AUGUST 2012

Pace Car Rapid Learning Network Call Summary

Top of Mind Topics for Health Home Design and Implementation

The 5th Pace Car call on June 12, 2012 was designed to provide states with an opportunity to discuss "top of mind" issues around health homes design and implementation and solicit information from their peers related to current implementation challenges. With the conversation structured around identified issues in four of the Pace Car states, there was a rich discussion around: (1) sharing clinical data with health home providers; (2) hospital referral of health home-eligible patients; and (3) payment requirements and service documentation. For more information about the Pace Car Rapid Learning Network, visit Medicaid.gov.

Following are key takeaways from the conversation.

- **Sharing Comparative Clinical Data**: One state is working on developing a central repository where health home data will be stored, and is looking for input and suggestions from its peers on how to share clinical data with individual health homes in a meaningful way. In general, states are still developing their systems for this type of reporting. Much of the current activity is around sharing historical utilization data with providers to facilitate engagement and care management efforts. In the future, however, most participating states plan to implement systems for reporting measures of clinical performance back to providers. For example, one state explained it is contracting with a third-party that will aggregate data from multiple payers and provide a web-based reporting system that providers can access. Another state is figuring out what a more sophisticated information portal would look like, and has brought in a vendor to help develop a roadmap. States have offered to share available templates.

- **Hospital Referral of Eligible Health Home Patients**: Another area of interest is around how states are dealing with the federal requirement to have hospitals refer eligible patients to health homes. Some of the states have developed systems for notifying health homes of admissions for individuals already enrolled; however, addressing the population not yet enrolled is a more challenging issue and one that is not yet completely resolved. The discussion did, however, provide an opportunity to share helpful suggestions around meeting this requirement, such as: (1) collaborating with hospital associations to engage hospitals on this and related issues; (2) requiring health homes to establish MOUs with local hospitals; (3) generally encouraging the development of relationships between hospitals and health homes; and (4) creating a full-time hospital liaison position, as one state has done with signs of early success.

- **Payment Requirements and Service Documentation**: States are also interested in how the service documentation requirement could be met in the general context of moving away from a fee-for-service program. States are struggling with this issue, and are trying to balance between focusing on quality and outcomes while building in accountability for service provision. The states are taking a range of approaches to documentation requirements:

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1. One state requires providers to provide a monthly attestation via a web-based portal that health home services have been delivered, subject to state audit.

2. Another state has similar requirements, and developed a guidance document for providers defining examples of activities that would fulfill health home service requirements (for example, around outreach/engagement and care management, including activities outside of face-to-face visits.)

3. A third state is requiring its providers to document services delivered by submitting claims; however, warned that this has been time consuming for providers.

In addition, states are interested in learning about what procedure codes others are using that match the federal service categories. For the most part, states have not found any existing codes that matched neatly. One state decided to use two rate codes: one for outreach and engagement activities and one for active care management once individuals are fully enrolled and engaged.