Public Notice	
Whether Comment is Solicited (Indicate whether public comment was solicited. Public Notice is required for new Health Homes programs and for changes to payment methodologies.)	Public comment has been solicited.
Method of Public Comment (Indicate how public comment was solicited, such as newspaper, publication in state administrative record, website notice, and public hearing. For each method, indicate date and location of notice.)	The Department of Health and Mental Hygiene has continuously solicited public comment regarding the State's broader Behavioral Health Integration process, of which the Health Home initiative Is a part. A formal comment period was open from May through August, 2012. The Department established a dedicated email account for this purpose, listing the address on the Department's website. The Department formed a Chronic Health Home Workgroup during this period, and held meetings open to the public on the following occasions: • June 14, 2012, 10:00-12:00pm at UMBC Tech Center, 1450 S Rolling Rd, Baltimore, MD 21227 • July 12, 2012, 10:00-12:00pm at UMBC Tech Center, 1450 S Rolling Rd, Baltimore, MD 21227 • August 9, 2012, 10:00-12:00pm at UMBC Tech Center, 1450 S Rolling Rd, Baltimore, MD 21227 Additionally, the Department has conducted two informational webinars open to stakeholders, after which further comments were directed to the email address listed on the website. These webinars occurred on the following dates: • December 5th, 2012 1:30-3:30pm • December 10, 2012, 11:00-1:00pm
Tribal Input	
Whether Input is Solicited (Indicate whether tribal input was solicited. Tribal input is required if the State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.)	Tribal input has been solicited
Organization Consulted for Tribal Input (Indicate which organizations	National Council for Urban Indian Health (NCUIH) Region 1

were consulted for tribal input)	
Method of Tribal Input **(**For each organization consulted, indicate the date, method, and location of consultation)	The Department shared a draft State Plan Amendment via email with the NCUIH Region 1 representative to solicit comment on January 2nd, 2012. The Department received feedback and conversations continue to date.
Health Home Population Criteria and Enrollment	
Geographic Area (Describe whether statewide or targeted. If targeted, describe if targeted by county, city, region, or other)	Statewide
Population Criteria (Indicate if State will be using 2 or more chronic conditions, 1 and being at risk for another or 1 serious and persistent mental illness and include the targeted chronic conditions list.)	The State will offer Health Home Services to individuals diagnosed with: One serious and persistent mental illness Or Serious emotional disturbance *Or* An opioid substance use disorder *and* at-risk for another chronic condition based on tobacco, alcohol, or other non-opioid substance use. Maryland's Chronic Health Homes will target three populations with serious chronic health needs. This includes individuals with serious persistent mental illness (SPMI), children with serious emotional disturbance (SED), and individuals diagnosed with an opioid substance use disorder and at risk for an additional chronic condition. The risk factors include tobacco, alcohol, or other non-opioid substance use. <u>Description of population selection criteria</u> An individual must meet all criteria in the SPMI, SED or opioid substance use disorder categories below to qualify for Chronic Health Home services below. Some may qualify based on more than one category. Eligibility criteria based on SPMI: 1. The consumer has been diagnosed with SPMI, meeting all relevant medical necessity criteria to receive psychiatric rehabilitation program (PRP) or mobile treatment (MT) services. 2. The individual must be engaged in outpatient mental health treatment with a PRP or MT program, including assertive community treatment (ACT) programs. Eligibility criteria based on SED:

	1. The consumer has been diagnosed with SED, meeting all relevant medical necessity criteria to receive psychiatric rehabilitation program (PRP) services. 2. The consumer must be engaged in outpatient mental health treatment with a psychiatric rehabilitation program (PRP). 3. The consumer is not currently receiving either of the following services, which would be duplicative of Health Home services: a. 1915i waiver b. Targeted Case Management (TCM) Eligibility criteria based on opioid substance use disorder: 1. The consumer has been diagnosed with an opioid substance use disorder. 2. The consumer must be engaged in treatment with an opioid maintenance therapy program. 3. The consumer is determined to be at risk for additional chronic conditions due to tobacco, alcohol, or other non-opioid substance use.
Enrollment of Participants (Describe how the individuals will be assigned to the health home, including whether eligible individuals can opt-in to a Health Home or are auto-assigned with an option to opt-out):	The State will initially work with providers to pre- enroll all consumers with an SPMI, SED, or diagnosis receiving care at a Health Home-certified PRP, Mobile Treatment or OTP program with their current provider, with final enrollment contingent upon participant consent, and—in the case of OTP participants—identification of a qualifying risk factor. On an ongoing basis, the Health Home will enroll consumers only after they have been enrolled for the provider's applicable PRP, MT, or OTP services, thus ensuring that all relevant medical necessity criteria has been met to confirm the qualifying diagnosis. Eligible participants may enroll with any one Health Home provider they wish, contingent upon receiving the respective PRP, MT, or OTP services with that provider. During enrollment, the Health Home will provide participants, and their caretakers or guardians, as appropriate, with a brief explanation of Health Home services and objectives, and describe the process for individuals to opt-out if desired. Enrollment is complete upon provider submission of the participant's online eMedicaid intake report and signed consent to the program's data sharing elements. This consent will authorize sharing of information between identified health care providers, the State, applicable Managed Care Organizations (MCOs) and Administrative Service Organizations (ASOs) for the purpose of improved care coordination and program evaluation. This will include, but not be limited to, all pharmacy information, hospital encounters, and services received. The Health Home will notify other identified treatment providers (e.g., primary care and specialists such as OB/GYN) about the goals and types of Health Home services as well as encourage participation in care coordination efforts. The State will use claims data to identify consumers who are not currently receiving care with a Health Home-certified PRP, Mobile Treatment or OTP provider, but who may be eligible and could benefit significantly from the services. This includes individuals with an SPMI, SED or opioid substance use disorder diagnosis who experience frequent emergency department usage, inpatient hospitalizations, or increases in the level of care. Lists of such individuals are currently maintained by the Department as well as MCOs and the ASO, who may assist in the identification, outreach, and referral of potential participants among their own consumers. The State, MCO, or ASO will outreach to these individuals and obtain consent to refer them to a Health Home

	provider near their residence. The Health Home to which the consumer has been referred may then attempt to enroll the consumer. Hospitals will act as an additional referral source, identifying potentially eligible patients whom they encounter and informing them of the Health Home program and nearby Health Home providers. Lastly, agencies such as the Department of Social Services, the criminal or juvenile justice system, or Core Service Agencies (CSAs) may act as additional referral sources. The school system may play a similar referring role in the case of children. The State will perform outreach to such referral sources prior to implementation of the program to familiarize them with the Health Home purpose and referral protocols, as well as alert them to opportunities for continued collaboration with Health Home providers.
Health Home Provider Requirements	
Provider Infrastructure (Indicate whether designated providers, team of health care professionals or health team)	Designated Providers as described in Section 1945(a)(5)
Types of Providers (Indicate the types of providers to be included, such as those listed in Section 1945(a)(5), 1945(a)(6), and 1945(a)(7). For each type, indicate provider qualifications and standards.)	Designated Providers as described in Section 1945(a)(5) Health Homes must be licensed by the Department of Health and Mental Hygiene as a Psychiatric Rehabilitation Program (PRP), a Mobile Treatment (MT) provider or an Opioid Treatment Program (OTP). Additionally, such providers must: 1. Be enrolled as Maryland Medicaid Provider; 2. Be accredited, or in the process of gaining accreditation, as a Health Home through an approved accrediting body, including the Commission on Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or the Council On Accreditation (COA); 3. Be enrolled with the Chesapeake Regional Information System for our Patients (CRISP) to receive hospital encounter alerts within 3 months of beginning Health Home service provision; 4. Be enrolled with the State's Administrative Services Organization (ASO) in order to access real-time pharmacy data for Health Home enrollees; and 5. Demonstrate their ability to participate in data collection and reporting activities These requirements set the ground work for assuring that Health Home enrollees will receive appropriate and timely access to medical, behavioral, and social services in a coordinated and integrated manner. In a supplemental application to the State, a Health Home provider must propose a Health Home delivery model with a reasonable likelihood of being cost effective, as well as demonstrate their ability to complete monthly online eMedicaid reports, and maintain required staff ratios. All Health Home staff will agree upon and share a single care management record and conduct case reviews on a regular basis. Minimum staffing ratios for the Health Home services only as are follows:

	1. Nurse Care Manager: .5 full-time equivalent (FTE) per 125 Health Home enrollees 2. Health Home Director: .5 FTE per 125 Health Home enrollees. Health Homes with less than 125 enrollees may employ 1 FTE individual to serve as both the Nurse Care Manager and Health Home Director, provided that individual is licensed and legally authorized to practice as a registered nurse. Health Homes with more than 250 members (thus requiring 2+ directors) may choose to designate a lead Health Home Director and subsequent Deputy Directors or other key management staff. 3. Physician or Nurse Practitioner: One (1) hour per Health Home enrollee per 12 month period for a physician or two (2) hours per Health Home enrollee per 12 month period for a nurse practitioner. 4. Administrative Support Staff: .25 FTE per 125 Health Home enrollees. Contingent upon Department approval, a portion of the funds allocated for the administrative staff member(s) may be directed instead towards a provider's electronic care management tool that addresses the administrative Health Home tasks. The staffing ratios specified as "per 125 Health Home enrollees" act as a minimum, requiring providers with less than 125 enrollees to maintain this level regardless of their enrollment. Smaller Health Homes may form a consortium to share Health Home staff and thus costs, contingent upon geographic proximity and State approval of a plan detailing the planned collaboration.
Supports for Providers (Describe the methods by which the State will support health homes providers in meeting requirements for the service)	The State will offer educational opportunities for Health Home providers such as webinars and regional meetings to encourage information sharing and problem-solving. Additionally, regular communication and feedback between the State and individual Health Homes will facilitate a collaborative and responsive working relationship. The State will provide initial training and ongoing technical assistance to support Health Homes in demonstrating the following Health Home functional components: 1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Home services; 2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines; 3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders; 4. Coordinate and provide access to mental health and substance abuse services; 5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care; 6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families; 7. Coordinate and provide access to individual and family supports, including referral to community, social support, and

	recovery services; 8. Coordinate and provide access to long-term care supports and services; 9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services; 10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and 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. The Maryland Department of Health and Mental Hygiene will closely monitor Health Home providers to ensure their services meet Maryland's Health Home standards as well as CMS' Health Home core functional requirements stated above. Oversight activities will include, but not be limited to: medical chart and care management record review, site audits, and team composition analysis.
Provider Standards (Describe the State's minimum requirements and expectations for Health Homes providers)	A Health Home provider serves as the central point for directing person-centered care with the goal of improving patient outcomes while reducing avoidable health care costs. This includes preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes by addressing primary medical, specialist, and behavioral health care through direct provision, or through contractual arrangements with appropriate service providers, of comprehensive, integrated services. While providers are afforded a degree of flexibility in the design and implementation of their Health Homes, they must meet certain requirements in addition to those delineated in section iii. These standards are detailed below. <u>General Qualifications</u> 1. Health Home providers must be enrolled in the MD Medicaid program as a PRP,OTP, or Mobile Treatment provider and agree to comply with all Medicaid program requirements. 2. Health Home providers must be accredited by, or demonstrate their intention to seek accreditation from, an approved accrediting body as a Health Home, as detailed below: a. Submission of the Commission on Accreditation of Rehabilitation Facilities' letter of Intent to Survey for the Health Home accreditation under the Behavioral Health standards manual b. Providers with pre-existing accreditation from The Joint Commission may choose to pursue the organization's Health Home accreditation when it is released. Providers must attest that they will begin the accreditation process as soon as the product becomes available. Failure to apply for accreditation in a timely manner may result in revocation of Health Home status. c. Psychiatric Rehabilitation Providers serving children may pursue accreditation from CARF, The Joint Commission (as

	specified above), or the Council on Accreditation's (COA) case management service standards. 3. Health Home providers must directly provide, or subcontract for the provision of, Health Home services. The Health Home provider remains responsible for all Health Home program requirements, including services performed by the subcontractor. 4. Health Home teams will provide care coordination and integration of health care services to all Health Home enrollees, with each individual's care under the direction of a dedicated care manager accountable for ensuring access to medical and behavioral health care services and community social supports as defined in the enrollee ITP. 5. Health Home providers must demonstrate their ability to perform each of the eleven CMS Health Home core functional components (refer to section Support for Providers), including: a. processes used to perform these functions; b. processes and timeframes used to assure service delivery takes place in the described manner; and c. descriptions of multifaceted Health Home service interventions that will be provided to promote patient engagement, participation in their plan of care, and that ensures patients appropriate access to the continuum of physical and behavioral health care and social services. 6. Health Home providers must agree to convene regular, ongoing, documented internal Health Home team meetings to plan and implement goals and objectives of practice transformation 7. Health Home providers must agree to participate in CMS and state-required evaluation activities including required reports documenting Health Home service delivery as well as clients' health outcomes and social factors including but not limited to housing, employment, and education. 8. Health Home providers will maintain compliance with all of the terms and conditions as a Health Home provider or face termination as a provider of Health Home services 9. Health Home providers must present a proposed Health Home delivery model that the state determines to have a reasonable likelihood of being cost-effective. 10. Health Homes providing PRP services to children must demonstrate a minimum of 3 years of experience providing services to children. <u>Ongoing Provider Qualifications</u> Following enrollment, Health Home providers must also: a) Develop an internal protocol for reviewing and responding to hospital encounter alerts and pharmacy use data within 3 months of enrollment; b) Demonstrate adequate staffing levels have been reached, meeting all required qualifications. These levels must be met prior to beginning service provision. c) Develop a quality improvement plan to address gaps and opportunities for improvement identified during and after the application process; d) Demonstrate continuing development of fundamental Health Home functionality at 6 months and 12 months through an assessment process to be applied by the state; e) Demonstrate significant improvement on clinical indicators;

	f) Provide a Health Home that demonstrates overall cost effectiveness; and g) Obtain Health Home accreditation within 18 months of beginning service provision, or demonstrate significant progress towards this goal.
Health Home Service Delivery System	
Type of Service Delivery System (Indicate whether services are provided Fee for Service, using Primary Care Case Management, using Risk-Based Managed Care, or another service delivery system)	Although the majority of Health Home participants will be enrolled with an MCO, specialty mental health services are currently delivered through an ASO. Health Home services will be reimbursed directly to providers through the Department's Fee for Service system, using a capitated per member, per month rate.
PCCM Information (Indicate whether duplicate payments are provided to PCCM and health homes and, if so, describe the payment methodology for PCCM health homes)	Health Home services and corresponding payments will not be duplicated elsewhere. Health Home services are not provided to this population in a primary care setting due to the unique and intensive needs associated with the SPMI, SED, and opioid substance use diagnoses. Therefore, although Health Homes will collaborate as appropriate with primary care providers to coordinate care, services and payments will not be duplicative of any primary care case management.
Risk-Based Managed Care Information (Summarize contract language regarding health home services and indicate whether health homes are paid as part of the capitation rate. If not, describe the payment methodologies for health homes in risk-based managed care.)	All Health Home payments, including those for Maryland HealthChoice participants enrolled in managed care plans will be made directly from the State to the Health Home provider. Under the current Managed Care Organization (MCO) contracts, a portion of the general capitated rate paid to MCOs is designated for care coordination; therefore, MCOs and Health Homes will be expected to collaborate for the purposes of improving participant outcomes and efficient comprehensive care, without duplication of services. This includes the following actions: 1. Each MCO will be informed of its members enrolled in Health Home services and will designate a contact person for Health Home providers to allow for coordination of care. 2. MCOs and Health Homes will establish protocols for collaboration, including clear roles and responsibilities in care management and coordination. 3. The MCO or ASO may assist each other in identifying and performing outreach to members who may be eligible for Health Home enrollment and could significantly benefit from these services. 4. The Health Home provider will provide Health Home services in collaboration with MCO network primary care physicians in the same manner as they will collaborate with any other primary care physician who is serving as the PCP of an individual enrolled in the Health Home.
Payment Methodology	

Type of Payment Methodology
(Indicate whether services are provided Fee for Service, using Primary Care Case Management, using Risk-Based Managed Care, or another model)

Payment Type: Per member, per month (PMPM)
Provider Type: PRP, MT and OTP Health Home Providers
Maryland State Medicaid providers eligible to become Health Homes include those licensed as Opioid Treatment Programs (OTPs), Psychiatric Rehabilitation Programs (PRPs), or Mobile Treatment providers, accredited as a Health Home by an approved accrediting body, and meeting all Health Home provider standards set forth by the State.

Description
Eligible Health Homes will be paid a PMPM rate according to the methodology detailed below. All payments are contingent upon the Health Home meeting the requirements set forth in the Home Health applications, as determined by the State of Maryland. Failure to meet such requirements is grounds for revocation of Home Health status and termination of payments. The State of Maryland plans to periodically audit Health Homes to confirm adherence to all regulations and requirements. Health Home providers will bill the State Medicaid Agency directly for all enrolled participants at the end of each month upon completing the required service provision reporting.

Care Management Fee
Health Home provider reimbursement will fund only Health Home functionalities that are not covered by any of the currently-available Medicaid funding mechanisms, including the HealthChoice Managed Care Organizations. Payment amounts have been calculated based on costs resulting from the increased staff and additional expenses necessary to deliver care coordination targeting chronic health conditions among the SPMI, SED and opioid substance use disorder populations. The payment methodology for Health Homes is independent of, and in addition to, the existing fee-for service or Managed Care plan payments for direct service.

Health Homes will bill for all enrollees at the end of each month. The provider may begin billing for a Health Home participant when the intake portion of that individual's eMedicaid file has been completed with the necessary demographics, qualifying diagnoses baseline data, and consent form. The ongoing criteria for receiving a monthly PMPM payment is:

1. The individual is identified in the state-run Medicaid Management Information System (MMIS) as Medicaid-eligible and authorized to receive PRP, MT, or OTP services;
2. The individual is enrolled as a Health Home member at the billing Health Home provider; and
3. The individual has received a minimum of one Health Home service in the previous month, and this has been documented in the eMedicaid system.

Explanation of Fee Calculation

Role	Staffing Ratio & Employment Cost*	PMPM Rate	Responsibilities
Nurse Care	.5 FTE/125	$35.16	a. Develop wellness & prevention initiatives

	Manager	enrollees $105,465/year		b. Facilitate health education groups and provide direct health and prevention education to participants and caretakers/guardians, as appropriate. a. Participate in the initial treatment plan development for all of their Health Home enrollees b. Assist in developing treatment plan health care goals for individuals with, or at risk for, co-occurring chronic diseases c. Consult with Community Support Staff about identified health conditions d. Assist in contacting medical providers & hospitals for admission/discharge e. Provide training on medical diseases, treatments, & medications f. Track required assessments, screenings, and immunizations g. Assist in implementing technology programs & Initiatives h. Monitor HIT tools & reports for treatment medication alerts and hospital admissions/discharges i. Monitor & report performance measures & outcomes
	Health Home Director	.5 FTE/125 enrollees $135,388/year	$45.13	a. Provides leadership to the implementation and coordination of Health Home activities b. Champions practice transformation based on Health Home principles c. Develops and maintains working relationships with primary and specialty care providers including inpatient facilities d. Monitors Health Home performance and leads improvement efforts e. Designs and develops prevention and wellness initiatives
	Physician OR Nurse Practitioner	1 OR 2 hrs/enrollee/yr $100/year	$8.33	a. Participates in treatment planning b. Consults with provider psychiatrist (if applicable) c. Consults regarding specific consumer health issues d. Assists coordination with external medical providers
	Admin. Support Staff	.25 FTW/125 enrollees $63,091/year	$10.52	a. Referral tracking b. Training and technical assistance c. Data management and reporting d. Scheduling for Health Home Team and enrollees e. Chart audits for compliance f. Reminding enrollees regarding keeping appointments, filling prescriptions, etc g. Requesting and sending medical Records for care coordination
	TOTAL PMPM		**$98.87**	
	* Includes salary, FICA, health insurance, retired health insurance, and unemployment Sources: Bureau of Labor Statistics, May 2011 State Occupational Employment and Wage Estimates: Maryland			
Will payment methodology be tiered? If yes, provide	Payments will not be tiered.			

methodology for tiering the payments, such as severity of a person's condition; provider capabilities; or use of incentive payments).			
Health Home Services			
Comprehensive Care Management	**Service Definition**	**Ways HIT Will Link**	**Provider Types Furnishing the Service**
	All members of the Health Home team will collaborate to provide comprehensive care management services with active participation from patients and family/caregivers. This will include the following elements: a. Initial assessment: The Health Home will conduct a standardized, high quality, comprehensive assessment of the enrollee's physical, mental health, chemical dependency and social service needs, if no such assessment has been performed by a licensed health provider in the preceding 6-month period. The Health Home will request records from the individual's PCP and other providers to inform the development of the Individualized Treatment Plan (ITP). b. Development of Care plan: Using the initial assessment, the Health Home team will work with the consumer to develop an ITP including client goals and timeframes, community networks and supports, and optimal clinical outcomes. c. Delineation of roles: The Health Home will assign each team member clear roles and responsibilities. Participant ITPs will identify the various providers and specialists within	All Health Homes will have access to the State's online eMedicaid portal, allowing providers to report and review participant intake, assessment, assigned staff, ITP, clinical baselines and data relating to chronic conditions, as well as Health Home services provided, such as referrals made and health promotion activities completed. EMedicaid will generate reports of the aforementioned data at a participant or provider level. Additional access to hospital encounter and pharmacy data through the Chesapeake Regional Information System for Our Patients (CRISP) Electronic Notification System and the State's administrative services organization (ASO), respectively, will enable Health Homes to gain a more comprehensive understanding to their participants' care and health status.	Health Home Director, Nurse Care Manager, Physician or Nurse Practitioner Consultant, Administrative Support Staff

	and outside the Health Home involved in the consumer's care. d. Monitoring and reassessment: the Health Home will monitor individual health status and progress towards ITP goals, documenting progress and adjusting care plans as needed. The Provider will also monitor population health status and service use to determine adherence to or variance from treatment guidelines. e. Outcomes and Reporting: The Health Home will use the eMedicaid portal and other available HIT tools possibly including EHR, to review and report quality metrics, assessment and survey results, and service utilization in order to evaluate client satisfaction, health status, service delivery, and costs.		
Care Coordination and Health Promotion	**Service Definition**	**Ways HIT Will Link**	**Provider Types Furnishing the Service**
	Care coordination will include implementation of the consumer-centered ITP through appropriate linkages, referrals, coordination and follow-up to needed services and support. Specific activities include, but are not limited to: appointment scheduling, referrals and follow-up monitoring, participation in hospital discharge processes, and communication with other providers and supports, including school service providers. The Health Home provider will assign each enrollee a Care Manager who will be responsible for coordinating the individuals' care and ensuring implementation of the treatment plan in partnership with the individual and family, as appropriate.	The eMedicaid online portal will allow Health Homes to report and review referrals made to outside providers, social and community resources, and individual and family supports. Access to CRISP hospital encounter alerts will facilitate prompt discharge planning and follow-up. As the State continues to develop eMedicaid's capabilities, claims data will ultimately populate fields in the eMedicaid system, allowing Health Home providers to better understand and track	Care Coordination: Administrative Support Staff, Nurse Care Manager, Health Home Director Health Promotion: Nurse Care Manager

	The Health Home provider will be required to develop policies and procedures to facilitate collaboration between primary care, specialist, and behavioral health providers, as well as community-based organizations and for children, school-based providers. Such policies will clearly define the roles and responsibilities of each in order to ensure timely communication, use of evidence-based referrals, follow-up consultations, and regular, scheduled case review meetings with all members of the Health Home team. The Health Home will ensure that all regular screenings and immunizations are conducted through coordination with the primary care or other appropriate provider. The Health Home provider will have the option of utilizing technology conferencing tools including audio, video and /or web deployed solutions when security protocols and precautions are in place to protect Protected Health Information (PHI) to support care management/coordination activities. Health Promotion services assist patients and families to participate in the implementation of their care plan and place a strong emphasis on skills development for monitoring and management of chronic and other somatic health conditions. Health Services will include health education and coaching specific to an individual's condition(s), development of a self-management plan, medication review and education, and promotion of healthy lifestyle interventions. Such interventions may include, but are not limited to those that encourage substance use prevention, smoking cessation, improved nutrition, obesity	their participant needs, services received, and identify opportunities for improved care coordination. Health Home providers will use the eMedicaid portal to document, review, and report health promotion services delivered to each enrollee. Additionally, periodic updates to clinical outcomes may be reported in tandem with the related health promotion services delivered—for example, while reporting a discussion regarding physical activity in the eMedicaid portal, the Health Home would note the participant's weight and BMI.	

	reduction, and increased physical activity. Health Homes working with children will emphasize these preventive health initiatives, while actively involving parents and families in the process. This will include identifying conditions for which the child may be at risk due to family, physical, or social factors, and working with the patient and caregivers to address these areas.		
Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)	**Service Definition** Health Homes will provide services designed to streamline plans of care, reduce hospital admissions, ease the transition to long-term services and supports, interrupt patterns of frequent hospital emergency department use, and ensure timely and proper follow up care. The Health Home will increase consumers' and family members' ability to manage care and live safely in the community, shifting the use of reactive care and treatment to proactive health promotion and self-management. To accomplish this, the Health Home provider will utilize the CRISP Encounter Notification Service to receive alerts when a hospital encounters a Health Home enrollee. Providers will establish a clear protocol for responding to CRISP alerts or notification from any other inpatient facility to facilitate collaboration in treatment, discharge, and safe transitional care. Care Managers will follow up with consumers within five days of discharge via home visit, phone call, or scheduling an on-site appointment.	**Ways HIT Will Link** All Health Homes will be required to enroll with CRISP in order to receive alerts of hospital admissions, discharges, or transfer among their Health Home patient panel. Real-time access to this information will allow Health Home providers to provide prompt coordination and follow-up care. This ability will be augmented by real-time access to pharmacy data that may aid in medication reconciliation.	**Provider Types Furnishing the Service** Health Home Director, Nurse Care Manager, Physician or Nurse Practitioner Consultant, Administrative Support Staff
Individual and Family Support Services	**Service Definition** Services will include, but are not limited to,	**Ways HIT Will Link** The eMedicaid tool will allow	**Provider Types Furnishing the Service** Health Home Director, Nurse Care Manager,

	advocating for individuals and families; assisting with, obtaining, and adhering to medications and other prescribed treatments; identifying resources for individuals and families to support them in attaining their highest level of health and functioning in their homes and in the community, including transportation to medically-necessary services; improving health literacy; increasing the ability to self-manage care; facilitating participation in the ongoing revision of care/treatment plan; and providing information as appropriate on advance directives and health care power of attorney in order to allow them to make informed decisions in advance of any unforeseen health crisis. All provider types eligible to become Health Homes currently specialize in behavioral health services and a significant majority provides peer support services on-site. The Health Home will encourage participants to utilize these peer supports as appropriate, as well as making referrals to support groups and self-care programs to increase patients' and caregivers' knowledge of the individuals' diseases(s), promote the enrollee's engagement and self-management capabilities, and help the enrollee improve adherence to their prescribed treatment. The Health Home provider will ensure that all communication and information shared with the enrollee, the enrollee's family and caregivers, as appropriate, is language, literacy and culturally appropriate.	Health Home providers to document, review, and report individual and family support services delivered, including referrals to outside groups or programs. Using real-time pharmacy data, Health Home providers will be better able to assist individuals in obtaining and adhering to prescription medications.	Administrative Support Staff
Referral to Community and	**Service Definition**	**Ways HIT Will Link**	**Provider Types Furnishing the Service**

Social Support Services	The Health Home will identify available community-based resources and actively manage appropriate referrals, access to care, and engagement with other community, social, and school-based supports. Specific services will include, but are not limited to: providing assistance for accessing Medical Assistance, disability benefits, subsidized or supported housing, personal needs support, peer or family support, and legal services, as appropriate. The Health Home will assist in coordinating these services and following up with consumers post service engagement.	Using the eMedicaid online portal, Health Home providers may document, report, and review referrals to community-based resources.0	Health Home Director, Nurse Care Manager, Administrative Support Staff
Use of Health Information Technology to Link Services	**Service Definition**		**Provider Types Furnishing the Service**
Health Homes Patient Flow (Describe the patient flow through the State's Health Homes system. The state must submit flow-charts of the typical process an individual would encounter)	*Referral and Enrollment* As detailed above, potential Health Home participants may be informed of the Health Home option and referred to a Health Home provider in their region by a variety of sources. Upon engaging with a potential participant, the Health Home will enroll the individual in the appropriate PRP, MT, or OTP services for which they are eligible, and in the case of OTP patients, identify the qualifying risk factors that place them at risk for additional chronic conditions. The Health Home will then explain the data-sharing elements of the program and obtain consent from the participant. Finally, the provider will create an entry and intake for the participant in the eMedicaid system, effectively enrolling them in the Health Home. *Participation* While participating in the Health Home, an individual will receive a minimum of one Health Home service per month, to be documented in the eMedicaid portal. An assigned nurse care manager will monitor their care and health status, and the Health Home team will assist with the provision of Health Home services as necessary. The Health Home will periodically reassess participants, and in doing so determine whether Health Home services are necessary. *Discharge* Discharge from the Health Home will primarily result from incidents such as relocation, transfer, incarceration, or loss of eligibility. In such cases, the Health Home		

	provider will follow discharge protocol appropriate to the circumstances. This 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. The Health Home provider will report in eMedicaid the discharge of a participant, as well as note the completion of discharge planning.	
Assurances		
The State provides assurance that eligible individuals will be given a free choice of health homes providers.		
The States provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving health homes services.		
The State assures that hospitals participating in the State plan or waiver of such plan will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.		
The State 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.		

The State provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.		
The State will report to CMS information submitted by health home providers to inform the evaluation and Report to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.		
Monitoring		
Describe the State's methodology for tracking avoidable hospital readmissions to include data sources and measure specifications.	**Data Sources**	**Measures Specifications**
	Claims	Using claims data, the State will track avoidable hospital readmissions by calculating ambulatory care sensitive conditions (ACSC) readmissions per 1000 enrollees. To calculate this rate: (# of readmissions with a primary diagnosis consisting of an Agency of Healthcare Research and Quality (AHRQ) ICD-9 code for ambulatory care sensitive conditions/member months) x 12,000.
Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measures specifications.	**Data Sources**	**Measures Specifications**
	Claims	To measure cost savings generated by Chronic Health Homes, the State may compare the costs per member per month for participants by Health Home provider and by condition to costs for comparison groups of OTP, MT, and PRP participants enrolled with non-Health Home providers. The State may also

		compare overall costs between the groups for emergency room utilization, hospitalizations, nursing facility admissions, and pharmacy utilization. In this assessment, the State may review each Chronic Health Home independently for its overall costs and the allocation of its funds amongst services provided to inform future implementation and process modifications.
Describe the State's proposal for using health information technology in providing health home services under this program and improving services 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. <u>eMedicaid Portal:</u> eMedicaid is a web-based portal accessible to all networks, allowing Health Home providers to keep a record of services delivered, referrals made, and clinical and social outcomes related to the individuals' chronic conditions. The portal is secure, with Health Homes' access limited to access the records of their own current enrollees. Providers may upload patient ITPs, as well as reporting specific services delivered in comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referrals to community and social supports. They may also record baseline data at intake related to chronic conditions, such as BMI, blood pressure, global assessment of functioning (GAF) score, and others. In future years, it is the State's intention to program eMedicaid to link with the MMIS system to automatically populate fields in eMedicaid with claims data for each participant. A reporting function will enable providers to generate monthly summary reports for submission to the State, as well as to track service provision and recorded outcomes at the individual or provider level. 2. <u>Chesapeake Regional Information System for our Patients (CRISP):</u> All Health Home providers must enroll with CRISP's Electronic Notification System to receive hospital encounter alerts. This entails an initial upload of the Health Home's patient panel with all necessary demographic information, followed by monthly panel updates, as well as the set up of a direct message inbox and/or an interface with the provider's EHR to receive alerts. 3. <u>Pharmacy Data:</u> Maryland Medicaid's ASO maintains a real-time database of Medical Assistance participants' pharmacy claims. Health Homes will be required to connect with the ASO in order to access their enrollees' pharmacy data, including the following fields: date filled, drug name and strength, metric quantity, days' supply, amount paid, prescriber ID and name, and pharmacy ID and name. 4. <u>Electronic Health Records (EHR) and Clinical Management Systems:</u> Qualification as a Health Home provider is in part dependent upon the ability to report detailed performance metrics, measure improvement in care coordination, and gauge clinical outcomes on a provider level. Providers who do not currently use a robust EHR or clinical management system may determine that such a tool is necessary to meet the	

	reporting and care coordination requirements of the Health Home program, as well as to improve their overall care capabilities.

Evaluations – Describe how the state will collect information from health home providers for the purpose of determining the effects of this program on reducing:				
Hospital Admissions	**Description**	**Measure Specification, including numerator and denominator**	**Data Source**	**Frequency of Data Collection**
	The Department will collect and evaluate data regarding hospital admissions among Health Home participants to determine the effectiveness of the program in reducing these rates.	a. Inpatient admissions per 1000 Health Home participants per month, stratified by mental health diagnoses and all other diagnoses. b. Potentially preventable readmissions within 30 days as a percentage of potentially preventable hospital admissions, stratified by mental health diagnoses and all other diagnoses. c. Mental health readmissions within 30 days. d. Hospital admissions with congestive heart failure and/or heart disease as a primary or secondary diagnosis, per 1000 Health Home participants per month. e. Hospital admissions with asthma complications as a primary or secondary diagnosis, per 1000 Health Home participants per month. f. Hospital admissions with substance use disorder as a primary or secondary diagnosis, per 1000 Health Home participants per month. g. Hospital admissions with diabetes-related complications as a primary or secondary diagnosis, per 1000 Health Home participants	Claims/Encounters	Annual data collection and reporting

		per month. h. Hospital admissions with HIV/AIDS-related complications as a primary or secondary diagnosis, per 1000 Health Home participants per month. i. Hospital admissions with viral hepatitis-related complications as a primary or secondary diagnosis, per 1000 Health Home participants per month. j. Hospital admissions with mental health conditions as a primary or secondary diagnosis, per 1000 Health Home participants per month. k. Hospital admissions with hypertension related complications as a secondary diagnosis, per 1000 Health Home participants per month. l. Hospital admissions with obesity related complications as a secondary diagnosis, per 1000 Health Home participants per month. m. Hospital admissions with chronic kidney disease complications as a primary or secondary diagnosis, per 1000 Health Home participants per month. n. Costs per member per month, aggregated and by CHH provider.		
Emergency Room Visits	**Description**	**Measure Specification, including numerator and denominator**	**Data Source**	**Frequency of Data Collection**
	The Department will collect and evaluate data regarding emergency room visits among Health Home participants to determine the effectiveness of the program in reducing	a. Emergency Department (ED) visit rate per 1000 Health Home participants per month, stratified by mental health diagnoses and all other diagnoses. b. Asthma ED visit rate per 1000 Health Home participants per month. c. Diabetes-related ED visit rate per 1000 Health Home participants per month. d. Substance use disorder ED visit rate per 1000	Claims/Encounters	Annual

	these rates.	Health Home participants per month. e. Congestive heart failure and/or heart disease ED visit rate per 1000 Health Home participants per month. f. HIV/AIDS-related ED visit rate per 1000 Health Home participants per month. g. Hepatitis C-related ED visit rate per 1000 Health Home participants per month. h. Obesity-related complications ED visit rate per 1000 Health Home participants per month. i. Chronic kidney disease ED visit rate per 1000 Health Home participants per month. j. Hypertension related ED visit rate per 1000 Health Home participants per month. k. Costs per member per month, aggregated and by CHH provider.		
Skilled Nursing Facility Admissions	**Description**	**Measure Specification, including numerator and denominator**	**Data Source**	**Frequency of Data Collection**
	The Department will collect and evaluate data regarding skilled nursing facility admissions among Health Home participants to determine the effectiveness of the program in reducing these rates.	a. Nursing Facility admission rate per 1000 Health Home participants per month, all facility admissions. b. Costs per member per month, aggregated and by CHH provider.	Claims/Encounters	Annual
Evaluations - Describe how the state will collect information for purposes of informing the evaluations, which will ultimately determine the nature, extent and use of this program as it pertains to the following:				
Hospital Admission Rates	The State plans to capture hospital admission rates and readmission rates per 1000 Health Home participants per month, as described in the preceding section and in the supporting Quality Measures document. The State may evaluate the rates using comparison groups of individuals receiving care from non-participating PRP and OMT providers. A goal of the Health Homes is to reduce inappropriate ED usage, especially for individuals with chronic conditions. With the aid of state and academic partners, the State will use ED classifications developed by researchers at the New York			

	University Center for Health and Public Service Research to classify the appropriateness of ED care for Health Home participants and compare usage with groups of OMT participants and PRP participants receiving care via the traditional Medicaid program. This methodology categorizes emergency visits as follows: 1. *Non-emergent*: Immediate care was not required within 12 hours based on patient's presenting symptoms, medical history, and vital signs 2. *Emergent but primary care treatable*: Treatment was required within 12 hours, but it could have been provided effectively in a primary setting (e.g., CAT scan or certain lab tests) 3. *Emergent but preventable/avoidable*: Emergency care was required, but the condition was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness (e.g., asthma flare-up) 4. *Emergent, ED care needed, not preventable/avoidable*: Ambulatory care could not have prevented the condition (e.g., trauma or appendicitis) 5. *Injury*: Injury was the principal diagnosis 6. *Alcohol-related*: The principal diagnosis was related to alcohol 7. *Drug-related*: The principal diagnosis was related to drugs 8. *Mental health-related*: The principal diagnosis was related to mental health 9. *Unclassified*: The condition was not classified in one of the above categories by the expert panel The State also may use hospital readmissions data for Health Home participants to determine if care managers are establishing prompt contact with patients and their physicians to coordinate care after hospitalization discharge.
Chronic Disease Management	The State may modify standardized assessment tools using claims data, encounter data, pharmacy data, and qualitative interviews with Health Home administrative staff and providers, to determine implementation of the following components: 1. inclusion of preventive and health promotion services; 2. coordination of care between primary care, specialty providers and community supports; 3. emphasis on collaborative patient decision making and teaching of disease self-management; 4. structuring of care to ensure ongoing monitoring and follow-up care; 5. facilitation of evidence-based practice; and 6. use of clinical information systems to facilitate tracking of care as well as integration between providers. In addition, the State may conduct comparative evaluations that focus on groups at-risk to incur high costs to determine the success and cost-effectiveness of the Health Homes.
Coordination of Care for Individuals with Chronic Conditions	Using the Chronic Health Homes tool on eMedicaid, the State will monitor Health Home providers to ensure they are coordinating care effectively for participants. The State may assess provision of care coordination services by measuring:

	1. the level of contacts made by care managers during and after hospitalization; 2. the frequency of telephonic and/or face-to-face contact with participants after hospitalization discharge; 3. the level of active care management for high-risk participants; and 4. behavioral activity and engagement of high-risk participants in response to care management interventions. Oversight activities may include, but not be limited to: medical chart and care management record review, site audits, team composition analysis, and review of types and number of contacts.
Assessment of Program Implementation	The State will have the capacity to assess and monitor ongoing performance of the Health Homes program with the aid of claims and encounter data, pharmacy data, the eMedicaid case management tracking tool, and regularly scheduled educational activities and meetings. Through a combination of evaluation data, information from training sessions, feedback from the regional meetings, and information gathered from practice representatives and participants, the State and Health Home providers may identify ineffective practices and implementation challenges and develop potential solutions. The State may assess if Health Homes have developed and implemented a tool to track and monitor recipient encounters with providers and inpatient facilities. The State may also perform evaluations of patient volume levels, the percentage of participants who opt out of Health Home services, achievement of participation goals set by each Health Home provider, and retention rates.
Processes and Lessons Learned	The State may provide training and education opportunities for health home providers, such as webinars, regional meetings, and/or training sessions to foster shared learning, information sharing, and problem solving. These forums may permit discussion of successful and unsuccessful implementation strategies, along with frequent communication, feedback, learning activities, and technical assistance. The State also may monitor Health Home processes by assessing evaluation data, conducting medical chart and care management record reviews, site audits, team composition analysis, and review of types and number of contacts between Health Home case managers and participants.
Assessment of Quality Improvements and Clinical Outcomes	The State requires each Chronic Health Home to use a tracking tool to input information related to participants' services and overall health. In addition to assisting the Chronic Health Home with coordination of care and case management, the tool tracks information tied to the qualifying chronic condition, such as Body Mass Index (BMI), blood pressure levels, smoking cessation activities, diabetes screening test results, and attendance and participation in alcohol and drug dependence treatment programs. Data collected may inform the individual's plan of care, proper follow-up protocols upon the recipient's hospitalization discharge, health promotion services, and management of chronic conditions overall. The State's current HEDIS™ measures for Medicaid-eligible adults that correspond with measures recommended by CMS for Health Home efforts are Ambulatory Care – Sensitive Condition Admission, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, and Controlling High Blood Pressure. The State may opt to evaluate additional HEDIS™ measures for adults that link to overall health promotion, such as Adult BMI Assessment, Medical Assistance with Smoking and Tobacco Use Cessation, Comprehensive Diabetes Care: Hemoglobin A1c Testing and LDL-C Screening, Annual Monitoring for Patients on Persistent Medications, Breast Cancer Screening, Cervical Cancer Screening, Chlamydia Screening in Women Ages 21-24, Postpartum Care Rate, Controlling High Blood Pressure, and the CAHPS survey to evaluate experience of care. These measures may be obtained using claims data, encounter data, medical chart reviews, survey responses, and pharmacy data. The State also may incorporate Medicare data to evaluate the Health Home's

	impact on the dual eligible population. The endpoint evaluation may also identify and assess the number and types of outcomes indicative of poorly managed care of chronic conditions at the patient level. Examples include multiple ED visits, hospital re-admissions, and preventable disease-specific complications.
Estimates of Cost Savings (if different from the method described under monitoring)	To measure cost savings generated by Chronic Health Homes, the State may compare the costs per member per month for participants by Health Home provider and by condition to costs for individuals receiving care from non-participating PRP and OMT providers. The State may also compare overall costs for emergency room utilization, hospitalizations, nursing facility admissions, and pharmacy utilization. In this assessment, the State may review each Chronic Health Home independently for its overall costs and the allocation of its funds amongst services provided to inform future implementation and process modifications.

Quality Measures were moved to an administrative reporting document separate from the State Plan Amendment (SPA) and required after SPA approval