OHIO MEDICAID HEALTH HOMES FOR THOSE WITH SERIOUS AND PERSISTENT MENTAL ILLNESS

Documentation, Billing & Regulatory Requirements Committee

AGENDA

November 15, 2011

1:00 – 4:00 p.m.

Rhodes, Rm. 806

Purpose: *develop recommendations related to aligning documentation, billing and other regulatory requirements to support integration; review certification, licensure and national accreditation standards to assure a bi-directional approach to integration that is balanced, including expansion of accreditation and development of new standards to formally recognize the emerging service delivery model of Behavioral Health Homes.*

- **Welcome & Introductions**
- **Review of Purpose**
- **Review of State Plan Examples**
- **Review of Service Definitions**
- **Review of CARF Standards of Integrated Care**
- **Review of Joint Commission Standards of Integrated Care**
- **Review of NCQA Comparison**
- **Regulatory and Accreditation**
- **Documentation**
- **How do Regulatory/Accreditation & Documentation interact with Core Elements**

Documentation, Billing and Regulatory Requirements
November 15, 2011
Meeting Minutes

Attendees: Angie Bergefurd, Leslie Brose, Ami Cole, Debbie Daniel, Cynthia Holstein, Mark Johnson, Terry Jones, Afet Kilinc, Heather King, Teresa Lampl, Jody Lynch, Lynne Lyon, Merissa McKinstry, Mark Mecum, Jim Miller, Barb Namett, Chris Neumann, Mike Robinson, Peggy Smith, Jonas Thom, Diane Wright,

Meeting convened at 1:10 p.m.

Welcome & Introductions
Angie Bergefurd opened the meeting and the group introduced themselves round table. Angie provided a brief overview of the health homes kick-off meeting, which took place on November 3, 2011. Angie's presentation from this meeting was distributed in the meeting packet. She reviewed the meaning of health homes in the context of this work: integrated behavioral and physical health care for children and adults with serious and persistent mental illness that uses a patient-centered, team-based approach and addresses the holistic needs of the person.

Angie explained that the state will be required to engage in a SAMHSA consultation to ensure that we are properly integrating behavioral and physical healthcare in our health homes. She added that there are specific activities under the health home service; different components of this service are outlined on slide 5 of the presentation. Many different populations are eligible for health home services; SPMI is its own qualifying category. There are other chronic conditions which also qualify individuals for health home services. Dual eligibles are not allowed to be excluded and exclusions based on age are not allowed.

Services for the first 8 quarters will get a 90% reimbursement from CMS, as opposed ot the usual 60% for other services. There is flexibility allowed in payment design. Currently, the state is planning to use a monthly reimbursement system. It will be very important to assure that we are not duplicating services between health home services and other services, particularly CPST. Overlap will exist in terms of what is currently being provided as CPST service; this will need to be built into the payment methodology. The state views community mental health centers as best positioned to become health homes.

Jon Barley added that the health homes budget initiative is in line with other initiatives that the Office of Health Transformation supports, such as patient-centered medical homes. Ohio Department of Health Director Dr. Wymyslo is behind a great effort to transform all practice sites to a patient-centered medical home model. Another area of focus for the Office of Health Transformation is integration of physical and behavioral health and electronic medical records. Afet Kilinc added that the state has made the serious and persistent mental illness population a priority; we are under a tight deadline to implement this initiative.

Review of Purpose
Angie reviewed the purpose of the group briefly. The group is charged with developing recommendations to align documentation, billing, and other regulatory requirements to support the integration of behavioral and physical health. Part of this work is to review standards for certification, licensure and accreditation to assure a balanced approach to integration. This will most likely include expanded accreditation and the implementation of new standards that will formalize the health homes service delivery model.

Review of State Plan Examples

Angie stated that two examples of state plan amendments were provided in the meeting handouts. The Missouri plan has been approved by CMS and the Rhode Island plan was recently submitted. The purpose of these examples is to give the group a sense of what will be required for conversations with CMS. This group will discuss program design in order to begin contact with CMS, and will need to make note of operational issues throughout this process. The state is contracting with Healthcare Management Associates to prepare the state plan amendment. Alicia Smith is the state consultant from Healthcare Management Associates. She helped Missouri and Rhode Island throughout the process of drafting and submitting their state plans.

Both state plan amendment examples contain sections that outline provider standards, requirements, core elements and basic requirements of health homes. Page 5 of the Missouri plan focuses on standards and qualifications. This is an example of the level of detail we will be required to provide in the Ohio state plan amendment. Missouri and Rhode Island both address the electronic health record in their state plan amendments. They are further in developing an electronic health record than we are, so our requirements will be different.

The core requirements will also be different among states. It is important to note that both Missouri and Rhode Island have wellness requirements and ongoing provider qualifications. Afet and Kara Miller have already done a significant amount of work in this area. The Rhode Island state plan amendment also contains a provider standards example that is worth noting. This outlines which people need to be on the care team, specific care models and how to connect with hospitals. Terry Jones pointed out that Missouri has already been engaged in integrated care for ten years and is just now seeking reimbursement for health home services. Rhode Island is similar to Ohio in that they have been reimbursing for CPST but have not provided integrated care.

Review of Service Definitions

Afet reviewed the draft service definitions that were provided in the meeting packet. She explained that the federal definitions are provided, along with an expanded definition of each. The health home service is a single service that contains a number of components which overlap with one another. Each definition provides information about who is eligible for the service.

CMS has not provided specific guidance or descriptions of these services, so states must define them individually. The definitions are slightly different among states but have a number of similarilities. Angie pointed out that the service definitions are generic and not specific to behavioral health. They are meant to be integrated and consistent across all health homes. Health information technology should be considered in developing these services, as we must be able to explain to CMS the manner in which we will be using it in each service area.

- ***Comprehensive Care Management*** includes a comprehensive health assessment that requires behavioral health assessments for dual disability, substance abuse and mental health. This service also covers wellness and psycho-social needs. After the health assessment is performed initially, a team will be formed for the individual that will work together to create an integrated care plan. This plan must be updated regularly and

must include the crisis plan.

- ***Care Coordination*** is meant to ensure that all care needs are met and that the individual is linked to all needed services, including medication management, tracking test results, following up on referrals and coordination around discharge from or admission to outside care. This service also includes coordinated care during crises, as well as development and monitoring of the care treatment plan. Many providers are currently only updating the care treatment plan quarterly, every 6 months or yearly, but the health home care treatment plan must be updated every 90 days.
- ***Health promotion*** involves educating consumers and family members about the consumer's health conditions. Wellness-related, health enhancing assistance is also available with this service. This service helps consumers to connect to evidence-based practices, such as those that assist with smoking cessation and the development of recovery action plans or advance directives.
- ***Transition of care*** specifically includes any transitions from inpatient to outpatient or vice versa; it facilitates transitional situations across all state systems. The underlying goal is to prevent unnecessary inpatient admissions and other adverse outcomes.
- ***Individual and family supports*** provide direct assistance to individuals, help them to self-manage conditions and facilitate service access. A patient and family advisory council is included in this service as a result of feedback from stakeholders.
- ***Referrals to community and social supports*** help individuals to access supports related to a wide variety of community, social and recovery services.

Teresa Lampl raised a question about why referral is a separate service when it is already embedded in care coordination. Afet explained this is meant to encourage holistic coordination; the referral process must be tracked from beginning to end. She added that the referral aspect of the health home service is an example of the overlap that she was speaking of previously. She explained that ODMH used the CPST service definition and ODADAS used the case management service definition as guides in developing the components of the health home service. Language from these services was copied into this document to ensure that nothing was missed. Afet emphasized that the document can still be polished and refined with the group's input.

A question was raised about the role of managed care. Jon stated ODJFS is still working out the details, but currently is planning for managed care and health homes to work closely together so that relevant information can be easily shared. Jon also explained that ODJFS has changed the focus of what is required of managed care plans for care management. They are concentrating on the "hot spotters" using a face-to-face care management strategy that health homes could easily adapt. He added that managed care could still administer the program for people who are on fee for service plans, acting on behalf of these individuals. The same functions will be performed regardless of whether the person is on managed care or fee for service.

A question was raised about whether health home service and CPST service could be provided simultaneously. Angie stated that a portion of CPST will not overlap with health home service; the state wants to be able to implement a process in which billing for this portion of CPST can continue, perhaps using a modifier. However, overlap between these services will occur, and in these instances the service would be billed as a health home service rather than CPST.

Information about which services overlap and which do not will be distributed to the field when available.

A question was raised about why the 90 day requirement was made. Afet will follow up on this; she believes that it was either a CMS requirement or a work group decision. Teresa added that this is also an insurance requirement that is currently in state statute.

Teresa stated that verifying that people attend appointments is a barrier for consumers with serious and persistent mental illness and/or substance abuse disorder. She asked whether this will be reimbursable as a CPST service or if the health home will employ people to navigate consumers in this process. Afet stated that this type of service is addressed in the Individual and Family Supports service definition, but it can be made clearer. She added that the overall vision of the state is that there will be less worry about whether the things that clinicians do are reimbursable and more focus on taking care of the consumer.

Jonas asked whether the state has thought about the level of specificity that will be required for health assessment vs. obtaining information from outside providers. Angie stated that these services are meant more for coordination than for direct treatment. Afet added that the role of care management is to compile information and make arrangements with the care team to add needed data to health home records.

Review of Core Elements Document

Angie discussed the document included in the meeting packet that outlines qualifying core elements for Medicaid health homes. She stated that feedback is needed from the group on the meaningful use requirement. Specifically, the state would like to know whether it is recommended that we use a phased-in approach rather than a day one requirement.

Another important element to consider is clearly demonstrating behavioral and physical health care integration in the health home. This may vary widely among health homes. The key element is orientation of the consumer to the health home, ensuring that each consumer truly understands the service.

The core elements document is meant to be a high-level summary of the requirements that will eventually be transferred into the SPA as provider requirements. Afet and Kara have begun to look into accreditation to see whether already existing requirements meet the needs of the health home model. Some areas will not need further accreditation and others will.

Review of NCQA Comparison

Afet stated that initially, the state work group attempted to align certification requirements across the certifying bodies, but quickly discovered that this was neither feasible nor helpful. This group discussed core elements and how to certify for them at length. In researching accreditation to find overlap with the core elements, Afet prepared a crosswalk between the different accrediting bodies, which was distributed to the group.

Angie stated that the state wants to be able to use different models rather than a one size fits all approach. There will be different ways of meeting requirements to become a health home. Afet

added that the state also wants to avoid duplicative requirements and unneccesary administrative burden. She stated that none of the accreditations meets the necessary requirements on its own, so a hybrid approach will be needed.

Afet reviewed each of the different types of health homes and compared their requirements to the requirements met by the different accrediting bodies. She stated that meaningful use and electronic health records have been earmarked for a phase-in approach. The columns marked with an "x" need additional evaluation because they do not adequately address the requirements. A suggestion from the group to involve primary care in this work was noted.

The group reviewed and provided feedback on the following elements of the crosswalk:

- ***Meaningful Use*** - group agreed that this will be required as a phase-in approach using CMS standards. An outline of the plan to achieve meaningful use will be required during the health home application process.
- ***Health Information Technology*** **–** group agreed that this will be required as a phase-in approach. The goal is to work toward a single integrated care plan. They also agreed that agencies must have at least one relationship with a primary care provider.
- ***Health Record Integration*** – group agreed that providers need to be able to demonstrate how they have a relationship with primary care. They will need to have documentation around assessment and treatment planning integration, as well as how the exchange of information will occur across providers.
- ***Orientation of Patient to Health Home*** – group agreed to follow up on whether this item can be linked to already existing certification or accreditation standards.
- ***Team of Health Professionals with an accountable RN care manager*** – group agreed to use a phase-in aproach with this requirement. The agency will need to explain how this requirement will be met during the application process. James Miller suggested that the agreement with primary care will state that the primary care organization will provide the RN care manager.
- ***Population Management*** – group agreed to use a phase-in approach with this requirement. It was noted that this is an important requirement and that perhaps requiring it in some form (basic data base or spreadsheet) on day one is best.
- ***Expanded Access*** – group noted that telephone access is a separate category. After a lengthy discussion, they agreed that they need to sort out the difference between expanded access and urgent, emergent issues that require same day appointments before recommendations can be made in this category. It was also agreed that telemedicine flexibility is needed for medication management. The group agreed that although the goal is not to stop providers from referring consumers to higher levels of care if they are needed, it does not necessarily matter which professional provides needed same day care if it prevents these consumers from needing higher levels of care.
- ***Test Tracking, Referral, and Follow-up*** – group noted that this requirement overlaps with CMS meaningful use requirements. There are many steps after making the initial referral. Jonas recommended looking at detail provided in the Missouri state plan amendment as a guide.

Review of CARF Standards of Integrated Care

Afet reviewed the most recent CARF Standards of Integrated Care information. She pointed out that Section 3 discusses specialized standards for care teams. This list was created for integrated programs that live within behavioral health centers. Teams can be collocated while remaining as separate organizations that have agreements related to coordination of services. CARF standards cover behavioral health care providers placed within a physical health care clinic, as well as behavioral health providers that open primary care clinics. Afet also noted that Sections 1 and 2 apply to integrated care programs.

CARF is also working on standards for health homes. Part of this work has involved consulting with Missouri professionals in this area. The state is considering requiring CARF accreditation for health homes, but this has not yet been decided.

Next Steps/Next Meeting

- Scenarios related to process flow will be distributed to the group prior to the next meeting.
- The state would like input on any barriers to this work before next meeting.
- Next meeting will take place Tuesday, November 29, 2011 at 1 p.m. in Rhodes State Office Tower, Room 806.