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 populations under age 75 years. http://www.guideline.gov/content.aspx?id=15067	**Numerator Description** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years **Denominator Description** Total mid-year population under age 75	Medicaid Claims/ Medical Record	Every 6 months
3. Care Transition – Transition Record Transmitted to Health care Professional	Care transitions: percentage of individuals , regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge. http://qualitymeasures.ahrq.gov/content.aspx?id=15178	**Numerator Description** Members for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge **Denominator Description** All members , regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care	Medicaid Claims (Denom.) Survey/ Medical Record (Num.)	Yearly
4. Follow-Up After Hospitalization for Mental Illness	Mental health: percentage of discharges for individuals 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 and 30 days of discharge http://qualitymeasures.ahrq.gov/content.aspx?id=14965	**Numerator Description** An outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7and 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. **Denominator Description** Individuals 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on	Medicaid Claims	Monthly

		or between January 1 and December of the measurement year		
5. Plan - All Cause Readmission	For individuals 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	**Numerator Description** Count the number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination **Denominator Description** Count the number of Index Hospital Stays for each age, gender, and total combination	Medicaid Claims	Monthly
6. Screening for Clinical Depression and Follow-up Plan	Percentage of individuals aged 18 years and older screened for clinical depression using a standardized tool and follow-up documented	**Numerator Description** Total number of members from the denominator who have follow-up documentation **Denominator Description** All members 18 years and older screened for clinical depression using a standardized tool	Medical Record	At the time of admission (new admissions) Everyone else yearly unless clinical symptoms indicate otherwise
7. Blood Pressure Screening	Number and percent of individuals 18-85 years of age who a had diagnosis of hypertension and whose blood pressure was adequately controlled (140</90) during the measurement year	**Numerator Description** Number of individuals ages 18-85 with a diagnosis of hypertension who's most recent, representative BP is adequately controlled during the measurement year. For a member's BP to be controlled, both systolic and diastolic BP must be <140/90mmHg **Denominator Description** All individuals ages 18-85 with a diagnosis of hypertension A member is considered as having hypertension if there is at least one outpatient encounter with such a diagnosis during the first six months of the measurement year.	Medicaid Claims /Medical Record	Quarterly

8. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Percentage of individuals with a new episode of alcohol or other drug (AOD) dependence who received the following: • Initiation of AOD treatment. • Engagement of AOD treatment.	**Numerator** Initiation of Alcohol and other Drug (AOD) Dependence Treatment: Members with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis. Engagement of Alcohol and other Drug (AOD) Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted. **Denominator** Individuals 13 years of age and older as of December 31 of the measurement year with a new episode of alcohol or other drug (AOD) during the intake period, reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators.	Medicaid Claims/ Medical Record	Monthly

District of Columbia Health Home Quality Measures				
Topic	**Measure**	**Numerator/Denominator**	**Likely Data Source**	**Minimum Frequency for Monitoring**
Prevention Quality Indicator: Chronic Conditions Composite	Total number of admissions for ambulatory care for chronic conditions per 100,000 members age 18 and older. This measure includes admissions for the following Prevention Quality Indicators (PQIs): PQI 1:Diabetes, short- term complications PQI3: Diabetes, long-term complications PQI5:COPD or Asthma PQI7: Hypertension PQI8: Heart Failure PQI:13: Angina without Procedure PQI:14: uncontrolled Diabetes PQI:15 Asthma in younger adults PQI:16 Lower extremity amputation among individuals with diabetes	**Numerator Description** Discharges for members ages 18 and older who meet the inclusion and exclusion determinates for any of the following PQIs: PQI 1:Diabetes, short- term complications PQI3: Diabetes, long-term complications PQI5:COPD or Asthma PQI7: Hypertension PQI8: Heart Failure PQI:13: Angina without Procedure PQI:14: uncontrolled Diabetes PQI:15 Asthma in younger adults PQI:16 Lower extremity amputation among individuals with diabetes **Denominator Description** The members enrolled in a Health Home during the Opt-In year	Medicaid Claims/ Medical Record	Yearly
Emergency Department (ED) Utilization	Reduce utilization associated with avoidable (preventable) emergency room visit Average number of ED visits per member per Opt-In year	**Numerator Description** Number of visits per member per year **Denominator Description** All individuals during the measurement year	Medicaid Claims/ Medical Record	Yearly
Tobacco Cessation Screening	Percent of individuals who receive advise to quit smoking; and percent of individuals whose practitioners recommended or discussed smoking cessation techniques/program	**Numerator Description** Number of individuals using tobacco who within the measurement year have been provided with direct counseling on how to quit smoking **Denominator Description** Number of individuals using tobacco	Medical Record	At the time of admission (new admissions) Everyone else yearly unless clinical symptoms indicate otherwise
Tobacco Cessation	Percent of individuals who participate in smoking cessation program	**Numerator Description** Number of individuals using tobacco during the measurement who quit smoking **Denominator Description** Number of individuals using tobacco	Medical Record	Yearly

Comprehensive Care Plan (CCP) Identifies Behavioral, Physical and Community Support Needs	Percent of individuals whose CCP includes documentation of a current plan with an assessment, with delineation of Behavioral, Physical and Community Support Needs; and the appropriate referrals/linkage	**Numerator Description** Percentage of individuals during the measurement year whose IRP includes documentation of a current plan with an assessment, with delineation of Behavioral, Physical and Community Support Needs; and the appropriate referrals/linkage **Denominator Description** All individuals during the measurement year	Medical Record	Yearly
Individuals with regular physical health exams/check-ups	Percent of individuals having at least one physical exam during the measurement year	**Numerator Description** Percentage of individuals during the measurement year who received at least one physical exam **Denominator Description** All individuals during the measurement year		Yearly
Consumers Satisfaction	Percentage of individuals who reported overall satisfaction with services received from their Health Home consumer's care.	**Numerator Description** Number of individual satisfied with service received **Denominator Description** Number of individuals receiving Health Home services	Satisfaction Survey	Yearly or at the time of a planned discharge

ATTACHMENT #2 SELECTED HEALTH HOME RESOURCES

GOVERNMENT OF THE DISTICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Selected Health Home Selected Resources

FEDERAL

Centers for Medicare and Medicaid Services, Health Home Information Resource Center

http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html

Substance Abuse and Mental Health Services Administration, Health Home Resources

http://beta.samhsa.gov/health-reform/health-care-integration/health-homes

STATE

Alabama http://medicaid.alabama.gov/newsdetail.aspx?ID=7798

Idaho http://healthandwelfare.idaho.gov/Medical/Medicaid/IdahoHealthHome/tabid/2118/

Maine http://mainehealth.org/mhbody.cfm?id=7854

Maryland
http://dhmh.maryland.gov/bhd/SitePages/Health%20Home%20Requirement%20Information.aspx

Missouri http://dss.mo.gov/mhd/cs/health-homes/

New York http://www.health.ny.gov/healthcare/medicaid/program/medicaidhealthhomes/

Ohio http://healthtransformation.ohio.gov/CurrentInitiatives/CreateHealthHomes.aspx

Rhode Island http://aspe.hhs.gov/daltcp/reports/2012/HHOption-RI.pdf

South Dakota http://dss.sd.gov/healthhome/index.asp

Vermont
http://hcr.vermont.gov/sites/hcr/files/VTSPAConceptPaperfinalCMS100212.pdf

Washington http://www.hca.wa.gov/Pages/healthhomes.aspx

Wisconsin http://www.dhs.wisconsin.gov/medicaid/Behavioral-Health/index.htm **SELF-MANAGEMENT**

Agency for Healthcare Research and Quality, *Self-Management,* Prevention and Chronic Care Program, United States Department of Health and Human Services

http://www.orau.gov/ahrq/smshome.html

Centers for Disease Control and Prevention, Interventions for Mental Illness and Chronic Disease

http://www.cdc.gov/mentalhealth/aboutus/micd.htm

Center for Healthy Living, National Council on Aging

http://www.ncoa.org/improve-health/center-for-healthy-aging/chronic-disease/

Kera News, Chronic Illness and Mental Health, 2013 http://keranews.org/post/chronic-illness-and-mental-health

Mental Health America of Greater Houston, *Mental Health and Chronic Illness*

http://www.mhahouston.org/mental-health-and-chronic-illness/

Substance Abuse and Mental Health Services Administration, Illness Management and Recovery Evidence-Based Practices, H.H. Publication No: SMA-09-4462, 2010
http://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4463

DEFINITIONS

When used in this chapter, the following words shall have the meanings ascribed:

Approved Qualified Practitioner-a qualified practitioner responsible for overseeing the development and approval of the Individual Recovery Plan (IRP). The approving qualified practitioner serves on the Diagnostic /Assessment team. Only a psychiatrist, psychologist, LICSW, APRN or LPC may act as a AQP.

Behavioral Health Care – care that promotes the well-being of individuals by intervening and preventing incidents of mental illness, substance abuse, or other health concerns.

Billing Attestation – the billable service in iCAMS for Health Homes. The service must be scheduled for the first of every month and signed by the Health Home Director or their designee after verification that the monthly services have been completed.

Chronic Physical Condition – a somatic health condition, such as asthma, cardiovascular disease, diabetes, substance use disorder, and/or Human Immunodeficiency Virus.

Comprehensive Care Plan or CCP – an individualized plan to provide Health Home services to address a consumer's behavioral and physical chronic conditions, based on assessment of health risks and the consumer's input and goals for improvement.

Consumer – a person who seeks or receives mental health services or mental health supports funded or regulated by the Department.

Core Services Agency or CSA – a community-based provider that has entered into a Human Care Agreement with the Department to provide specific MHRS in accordance with the requirements of chapter 34 of this subtitle.

Cultural and Linguistic Competence - a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations. Culture refers to integrated patterns of health human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, institutions of racial, ethnic, religious or social groups. Competence implies having the capacity to function effectively as individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

Department of Behavioral Health or DBH – the District of Columbia agency that regulates the District's mental health and substance abuse treatment system for adults, children, and youth.

Health Home – an entity that is certified by the Department of Behavioral Health, that uses a patient-centered approach to coordinate a consumer's behavioral, primary, acute or other specialty medical health care services.

Health Home Team – the Health Home staff that delivers services to a specific group of consumers in their assigned Health Home teams. A Health Home Team includes the Health Home Director, Primary Care Liaison, Nurse Care Manager(s) and Care Coordinator(s).

High Cost Chronic Medical Conditions – medical conditions that create the need for intensive or long-term treatment and therefore make the cost of the individual's treatment higher than the average Medicaid beneficiary

iCAMS - Integrated Care Applications Management System (iCAMs) is the Internet Technology (IT) solution developed for DBH by Credible Wireless. It will serve as the core component of a comprehensive health information technology/exchange (HIT/E) for the District's Health Home Benefit Program to be used by all Health Home Providers as the single electronic medical record for Health Home consumers.

Integration of Care[16]**-** the systematic coordination of general and behavioral healthcare. The integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.

Mental Health Rehabilitation Services or MHRS –palliative services provided by a Department-certified community mental health provider to consumers in accordance with the District of Columbia State Medicaid Plan, the Medical Assistance Administration (MAA) (now Department of Health Care Finance (DHCF))/ Department Interagency Agreement, and chapter 34 of this subtitle.

Person Centered[17] **-** The person-centered planning process is an ongoing process involving the consumer, their family, and other supports. Its intent is to identify and address a consumer's changing strengths, capacities, goals, preferences, needs, and desired outcomes. The information gathered in the process along with medical assessments is used to create a person-centered plan. The plan is necessary to address a consumer's long-term care needs as an alternative to institutionalization.

Serious and Persistent Mental Illness – 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-IV or its ICD-9-CM equivalent (and subsequent revisions) with the exception of DSM-IV "V" codes, substance abuse disorders, intellectual disabilities and other developmental disorders, or seizure disorders, unless those exceptions co-occur with another diagnosable mental illness.

[16] http://www.integration.samhsa.gov/about-us/what-is-integrated-care
[17] https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/hcbs-tk2-care-plan-requirements-booklet.pdf