

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

Documentation, Billing & Regulatory Requirements Committee

AGENDA

November 29, 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 Last Meeting Recommendations
- Case Studies
- Updates from Other Committees
- Next Steps
- Next Meeting: December 16, 2011

1:00 p.m. – 3:00 p.m. Rhodes State Office

Tower Lobby Hearing Room

Documentation, Billing & Regulatory Requirements Committee
November 29, 2011
Meeting Minutes

Attendees: Dan Arnold, Peggy Bardnell, Jon Barley, Angie Bergefurd, Debbie Daniel, Cynthia Holstein, Terry Jones, Afet Kilinc, Heather King, Teresa Lampl, Jody Lynch, Merissa McKinstry, Mark Mecum, Kara Miller, Jennifer Millisor, Barb Namett, Christine Neumann, John Seseck, Peggy Smith, Jonas Thom, Diane Wright

Welcome & Introductions

Angie Bergefurd opened the meeting and the group introduced themselves round table.

Review of Last Meeting Recommendations

The group reviewed the recommendation document included in the meeting packet. Below is a summary of the discussion around each of the recommendations.

Comprehensive Care Management

Cynthia Holstein stated that she thought the group decided in the last meeting to soften the requirement around partnerships. Angie asked whether the third bullet covers this concern. Cynthia asked whether the partnerships need to be documented in writing. Angie stated that this should be left to the group. Patrick Beatty feels that it makes sense to have something in writing; otherwise, a loose arrangement in which the players are unknown may result. It is better in his opinion to clarify the relationship, recognizing the core group of professionals in the health home. Cynthia stated that she does not think it is feasible to require partners to sign a document that formalizes the relationship.

The group discussed the legal meaning behind different ways of documenting these relationships. Patrick stated that the form itself is not as important as the awareness among the parties involved that they are part of the health home. Mutual recognition needs to be present; it needs to be a two-way relationship to be a partnership.

Mark Mecum pointed out that there seem to be different levels of partnerships; some are core relationships and some are on the fringe. Jon Barley agreed, stating that the core providers will differ depending on the case. For example, a diabetic health home consumer would need to have the endocrinologist as one of the core partners, but health home consumers with other chronic conditions will need different specialists.

Jon stated the he feels that this should be up to the discretion of the site; the clinicians will know who needs to be in the partnership. The group agreed, recommending that the core membership will be developed based on the needs of the health home participants and will be decided by the health home clinicians. Cynthia suggested removing the word "formalize" from the second and third bullets and replacing it with the word "establish."

Cynthia and Teresa Lampl pointed out that requiring signatures, formalized agreements, MOUs, etc. may create a barrier to partnerships. Cynthia added that this could also interfere with the partnerships that already exist. Patrick stated that he still feels that it is important to demonstrate that both parties recognize the partnership. Teresa feels that the importance lies in demonstrating that the partnership exists; the practice of performing comprehensive care

Documentation, Billing & Regulatory Requirements Committee
November 29, 2011
Meeting Minutes

management will demonstrate this. She stated that it is not practical to expect all parties involved in health homes to reach an MOU.

Afet Kilinc stated that many agencies already have established relationships. For each agency there will be different situations. She feels that if we approach the idea of formalizing the relationship in a flexible and creative manner, it should not be difficult. She envisions both formal and informal partnerships. Cynthia stated that she would like to have the option of whether it is a formal or informal relationship. Afet added that this is also about the strength and stability of the relationship; this also needs to be demonstrated.

Diane Wright stated that there are many different potential partnership arrangements. It would be challenging to keep up with all of the different providers that people will want to see. If there are a large number of providers in the area, this will be difficult to track while ensuring that consumers have freedom to choose their provider. She does not want to coerce people into seeing a particular provider if they are already connected.

Jonas Thom pointed out that this could become a problem with primary care. He stated that some providers might not want to be involved in the health home; in these cases, the health home might want to steer patients to other providers. Chris Neumann stated that she was thinking about this as well; she suggested that we may need to think about the specifics of the relationship, what will be required. She added that we need to be specific that this is a different kind of relationship. Jon agreed with this, stating that we need to make sure that it is clear that this is a new way of doing things; care is provided using a team approach, caring for the whole person.

Afet added that the health home clinicians will need to work closely with their partners to educate them about comprehensive care management. Jon stated that OHT chose SMI specifically because they felt this was preferable over having physical health bring in behavioral health. Angie suggested adding language in the section about partnerships that discusses collaborative treatment planning and assessment using a team-based approach. The group agreed to this suggestion.

Care Coordination

The group agreed to change the language regarding formalizing agreements with hospitals similarly to the changes in the comprehensive care management section. Angie pointed out that this section talks about updating the treatment plan more frequently. Afet stated that she followed up with Kara Miller on where the requirement came from. Kara stated that this came from a Medicaid managed care plan requirement regarding updating treatment plans. For some physical health conditions, it is important to re-evaluate the plan on a more frequent basis.

Health Promotion

The group agreed with the recommendation as it appears on the document.

Transition of Care

Documentation, Billing & Regulatory Requirements Committee
November 29, 2011
Meeting Minutes

The group agreed with the recommendation as it appears on the document.

Individual and Family Supports

Angie pointed out that the Consumer and Family Engagement Committee is recommending that a consumer advisory council be required. The group agreed with this recommendation.

Angie stated that the departments are supportive of utilizing a peer support service. The core group of state agency staff discussed the importance of including peer supports, but decided not to require it. John Sesek asked what the profile of the peer support staff would be, whether it would be a professionally licensed individual. Angie responded that the state is not envisioning a position in which the person would need professional licensing. Afet pointed out that the Ohio Empowerment Coalition is working on creating a certification for peer support and a committee led by Terry Jones is also forming to add peer support as a Medicaid covered service.

Referrals to Community and Social Supports

Kara asked whether follow-up and validation of referrals to community and social supports is addressed in this section. Afet stated that she believes that the service definition covers this. Angie added that this document is meant to complement the service definitions. The group agreed with the recommendation as it appears on the document.

Core Element/Health Home Requirements Recommendations:

Overarching Requirements

Barb Namett asked whether a time frame will be included in the last bullet under this section. Angie stated that this will not be required on day one, but the health home will need to be able to demonstrate that they are working toward meeting the requirement. Afet added that there will be different ways to meet the requirements; it will be flexible. Teresa asked if the expectation would be that the health home would meet the requirement within the next three years; this would mean that it could simply add to its already existing accreditation when it is time to renew it. Afet agreed that this would be the expectation.

If accreditation is not available, the state wants the health home to be able to demonstrate that the core elements are met. The state would strongly encourage accreditation for integration. Accreditation is only one way to meet the core element requirements, but there are other ways to demonstrate that they have been met. Teresa recommended adding NCQA under the national bodies in the third bullet, stating that we need to watch our language so that we are clear that we are encouraging integration. The group agreed to this suggestion.

Meaningful Use of Electronic Requirements

Angie stated that the Health IT Committee is already looking at recommendations related to meaningful use. This group talked about a phased-in approach to the use of technology, with the goal of being able to meet meaningful use requirements within a set timeframe (not necessarily within one year as it states in the document).

Integration of Physical and Behavioral Health

The group agreed with the recommendation as it appears in the document, with exception of

Documentation, Billing & Regulatory Requirements Committee
November 29, 2011
Meeting Minutes

replacing the word "formalize" with "establish."

Orientation of Patient to Health Homes

The group agreed with the recommendation as it appears in the document.

Ensure Services are Culturally and Linguistically Appropriate

The group agreed with the recommendation as it appears in the document.

Use a Single, Integrated Care Treatment Plan

Teresa raised concern about the fact that the treatment plan requirements are changing; she does not feel comfortable requiring this specific document when it is being changed. She recommended changing the sentence in the first bullet; wording it this way is problematic considering that draft documentation reduction language has already been filed. Angie will re-work the wording so it does not appear to be tying providers to a specific document or administrative code.

Referral and Linkage to community Services

The group agreed to the recommendations as they appear in the document.

Team of Health Professionals with an Accountable RN Care Manager

The group agreed to the recommendations as they appear in the document.

Population Management – Clinical Data and Evidence and Guidelines to Generate Point of Care Reminders

The group agreed to the recommendations as they appear in the document.

Expanded Access to Routine and Urgent Care

Afet explained that there are three different ways to expand access: via telephone, e-mail, or face-to-face interaction. Jonas pointed out that all managed care providers are required to provide 24 hour a day access to a telephone line to healthcare providers. He feels that this expanded access should be offered for both physical and behavioral health. Teresa asked if one of the expectations will be that the health home has some kind of expanded access outside of a typical Monday through Friday, 8 a.m. to 5 p.m. schedule. It was agreed that this would be expected.

Teresa pointed out that electronic access is not something that can always be used with consumers; for this reason, it may be challenging for providers to meet this expectation. However, telephone and face-to-face access is feasible. Chris recommended separating expanded access and urgent access. She asked whether urgent care will be for existing clients or for anyone that needs it. Afet stated that it would be for existing clients only. Chris stated that it would be helpful to have this better defined.

Cynthia asked if it is stipulated that expanded access means face-to-face hours. Afet stated that this would be true if it was a routine service. Kara stated that the intent is to provide services outside of the facility's usual hours. Jon added that the idea behind this is to promote patient-

Documentation, Billing & Regulatory Requirements Committee
November 29, 2011
Meeting Minutes

centeredness; regular hours are not always ideal for the patient. Afet stated that a patient survey would be helpful for this, to find out what times are good for the consumers. Kara the goal is to provide expanded access to avoid higher levels of care, such as emergency department visits.

Peggy Bardnell raised the point that mental health is more prepared to offer 24 hour access than physical health. In small rural counties, the emergency room is the only place to go for weekend or after hour physical healthcare. In these cases, it will be challenging for physical health to meet the expanded access requirement. Christine also asked whether every health home provider will need to have the capacity to treat both children and adults; Jon clarified that they will not all necessarily be required to do so.

The group recommended that expanded access will mean that hours are extended and same day appointments will be offered. The state will do additional work around this section. Members agreed that hours will need to be expanded beyond traditional office hours; these hours will not be specifically prescribed, but providers will need to be able to describe how they will provide expanded access and be able to provide appointments quickly when needed. It was also agreed that "routine" and "urgent" will be more clearly defined.

Same Day Appointments and After Hours Access to routine and Urgent Care

The group recommended that the health home be required to demonstrate responsiveness to need. Again, "routine" and "urgent" care need to be more clearly defined. They also discussed the fact that managed care can help to provide linkages to other resources for emergency care.

Test Tracking, Referral and Follow Up

The group agreed with the recommendations as they appear on the document.

Case Studies

Afet reviewed the case studies with the group, beginning with the first case of a nine year old girl. The health home worked together to help this child to eventually be diagnosed with diabetes, followed up on her treatment for this condition as well as behavioral health conditions, and helped her to be placed into a foster home in which she was later adopted. Afet and Angie both pointed out that this is just an example and that it could be changed in many ways. Another example provided in the packet which describes an SPMI adult was sent to SAMHSA and will be part of the state's discussion with them on Thursday.

Chris recommended highlighting the differences between the roles of the care manager and the traditional CPST worker in the case studies as much as possible. She also suggested emphasizing who the decision makers are in determining if hospitalization is needed. She feels that focusing on what CPST workers would continue to do in these cases, as well as what they would no longer do, would be helpful. The group agreed with her suggestions.

Teresa stated that she read the examples as focusing too much on primary care without talking enough about behavioral health care. She would like to see more discussion about behavioral

Documentation, Billing & Regulatory Requirements Committee
November 29, 2011
Meeting Minutes

health care coordination in health homes. Afet and Angie agreed that more could be added regarding behavioral health care; they may have concentrated too much on ensuring that physical healthcare coordination was included.

Jonas stated that he began to think about the implementation of the case studies and the “behind the scenes” work that will be involved. He also recommended showing expanded hours in future case studies. Afet and Angie agreed with this recommendation. Angie added that the goal of these particular case studies was to show patient flow.

Cynthia asked whether a person could be a CPST worker and also a coordinator on the health home team. Afet stated that the CPST worker could continue to do non-health home CPST work and serve as a care manager aid at the same time. The patient will have more reinforced care because he or she will have more care providers and resources than before. She also stated that that current staff can serve in different roles in the health home.

Afet also stated that the disruption issue is not just at the patient level, but at the staff level as well. She feels that it is better to use the staff that is already part of the agency; a health home can be built around the already existing staff. Rather than figuring out creative ways to get Medicaid to pay for consultative services, these services will be paid via the health home.

It was noted that the reimbursement team is looking at establishing a case load size. They need to base this on what the ideal team size would be, and then judge how many patients they can carry. Angie stated that the case load size does not necessarily need to be determined for CMS. CMS is more interested in methodologies that are used to determine the rate. Jonas stated asked whether the state will need to cost out the rates; if this will be required, they will need to know the case load. Angie stated that she does not necessarily think that they will be looking at this before submitting the plan to CMS. CMS is more interested in avoiding duplication.

Next Steps/Next Meeting

- ODMH staff will revise the recommendation document and distribute to the group for feedback.
- Updates on all health home committees will be provided at the wrap-up meeting, which is scheduled for December 16, 2011, 1-4 p.m. in the Rhodes Lobby Hearing Room.