Service Inventory of Managed Care Entities to Support Development of a Health Homes State Plan Amendment

March 2012

MassHealth Managed Care Entities (MCO, SCO, PACE)

Health Homes Inventory to Support State Plan Amendment Development

The purpose of this document is to gather information about this managed care entity's (MCE) Care Management Services as supporting information for a State Plan Amendment (SPA) Application to CMS.

Please add more space as needed; answers may be brief and in bullet form, if desired.

Please provide information about the array of care management services and programs in the context of these CMS Eligibility Criteria: An individual must have two or more chronic conditions, one condition and the risk of developing another, **or** at least one serious and persistent mental health condition. The *chronic conditions* listed in statute include a mental health condition, a substance abuse disorder, asthma, diabetes, heart disease, and obesity (as evidenced by a BMI of > 25).

Health Home Care Management (CM)

> **Definition of service**: a Health Home provides access to comprehensive care management, including assessment, development, and implementation of a person-centered plan that includes and integrates physical, mental health, chemical dependency, and social service needs. An interdisciplinary team is designated to carry out the plan. Peer support may be included as part of care management.

1. What is this MCE's definition of care management?
2. Does the MCE have a specific protocol, software or set of criteria to identify members who would benefit from comprehensive care management? Are certain conditions or diseases specifically identified? What is the risk stratification process?
3. Describe the formal care management enrollment process. Do members opt out of care management? Is there a roster that is regularly updated?
4. Are Individual Care Plans developed and signed by members and primary care clinicians?
5. Are members enrolled in care management for a specific length of time? If not, how is the length -of-stay (LOS) measured?
6. How is each contact or interaction with the member recorded?
7. Is there a CM record that is separate from the member record generally? Are member-specific Care Management records and Individual Care Plans accessible to all members of the care team, including primary care clinicians? Is on-line entry and access to records available to members of the care team?

8. Does the MCE send a list of high risk members to practices? How often?
9. If CM services are not provided by MCE employees, how is information about care management for specific members shared among the care team? How are records shared electronically?
10. How does the MCE minimize duplication of Care Management services between the practice sites and the MCE?
11. What, if anything, would need to be changed, expanded or redirected to meet Health Home requirements for the required Care Management services?

Health Home Care Coordination (CC):

Description of Service: Care coordination is separate and distinct from care management. A CC specialist is responsible for coordinating services across medical, social, and vocational/education services. Tasks include appointment scheduling, conducting referrals and following up. All team members have access to centrally located records. The specialist assures implementation of the care plan, including meeting member's preferences and improving the health of the member. The specialist conducts regular case review meetings.

1. What is your plan's definition of Care Coordination?
2. How does the MCE differentiate between care management and care coordination?
3. Is there a separate process for identifying members for Care Coordination? If so, please describe how members are identified as in need of Care Coordination.

4. Do specialists currently provide Care Coordination?
 	
    a. If so, what are the qualifications of specialists? What are the caseloads? Are care coordinators licensed or unlicensed staff?
 	
    b. If not, how is Care Coordination provided?

5. How are Care Coordination services provided (e.g. phone calls, targeted outreach, community workers?)?
6. How do Care Coordination services assist with linkages to non-medical social services? Are there formal mechanisms, such as "Memoranda of Understanding" or network alliances that create links in a specific locale?
7. Does Care Coordination provide appointment reminders, referral assistance and follow up care?

8. Does Care Coordination conduct regular case review meetings with members of the care team?
9. Are member-specific Care Coordination records and Individual Care Plans accessible to all members of the care team, including primary care clinicians? Is on-line entry and access to records available to members of the care team? Are these records integrated with Care Management records?
10. Are all care coordination contacts and services recorded in member-specific records? How are these records integrated with information about other services?
11. How are members in Care Coordination educated about consent options and implications of information sharing?
12. What, if anything, would need to be changed, expanded or redirected to meet Health Home requirements for Care Coordination?

Health Home Health Promotion:

Description of Service: Health education is tailored to an individual's condition and health/wellness goals, including development of self management plans and support for health-promoting lifestyle intervention, including resources for smoking cessation, diabetes, asthma, and hypertension.

1. For any member enrolled in CM, describe how the MCE provides specific health promotion activities appropriate to the member's diagnosis(es), age, race, ethnicity, language, socioeconomic, and socio-cultural needs.
2. How does the MCE track the number of members in CM and CC who:
a) Develop self management plans <u>with support and encouragement</u> from assigned MCE staff
b) Access smoking cessation services
c) Establish goal of improved nutrition/physical fitness
d) Receive other services related to health promotion for diabetes, asthma and hypertension.
3. Does MCE staff directly provide health education/promotion? If so, list the positions, full time equivalent status, and staff to enrollee ratio? If not, describe how these activities are provided in the context of primary care and other providers' activities.
4. How is enrollee engagement in health education/promotion documented in the

member's record?
5. How is data used to assess and measure the effect of health education/promotion services? What results are measured? What are the results?
6. What if anything would need to be changed, expanded or redirected to meet the requirements of Health Home Health Promotion services? How does this align with the MCE's overall plans for Health Promotion services?

Comprehensive Transitional Care:

Definition of Service: Services include notification of PCP when a health home patient is admitted to a hospital setting. Participation in discharge planning where possible. Collaboration with inpatient team to secure records, achieve medication reconciliation, and schedule timely follow up appointments.

1. What is the MCE's definition of Transitional Care?
2. What processes will be in place so all Medicaid provider hospitals identify and refer clients to a health home provider?
3. As part of Comprehensive Transitional Care, how are the following services provided? Include who is responsible for arranging and providing the service. a) PCP notification and follow up appointments b) Medication reconciliation c) Pre-discharge visits d) In home visits e) Screening for Behavioral Health needs prior to inpatient discharge f) Other (please describe)
4. How are comprehensive transitional care services tracked and reported for members in CM? How does the MCE know how many members have been re-hospitalized within the last 30 days? How does the MCE know how many members have seen a primary or specialty care provider within 30 days of hospital discharge?
5. How is this information shared with other members of the Care Management team, including the primary care clinician?
6. What if anything would need to be changed, expanded or redirected to meet the

> requirements of Comprehensive Transitional Care? How does this align with the MCE's overall plans for Comprehensive Transitional Care?

Individual and Family Support

Definition of Service: Incorporate patient and family care preferences, education and support for self-management and self help recovery. The care plan is accessible to the individual. Includes supports for health literacy, transportation to medical appointments, and ongoing revision of care plan

1. How does the MCE define patient and family support? Is this a stand alone activity? If not, please describe how and when this set of services is delivered and tracked.

2. How do individuals in CM have access to their individual care plans? Can individuals in CM negotiate with the CM team for modifications in their individual care plan (e.g. dietary substitutions/exchanges for weight management based on cultural/religious preferences etc)? Are members developing their individual plans? What is the role of the individual member in the plan development?

3. How are member and family preferences, education and support for self-management and self-help recovery incorporated into the individual care plan development process?

4. What is the role, if any, of peers and individuals in recovery in providing patient and family support?

5. What is the schedule for reviewing and updating individual care plans? Who is responsible for updating individual care plans? Is this a process that is done jointly by the CM team and the member?

6. How is health information technology used to ensure that clinicians have access to the individual care plan?

7. What if anything would need to be changed, expanded or redirected to meet the requirements for Individual and Family Support Services? How does this align with the MCE's overall plans for Individual and Family Support Services?

Referral to Community and Social Supports: Referral to community and social supports, including assistance obtaining and maintaining eligibility for public benefits. The plan of care should include community and social supports.

1. Describe the specific needs of your members for referrals to community and social services; how these needs are assessed; and how the MCE assists members with obtaining these services.

2. Who is responsible for assisting members with community and social supports? Do these

individuals have special expertise in or knowledge of community and social supports?
3. What role do MCE contracted providers play in referrals and linkages to community and social services?
4. Are all members in Care Management offered referrals to community and social supports and assistance in maintaining eligibility for public benefits?
5. How are these referrals communicated and tracked? Is there a mechanism for follow-up? How is this information shared within the MCE?
6. Is this information incorporated into the individual care plan? If not, where is the information documented and how is it tracked?
7. How is health information technology used to ensure that clinicians and other members of the care team have access to this information?
8. What if anything would need to be changed, expanded or redirected to meet the requirements for referrals to community and social supports? How does this align with the MCE's overall plans for encouraging access to community and social supports?

Data Sheet for MCE Health Homes Assessment
Calendar 2011

	Average Number of Members Per Month	Distinct or Unique Count of Individuals
Members identified via Predictive Modeling for Care Management		
Members referred by Clinicians for Care Management		
Self Referrals for Care Management		
Total Number of Members Eligible for Care Management		
Total Number of Members Enrolled in Care Management		
Average Duration or "Length of Stay" (LOS) in Care Management (in months)		
Adult Members Enrolled in Care Management with at least one of the following conditions:		
Asthma		
Diabetes		
CHF		
Obesity		
SPMI		
Total Unique Count of Members with One of these Conditions		
Members Receiving Care Coordination Services Only		
Members Eligible for Care Coordination Services Only		
Average LOS in Care Coordination (in months)		

Administrative Information

Total Cost of Serving Members Currently Receiving Care Management, Care Coordination, Health Promotion, Individual and Family Support, Transitional Care and Community Support Referrals	$
Number of FTEs per month who provided any of the six Health Homes services, including MCE staff and contracted staff.	
Number of FTEs per month who provided Care Management including MCE staff and contracted staff.	
Number of FTEs per month providing only Care Coordination services and who are not included in the Care Management FTE estimate, including MCE staff and contracted staff.	