CHCS Center for Health Care Strategies, Inc.

TECHNICAL ASSISTANCE TOOL

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Using Care Management Entities for Behavioral Health Home Providers: Sample Language for State Plan Amendment Development

As states explore health home opportunities presented by the Affordable Care Act to improve the quality and cost of care for individuals with serious and persistent mental illness and/or other chronic conditions, they may want to consider Care Management Entities (CMEs) to serve as behavioral health home providers for children and youth with severe behavioral health needs.

CMEs serve as centralized accountable hubs for the coordination of all care for children with complex behavioral health challenges who are involved in multiple systems and their families. These entities can provide a customized approach to behavioral health homes for individuals with historically high health care costs and poor health and social outcomes. CMEs provide: A youth guided and family-driven strengths-based approach that is coordinated across agencies and providers; intensive care coordination; home- and community-based services; and peer supports.

Since health home-required services are similar to CME functions, the CME model offers the potential to serve as a health home. Required services which include: (1) comprehensive care management; (2) individual and family support services; (3) care coordination and health/behavioral health promotion; (4) linkage to social supports and community resources; and (5) transitional care across multiple settings/systems, are similar to functions of CMEs. Health homes are also required to use health information technology to facilitate service linkages.

BACKGROUND

This resource was developed by the Center for Health Care Strategies (CHCS) through its role as the coordinating entity for a five-year, three-state Quality Demonstration Grant project funded by the Centers for Medicare & Medicaid Services under the Children's Health Insurance Program Reauthorization (CHIPRA) Act of 2009. The multi-state grant is supporting lead-state Maryland, and partner states Georgia and Wyoming, in implementing or expanding a CME approach to improve clinical and functional outcomes, reduce costs, increase access to home- and community-based services, and increase resiliency for high-utilizing Medicaid- and CHIP-enrolled children and youth with serious behavioral health challenges.

This technical assistance resource was created to help the states participating in the CHIPRA CME Collaborative think through key elements of a behavioral health home, utilizing CMEs as designated providers for specialized populations. The language may be employed in the context of a broader SMI/SED State Plan Amendment, as described in Section 1945(h) (5) of the Affordable Care Act. The guide includes recommended language, references to ACA provisions and state examples in the "comment boxes" throughout. It is not intended either to suggest or ensure the approval of a health home State Plan Amendment by CMS. Health homes may not be targeted by age and CMEs represent one approach to behavioral health homes that would need to be launched in tandem with other models that may more aptly address the needs of adults with behavioral health needs.

Visit www.chcs.org for more information on the CHIPRA CME Collaborative.

This document provides sample language to help states structure their dialogue with the Substance Abuse and Mental Health Services Administration and submission to the Centers for Medicare & Medicaid Services regarding the use of CMEs as behavioral health homes. It can help state Medicaid agencies articulate how CMEs may serve as designated health home providers for children and youth with Serious Emotional Disturbances (SED). The document includes recommended language and references to ACA provisions and state examples in "comment boxes." A future guide will address the ACA opportunity for CMEs to function as health teams within supported organizations such as community mental health centers.

States pursuing health home SPAs must ensure that there is no duplication of services (e.g., between health homes and medical homes), and may therefore need to develop and submit separate supporting documentation that explains how duplication in health home services will be avoided.

The health home state plan amendment (described in the November 16, 2010 State Medicaid Director Letter, https://www.cms.gov/smdl/downloads/SMD10024.pdf) is submitted electronically to CMS. The web-based submission process is outlined in the December 22, 2010 CMCS Informational Bulletin https://www.cms.gov/CMCSBulletins/downloads/CIB-12-22-10.pdf). This document is intended to replicate the fields required for the health home SPA. In the interest of aligning with an already CMS-approved health home SPA, the format of this document matches the PDF version of the approved RI CEDARR health homes SPA. (It should be noted, however, that the RI CEDARR SPA is focused on a broader population of children with special health care needs.) Headings and sections are SPA template language.

This document was developed under grant CFDA 93.767 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal Government.

SAMPLE

CME Health Home State Plan Amendment Sample Language

I. Geographic Limitations

A. Health Homes will be provided as follows: Statewide Basis
B. If Targeted Geographic Basis: N/A

II. Population Criteria

A. One serious mental illness
B. Two chronic conditions (*from the list of conditions below)*:
1.Mental Health Condition
2.Substance Use Disorder

Please Note:

(1) Areas shaded in gray are author's notes/comments.

(2) Blue boxes provide further guidance along with references to ACA provisions and some state-specific examples.

(3) Edits in red indicate modifications to original language.

Description of Other Chronic Conditions Covered
Care Management Entities (CMEs) will be [*enter state name*] designated provider for individuals under the age of 21 who meet the criteria for serious emotional disturbance (SED) as defined by the following: The health home (HH) enrollee currently has, or at any time during the past year has had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within ICD -10 or DSM-IV-TR (and subsequent revisions) of the American Psychiatric Association with the exception of other V codes, substance use, and developmental disorders, unless these disorders co-occur with another diagnosable disturbance. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects. The diagnosable disorder identified above has resulted in functional impairment that substantially interferes with or limits the health home enrollee's role or functioning in family, school, or community activities. Functional impairment is defined as difficulties that substantially interfere with or limit the enrollee in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment. Enrollees who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition. Additionally, the health home enrollee: 1) needs or receives multiple services from the same or multiple provider(s); OR 2) needs or receives services from state agencies, special education, or a combination thereof; AND needs a care planning team to coordinate services the enrollee needs from multiple providers or state agencies, special education, or a combination thereof.

Eligible individuals must have either undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime, (e.g., emergency services, partial hospitalization or inpatient hospitalization, psychiatric residential treatment); or have impaired role functioning. In addition, the enrollee may exhibit inappropriate social behavior which results in demand for intervention by the mental health and/or judicial system.

Implementation of CME health home services will facilitate care planning and coordination of services for enrollees, with serious emotional disturbance (SED), under the age of 21, who are enrolled in Medicaid and CHIP.

Care planning is driven by the needs of the health home enrollee and developed through a wraparound planning process consistent with systems of care philosophy.

III.Provider Infrastructure

Designated Providers as described in § 1945(h)(5)
[*Enter state name*] has [*enter number of*] CMEs, that form a statewide, fully coordinated, mental health delivery system, ensuring access to a comprehensive range of services to individuals with serious behavioral health challenges. All [*enter number*] CMEs are licensed by the state under the authority of [*enter state name*] General Laws and operate in accordance with Rules and Regulations for the Licensing of Behavioral Healthcare Organizations. The [*enter number*] CMEs will serve as designated providers of CME health home services.

The [*enter number*] CMEs represent the only entities that would meet eligibility requirements as a CME health home and all will be required to meet identical CME health home certification requirements, described under the Provider Standards section of this State plan amendment. Each CME health home is responsible for establishing a fully coordinated service network within its own geographic area and for coordinating service provision with other geographic areas. Certification specifications for CME health homes will stipulate requirements for linkages with other health care providers and community supports as well as specify requirements for the establishment of transitional care agreements with inpatient and long-term care settings. The team of health professionals responsible for conducting or acting on findings associated with comprehensive care management, care coordination, comprehensive transitional, etc., will vary according to the unique needs of individuals served. However, the team will minimally consist of a Master's Level Team Care Coordinator Supervisor who will serve as the central coordinator for health home services, Consulting Psychiatrist or Psychiatric Nurse Mental Health Clinical Specialist, MA Level Clinician or Bachelor Level Care Coordinator and Family/Youth Peer Support Specialist (aka Family Partner). Other health team members may include, but are not limited to: primary care physicians, pharmacists, substance use disorder specialists, vocational specialists and community integration specialists.

Since the health home teams consist of individuals with expertise in several areas, any team member operating within his or her scope of practice, area of expertise and role or function on a health home team, may be called upon to coordinate care as necessary for an individual, (i.e., the bio-psychosocial assessment can only be conducted as described under Care Management; however, a care coordinator or family partner operating in the role of a hospital liaison may provide transitional care, health promotion and individual and family support services, as an example). Certification requirements for CME health home providers specify that each health home indicate, for example, how each provider will: (1) structure team composition and member roles in CMEs to achieve health home objectives; (2) coordinate with primary care (which could include co-location, embedded services, or the implementation of referral and follow-up procedures outlined in memoranda of understanding); (3) formalize referral and transition agreements with hospitals and psychiatric residential treatment facilities for comprehensive transitional care; and (4) carry out health promotion activities. CMEs provide care using a whole-person; values-based approach that coordinates behavioral health, primary care, and other needed services and supports across child-serving systems. CMEs will engage in a variety of learning activities and supports, specifically designed to ensure that they operate as health homes and provide care using a consistent model that fully coordinates behavioral health, primary care and other needed services and supports.

Learning activities will support providers of health home services in addressing the following components:

- Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
- Coordinate and provide access to:
    - high-quality health care services informed by evidence-based clinical practice guidelines;
    - preventive and health promotion services, including prevention of mental illness and substance use disorders;

Designated Providers

Per § 1945 (h) (5):
The term "designated provider" means a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined by the State and approved by the Secretary to be qualified to be a health home for eligible individuals with chronic conditions on the basis of documentation evidencing that the physician, practice, or clinic—(A) has the systems and infrastructure in place to provide health home services; and (B) satisfies the qualification standards established by the Secretary under subsection (b).

There is also the option to use a "Team of Health Care Professionals" as described in Section 1945 (h) (6):
Team of health care professionals.—The term "team of health care professionals" means a team of health professionals (as described in the State plan amendment) that may—(A) include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State; and (B) be free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary.

As well as the option to use a "Health Team" as described in section 1945 (h) (7), via reference to Section 3502:
The health team includes an interdisciplinary, inter-professional team of health care providers, as determined by the Secretary; such team may include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians' assistants.

  - mental health and substance abuse services;
  - 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);
  - chronic disease management, including self-management support to individuals and their families;
  - individual and family supports, including referral to community, social support, and recovery services;
  - long-term care supports and services;
- Develop a person-centered plan of care for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;
- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health home team and individual and family caregivers, and provide feedback to primary care practices, as feasible and appropriate, and;
- 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 CME provides a single point of accountability for ensuring that medically necessary services are accessed, coordinated, and delivered in a strength-based, individualized, family/youth-driven, and ethnically, culturally, and linguistically relevant manner. CMEs facilitate increased access and coordination with primary care and medical homes. Services and supports, which are guided by the strengths and needs of the enrollee, are developed through a wraparound planning process consistent with systems of care philosophy that results in an individualized and flexible plan of care for the enrollee and family. CMEs are designed to facilitate a collaborative relationship among a health home enrollee with SED, his/her family, and involved child-serving systems and providers in order to support the parent/caregiver in meeting the enrollees' needs. The care planning process ensures that a care coordinator organizes and matches care across providers and systems to enable the enrollee to be served in his/her home community.

[*Enter state name*] will auto-assign individuals to a health home with the option of opting out to choose another eligible health home provider. Individuals assigned to a health home will be notified by the state via U.S. mail and other methods as necessary about their assignment. Should individuals desire to receive health home services from another health home provider they will be able to change their health home assignment. Potentially eligible individuals receiving services in the hospital emergency department (ED), psychiatric residential treatment facility, or as an inpatient, will be notified about eligible health homes and referred to a health home provider in their geographic area. Eligibility for health home services will be identifiable through data provided by Medicaid managed care organizations (MCOs) and other information from the state's Medicaid data warehouse. CME health home providers to which individuals have been auto-assigned will receive communication from the state regarding an individual's enrollment in health home services. The health home will in turn notify other treatment providers (e.g., primary care and specialists) about the goals and types of health home services as well as encourage participation in care coordination efforts.

Most enrollees have a primary care provider (PCP), or a medical home. If an enrollee does not, the CME will assist the parent/caregiver in accessing an appropriate PCP, or a medical home provider. The CME shall ensure coordination of care with the enrollee' primary medical care provider; this includes tracking whether EPSDT requirements for CME-involved individuals has been met. CME staff is expected to develop procedures to ensure the coordination between the CME and the enrollee's medical home, including the MCO.

IV. Service Definitions

A. Comprehensive Care Management

1. Service Definition

OVERARCHING STATEWIDE DEFINITION:
This definition will be state-specific and does not pertain exclusively to CME but to HH.

CME-SPECIFIC DEFINITION: Comprehensive care management is provided by the CME by working with the health home enrollee to: (1) assess current circumstances and presenting issues, identify strengths and needs, and identify resources and/or services to assist the health home enrollee to address their needs through the provision of an initial intake and needs determination; (2) develop an Individual Care Plan that will include enrollee-specific goals, treatment interventions, and meaningful functional outcomes; and (3) on a regular basis, review and revise the Individual Care Plan to determine efficacy of interventions and emerging needs. Integral to this service is ongoing communication and collaboration between the CME Care Plan Team and the enrollee's primary care physician/medical home, managed care organization, behavioral health and institutional/long-term care providers. This service will be performed by the care coordinator with support from the family partner.

Comprehensive care management services are conducted with high-need individuals, their families, and supporters to develop and implement a whole-person oriented treatment plan and monitor the individual's success in engaging in treatment and supports. Comprehensive care management services are carried out through use of a bio-psychosocial assessment including the Child Adolescent Strengths and Needs (CANS).

A bio-psychosocial assessment of each individual's physical and psychological status and social functioning is conducted for each person evaluated for admission to the CME. Assessments may be conducted by a psychiatrist, registered nurse or a licensed and/or master's prepared mental health professional (consistent with the [*enter state name*] Rules and Regulations for the Licensing of Behavioral Healthcare Organizations). The assessment determines an individual's treatment needs and expectations of the individual served; the type and level of treatment to be provided; the need for specialized medical or psychological evaluations; the need for the participation of the family or other support persons; and identification of the staff person(s) and/or program to provide the treatment.
Based on the bio-psychological assessment, a strengths-based, goal-oriented, person-centered, individualized care plan is developed, implemented and monitored by a multi-disciplinary team in conjunction with the individual served.

Comprehensive care management services may be provided by any member of the CME health home team; however, master's or bachelor's level care coordinators will be the primary practitioners providing comprehensive care management services.

2. *Ways Health IT Will Link*

The information in this section will be state–specific and depend on what the state has for information systems and where it is with HIT. The paragraph below (slightly modified version of what appears in the RI CEDARR SPA – modifications appear in red) is used for illustration purposes only.

CME health homes utilize a secure HIPAA compliant electronic case management system to support the activities required in order to provide comprehensive care management. These activities include: (1) identifying client needs by gathering data from other resources including medical and human service providers, school programs, child welfare and juvenile justice; (2) integrating the information into the care planning process; (3) developing the enrollee-specific, individualized treatment plan; (4) facilitating cross-system coordination, and integration and supports access to specific

Comprehensive Care Management Statewide Definitions

RI definition (with recommended changes) for illustration: *Comprehensive care management services are conducted with an individual and involve the identification, development and implementation of care plans that address the needs of the whole person. Family/Peer Supports may be included in the process. The service involves the development of a care plan based on the completion of an assessment. A particular emphasis is the use of ~~the~~ multi-disciplinary teams including medical **and behavioral health** personnel who may or may not be directly employed by the provider of the health home. The recipient of comprehensive care management is an individual with complex ~~physical and~~ behavioral health needs.*

MO definition (with recommended changes) for illustration: *Comprehensive care management services are conducted by the Nurse Care Manager, Primary Care Physician Consultant, the Health Home Administrative Support staff and Health Home Director with the participation of other team members and involve:*
***a.** Identification of high-risk individuals and use of client information to determine level of participation in care management services;*
***b.** Assessment of preliminary service needs; treatment plan development **utilizing a high quality Wraparound approach**, which will include **individualized** ~~client~~ goals, preferences and optimal clinical outcomes;*
***c.** Assignment of health team roles and responsibilities;*
***d.** Development of treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions;*
***e.** Monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines and;*
***f.** Development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.*

service interventions to address the medical, social, behavioral and other needs of the enrollee; (5) ensuring active participation of the eligible health home enrollee in the provision of care; and (6)_ assessing progress, and collecting and analyzing both utilization and outcome data. The CME also accesses the state's health information system [enter name of system if there is one] *that provides access to information vital to the provision of comprehensive care management. This information includes: blood lead levels; immunizations; medications; newborn developmental assessment; hearing assessment; WIC and early intervention participation. CME health homes will also offer to enroll all clients into the state's* [enter state name] *electronic health information exchange.*

B. Care Coordination

1. Service Definition

OVERARCHING STATEWIDE DEFINITON:
This definition will be state-specific and does not pertain specifically to CME.

CME-SPECIFIC DEFINITION: Care coordination provides a single point of accountability for ensuring that medically necessary services and supports are accessed, coordinated, and delivered in a strengths-based, individualized, family/youth-driven, and ethnically, culturally, and linguistically relevant manner. Services and supports, which are guided by the needs of the enrollee, are developed through a wraparound care planning process consistent with systems of care values that results in an individualized and flexible plan of care for the enrollee and family. Care coordination is designed to facilitate a collaborative relationship among an individual with SED, his/her family, and involved systems to support the parent/caregiver in meeting the enrollee's needs. The care coordination care planning process ensures that a care coordinator organizes and matches care across providers and child serving systems to enable the enrollee to be served in their home community.

Care coordination includes the development and implementation of the individual care plan through the wraparound care planning process for attainment of the individuals' goals and improvement of clinical outcomes and functioning. Care coordinators are responsible for conducting care coordination activities across providers and settings. Care coordination involves case management necessary for individuals to access medical, social, vocational, educational, as well as other individualized supportive services, including, but not limited to: (1) assessing support and service needed to ensure the continuing availability of required services; (2) assisting in accessing necessary health care and follow-up care and planning for any recommendations; (3) assessing housing status and providing assistance in accessing and maintaining safe and affordable housing; (4) conducting outreach to family members, teachers, and significant others in order to maintain individuals connection to services, and expand social and support network; (5) assisting in locating and effectively utilizing all necessary community services in the medical, social, educational, legal and behavioral health care areas and ensuring that all services are coordinated, and; (6) coordinating with other providers to monitor individuals' health status, medical conditions, medications and side effects. Care coordination services may be provided by any member of the CME health home team; however, bachelor and master level care coordinators and family partners will be the primary practitioners providing care coordination services.

The paragraph on care coordination below is a modified version of what appears in the RI CEDARR SPA. With the changes (which appear in red), all of it would be good to include for a CME HH application.

Care Coordination Statewide Definitions

RI's definition (it does not pertain specifically to CME):

Care coordination is the implementation of the treatment plan developed to guide comprehensive care management in a manner that is flexible and meets the need of the individual receiving services. The goal is to ensure that all services are coordinated across provider settings, which may include medical, social and, when age appropriate, vocational educational services. Services must be coordinated and information must be centralized and readily available to all health home team members. Changes in any aspect of an individual's health must be noted, shared with the team, and used to change the care plan as necessary. All relevant information is to be obtained and reviewed by the team.

MO's definition (it does not pertain specifically to CME):

Care Coordination is the implementation of the individualized treatment plan (with active client involvement) through appropriate linkages, referrals, coordination and follow-up to needed services and supports, including referral and linkages to long term services and supports. Specific activities include, but are not limited to: appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes and communicating with other providers and clients/family members. Nurse Care Managers with the assistance of the Health Home Administrative Support staff will be responsible for conducting care coordination activities across the health team. The primary responsibility of the Nurse Care Manager is to ensure implementation of the treatment plan for achievement of clinical outcomes consistent with the needs and preferences of the client.

Care coordination is designed to be delivered in a flexible manner best suited to the individual and family's preferences and to support goals that have been identified by developing linkages and skills in order for enrollees and families to reach their full potential and increase their independence in obtaining and accessing services. This includes:

- *Follow up with families, primary care provider, service providers, and others involved in the enrollee's care to ensure the efficient provision of services.*
- *Provide information to families about specific disorders, treatment and provider options, systems of support, services, assistance and legal rights available to individuals with serious emotional disorders ~~Children with Special Health Care Needs~~ and their families, resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, funding options, school-based services, faith based organizations, etc.*
- *Service delivery oversight and coordination to ensure that services are being delivered in the manner that satisfies the requirements of the individual program(s) and meet the needs of the health home enrollee.*
- *Assistance in locating and arranging specialty evaluations as needed, in coordination with the enrollee's primary care provider. This also includes follow-up and ongoing consultation with the evaluator as needed. This service will be performed by the licensed clinician or the family service coordinator depending on the exact nature of the activity.*

2. Ways Health IT Will Link

This is same as in #2 under Comprehensive Care Management; information for this section will be state-specific and depend on where a state is with HIT and its process for linkage to EHR.

C. Health Promotion

1. Service Definition

OVERARCHING STATEWIDE DEFINITION: Statewide definition will be state-specific.

CME HEALTH HOME SPECIFIC DEFINITION: Health promotion assists enrollees and their families in implementing the Individual Care Plan and developing the skills and confidence to independently identify, seek out, and access resources that will assist in: (1) managing and mitigating the enrollee's behavioral health condition(s); (2) preventing the development of secondary or other chronic conditions; (3) addressing family and enrollee engagement; (4) promoting optimal physical and behavioral health; and (4) addressing and encouraging activities related to health and wellness. This service will include the provision of health education, information, and linkage to resources with an emphasis on resources easily available in the families' community and peer group(s). This service will be performed by the CME care coordinator (bachelor or master level), or the family partner depending on the exact nature of the activity.

2. Ways Health IT Will Link

Information for this section will be state-specific and depend on where they are with HIT and their process for linkage to EHR.

D. Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)

1. Service Definition

Ways Health IT Will Link: Care Coordination

Example from RI CEDARR SPA: *The electronic case management system described above will also be utilized to support the delivery of Care Coordination by providing easy and immediate access to comprehensive information and tools (such as the individual care plan, contact information, other involvements such as school, behavioral health and specialty care) that will assist the CEDARR Health Homes Team in meeting the needs of each child and family.*

Health Promotion Definition

RI's statewide definition: *Health promotion services encourage and support healthy ideas and concepts to motivate individuals to adopt healthy behaviors. The services also enable individuals to self-manage their health.*

Ways Health IT Will Link: Health Promotion

Example from RI CEDARR SPA: *See Care Coordination description above. In addition, CEDARR Health Homes provide their staff with access to a wide range of resources/educational material(s) in multiple formats for use in supplementing and facilitating Health Promotion activities. This information will be provided in a format that is most appropriate for the child and families use, including multiple languages.*

OVERARCHING STATEWIDE DEFINITION: Statewide definition will be state-specific.

CME HEALTH HOME SPECIFIC DEFINITION: Transitional care will be provided by the CME to existing clients who have been hospitalized or placed in other non-community settings, such as psychiatric residential treatment facilities, as well as to newly identified clients who are entering the community. The CME care coordinator and team will collaborate with all parties involved including the facility, primary care physician, MCO (if enrolled), and community providers to ensure a smooth discharge and transition into the community and prevent subsequent re-admission(s). Transitional care is not limited to institutional transitions, but applies to all transitions that will occur throughout the development of the enrollee and includes transition from and to school-based services and pediatric services to adult services. This service will be performed by the care coordinator (bachelor or master level), with the support of the family partner.

2. *Ways Health IT Will Link*

Information for this section will be state-specific and depend on where each state is with HIT and its process for linkage to EHR. (See section above on *Ways Health IT Will Link: Care Coordination and Health Promotion* for examples.)

E. Individual and Family Support Services (including authorized representatives)

1. *Service Definition*

OVERARCHING STATEWIDE DEFINITION: Statewide definition will be state-specific.

CME HEALTH HOME SPECIFIC DEFINITION: The CME health home team is responsible for providing assistance to the family in accessing and coordinating services. These services include the full range of services that impact on individuals with SED and include, but are not limited to, behavioral health, physical health, education, substance abuse, juvenile justice, child welfare and social and family support services. The CME health home team will actively integrate the full range of services into a comprehensive individualized plan of care. With agreement of the family, the CME team can play the principal role as organizer, information source, guide, advocate, and facilitator for the family by helping the family to assess strengths and needs, identifying treatment goals and needed services, and navigating agency and system boundaries. This service will be performed by the care coordinator (bachelor or master level), and the family partner depending on the exact nature of the activity.

2. *Ways Health IT Will Link*

Information for this section will be state-specific and depend on where they are with HIT and their process for linkage to EHR. (See section above on *Ways Health IT Will Link: Care Coordination and Health Promotion* for examples.)

F. Referral to Community and Social Support Services

1. *Service Definition*

OVERARCHING STATEWIDE DEFINITION: Statewide definition will be state-specific.

Comprehensive Transitional Care Definition

RI state definition:
Comprehensive transitional care services focus on the movement of individuals from any medical/psychiatric inpatient or other out-of-home setting into a community setting, and between different service delivery models. Members of the health team work closely with the individual to transition the individual smoothly back into the community and share information with the discharging organization in order to prevent any gaps in treatment that could result in a re-admission.

Individual and Family Support Services Definition

RI state definition:
Individual and family support services assist individuals to access services that will reduce barriers to treatment and improve health outcomes. Family involvement may vary based on the age, ability, and needs of each individual. Support services may include advocacy, information, navigation of the treatment system, and the development of self-management skills.

MO state definition:
Individual and family support services activities include, but are not limited to: advocating for individuals and families, assisting with obtaining and adhering to medications and other prescribed treatments. In addition, health team members are responsible for identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services. A primary focus will be increasing health literacy, ability to self manage their care and facilitate participation in the ongoing revision of their care/treatment plan. For individuals with DD the health team will refer to and coordinate with the approved DD case management entity for services more directly related to Habilitation and coordinate with the approved DD case management entity for services more directly related a particular healthcare condition. Nurse Care Managers will provide this service.

CME HEALTH HOME SPECIFIC DEFINITION:
The paragraph below was adapted from RI CEDARR SPA, but is applicable for CME HH:

Referral to community and social support services will be provided by members of the CME health home team and will include information about formal and informal resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, funding options, school-based services, faith based organizations, etc. Whenever possible, families will be informed of opportunities and supports that are closest to home, that are the least restrictive and that promote integration in the home and community. The CME health home team will emphasize the use of informal, natural community supports as a primary strategy to assist health home enrollees and families. This service will be performed by the care coordinator or the family partner coordinator depending on the exact nature of the activity. See Care Coordination description above.

Referral to Community and Social Support Services Definition

RI state definition:
Referrals to community and social support services ensure that individuals have access to a myriad of formal and informal resources. Ideally, these resources are easily accessed by the individual in the service system and assists individuals in addressing medical, behavioral, educational, and social and community issues.

2. *Ways Health IT Will Link*

Information for this section will be state-specific and depend on where they are with HIT and their process for linkage to EHR. (See section above on *Ways Health IT Will Link: Care Coordination and Health Promotion* for examples.)

V. Provider Standards

Each state will need to determine whether/how it "certifies" or credentials the CME.
The paragraphs below were adapted from RI CEDARR SPA but are applicable for CME HH.

[Enter state name] *has established Certification Standards for CMEs and will utilize those standards as the basis to certify health home providers. The standards can be found at:*

In addition an appendix to the existing Certification Standards [name or # of appendix] *has been developed that relates to the health homes initiative. The text of the appendix follows:*

Section 2703 of the Patient Protection and Affordable Care Act of 2010 afforded states the option of adding "Health Homes for Enrollees with Chronic Conditions" to the scope of services offered to individuals receiving Medicaid by applying for an amendment to the [enter state name] *Medicaid State Plan. This provision is an important opportunity for* [enter state name] *to address and receive additional federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons across the lifespan with chronic illness.*

The [enter state and agency name], *as the designated Medicaid entity, submitted a request to the Centers for Medicare & Medicaid Services (CMS) on* [enter date], *to designate CMEs as Health Homes for Individuals with Severe Emotional Disturbance (SED).*

The design of the CME makes this a unique opportunity to implement the principles of the Section 2703 Health Homes provision within an existing infrastructure of providers, trained professionals, and engaged stakeholders. Utilizing CMEs as designated health home providers for individuals with SED will allow [enter state name] *to begin implementing this program with a minimum of delay and expenditure of valuable resources. For purposes of the health homes initiative, all current and future certified CMEs will be required to abide by these requirements, in addition to the existing CME certification standards* [developed or revised in enter year here…].

A. Health Homes Requirements

1. *Population Criteria*

Massachusetts medical necessity criteria were used for this section.
Medicaid recipients who meet the following criteria are eligible for CME health home services:
The individual meets the criteria for serious emotional disturbance (SED) as defined by either *Part I* or *II* of the criteria below.

Part I:
The individual currently has, or at any time during the past year has had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within ICD -10 or DSM-IV-TR (and subsequent revisions) of the American Psychiatric Association with the exception of other V codes, substance use, and developmental disorders, unless these disorders co-occur with another diagnosable disturbance. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects. The diagnosable disorder identified above has resulted in functional impairment that substantially interferes with or limits the individual's role or functioning in family, school, or community activities. Functional impairment is defined as difficulties that substantially interfere with or limit the individual in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment. Individual who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

Part II:
The individual exhibits one or more of the following characteristics over a long period of time and to a marked degree that adversely affects educational performance: an inability to learn that cannot be explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; inappropriate types of behavior or feelings under normal circumstances; a general pervasive mood of unhappiness or depression; or a tendency to develop physical symptoms or fears associated with personal or school problems. The emotional impairment is not solely the result of autism, developmental delay, intellectual impairment, hearing impairment, vision impairment, deaf-blind impairment, specific learning disability, traumatic brain injury, speech or language impairment, health impairment, or a combination thereof.

2. *Provider Standards*

Some states are requiring eligible providers to apply for health homes. This may be something to consider doing. State-specific standards will apply.

Current CME certification standards, under which all CMEs operate, will be utilized as the provider standards for CME health homes. In addition, all providers of health home services agree to:

- Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
- Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
- Coordinate and provide access to preventive and health promotion services, particularly prevention of mental illness and substance use disorders;
- Coordinate and provide access to mental health and substance abuse services;
- Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up, participation in discharge planning, and facilitating transfer from settings including inpatient hospitals and psychiatric residential treatment facilities, to community settings as well as transfer from a pediatric to an adult system of health care;
- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
- Coordinate and provide access to long-term care supports and services;
- Develop a person-centered individual care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;

- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the CME team and individual and family caregivers, and provide feedback to primary care practices and Medical Homes, as feasible and appropriate; and
- 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 cost and quality of care outcomes at the population level.
- Establish a protocol to gather, store and transmit to the State all data elements required to fulfill the reporting requirements of the health home Initiative.

3. *Health Home Services*

Health homes are required to provide the following services to all eligible individuals.

Comprehensive Care Management: Comprehensive care management is provided by the CME by working with the health home enrollee to: (1) assess current circumstances, present issues and strengths, identify continuing needs, and identify resources and/or services to assist the health home enrollee to address their needs through the provision of an Initial Family Intake and Needs Assessment; (2) develop an Individual Care Plan that will include enrollee-specific goals, treatment interventions and meaningful functional outcomes; and (3) regularly review and revise the Individual Care Plan to determine efficacy of interventions and emerging needs. Integral to this service is ongoing communication and collaboration between the CME and the enrollee's primary care physician/medical home. CME (care coordinator, licensed clinician and family partner) shall utilize the initial intake and needs assessment (CANS), Individual Care Plan (ICP) and Care Planning Review (CPR) to provide comprehensive care management.

Care Coordination: Care coordination in the CME provides a single point of accountability for ensuring that medically necessary services are accessed, coordinated, and delivered in a strengths-based, individualized, family/youth-driven, and ethnically, culturally, and linguistically relevant manner. Services and supports, which are guided by the needs of the individual, are developed through a Wraparound care planning process consistent with systems of care values that results in an individualized and flexible plan of care for the enrollee and family. Care coordination includes case management necessary for individuals to access medical, social, vocational, educational, as well as other individualized supportive services, including, but not limited to: (1) assessing supports and services needed to ensure the continuing availability of required services; (2) assisting in accessing necessary health care; and follow up care and planning for any recommendations; (3) assessing housing status and providing assistance in accessing and maintaining safe and affordable housing; (4) conducting outreach to family members and significant others in order to maintain individuals' connection to services, and expand social network; (5) assisting in locating and effectively utilizing all necessary community services in the medical, social, legal and behavioral health care

Reporting Requirements:
Consider Your Timeline for HIT Capacity

Example from NY SPA:
(NY has expectation for initial capacity as well as final standards for HIT capacity at 18 month mark)
Health home providers will make use of available HIT and access data through the regional health information organization (RHIOs)/Qualified Entities (QE) to conduct these processes as feasible, to comply with the initial standards cited in items 6a.-6d for implementation of health homes. In order to be approved as health home provider, applicants must provide a plan to achieve the final standards cited in items 6e.-6i. within eighteen (18) months of program initiation.

Initial Standards
6a. *Health home provider has structured information systems, policies, procedures and practices to create, document, execute, and update a plan of care for every patient.*
6b. *Health home provider has a systematic process to follow-up on tests, treatments, services and, and referrals which is incorporated into the patient's plan of care.*
6c. *Health home provider has a health record system which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers and which allows for population management and identification of gaps in care including preventive services.*
6d. *Health home provider makes use of available HIT and accesses data through the RHIO/QE to conduct these processes, as feasible.*

Final Standards
6e*. Health home provider has structured interoperable health information technology systems, policies, procedures and practices to support the creation, documentation, execution, and ongoing management of a plan of care for every patient.*
6f. *Health home provider uses an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers. If the provider does not currently have such a system, they will provide a plan for when and how they will implement it.*
6g. *Health home provider will be required to comply with the current and future version of the Statewide Policy Guidance (http://health.ny.gov/technology/statewide_policy_guidance.htm) which includes common information policies, standards and technical approaches governing health information exchange.*
6h. *Health home provider commits to joining regional health information networks or qualified health IT entities for data exchange and includes a commitment to share information with all providers participating in a care plan. RHIOs/QE provides policy and technical services required for health information exchange through the Statewide Health Information Network of New York (SHIN-NY).*
6i. *Health home provider supports the use of evidence based clinical decision making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance. One example of such a tool is PSYCKES.*

areas and ensuring that all services are coordinated, and; (6) coordinating with other providers to monitor individuals' health status, medical conditions, medications and side effects. Care coordination will be performed by the member of the CME team (care coordinator or family partner) who is most appropriate based upon the issue that is being addressed.

Health Promotion: Health promotion assists enrollees and families in implementing the Individual Care Plan and in developing the skills and confidence to independently identify, seek out and access resources that will assist in: (1) managing and mitigating the enrollee's condition(s); (2) preventing the development of secondary or other chronic conditions; (3) addressing family and enrollee engagement; (4) promoting optimal physical and behavioral health; and (5) addressing and encouraging activities related to health and wellness. This service will include the provision of health education, information, and resources with an emphasis on resources easily available in the families' community and peer group(s). CME staff (care coordinator and family partner as appropriate) shall utilize individual and group meetings, modeling, training, and coaching to provide health promotion.

Comprehensive Transitional Care: Transitional care will be provided by the CME to both existing clients who have been hospitalized or placed in other non-community settings such as psychiatric residential treatment facilities, as well as newly identified clients who are entering the community. The CME will collaborate with all parties involved including the facility, primary care physician, MCO (if enrolled) and community providers to ensure a smooth discharge into the community and prevent subsequent re-admission(s). Transitional care is not limited to institutional transitions, but applies to all transitions that will occur throughout the development of the enrollee and includes transition from early intervention into school-based services and pediatric services to adult services. CME staff (care coordinator and family partner) will use intensive care coordination to provide comprehensive transitional care.

Individual and Family Support Services: The CME is responsible for providing assistance to the family in accessing and coordinating services. These services include the full range of services that impact on enrollees with SED and include, but are not limited to, physical health, behavioral health, education, substance abuse, juvenile justice, child welfare, and social and family support services. The CME will actively integrate the full range of services into a comprehensive plan of care. With the family's permission, the CME plays the principal role as organizer, information source, guide, advocate, and facilitator for the family by helping the family to assess strengths and needs, identify treatment goals and services, and navigate agency and system boundaries. CME staff (care coordinator and family partner) will use intensive care coordination to provide individual and family support services.

Referral to Community and Social Support Services: Referral to community and social support services will be provided by the CME and will include information about formal and informal resources beyond the scope of services covered by Medicaid, such as those that may be available from other parents, family members, community-based organizations, service providers, grants, social programs, funding options, school-based services, faith-based organizations, etc. Whenever possible, families will be informed of opportunities and supports that are closest to home, that are the least restrictive and that promote integration in the home and community. CME staff will emphasize the use of informal, natural community supports as a primary strategy to assist enrollees and families. CME staff (care coordinator and family partner) will use intensive care coordination (ICC) to provide referrals to community and social supports.

4. *Additional Requirements*

To fully achieve the goals of the health homes initiative, certain actions that were previously viewed as suggested are now required and subject to [*EOHHS or state's oversight agency*] performance review requirements. Those include:

- Documented periodic (at minimum yearly) outreach to the child's primary care physician/medical home and Medicaid MCO (if applicable)
- Documented yearly Body Mass Index (BMI) Screening for all individuals six years of age or older. If BMI screen is not clinically indicated, reason must be documented
- Documented yearly depression screening utilizing the Center for Epidemiological Studies Depression Scale for Children (CES-DC) (or equivalent) for all individuals 12 years of age or older. If depression screening is not clinically indicated, reason must be documented
- Yearly review of immunizations, screenings and other clinical information contained in the [*enter state name*] Health Information System

In order for an entity to be certified as a CME health home they must agree, in writing, to abide by the existing CME certification/credentialing standards as described in appendix (*insert state-specific criteria in an appendix*).

VI. Assurances

A. The State assures that hospitals participating under the state plan or a 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.
B. 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.
C. The State will report to CMS information submitted by health home providers to inform the evaluation and Reports to Congress as described in section 2703(b) of the Affordable Care Act, and as described by CMS.

VII. Monitoring

A. *Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications.*
This will be state-specific.

B. *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 measure specifications.*
This will be state-specific.

C. *Describe the State's proposal for using health information technology in providing health home services under this program and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).*
This will be state-specific.

VIII. Quality Measures: Goal-Based Quality Measures

All Quality Measures will be state-specific.

Please describe a measureable goal of the health home model that will be implemented using measures within the domains listed below.
The measures may or may not be tied to the services depending on the goal. If the measure is tied to a service, please complete the service-based quality measure section. If the measure is tied to a goal, please complete the goal-based measure section.

A. Goal 1: *Improve Functioning:* The Child Adolescent Strengths and Needs (CANS) evaluation tool is completed with all enrollees and caregivers and provides information about functioning in multiple areas (e.g., problem presentation, risk behaviors, caregiver strengths and needs, child safety, functioning, strengths). It is a strengths-based, information integration tool that provides a profile of children and their families along a set of six dimensions related to service planning and decision making. It monitors outcomes of services—dimension scores have been shown to be valid outcome measures in various levels of care and settings, including residential treatment, intensive community treatment, foster care and treatment foster care, community mental health, and juvenile justice programs. The tool is administered at enrollment, at any time the enrollee transitions to different level of care or at six months (whichever comes first), and at discharge.

Methodology: Tracking Avoidable Hospital Readmissions

Example adapted from RI CEDARR SPA
The state will measure re-admissions per 1000 member months for any diagnosis using a pre/post-period comparison among eligible CME Health Home clients. The data source will be claims and encounter data available in the Medicaid data warehouse.

Methodology: Tracking Cost Savings from Improved Chronic Care Coordination

Example adapted from RI CEDARR SPA
The State will annually perform an assessment of cost savings using a pre/post-period comparison of CME health home clients. Savings calculations will be based on data garnered from the MMIS, encounter data from Health Plans, encounter data submitted the Health Home providers, and any other applicable data available from the [enter state name] Data Warehouse.

Description of Use of HIT

Example adapted from RI CEDARR SPA (modifications are highlighted)
The State will phase-in the use of HIT to support health home services. Initially, providers will be supported in their delivery of health home services through data profiles supplied by Medicaid managed care plans for the 60% of the health home-eligible CME population enrolled in MCOs. The state is currently working with the MCOs to develop health utilization profiles minimally comprised of the components below.
1) Claims Data to identify member's pattern of utilization based on previous 12 months (#Emergency Room Visits, Last ER Visit Date, Last ER Visit Primary Diagnosis, #Urgent Care Visits; Use of PRTFs);
2) Claims data to identify member's primary care home (#PCP Sites, #PCP visits to current PCP Site.
3) Prescription Drug information;
4) Behavioral Health Utilization.

In addition CME, Health Homes also accesses the [enter state name] Child Health Information System which provides access to information vital to the provision of Comprehensive Care Management. This information includes: Blood Lead levels, Medications, Immunizations, Newborn Developmental Assessment, Hearing Assessment, WIC and Early Intervention participation.
CME Health Homes will also offer to enroll all clients into [enter state's name] electronic health information exchange.

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will Be Utilized
The percentage of enrollees who show improvement on CANS	CANS	*Numerator:* Number of enrollees with improved functioning on CANS *Denominator:* Number of enrollees to whom CANS was administered	The state will use the CME IT system to collect and store CANS data. Monitoring of progress towards identified health home goals will be accomplished through the analysis of reports submitted on a regular basis by the CME health homes. In addition, [*Enter state name*] will use the following sources of data to monitor the impact of its health home (HH) program on quality: (1) an outcomes survey administered to all CME families on intake and yearly thereafter; (2) charts (either electronic or paper); and (3) a client satisfaction survey. The state exercised prudence in selecting measures to not overburden CME or IT staff with new data collection and analysis. Standard, validated measure specifications where they exist will be used to increase the ability to make comparisons across populations, programs, and states.

2. Experience of Care

Measure	Data Source	Measure Specification	How Health IT Will Be Utilized
The percentage of enrollees who report increased resiliency	California Healthy Kids Survey Resiliency Module	*Numerator*: The number of enrollees who report increased resiliency *Denominator*: All CME enrollees administered the CA Health Kids Survey Resiliency Module	The CA Health Kids Survey Resiliency Module will be administered at entry, six months, discharge, and six months post discharge, with data stored in the CME IT system. Monitoring of progress toward identified health home goals will be accomplished through the analysis of reports submitted on a regular basis by the CME health homes.

3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will Be Utilized
The percentage of CME plans of care that meet Wraparound Fidelity Index (WFI) parameters	National Wraparound Initiative Wraparound Fidelity Index	*Numerator*: The number of CME plans of care that meet WFI parameters *Denominator*: All CME plans of care	CME plans of care are stored within the CME IT system; plans of care will be measured against WFI standards annually. Monitoring of progress toward identified health home goals will be accomplished through the analysis of reports submitted regularly by the CME health homes.

B. Goal 2: *Increase time spent in the home and community (i.e., least restrictive placement)*

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will Be Utilized
Percent of days in a home-type setting (including home, independent living, foster care, kinship, relative and legal guardian)	CME IT System	*Numerator:* Number of days spent in home-type setting *Denominator:* Number of days individual is enrolled in CME	The state will use the CME IT system to collect and store CANS data. In addition, monitoring of progress towards identified health home goals will be accomplished through the analysis of reports submitted on a regular basis by the CME health homes. In addition, [*Enter state name*] will use the following sources of data to monitor the impact of its health home (HH) program on quality: (1) an outcomes survey administered to all CME families on intake and yearly thereafter; (2) charts (either electronic or paper); and (3) a client satisfaction survey. The state exercised prudence in selecting measures to not overburden CME or IT staff with new data collection and analysis. Standard, validated measure specifications where they exist will be used to increase the ability and CMS's to make comparisons across populations, programs, and states.

Measure	Data Source	Measure Specification	How Health IT Will Be Utilized
Percent of days attended school	CME IT System	*Numerator:* Number of days attended school *Denominator:* Number of school days during individual's enrollment with CME HH	

2. Experience of Care

Measure	Data Source	Measure Specification	How Health IT Will Be Utilized
The percentage of CME families reporting that their experience with care has improved their capacity to better manage their child's behavioral health challenges at home	Family Empowerment Scale (FES)	*Numerator*: Number of families reporting their experience with care has improved their capacity to better manage child's behavioral health challenges at home *Denominator*: Number of families administered FES	FES will be administered at entry, six months, discharge, and six months post discharge, with data stored in the CME IT system. Monitoring of progress toward identified health home goals will be accomplished through the analysis of reports submitted on a regular basis by the CME health homes.

3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will Be Utilized
The percentage of CME plans of care that incorporate home and community based alternatives and natural supports to out-of-home settings	CME IT system	*Numerator*: The number of CME plans of care that include home and community alternatives and natural supports to out-of-home settings *Denominator*: The number of CME plans of care	CME plans of care are stored within the CME IT system; plans of care will be assessed for inclusion of home and community based alternatives and natural supports periodically, and at minimum after each child and family team meeting. Monitoring of progress toward identified health home goals will be accomplished through the analysis of reports submitted on a regular basis by the CME health homes.

C. Goal 3: *Decrease the Use of Emergency Department and Inpatient Treatment for Ambulatory Sensitive Conditions*

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will Be Utilized
Percentage of CME enrollees with one or more ED visits who can be appropriately treated in a non-ED setting	Claims/ Encounter data	*Numerator*: Number of ED visits for conditions appearing in a state defined list of diagnoses that can be appropriately treated in a non-ED setting *Denominator*: Number of enrollees with ED visits	This will be unique to each state depending on what is in place and what is being developed with regard to HIT (e.g., if SYNTHESIS is used or there is linkage to EHR, etc.).
Percentage of CME enrollee with one or more psychiatric hospital admissions Length of stay of CME enrollees in inpatient psychiatric hospital or psychiatric residential treatment facility	Claims/Encounter Data Claims/Encounter data/ CME IT system	*Numerator:* Number of admissions for psychiatric hospital *Denominator*: Number of enrollees with acute admissions *Numerator:* Number of days CME enrollees were in inpatient psychiatric hospital or psychiatric residential treatment facility	

		Denominator: Number of days all enrollees meeting SED profile but not enrolled in CME were in inpatient psychiatric hospital or psychiatric residential treatment facility	

2. Experience of Care

Measure	Data Source	Measure Specification	How Health IT Will Be Utilized
Satisfaction with care	Annual Satisfaction Survey	*Numerator:* Families of CME enrollee saying they agree or strongly agree with each the following statements: - The care plan met my child's needs - I was assisted in identifying my child's needs. *Denominator:* All families who completed the annual family satisfaction survey *Numerator:* CME enrollees saying they agree or strongly agree that their needs were met *Denominator:* All CME enrollees who completed the annual enrollee satisfaction survey	The state will use the Medicaid data warehouse to collect and store historical Medicaid claims and encounter data. In addition, monitoring of progress towards identified health home goals will be accomplished through the analysis of reports submitted on a regular basis by the CME health homes. In addition, [*Enter state name*] will use the following sources of data to monitor the impact of its health home (HH) program on quality: (1) an outcomes survey administered to all CME families on intake and yearly thereafter; (2) charts (either electronic or paper); and (3) a client satisfaction survey. The state exercised prudence in selecting measures to not overburden CME or IT staff with new data collection and analysis. Standard, validated measure specifications where they exist will be used to increase the ability to make comparisons across populations, programs, and states.
Access to care	Annual Satisfaction Survey		

Goal 3: Clinical Outcomes – How Health IT Will Be Utilized

Example adapted from RI

The state will use the Medicaid data warehouse to collect and store historical Medicaid Claims and Encounter data. In addition, monitoring of progress towards identified Health Homes goals will be accomplished through the analysis of reports submitted on a regular basis by the CME Health Homes. In addition, [Enter state name] will use the following sources of data to monitor the impact of its health home (HH) program on quality: An outcomes survey administered to all CME families on intake and yearly thereafter; charts (either electronic or paper), and a client satisfaction survey. The state exercised prudence in selecting measures to not overburden CME or IT staff with new data collection and analysis. Standard, validated measure specifications where they exist will be used to increase the ability and CMS's to make comparisons across populations, programs, and states.

3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will Be Utilized
Medical follow up within seven days of ED visit for psychiatric reasons	Claims/Encounter Data	*Numerator:* Number of clients with ED visits for psychiatric reasons who had medical follow-up within seven days of visit *Denominator:* Number of ED visits for psychiatric reasons.	The state will use the Medicaid data warehouse to collect and store historical Medicaid claims and encounter data. Monitoring of progress toward identified health home goals will be accomplished through the analysis of reports submitted on a regular basis by the CME health homes. [*Enter state name*] will also use the following sources of data to monitor the impact of its health home (HH) program on quality: (1) an outcomes survey administered to all CME families on intake and yearly thereafter; (2) charts (either electronic or paper); and (3) a client satisfaction survey. The state exercised prudence in selecting measures to not overburden CME or IT staff with new data collection and analysis. Standard, validated measure specifications where they exist will be used to increase ability to make comparisons across populations, programs, and states.
Medical follow up within seven days of acute care psychiatric admission	Claims/Encounter Data	*Numerator:* Number admitted clients who had medical follow-up for psychiatric admission within 7 days of discharge *Denominator:* Number of admissions for psychiatric hospital	

D. Goal 4: *Improve the Quality of Transitions from Inpatient/Residential Care to Community*

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will Be Utilized
Percentage of discharges for admissions >7 days in length with active participation of Health Home staff.	Claims/Encounter Data	*Numerator:* Number of patients with Health Home staff service claim during dates of in-patient or PRTF stay *Denominator*: Number of clients with an in-patient or PRTF admission >7 days	
Percentage of discharges for admissions >7 days in length who are contacted by health home staff within 7 days of discharge.	Claims/Encounter Data	*Numerator:* Number of patients with health home staff service claim date of service is within 7 days of discharge date *Denominator:* Number of clients with an inpatient or Psychiatric Residential Treatment Facility admission >7 days	
Percentage of clients re-admitted or utilizing ED within 30 days of discharge with same diagnosis as admission	Claims/Encounter Data	*Numerator:* Number of patients with a re-admission or ED visit within 30 days of discharge with same diagnosis *Denominator:* Number of clients with an inpatient or PRTF admission	

2. Experience of Care

Measure	Data Source	Measure Specification	How Health IT Will Be Utilized
Satisfaction with Care	Annual Satisfaction surveys	*Numerator:* Families of CME enrollees saying they agree or strongly agree with each the following statements: - The care plan met my child's needs - I was assisted in identifying my child's needs. *Denominator:* All families of CME enrollees who completed the annual family satisfaction survey *Numerator:* CME enrollees saying they agree/strongly agree that the plan of care met their needs *Denominator:* All CME enrollees who completed the satisfaction survey	The state will use the Medicaid data warehouse to collect and store historical Medicaid claims and encounter data. In addition, monitoring of progress toward identified health home goals will be accomplished through the analysis of reports submitted on a regular basis by the CME health homes. In addition, [*Enter state name*] will use the following sources of data to monitor the impact of its health home (HH) program on quality: (1) an outcomes survey administered to all CME families on intake and yearly thereafter; (2) charts (either electronic or paper); and (3) a client satisfaction survey. The state exercised prudence in selecting measures to not overburden CME or IT staff with new data collection and analysis. Standard, validated measure specifications where they exist will be used to increase the ability to make comparisons across populations, programs, and states.
Accessibility of care	Annual Satisfaction Survey		

3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will Be Utilized
Percentage of enrollees with non-psychiatric admissions within 30 days of hospital discharge	Claims/Encounter Data	*Numerator:* Number of enrollees with an inpatient re-admission within 30 days of discharge *Denominator:* Number of enrollees with an inpatient non-psychiatric admission	The state will use the Medicaid data warehouse to collect and store historical Medicaid claims and encounter data. In addition, monitoring of progress towards identified health home goals will be accomplished through the analysis of reports submitted on a regular basis by the CME health homes. In addition, [*Enter state name*] will use the following sources of data to monitor the impact of its health home (HH) program on quality: (1) an outcomes survey administered to all CME families on intake and yearly thereafter; (2) charts (either electronic or paper); and (3) a client satisfaction survey. The state exercised prudence in selecting measures to not overburden CME or IT staff with new data collection and analysis. Standard, validated measure specifications where they exist will be used to increase the ability to make comparisons across populations, programs, and states
Percentage of enrollees with a psychiatric admission within 30 days of psychiatric hospital discharge	Claims/Encounter Data	*Numerator:* Number of enrollees with an inpatient psychiatric re-admission within 30 days of discharge *Denominator:* Number of enrollees with an inpatient psychiatric admission	

IX. Evaluations

A. Describe how the state will collect information from health home providers for purposes of determining the effect of this program on reducing the following (include the data source and frequency of data collection)**:**

1. **Hospital admissions**
   a. *Description:* Medicaid will compare rate of admissions and length of stays pre and post health home implementation
   b. *Data Source:* Claims and encounter data stored in the data warehouse
   c. *Frequency of Data Collection:* Bi-annually
2. **Emergency room visits**
   a. *Description:* Medicaid will compare number of ED visits pre and post health home implementation
   b. *Data Source:* Claims and encounter data stored in the data warehouse
   c. *Frequency of Data Collection:* Bi-annually
3. **Skilled Nursing Facility admissions** (Very few if any health home enrollees with SED served by CMEs are expected to be in skilled nursing facilities.)
   a. *Description:* Medicaid will compare number of skilled nursing facility admissions pre and post health home implementation
   b. *Data Source:* Claims and encounter data stored in the data warehouse
   c. *Frequency of Data Collection:* Bi-annually

B. 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:

1. **Hospital and psychiatric residential treatment facility admission rates**: Comparison of claims and encounter data pre and post implementation of health homes
2. **Chronic disease management**: Comparison of claims and encounter data pre and post implementation of health homes; family and enrollee surveys using FES and CA Health Kids Survey Resiliency Module
3. **Coordination of care for individuals with chronic conditions**: Comparison of quarterly and annual data pre and post implementation of health homes, including family and enrollee surveys using FES and CA Health Kids Survey Resiliency Module
4. **Assessment of program implementation:** Comparison of quarterly and annual data pre and post implementation of health homes, including use of Wraparound Fidelity Index
5. **Processes and lessons learned:** CME health homes survey to be developed for key stakeholders; and periodic focus groups with care coordinators, families and individuals
6. **Assessment of quality improvements and clinical outcomes:** Comparison of quarterly and annual data pre and post implementation of health homes
7. **Estimates of cost savings**

States will have to do individual calculations based on how they fund the CME and their CME projected costs. The generic CME example below is based on a new CHCS Medicaid Child Behavioral Health Utilization and Expenditure

Data Collection Methods

Hospital Admissions

MO SPA uses:
Description = Use of HEDIS 2011 codes for inpatient general hospital/acute care, inpatient alcohol and other drug services, and inpatient mental health services discharges (IPU, IAD, and MPT measures)
Data Source = Claims
Data Collection Frequency = Annual

Emergency Room Visits

MO SPA uses:
Description = Use of HEDIS 2011 codes for ED visits (part of ambulatory care (AMB) measure).
Data Source = Claims
Data Collection Frequency = Annual

Skilled Nursing Facility Admissions

MO SPA uses:
Description = Use of HEDIS 2011 codes for discharges for skilled nursing facility services (part of inpatient utilization – non-acute care (NON) measure).
Data Source = Claims
Data Collection Frequency = Annual

Estimates of Cost Savings Calculations

Example from RI CEDARR SPA: *Rhode Island Medicaid total spend (all services) on CEDARR enrolled children for SFY 2010 was $2,553 per member per month (PMPM). The predicted PMPM trend increase used in the actuarially certified rates is 7.2%. Using this trend increase, projected total spend (all services) on CEDARR enrolled children for SFY 2011 is $2,736 PMPM. RI Medicaid estimates that the Health Home intervention will reduce this trend by 5% - to a trend of 6.84%.*

Assuming that the Health Home intervention begins on October 1, 2011, one quarter of SFY 2012 will not have the "Health Home effect." Three quarters of SFY 2012 will. All four quarters of SFY 2013 will see the "Health Home effect." Assuming enrollment of 2,440 children, using this methodology, savings for SFY 2012 is $79.44 PMPM ($2,325,908.10 total). Using this methodology, savings for SFY 2013 is $95.43 PMPM or $2,794,253.24. Total aggregate savings over this period is $5,120,161.34. SFY 2010 = $2,553 PMPM SFY 2011 = $2,736.82 PMPM (7.2% increase over SFY 2010) SFY 2012 do nothing scenario = $2,933.87 PMPM (7.2% increase over SFY 2011) SFY 2012 Health Home scenario = $2,854.43 PMPM (one quarter of 1.8% increase, and 3 quarters of 5.13% increase) Savings in SFY 2012 = $2,933- $2,854.43 = $79.44 PMPM $79.44 PMPM x 2,440 children x 12 months = $2,325,908.10
SFY 2013 do nothing scenario = $3,145.11 PMPM SFY 2013 Health Home scenario = $3,049.67 PMPM Savings in SFY 2013 = $3,145.11 - $3,049.67 = $95.43 PMPM 95.43 PMPM x 2440 children x 12 months = $2,794,253.24
Total two-year savings = $2,325,908.10 + $2,794,253.24 = $5,120,161.34

study that shows the top 10% of children using behavioral health services cost $48,000 per child per year to Medicaid:

[*Enter state name*] Medicaid total spend (all services) on children with serious behavioral health challenges who would meet the criteria for a CME for SFY 2011 was $4,000 per member per month (PMPM). The predicted PMPM trend increase used in the actuarially certified rates is 7.2%. Using this trend increase, projected total spend (all services) on children with serious behavioral health challenges who would meet the criteria for a CME for SFY 2012 was $4,288 PMPM. [*Enter state name*] Medicaid estimates that the health home intervention will reduce this trend by 50% to a trend of 3.6%.

Assuming that the health home intervention begins on October 1, 2012, one quarter of SFY 2013 will not have the "health home effect." Three quarters of SFY 2013 will. All four quarters of SFY 2014 will see the "health home effect." Assuming enrollment of 3,000 children, using this methodology, savings for SFY 2013 is $175 PMPM ($6,300,000 total). Using this methodology, savings for SFY 2014 is $347 PMPM or $12,492,000 total). Total aggregate savings over this period is $18,792,000.

- SFY 2011: $4,000 PMPM
- SFY 2012: $4,288 PMPM (7.2% increase over SFY 2011)
- SFY 2013 do-nothing scenario: $4,597 PMPM (7.2% increase over SFY 2012)
- SFY 2013 health home scenario: $4,422 PMPM (one quarter of 1.8% increase, and 3 quarters of 3.6% increase)
- Savings in SFY 2013: $4597- $4422 = $175 PMPM x 3,000 individuals x 12 months = $6,300,000
- SFY 2014 do-nothing scenario: $4,928 PMPM
- SFY 2014 health home scenario: $4,581 PMPM
- Savings in SFY 2014 = $4,928 - $4581 = $347 PMPM x 3,000 children x 12 months = $12,492,000
- Total two-year savings: $6,300,000 + $12,492,000 = $18,792,000

Attachment 4.19-B: Health Homes for Individuals with Chronic Conditions – Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

X. Payment Methodology

A. Payment Type: Per Member Per Month

Provider Type: CME Health Home

Description: The CME payment methodology is based on an all-inclusive case rate that covers care coordination, administration, out of home placements, services, and discretionary expenses. No other Medicaid funding for the CME exists outside of the case rate.

B. Payment Type: Alternate Payment Methodology

Content in this section will be state-specific

Provider Type: CME Health Homes

Description: The health home service comprehensive care management translates to the following CME services - initial family intake and needs assessment (CANS), Individual Care Plan development (ICP) and review through the wraparound planning process consistent with systems of care philosophy and intensive care coordination, family/youth peer support. This service is performed by a care coordinator and a family partner, in consultation with the health home enrollee, enrollee's primary care provider, specialty provider(s), HCBS service provider(s), and MCO.

Alternate Payment Methodology

Example from RI CEDARR SPA:

- *The average level of effort required of the CEDARR Family Center service team in order to perform the specific service (see Figure 1 below);*
- *The relative level of effort by the Family Counselor and the Family Service Coordinator (see Figure 1);*
- *Development of a market based, hourly rate based, considering labor costs for staff with comparable qualifications and associated employment costs, including: (1) Prevailing wages for comparable personnel: Family Counselor (Licensed Clinician) - Masters Degree or above, prevailing wage; Family Service Coordinator- Less than Masters Degree, prevailing wage; (2) Adjustments to direct wages to recognize payroll taxes, fringe benefits, productivity standards (direct client service hours as a percentage of total work hours), administrative overhead.*

In 2009, Fixed Rates were developed for 3 CEDARR Services: Initial Family Intake and Needs Assessment (IFIND); Family Care Plan development (FCP); and Family Care Plan Review (FCPR). Figure 1 represents assumptions of time, level of effort and staff involvement in order to successfully complete each service per DHS service definition based on analysis of service delivery practices of CEDARR staff from 2001-2009.

Care coordination is defined in the CME as intensive care coordination. This function is performed by a care coordinator (100%).

Health promotion is defined in CME as intensive care coordination. This service is performed by a care coordinator (50%) and a family partner (50%).

Comprehensive transitional care is defined in CME as intensive care coordination. This service is performed by a care coordinator (50%) and a family partner (50%).

Individual and family support services are defined in CME as family peer support and intensive care coordination. This service is performed by a family partner (70%) and a care coordinator (30%).

Referral to community and social support services is defined in CME as intensive care coordination. This service is performed by a care coordinator (60%) and a family partner (40%).

Note #1: The senior or supervising care coordinator must be licensed by the state in one of the following disciplines: LICSW or LCSW (licensed (independent) social worker, psychologist, LMFT (licensed marriage and family therapist), LMHC (licensed mental health counselor), MD (medical doctor), RN (registered nurse), OT (occupational therapist), PT (physician therapist), and SLP (speech and language therapist

Note #2: The family partner has direct experience with individuals having SED as the result of being the parent of, or caregiver of a child with SED. In addition, the family partner must be certified /credentialed by the state.

Alternate Payment Methodology (cont.)

Figure 1

IFIND = $366.00
Cost Structure
Clinician = $66.50 per hour: .75 hours for travel, 1.5 hours for meeting time with family including work plan and crisis plan development, 1.25 hours for prep and follow-up activities. **3.5 hours total.**
Family Service Counselor = $38 per hour: .75 hours for travel, 1.5 hours for meeting time with family including work plan and crisis plan development, 1.25 hours for prep and follow-up activities. **3.5 hours total**.

Family Care Plan (FCP) = $347
Cost Structure
Clinician = $66.50 per hour: .75 hours for travel, 1 hour for meeting time with family, 0 hours for prep and follow-up activities, and 1.75 hours for plan development, including collaboration with PCP and MCO. **3.5 hours total.**
Family Service Counselor = $38 per hour: .75 hours for travel, 1 hour for meeting time with family , 1.25 hours for prep and follow-up activities, and 0 hours for Plan development, in collaboration with PCP and MCO. **3 hours total.**

Family Care Plan Review (FCPR) = $397
Cost Structure
Clinician = $66.50 per hour: .75 hours for travel, 1 hour for meeting time with family, 0 hours for follow-up activities, and 2.5 hours for plan review and revision, including collaboration with PCP and MCO. **4.25 hours total.**
Family Service Counselor = $38 per hour: .75 hours for travel, 1 hour for meeting time with family , 1.25 hours for follow-up activities, and 0 hours for Plan development, in collaboration with PCP and MCO. **3 hours total.**

Other CEDARR Health Home Billable Services
Health Needs Coordination: Per 15 minutes of effort, two rates based upon qualifications: (1) Masters Degree and above- $16.63 per unit ($66.52 per hour); (2) Less than Masters Degree- $9.50 per unit ($38.00 per hour).
Therapeutic Consultation: Per 15 minutes of effort, performed by Clinician $16.63 per unit ($66.52 per hour)