

Health Home State Plan Amendment

Submission Summary

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

Name of Health Homes Program: Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

State Information

State/Territory name: District of Columbia

Medicaid Agency: District of Columbia Department of Health Care Finance

Authorized Submitter and Key Contacts

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Proposed Effective Date: 1/1/2015

Executive Summary

Summary description including goals and objectives: Since 2012 the District of Columbia Departments of Health Care Finance, Health and Behavioral Health have been partnering to develop a program that would result in improved health outcomes, reduced avoidable hospital admissions, and emergency department (ED) visits among individuals with chronic health conditions. The goal is to achieve more comprehensive, coordinated, and cost-effective care for individuals with chronic conditions than what is generally provided when services are fragmented and uncoordinated across multiple health providers and systems. Following a year-long planning and data analysis effort, the Department of Health Care Finance determined that it would develop its Health Home benefit for individuals with serious and persistent mental health conditions, and continued working in collaboration with the Department of Behavioral Health, formerly the Department of Mental Health, to establish the Health Home model of care for the target population described in this Medicaid State Plan Amendment.

On October 1, 2013 the District of Columbia established the Department of Behavioral Health (DBH), combining treatment and support for residents with mental and/or substance use disorders (SUD). The new Department merges the former Department of Mental Health and the Addiction Prevention Recovery Administration (APRA), which was formerly located within the Department of Health (DOH). The new DBH promotes the integration of mental health and SUD treatment and has the responsibility for addressing the needs of individuals who are seeking assistance for a SUD, a mental health condition or both. DBH will build on its service integration efforts through the implementation of Medicaid Health Home services for individuals with serious and persistent mental health conditions. Health Homes will be responsible for the coordination of care for eligible individuals who, in addition to serious and persistent mental health conditions, may also have co-occurring chronic medical conditions, including substance use disorders.

The goals of District of Columbia Health Homes for eligible beneficiaries are aligned with those of the Centers for Medicare & Medicaid Services (CMS) and are to improve the integration of physical and behavioral health care; lower rates of hospital emergency department (ED) use; reduce avoidable hospital admissions and re-admissions; reduce healthcare costs; improve the experience of care, quality

of life and consumer satisfaction; and improve health outcomes. In addition, the District expects to achieve better care coordination and management of health conditions as well as increase the use of preventive and wellness management services.

Under the District’s approach to Health Home implementation, a Health Home provider is the central point for coordinating patient-centered and population-focused care for both behavioral health and other medical services. Communication and collaboration within Health Homes and among external health care partners will be supported by DBH’s web based electronic medical record and billing system called the Integrated Care Applications Management System (iCAMS), and is intended to prevent hospital admissions/readmissions and avoidable ED visits, enabling timely post-discharge follow-up and improving patient outcomes by addressing the full spectrum of individuals’ health needs (i.e., primary care, behavioral health, specialty services, long-term services and supports).

Designated providers that meet the standards of a Health Home as defined by the District will provide Health Home services.

Federal Budget Impact

Federal Fiscal Year		Amount
First Year	2015	TBD
Second Year	2016	TBD

Federal Statute/Regulation Citation

Governor’s Office Review

- No Comment
- Comments received:
- No response within 45 days.
- Other: Not Applicable

Submission – Public Notice

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

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

Indicate how public notice was solicited:

- Newspaper Announcement

Name:

Date of Publication:

Locations Covered:

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

Date of Publication: TBD

Email to Electronic Mailing List or Similar Mechanism.

Date of Email or other electronic notification:

Description:

Website Notice

Select the type of website:

Website of the State Medicaid Agency or Responsible Agency

Date of Posting: TBD

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

Website for State Regulations

Date of Posting:

Website URL:

Other Website

Type:

Date of Posting:

URL:

Public Hearing or Meeting

Date: June 11, 2014

Time: 3:30 – 5:00 pm

Location: 1300 1st Street, NE Washington, DC 20002

Other Method

Name:

Date:

Description:

Submission – SAMHSA Consultation

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

Date of consultation: 06/06/2013

Health Homes Population Criteria and Enrollment

Population Criteria

One or more serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition: Criteria for a serious and persistent mental health condition are defined in D.C. Code § 7-1131.02. Individuals eligible for Health Home services have a diagnosable mental, behavioral, or emotional disorder (including those of biological etiology) which substantially impairs the mental health of the person or is of sufficient duration to meet diagnostic criteria specified within the DSM-IV or its ICD-9-CM equivalent (and subsequent revisions) with the exception of DSM-IV "V" codes, substance abuse disorders, intellectual disability, and other developmental disorders, or seizure disorders, unless those exceptions co-occur with another diagnosable mental illness.

Geographic Limitations

Health Homes services will be available statewide

Enrollment of Participants

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

Opt-In to Health Homes provider

Describe the process used:

Automatic Assignment with Opt-Out of Health Homes provider

Describe the process used: The District will use an automatic assignment with opt-out method to enroll eligible Medicaid beneficiaries with a Health Home provider. Individuals eligible for Health Home services will be identified and assigned to a Health Home provider by the District using Medicaid claims and encounter data. The goal will

be to assign consumers to the Health Home provider with which they are currently enrolled to enhance service coordination. However, consumers will have the right to select an alternate Health Home provider if they choose. If overall Health Home capacity is not sufficient to serve the entire eligible population (particularly in the first few months of the program as provider capacity increases), the District will help providers target initial services to those most in need of comprehensive Health Home services. For individuals who have not recently received services from any certified Health Home provider, a protocol for informing the beneficiary of their eligibility for Health Home services and their options of service providers will be developed. As part of the enrollment process, individuals assigned to a Health Home provider will be contacted to participate in a face-to-face encounter with the Health Home provider. During the encounter, the provider and consumer will discuss: (1) the consumer's health status/risk factors; (2) benefits of Health Home service; (3) their rights and responsibilities related to disclosure of personal health information and the requirement to obtain consent to share relevant information with the consumer's care team; and (4) the "opt out" process for consumers to decline participation in Health Home services.

Individuals who opt out of Health Home services will be permitted to receive Health Home services at any time as long as they continue to meet Health Home service eligibility requirements. Individuals who opt out of receiving Health Home services may do so without jeopardizing their access to other medically necessary services from the Health Home provider. To avoid duplication in service delivery, individuals are not permitted to receive Health Home services during the same time they receive Community Support Services, which is currently offered as part of the District's Mental Health Rehabilitation Services (MHRS) benefit. The skill-building and coordination services offered through the MHRS Community Support Services will be offered to all enrolled individuals through the Health Homes benefit.

Individuals new to Medicaid or referred for Health Home services from hospitals or other settings with a diagnosis of serious and persistent mental illness will be eligible for this benefit. A protocol for informing individuals of their eligibility for Health Home services and their options of service providers will be developed.

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

Other

Describe:

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

Health Homes Providers

Types of Health Home Providers

Designated Providers

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

Community Mental Health Centers

Describe the Provider Qualifications and Standards: Designated providers of Health Home services for individuals with serious and persistent mental health conditions shall be Core Services Agencies (CSAs) or specialty providers of Assertive Community Treatment (ACT) identified by the District to meet the standards of a Health Home. In order to meet the Health Home standards, CSAs must be adequately staffed by teams of health care professionals that represent, at a minimum, the following functions:

- Health Home Director;
- Primary Care Liaison;
- Registered Nurse Care Manager; and
- Care Coordinator.

ACT providers must be adequately staffed by teams of health care professionals that represent, at a minimum, the following functions to meet Health Home standards:

- Primary Care Liaison;
- Registered Nurse Care Manager; and

- Care Coordinator.

Under the District's approach to Health Home implementation, a Health Home provider is the central point for coordinating patient-centered care and is accountable for reducing avoidable health care utilization and costs. Communication and collaboration within Health Home providers and among external health care partners is intended to prevent avoidable inpatient admissions/readmissions (e.g., hospital or skilled nursing facility) and avoidable emergency room visits, enable timely post-discharge follow-up and improve patient outcomes by addressing person-centered and population-focused health needs (i.e., primary care, behavioral health, specialty services, long-term services and supports).

Supports for Health Home Providers

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

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

Description: In order to ensure the delivery of quality Health Home services, the District will make available ongoing training and technical assistance opportunities for Health Home providers, including a curriculum of content modules delivered via various venues (e.g. meetings, webinars,

and teleconferences) to foster shared learning, information sharing and problem solving. Targeted efforts, beginning prior to program implementation, will focus on supports for providers as they implement Health Home policies and practices, develop their information infrastructure and data analytics, and begin to develop their Health Home workforce teams. Ongoing educational opportunities will be provided to support the provision of timely, comprehensive, high-quality Health Home services that are whole-person focused and that integrate medical and behavioral health, and other needed supports and social services. Helping Health Homes develop workforce competencies in delivering evidenced-based chronic care management, utilizing a combination of internal and external technical assistance resources to provide coaching and collaborative learning supports will be a priority. The District will communicate externally to other agencies, health providers and community stakeholders to support the collaborative engagement of these entities with Health Home providers as they coordinate delivery of health care services.

Another critical support that will help Health Homes accomplish the Health Home components listed in this state plan amendment is a coordinated care plan that will be embedded in iCAMS, DBH's new electronic medical record and billing system. The care plan will include an individualized, comprehensive approach for health care treatment and self-management. High priority chronic diseases will each have their own sub-plan in order to enable Health Home providers to quickly identify evidence-based process and outcome measures for each condition. The care plan will also serve as a source of information for monitoring and evaluation purposes. The District will facilitate the creation and updating of the care plans by developing a standard data sharing agreement that Health Home providers will execute with external health care providers to ensure the care plans reflect the mental health, primary care, substance abuse and social needs of the individual.

The District will maintain a close working relationship with the Health Home providers to monitor their implementation experiences and respond to learning needs that emerge. The District will also establish performance monitoring activities to closely monitor Health Home providers' activities to ensure their services meet the District's standards, as well as CMS' core functional requirements stated above. In addition to the review of ongoing program reports, oversight activities may include medical chart and care management record review, site audits, and team composition analysis.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services. Designated providers of Health Home services to individuals with serious and persistent mental health conditions will be Core Services Agencies (CSAs) or specialty providers of Assertive Community Treatment (ACT) identified by the District to meet the standards of a Health Home. Through the District's initial engagement efforts with CSAs and ACT providers, DBH will consider its analysis of Health Home eligible members and their existing relationships with CSAs and/or ACT providers, then solicit interest from as many CSAs and ACT providers as are interested and capable of meeting requirements to serve as Health Home providers. As part of the certification requirements that the District will establish, Health Home providers will be responsible for developing working relationships and partnership agreements, as appropriate, with primary care and community based service providers as necessary to deliver Health Home services to enrolled members. On an ongoing basis, the DBH will work collaboratively with the District of Columbia

Department of Health Care Finance (DHCF) to facilitate relationships between Health Home providers and Medicaid primary care, and other medical service, providers in order to coordinate services.

Provider Standards

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

Each eligible Health Home provider must meet standards established by DBH for certification as a Health Home provider and must meet expectations for maintaining certification through active participation in the DBH Health Home program of ongoing training, performance monitoring and reporting and evaluation.

Initial Certification Standards will include:

1. Enrolling with the District of Columbia Department of Health Care Finance (DHCF) as a Health Home provider and agree to comply with all Medicaid program requirements;
2. Providing a letter of intent expressing interest to acquire certification and comply with all Medicaid program requirements;
3. Participating in prescribed readiness activities outlined and required by the District in order to demonstrate the capacity to achieve and maintain DBH certification as a Health Home. *Readiness activities* include participating in training and program development efforts and showing the ability to hire and retain sufficient staff and other infrastructure capacity required by the District to provide comprehensive, team-based Health Home services to the panel of individuals assigned to them who agree to receive Health Home services. *Infrastructure capacity* means integrating use of the District's electronic health record system, iCAMS, to provide Health Home services, and instituting or agreeing to institute health information exchange via Direct Secure messaging or other means made available through the state's system to securely send and receive member data as part of providing Health Home services. At a minimum, following initial certification as a Health Home provider and at the start of the Health Home program, providers will be expected to enroll with Chesapeake Regional Information System for our Patients (CRISP) or other HIE services as directed by DBH, to receive hospital encounter alerts; and
4. Participating in a readiness assessment process conducted by the District prior to commencing the delivery of Health Home services, which evaluates the potential provider's ability to carry out the District's required Health Home services components.

In addition, on an ongoing basis as part of maintaining certification status, Health Home providers will be expected to:

1. Maintain sufficient staffing of all required members of Health Home teams as prescribed by the District and submit required reports indicating full time employee status, vacancies and other determined by the District. In order to meet the Health Home standards, CSAs must be adequately staffed by teams of health care professionals that represent, at a minimum, the following functions:

- Health Home Director;
- Primary Care Liaison;
- Registered Nurse Care Manager; and
- Care Coordinator.

ACT providers must be adequately staffed by teams of health care professionals that represent, at a minimum, the following functions:

- Primary Care Liaison;
 - Registered Nurse Care Manager; and
 - Care Coordinator;
2. Participate in federal and state-required evaluation activities including documentation and reporting of Health Home service delivery as well as consumers' health outcomes and social indications in iCAMS, the District's electronic health record system;
 3. Participate in activities sponsored by the District that contribute to the successful implementation and sustainability of Health Home services delivery, including: 1) training and other ongoing collaborative leadership and professional development activities to foster the development of Health Home related professional competencies and best practices; 2) monitoring and performance reporting; 3) continuous improvement activities; and 4) evaluation;
 4. Utilize resources made available by the District (e.g. iCAMS) or through partnerships with health plans or other external health care partners to conduct care management (e.g., develop and monitor care plans, collaborate and consult about consumers' care) and care coordination services (e.g., track utilization, lab results, pharmacy and medication use and referrals);
 5. Participate in required program assessments, at a frequency to be determined by DBH, to confirm that the Health Home meets all staffing and regulatory requirements, and demonstrate a quality improvement plan to address gaps and opportunities for improvement; and
 6. Establish data sharing agreements that are compliant with federal and state laws and regulations that establish protocols with external health care partners (e.g. federally qualified health centers [FQHCs], primary care providers, specialty providers, hospitals, skilled nursing facilities, and Medicaid managed care plans) to assure effective coordination and monitoring of health care services for the Health Home panel of patients and to assure the provision of efficient transitional care. The District may facilitate data sharing opportunities between Health Home providers and other provider types by constructing data sharing templates and identifying methods to electronically compile data in the District's iCAMS.

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

Fee for Service

Risk Based Managed Care

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

The current capitation rate will be reduced.

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

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

Other: To assure there is not duplication of effort, DHCF plans to develop a Memorandum of Understanding between Health Homes and Medicaid MCOs that explicitly describes the services to be coordinated and the essential aspects of collaboration between the Medicaid MCOs and Health Homes. Additionally, DHCF may modify the existing contracts between DHCF and the Medicaid MCOs that describes what collaboration with Health Homes entail, including a clear delineation of responsibilities between Medicaid MCOs and Health Homes for individuals eligible to receive care management and care coordination services from both entities.

Health Home Payment Methodologies

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

Fee for Service

Fee for Service Rates based on:

Severity of each individual's chronic conditions

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

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

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

Other: Describe

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

Per Member, Per Month Rates

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

While the District's payment methodology most closely resembles a per member per month (PMPM) payment, it is not a pure PMPM model, because it is not prospective and at least one service per month is required in order to obtain the monthly payment. Thus, we are calling our payment methodology a bundled case rate model. The monthly rate will be \$274.15 per member per month (in the months at least one service is provided) for those who are currently receiving Community Support Services (CSS) and \$88 per month for those currently receiving Assertive Community Treatment (ACT) services. Health Home providers will receive a first-time payment of \$548.29 for all new Health Home enrollees.

The District will implement the Health Home model of care to enhance the care coordination scope of Community Support Services and Assertive Community Treatment, which are two types of services currently delivered to individuals with serious and persistent mental health illness under the District's Mental Health Rehabilitation Services Medicaid state plan benefit. The distinction between CSS and ACT is that ACT serves a higher acuity population and already includes many of the support services being provided by Health Homes. The \$274.15 monthly rate will completely replace current CSS services for those who enroll in Health Homes. For Health Home providers who have traditionally served ACT consumers, their base payments will remain unchanged and the \$88.42 will serve as an add-on payment. Core Services Agency (CSA) providers deliver Community Support Services; Assertive Community Treatment (ACT) providers deliver ACT services. In some cases, the same agencies provide both services.

Minimum criteria for receipt of monthly Health Home bundled case payments are:

- Individual receiving the Health Home service is Medicaid eligible;

- Individual receiving the Health Home service is an enrolled participant of the billing Health Home provider; and
- The minimum Health Home service required to merit payment is documented in iCAMS.

Cost Considerations: The following outlines the principal salary, full time equivalent (FTE), and other cost considerations included in the case rate methodologies for the CSA and ACT Health Home payments.

CSA Health Home payment:

FTE staffing per 300 Health Home enrollees:

0.4 Health Home Director - \$90,000

3.0 Nurse Care Manager - \$98,205

0.3 Primary Care Liaison – \$116,150

Cost to deliver an average of 2 hours per member per month of services similar to CSS under the current payment methodology. Currently, an average of 1.5 hours of CSS services are provided to the Health Home eligible population. An additional 30 minutes per month of CSS-type services were added in order to enable CSS workers to provide the full range of Health Home services - \$176.00

Total case rate, which includes the costs of the Health Home services, plus the cost of the Health Home staff time: \$274.15

ACT Health Home Add-on Payment:

FTE staffing per 300 Health Home enrollees:

3.0 Nurse Care Manager - \$98,205

0.3 Primary Care Liaison – \$116,150

Total add-on rate, which includes the cost of the Health Home staff time: \$88.42

Health Home team members' salary and related costs were based upon figures submitted by the mental health provider community and are in alignment with a recently completed comprehensive rate review and adjustment conducted in 2013 by a national consulting firm for the District of Columbia Department of Behavioral Health (DBH). The independent rate study was part of a larger effort to assess the adequacy of the current Medicaid reimbursement rates for Medicaid mental health services. The estimated care management effort was informed by clinical experts who established staff-to-consumer ratios as well as average monthly contacts with Medicaid individuals by Health Home team members, as appropriate, based on individuals' need and team member roles. The provider levels were developed for the purposes of developing a monthly case rate, but if Health Home providers are able to show that they can effectively use other types of professionals to meet the needs of Health Home consumers, that is allowable.

In addition to the monthly rates, Health Home providers may receive a one-time reimbursement for the completion of each individual's initial intake and comprehensive assessment necessary for enrollment in the Health Home, which includes both psychosocial and medical components. Payment reflects the required face-to-face interaction between the consumer and members of

the Health Home team where consumers are oriented to the Health Home model of care and provided instructions about the District's "opt-out" process. The payment also reflects the cost that may be incurred for education and outreach to find consumers who are difficult to reach. Total one-time payment: \$548.29

The District believes that the bundled case rate model will offer Health Home providers new flexibility to provide care based on the needs of each consumer. It will leave room for creativity and innovation. While this flexibility will be critical at the start of the program, the District also recognizes that there will be a need to closely monitor the services being provided to ensure that the neediest consumers are being adequately served and that an appropriate level of services is being provided to all consumers.

In order to help the Health Home providers understand the level of services consumers are likely to need, the District will develop a methodology for identifying eligible Health Home consumers as low, medium or high risk. The District will encourage Health Home providers to focus the right level of care on the consumers according to need. Many of the monitoring metrics will be reported based on the risk category of the consumers, so Health Homes can understand the impact they are having on consumers with varying levels of need.

In order to monitor the level and range of services being provided under the Health Home program, the District will require Health Home providers to document the services provided to Health Home consumers in iCAMS. The level and range of services will be tracked over time in order to better understand the types of services that are most commonly provided and which yield the most success. Over the long term, these data can help the District understand whether more formal distinctions are needed in payment and benefit level for consumers of low, medium and high risk.

The District will review rates at the end of the initial two years of the Health Home program's implementation, and at a regular frequency thereafter, to ensure that rates are economic and efficient based on analyses of claims data and Health Home service delivery documented in iCAMS.

Incentive payment reimbursement

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

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

Health Home service payments will not result in any duplication of payment or services between Medicaid programs, services, or benefits (i.e. managed care, other delivery systems including waivers, any future Health Home state plan benefits, and other state plan services). The District does not provide coverage for targeted case management services under 1915(g). In addition, case management provided under the District's 1915(c) waivers is non-duplicative of Health Home services. The functions provided by 1915(c) case managers include determination of waiver eligibility, comprehensive assessment to determine unmet needs related to waiver services, planning of services provided under the waiver, qualification of waiver providers, authorization of waiver services, and monitoring of service provision. This type of specialized case management for individuals receiving long term services and supports and developmental disabilities services will continue to be necessary for individuals served under waivers and Health Homes.

- The State provides assurances that all governmental and private providers are reimbursed according to the same rate schedule.**
- The State provides assurances that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.**

Submission – Categories of Individuals and Populations Provided Health Homes Services

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

- Categorically Needy eligibility groups**

Service Definitions

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

Comprehensive Care Management

Definition:

Health Home staff will collaborate to provide comprehensive care management services to address the various stages of health and disease, with the goal of maximizing current functionality and preventing individuals from developing additional chronic conditions and complications. Comprehensive care management consists of: assessment of risk and identification of high risk sub-groups through use of a health risk assessment/patient health questionnaire; identification of whole-person service needs and construction of a comprehensive integrated care plan; assignment of different care management roles to members of the Health Home team; construction of standardized, evidence based, protocols and clinical pathways for management and monitoring of

chronic conditions; monitoring of the individual and population health status and service use to assure patient adherence and application of clinical pathways by relevant health care practitioners and; development and dissemination of reports on satisfaction, health status, cost and quality to guide Health Home service delivery and design.

Members of the team of healthcare professionals will use DBH's web based electronic medical record and billing system, called the Integrated Care Applications Management System (iCAMS), for population identification and proactive patient management; provide facilitated access to care based on evidence-based practice guidelines; use collaborative practice models that include the primary care physician and other care team providers; provide patient self-management support (may also involve other team members); work with patients to optimize control of their chronic conditions and prevent long-term complications; assist in transitions between settings; and provide patient education, with 'teach back', to ensure understanding. Comprehensive population management must address all stages of health and disease, with the goal of maximizing current functionality and preventing individuals from developing additional chronic conditions and complications.

In conducting comprehensive care management services, Health Home providers will coordinate the primary and behavioral health care and social service needs of consumers at the individual and population levels, and encourage consumer and family participation. This will include the following:

- a. Health Home team assignments: The Health Home providers will assess the risks and whole-person service needs of consumers to assign consumers to a Health Home team ;
- b. Development of Care Plan: For every consumer who joins a Health Home, a care plan will be developed. The plans will be updated routinely at a set frequency determined by the District. In addition, the care plan will be updated following an unplanned inpatient stay (i.e., hospital or skilled nursing facility). The District will review care plans at regular intervals to ensure they are complete and being updated regularly. The Health Home provider will create and update individualized integrated treatment and/or recovery plans, in partnership with each of their consumers, which includes the results of mental health assessments and the results of a comprehensive bio-psychosocial assessment. The care plan will include the Health Home member's self-identified care management goals and timeframes for addressing behavioral health and physical health priorities, as well as plans for levels of services including community networks and supports.
- c. Delineation of roles: The Health Home providers will assign each Health Home team member clear roles and responsibilities.
- d. Monitoring and Assessment: The Health Home providers will monitor individuals' health status and progress toward goals established in the care plan, documenting changes and adjusting the care plan as needed.
- e. Population-based Care Management: The Health Home providers will monitor its panel of members, to determine levels of consumer engagement, progress toward care management goals, and adherence to or variance from treatment guidelines. The Health Home provider will identify and prioritize population needs and trends, then implement appropriate population-wide treatment guidelines and interventions.
- f. Outcomes and Reporting: The Health Home providers will systematically review and report quality metrics, assessment results, and service utilization in order to evaluate health status, service delivery, and consumer satisfaction.

Comprehensive care management services may be provided by any member of the Health Home team, but are driven by protocols and guidelines developed by the Registered Nurse Care Manager or Primary Care Liaison, in collaboration with the consumer's mental health and SUD practitioners.

Describe how Health information technology will be used to link this service in a comprehensive approach across the care continuum A single information system –iCAMS – will provide integrated patient profiling and risk assessment, charting, care management and administrative functionality for managing service authorizations, payments and reports. All Health Homes will use iCAMS. This system will allow Health Home providers to report and review participant intake, assessment results, assigned Health Home team, integrated care plans, clinical baselines and data related to chronic conditions, as well as Health Home services provided, such as referrals made and health promotion activities completed. The system has functionality to stratify populations based on certain risk factors and to aggregate data from external sources (e.g., ambulatory electronic medical records used by federally qualified health centers [FQHCs] and other primary care providers, hospital information systems, and health information exchanges). The system will also assist in the development of care plans, facilitate provider empanelment, determine and assign tasks to Health Home team members, and create disease management protocols and generate reports.

Scope of benefit/service

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

Other (specify): Community Mental Health Centers

Care Coordination

Definition: Care coordination is the implementation of the treatment and/or recovery plan through appropriate linkages, referrals, coordination and follow-up to needed services and support. Care coordination may involve:

- a. appointment scheduling and providing telephonic reminders of appointments;
- b. telephonic outreach and follow-up to low-risk Health Home members who do not require face to face contact;
- c. ensuring that all regular screenings are conducted through coordination with the primary care or other appropriate providers;
- d. assisting with medication reconciliation;
- e. assisting with arrangements such as transportation, directions and completion of durable medical equipment requests;
- f. obtaining missing records and consultation reports;
- g. participating in hospital and emergency department transition care; and
- h. documentation in iCAMS.

At the population level, the Health Home provider will develop partnerships with primary care, specialists, and behavioral health providers, as well as community based organizations. Within these partnerships, the roles and responsibilities for each party will be clearly defined in order to ensure timely communication, use of evidence-based referrals, and follow-up consultations. The Health Home provider will ensure that screenings appropriate for specific chronic conditions are conducted through coordination with the primary care or other appropriate provider.

Care coordination services may be provided by any member of the Health Home team, but are driven by protocols and guidelines developed by the Registered Nurse Care Manager or Primary Care Liaison, in collaboration with the consumer's mental health and substance use disorder (SUD) practitioners.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum: The single information system--iCAMS, which will be used by all Health Homes will enable them to report and review referrals made to outside providers, social and community resources and individual and family supports. Through this system, Health Homes will be alerted of hospital events such as emergency department visits and hospitalizations, which will facilitate prompt discharge planning and follow-up. Also through this system, Health Home providers will have access to consumers' historical service utilization which will allow better tracking of consumer needs, services received and the identification of opportunity for improved care coordination.

Scope of benefit/service

- The benefit/service can only be provided by certain provider types.**
- Other (specify):** Community Mental Health Center

Health Promotion

Definition: Health Promotion services involve the provision of health education to the individual (and family member/significant other when appropriate) specific to his/her chronic illness or needs as identified in his/her comprehensive assessment. The service includes assistance with medication reconciliation and provides assistance for the individual to develop a self-management plan, self-monitoring and management skills and promotion of a healthy lifestyle and wellness (nutrition, substance abuse prevention, smoking prevention and cessation, nutrition counseling, increasing physical activity). Health promotion also involves connecting the individual with peer/recovery supports including self-help/self-management and advocacy groups, providing support for improving an individual's social network, and educating the individual about accessing care in appropriate settings.

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

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

Describe how Health information technology will be used to link this service in a comprehensive approach across the care continuum: All Health Homes in the District will use the same information system - iCAMS - to document, review, and report health promotion services delivered to each consumer. Additionally, clinical data such as height, weight and BMI will be recorded and reported periodically via iCAMS.

Scope of benefit/service

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

Other (specify): Community Mental Health Center

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

Definition: Comprehensive transitional care consists of efforts by the Health Home team members to reduce hospital emergency department and inpatient admissions, readmissions and length of stay through planned and coordinated transitions between health care providers and settings. The service seeks to interrupt patterns of higher than necessary use by providing ready access to the Health Home, and other lower levels of care through the provision of timely and effective communication between the inpatient setting and Health Home. The Health Home will increase consumers' and family members' ability to manage care and live safely in the community, shifting the use of reactive or emergency care and treatment to proactive health promotion and self-management.

Transitional care is defined as a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care. Transitional care is based on a comprehensive plan of care and the availability of health care practitioners who are well-trained in chronic care prevention and management and have current information about the consumer's goals, preferences, and clinical status. It includes logistical arrangements, education of the patient and family, and coordination among the health professionals involved in the transition. Transitional care, which encompasses both the sending and the receiving aspects of the transfer, is essential for persons with complex care needs.

At a minimum, key functions of transitional care include receiving notifications of emergency room visits, admissions, and discharges from hospitals and other care facilities; outreach to patients to ensure appropriate follow up after transitions; outbound phone call by the care manager or other team member to the consumer within 48 hours of discharge; and scheduled visits for consumers with the primary care provider and/or specialist within one week of discharge. To accomplish these functions, the Health Home provider will establish a clear protocol for responding to admission, discharge or transfer alerts from hospitals or any other inpatient facility to facilitate collaboration in treatment, discharge, and safe transitional care.

As part of consumer contacts during transitions, the Health Home provider will:

- a. review the discharge summary and instructions;
- b. perform medication reconciliation;
- c. ensure that follow-up appointments and tests are scheduled and coordinated;
- d. assess the patient's risk status for readmission to the hospital or other failure to obtain appropriate, community-based care; and
- e. arrange for follow-up care management, if indicated on the discharge plan.

Comprehensive transitional care services are provided primarily by the Registered Nurse Care Manager and Care Coordinator, but may be provided by any member of the Health Home team. However these services are driven by protocols and guidelines developed by the Registered Nurse Care Manager or Primary Care Liaison, in collaboration with the provider's mental health and substance use disorder (SUD) practitioners.

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

To enable critical information exchange, all Health Home providers will be expected to enroll with Chesapeake Regional Information System for our Patients (CRISP), or other HIE services as directed by DBH, to receive hospital event alerts (e.g. emergency department visits; hospital admissions, transfers and discharges) and both generate and receive continuity of care information. To the extent that hospitals and other inpatient settings have care transition programs, Health Home providers will be expected to coordinate with discharge planners to prevent duplication of services and to ensure that all essential functions of an effective care transition have been performed.

Scope of benefit/service

- The benefit/service can only be provided by certain provider types.**
- Other (specify):** Community Mental Health Services

Individual and family support, which includes authorized representatives

Definition: Individual and family support services include all the ways a Health Home provider supports the individual and their support team (including family and authorized representatives) in meeting their range of psychosocial needs and resources (such as medical transportation and other benefits to which they may be eligible). They provide for continuity in relationships between the consumer/family with their physician and care manager and can include advocacy on the consumer and family's behalf Individual and family support services also educate the consumer in self-management of their chronic condition; provide opportunities for the family to participate in assessment and care treatment plan development; and ensure that Health Home services are delivered in a manner that is culturally and linguistically appropriate. Additionally, these services include referrals to support services that are available in the consumer's community and assist with the establishment of and connection to "natural supports." They promote personal independence; assist and support the consumer in stressor situations; empower the consumer to improve their

own environment; include the consumer family in the quality improvement process including surveys to capture their experience with Health Home services; and allow consumers/families access to electronic health record information or other clinical information.

At the population level, services will include: collecting and analyzing individual and family needs data; developing individual and family support materials and groups regarding the areas listed above; soliciting community organizations to provide group support to the population; and providing training and technical assistance as needed regarding the needs of the population.

The Health Home provider will ensure that all communication and information shared with the consumer, and the consumer's family and caregivers, is in the appropriate language, literacy-level and is culturally appropriate.

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

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum: All Health Home providers will be using a single information system –iCAMS, to document, review, and report family support services delivered to each client.

Scope of benefit/service

- The benefit/service can only be provided by certain provider types.**
- Other (specify):** Community Mental Health Center

Referral to community and social support services, if relevant

Definition: Referral to community and social support services provide individuals with referrals to a wide array of support services that will help them overcome access or service barriers, increase self-management skills and achieve overall health. Referral to community and social support involves facilitating access to support and assistance for individuals to address medical, behavioral, educational, social and community issues that may impact overall health. The types of community and social support services to which individuals will be referred may include, but are not limited to:

- Wellness programs, including smoking cessation, fitness, weight loss programs
- Specialized support groups (i.e. cancer, diabetes support groups)
- Substance treatment links in addition to treatment - supporting recovery with links to support groups, recovery coaches, 12-step
- Housing resources
- Social integration
- Assistance with the identification and attainment of other benefits
- Supplemental Nutrition Assistance Program
- Connection with the Office of Rehabilitation Service to assist person in developing work/education goals and then identifying programs/jobs

- Legal assistance resources
- Faith-based organizations
- Access to employment and educational program or training

The Health Home provider will assist in coordinating the services listed above and following up with consumers after services have been received.

At the population level, the Health Home team will: develop and monitor cooperative agreements with community and social support agencies that establish collaboration, follow-up, and reporting standards; recruit agencies to enter in the those collaborative agreements; and provide training and technical assistance as needed regarding the special needs of the population.

Referral to community and social support services are primarily provided by the Care Coordinator and may be provided by any member of the Health Home team, but are driven by protocols and guidelines developed by the Registered Nurse Care Manager or Primary Care Liaison, in collaboration with the provider’s mental health and substance use disorder (SUD) practitioners.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum: All Health Home providers will be using a single information system –iCAMS – to document, report and review referrals to community-based resources.

Scope of benefit/service

- The benefit/service can only be provided by certain provider types.**
- Other (specify):** Community Mental Health Center

Health Homes Patient Flow

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

Eligibility and Enrollment:

Potential Health Home participants will be identified through a review of recent historical Medicaid claims or through referrals to DBH from Core Services Agencies (CSA) and/or hospitals and other inpatient facilities. DBH will assign each potential participant to a Health Home provider based upon his/her past CSA and/or ACT provider utilization or other criteria established by the District, including consumer choice. Upon engaging with a potential participant, the Health Home provider will orient the individual to the Health Home benefit and provide instruction about the Health Homes “opt-out” process. Next, the Health Home provider will explain the data sharing elements of the program and obtain consent. The Health Home provider will then conduct a comprehensive assessment of the individual, which includes the collection and assembly of historical service utilization data and medical information from external healthcare partners, including the consumer’s primary care provider, existing mental health and SUD plans of care, family/care

information that may support care, and care coordination needs. Results of the comprehensive assessment will be used to develop an integrated care plan and to assign individuals to a Health Home team. Next, the Health Home provider will document the results of the comprehensive assessment and integrated care plan into iCAMS. Finally, DBH will review the assessment and care plan for the individual and create an entry in the District's integrated care management system that enrolls an individual into the Health Home benefit.

Participation:

While participating in the Health Home benefit, an individual will receive a minimum of one Health Home service per month, to be documented in iCAMS, the District's electronic health record system. The Health Home will monitor their care and health status, and deliver Health Home services as necessary. The Health Home provider will reassess participants, and in doing so, determine the appropriate level of Health Home services based on the consumer's presenting conditions, needs and risk.

Suspension of Health Home Services:

Health Home services will be suspended as a result of incidents that would temporarily cause a loss in Medicaid eligibility (e.g. such as a short term jail stay or monthly change in income). In these instances, the Health Home provider will suspend Health Home eligibility and will not bill for those services. Individuals will have the ability to resume benefits once they are again eligible for Health Home services. The Health Home provider will report in iCAMS the suspension of an individual's benefit. Consumers will be discharged from the Health Home if they are incarcerated for longer than 180 days.

Discharge:

Discharge from a Health Home benefit will occur as a result of an individual's loss of Medicaid eligibility (e.g. as due to incidents such as long-term incarceration or permanent change in income), or an individual's decision to no longer receive Health Home services, thus opting out of the Health Home program. An individual may also be discharged from a Health Home if he/she no longer has a SMI diagnosis. In such cases, the Health Home provider will follow discharge protocol appropriate to the circumstances. Discharge planning may include the development of a discharge plan with referrals to the appropriate services and providers which will continue the individual's care and support to ensure continuity of care to the greatest extent possible. The Health Home provider will report in iCAMS the discharge of an individual.

Medically Needy eligibility groups

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

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

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

In line with the technical specifications for the core Home Health measures, DC will collect all-cause 30 day readmissions for all individuals enrolled in the Health Home program. We will use claims data from the Department of Health Care Finance.

Data are reported in the following categories:

- Count of Index Hospital Stays (IHS) (denominator).
- Count of 30-Day Readmissions (numerator).
- Average Adjusted Probability of Readmission (rate).

DHCF will calculate and report this measure for two age groups: age 18 to 64 and 65 and older. The measure will include all paid, suspended, pending, and denied claims. As of implementation, DHCF will not use a risk adjuster, but will be prepared to implement one if CMS selects a risk adjustment methodology.

While claims data will be an important source of information related to hospital admissions and readmissions, we recognize that the time lag of this data is not ideal for real time management of patient care. For that reason, we are also pursuing collaboration with the Chesapeake Regional Information System for our Patients (CRISP). CRISP is currently collecting admissions, discharge and transfer feeds from six District of Columbia hospitals. Through this mechanism, real-time notifications of the majority of hospital admissions will be available to Health Homes care coordinators.

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

The State plans to use historical data to track expected trend on medical spending for the eligible Health Home population. It will then compare expected trend with actual spending. The State may break down its trend data to compare costs related to emergency room utilization, hospitalizations, nursing facility admissions, and pharmacy utilization. In this assessment, the State may review each Health Home provider independently for its overall impact on total cost of care and then compare to other Health Home providers in the District to inform future implementation and process modifications.

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

1. The Integrated Care Applications Management System (iCAMS), the Internet Technology (IT) solution developed for DBH by Credible Wireless in 2013, will serve as the core component of a comprehensive health information technology/exchange (HIT/E) solution for the District's Health Home program. This system, which all Health Home providers will be required to use, will serve as the single platform for authorizing, capturing, tracking and claiming services provided to Health Home members including the six core Health Home services. iCAMS is secure, with Health Home providers' access limited to the records of their own current enrollees. The state will use reports from iCAMS to track enrollment within each Health Home provider, and compliance and outcomes at the individual and population levels.

iCAMS may be populated with information generated by Health Home member encounters with Health Home providers, including initial and periodic Health status and risk assessments, and via 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 within the Chesapeake Regional Information System for our Patients (CRISP) health information exchange;
- the District's MMIS from which periodic feeds of Medicaid encounter data will be generated and uploaded into iCAMS;
- Other administrative systems such as District of Columbia Access System (DCAS), the District's integrated 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
- High-volume labs and pharmacies for electronic lab results and medication prescription fills, respectively.
- iCAMS will support the following essential Health Home program functions:
 - o Initial screening and health/functional assessment, risk analysis and stratification;
 - o Proactive alerts to Health Home providers for – at a minimum - emergency room utilization, inpatient hospitalization, visits to certain provider types and when a member does not obtain a medication refill when expected;
 - o Care plan development enhanced by best practices and real-time intelligence about a patient's status, e.g. potential drug-to-drug interactions, multiple allergies, evidence gathered from patients with similar conditions; and
 - o Care plan administration where multiple Health Home team members will be able to access and work off a single care plan in a highly secure system environment.

2. Chesapeake Regional Information System for our Patients (CRISP): All Health Home providers must enroll with CRISP's Electronic Notification System to receive hospital, discharge and transfer (ADT) encounter alerts. This entails an initial upload of the Health Home provider's patient panel with all necessary demographic information, followed by monthly panel updates

to CRISP. The Health Home provider will set up a Direct message inbox, where ADT alerts will be securely sent by CRISP and accessed by the Health Home providers.

Quality Measurement

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

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

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

Evaluations

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

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

Hospital Admissions

Measure: In line with the CMS' core Health Home measure set, the District will monitor 30-day all cause readmissions, hospital admissions with a chronic disease diagnosis, and the rate of inpatient hospital utilization.

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

For all-cause 30-day readmissions:

The District will calculate the percentage 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 for Health Home enrollees age 18 and older. Data are reported in the following categories:

- Count of Index Hospital Stays (IHS) (denominator).
- Count of 30-Day Readmissions (numerator).
- Average Adjusted Probability of Readmission (rate).

DHCF will calculate and report this measure for two age groups: age 18 to 64 and 65 and older. The measure will include all paid, suspended, pending, and denied claims. As of implementation, DHCF

will not use a risk adjuster, but will be prepared to implement one if CMS selects a risk adjustment methodology.

For hospital admissions with a chronic condition diagnosis:

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

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

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

- PQI 1: Diabetes Short-Term Complications Admission
- PQI 3: Diabetes Long-Term Complications Admission
- PQI 5: COPD or Asthma in Older Adults Admission
- PQI 7: Hypertension Admission
- PQI 8: Heart Failure Admission
- PQI 13: Angina without Procedure Admission
- PQI 14: Uncontrolled Diabetes Admission
- PQI 15: Asthma in Younger Adults Admission
- PQI 16: Lower-Extremity Amputations Among Patients with Diabetes

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

Rate of Inpatient Hospital Utilization:

The District will calculate the rate of acute inpatient care and services (total, maternity, mental health, surgery, and medicine) per 1,000 enrollee months among Health Home enrollees.

The following methodology will be used:

- Discharge: Total number of discharges for each group.

- Discharge rate (discharges/1,000 enrollee months): Calculate the discharge rate for total inpatient, maternity, mental Health, surgery, and medicine by dividing the number of discharges by the number of enrollee months and multiply by 1,000, as follows:

- Discharge rate = (Number of discharges/number of enrollee months) x 1,000

- Days: Total number of days incurred for each group.

- Days rate (days/1,000 enrollee months): Calculate the days rate for total inpatient, maternity, mental Health, surgery, and medicine by dividing the total number of days incurred by the number of enrollee months and multiply by 1,000 as follows:

- Days rate = (Total days incurred/enrollee months) x 1,000

Data Sources: MMIS claims and encounter data

Frequency of Data Collection:

- Monthly
- Quarterly
- Annually
- Continuously
- Other Daily

Emergency Room Visits

Measure: Total Emergency Room visits by enrollee months per 1,000 Health Home enrollees

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

ED Visit Rate = (Number of ED visits/number of enrollee months) x 1,000, as specified in the core measures set

Data Sources: MMIS claims and encounter data.

Frequency of Data Collection:

- Monthly
- Quarterly
- Annually

Continuously

Other Daily

Skilled Nursing Facility Admissions

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

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

- Short Term Admission Rate = (Number of short term admissions/number of enrollee months) x 1,000
- Long Term Admission Rate = (Number of long term admissions/number of enrollee months) x 1,000

Data Sources: MMIS claims and encounter data.

Frequency of Data Collection:

Monthly

Quarterly

Annually

Continuously

Other Daily

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

Hospital Admission Rates: Hospital admissions are collected through claims data for admits provided under fee-for-service and through encounter data for admits provided under capitated managed care. Member month data will be collected from eligibility files.

Chronic Disease Management: A comprehensive care plan is being developed for the Health Home initiative that will be embedded in iCAMS, the electronic health record that will be used by all Health Home providers. Each consumer's care plan will include specific sub-plans for each relevant chronic disease. Our evaluation will monitor provider use of the disease-specific care plans, including whether a plan has been developed and regularly updated. Each disease-specific plan will have a limited set of

outcome metrics (for example, viral load for patients with HIV) that will be tracked in iCAMS for evaluation purposes. iCAMS data will be supplemented with selected claims data to monitor compliance with evidence-based protocols and proper pharmacy utilization.

Coordination of Care for Individuals with Chronic Conditions: Chronic disease management data is collected through administrative claims/encounter data, Registered Nurse Care Manager assessments, Health Home payment records, and Health Home encounter data verifying services received by clients (e.g., primary care, mental health, SUD treatment, mental health services, prescriptions, etc.). This data is obtained through the State's MMIS payment system. Registered Care Manager notes and assessments provide evidence of interaction and referrals and will be evaluated at time of monitoring.

Assessment of Program Implementation: The DC Health Home program will monitor:

- Rate of enrollment of eligible individuals into Health Home care coordination services;
- Rate of completed assessments;
- Rate of completed care plans;
- Frequency of and type of services provided to Health Home enrollees;
- Volume of Health Home services received relative to consumer need (tracking whether high-cost, high-need individuals are receiving the highest levels of services)

Processes and Lessons Learned: The District will implement a process improvement initiative that will track performance and provide technical assistance to help Health Home providers improve quality and outcomes.

Assessment of Quality Improvements and Clinical Outcomes: The District will collect the complete list of core measures, as outlined in the Health Home Administrative Component. Additional metrics may also be identified as we move toward and begin implementation of the program.

Estimates of Cost Savings

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

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