

## Health Home SPA Draft Q&A

The inquiries below represent a summary of the questions and comments received in response to the draft State Plan Amendment circulated in February for the upcoming Health Homes program. The Department has responded to each question received directly and/or in this document, and we hope that these explanations will prove helpful to all stakeholders.

- 1. Why is the eligibility criteria limited to those with SPMI or Opioid Substance Use Disorders at risk for additional chronic conditions, when others could equally benefit from Health Home services? Similarly, will the state consider allowing providers other than PRP, MT, and OMTs to serve as Health Homes (such as OMHCs), particularly for patients who may meet the SPMI, SED, or opioid addiction criteria?**

After careful consideration and input from stakeholders, the Health Home work group decided not to include OMHC-only clients in the initial Health Home State Plan amendment. For the first two years, the Health Home program will be in a pilot phase, during which the effectiveness of the program will be evaluated to determine its future. During this pilot phase, we believe it best to narrow the program's focus to individuals who are receiving care through PRPs, MT/ACT programs, or OTPs, because these individuals are: (1) very high in need; (2) usually somatically ill; and (3) enrolled in services with a regular treatment provider (and likely will be for years to come) that will also serve as their Health Home provider. These three aspects will facilitate the Health Home program evaluation during the pilot phase.

Narrowing the program's focus during the initial phase to those in PRPs, MT/ACT programs, and OTPs also means that inevitable provider enrollment and payment issues, which accompany any new project, can be worked out before the 8 quarters of enhanced federal match starts for additional populations. This means that the State can preserve federal money for additional populations until the Health Home program is running more smoothly and effectively.

- 2. The SPA mentions eligibility based upon opioid substance use disorder also includes the requirement that the individual is "at risk for additional chronic conditions due to tobacco, alcohol, or other non-opioid use." We are concerned that this would exclude individuals who currently have another chronic illness. We suggest including a statement in the SPA that the consumer has another chronic health condition or is determined to be at risk for additional chronic conditions due to tobacco, alcohol, or other non-opioid substance use.**

We have been advised by SAMSHA that, at this time, the best approach is to not include "has another chronic health condition" within the eligibility criteria based on opioid substance use disorder. Including this criterion would interfere with the implementation of future State programs geared toward the population of individuals with those other chronic health conditions. However, in addition to including "at risk for additional chronic conditions due to tobacco, alcohol, or other non-opioid use" within the eligibility criteria based on opioid substance use disorder, we have decided to include those with a history of tobacco, alcohol, or other non-opioid substance dependence. This should help prevent excluding individuals with opioid substance use disorders who would greatly benefit from Health Home services.

- 3. We are concerned about the possibility that MT/ACT consumers may, at some point in the future, be excluded from receiving Health Home services.**

The Department has included MT/ACT consumers in the State Plan Amendment (SPA) submitted to the Centers for Medicare and Medicaid (CMS) for approval. We have been informed that there is likely to be significant resistance to this due to concerns of duplicative services. We appreciate the materials prepared by the stakeholder community justifying the inclusion of MT/ACT consumers and will use these to advocate that these individuals be eligible for Health Home services. However, final approval ultimately falls to CMS.

- 4. What happens when patients are enrolled with an OTP provider and a PRP or MT provider who both have Health Homes, or if a patient wishes to transfer to a new Health Home?**

Individuals may receive Health Home services from any PRP, MT, or OTP Health Home provider, as long as they are only enrolled in one Health Home, and contingent upon receiving the respective clinical services from the same provider. Those receiving both PRP or MT services and OTP services from providers enrolled as Health Homes will have the option to choose which will serve as their Health Home. The selected Health Home will be expected to communicate with the additional provider for the purpose of care coordination. If an individual transfers their care from one Health Home to another, their eMedicaid records will be available to the new provider.

- 5. Incarceration is listed as a reason for discharge from a Health Home. Is it possible to keep a person who is incarcerated in a "suspended mode" which can be reactivated immediately upon release to ensure seamless re-entry into both behavioral health as well as somatic care services?**

When an individual loses Medicaid eligibility, as in the case of incarceration, their provider will no longer be reimbursed for the provision of Health Home services. However, their record will remain in eMedicaid, and if they re-enroll with Medical Assistance and subsequently with the Health Home upon release, their record will be reactivated, accessible to the provider, and service-provision may begin again.

- 6. Does the minimum staffing level per 125 enrollees mean that between 125 and 249 enrollees, this same minimum staffing level would apply and additional staff would only be required once the Health Home provider reaches 250 enrollees?**

A provider will be required to increase their staffing to the stated level upon reaching the applicable threshold (e.g. at 125 enrollment they must have a .5 FTE Nurse Care Manager, and upon reaching 250 enrollment this must increase to 1 FTE). Any increases in staffing between these set levels (e.g. increasing to a .8 FTE Nurse Care Manager when enrollment reaches 200) will be left to the discretion of the Health Home. This said, we encourage providers to seriously consider the level of staffing necessary to provide comprehensive Health Home services.

- 7. If the Health Home purchases and uses an electronic care management tool to address administrative Health Home tasks, must the Health Home still hire administrative support staff at a ratio of .25 FTE per 125 consumers?**

The administrative support staffing ratio is no longer a requirement. While we used the ratio to calculate the reimbursement rate, we recognize that some providers may have care management tools that perform some of the administrative functions of the Health Home. Therefore, as long as providers are able to meet the reporting and service requirements of the program, the extent to which they use administrative support staff versus care management tools will be left to their discretion.

**8. What are the credentials anticipated for nurse care managers and Health Home directors?**

We anticipate requiring that the nurse care manager be 1) a nurse practitioner or 2) a registered nurse, and that the Health Home director have 1) a bachelor's from an accredited institution and 2 years experience in health administration or 2) a master's from an accredited institution in a related field. As long as the FTE staffing ratio requirements are met, a health home staff member may serve as both a Nurse Care Manager and the Health Home Director.

**9. Can you provide more specifics about the initial assessment (what must be included, who can conduct it, etc.)?**

The initial assessment must be conducted by a physician or nurse practitioner, either at the Health Home or by the participant's PCP. We are in the process of further specifying the requirements of the assessment and will share this with providers as soon as it is available.

**10. Will Health Home providers have the option to combine and integrate the Health Home ITP with the PRP IRP (Individual Rehabilitation Plan) or the MT/ACT ITP?**

Health Home providers may combine and integrate the Health Home ITP with the participant's existing treatment plan ( plan of care, individualized treatment plan, individualized rehabilitation plan, etc), as long as the plan is updated to include specific Health Home goals and actions.

**11. Are electronic medical records a required capability for participation in the Health Home program?**

The State strongly recommends the use of EMRs by Health Home providers, but use of EMRs is not a requirement.

**12. Will there be training to familiarize providers with eMedicaid prior to the initiation of the Health Home program?**

Yes. We will communicate the date(s) of this training to providers in the coming months.

**13. We have concerns that the required data entry into the eMedicaid online portal will duplicate data entered into other electronic environments, such as an individual practice EHR, and that it will be a hardship for providers. We suggest that eMedicaid data entry requirements be minimized, and we ask whether an effort can be made to establish data links between eMedicaid and existing systems to eliminate the need for multiple entry of information.**

In designing the Health Home program, the State has attempted to keep administrative burden on providers to a minimum, while ensuring that the necessary elements are in place to track program

effectiveness and compliance. As such, providers will be required to report a patient's diagnoses and related baseline data into eMedicaid during intake, which will be updated periodically. On an ongoing basis, providers will report Health Home services delivered. eMedicaid is the only reporting tool that will be required by the State, and for those with existing EHR systems, we will work to see whether these may be able to fulfill or lessen the reporting efforts through linkages with the eMedicaid system or by generating equivalent reports. Additionally, eMedicaid will serve not only as a reporting tool, but will allow providers to review patient and provider-level data regarding health home services and outcomes in order to improve their care management and service delivery.

The additional HIT tools required by the program include the Chesapeake Regional Information System for our Patients and the State's Administrative Service Organization. These do not require any reporting duties by providers other than the periodic update of your patient panel.

**14. Will the State assist providers in the process of enrolling with CRISP to make sure that any technical and communication barriers are effectively and efficiently addressed?**

The Department will invite a representative from CRISP to the provider training session in order to directly address enrollment and use of the tool. They will provide a point of contact to assist with troubleshooting, and the State will assist as appropriate. For further information at this point regarding CRISP, provider may visit [www.crisphealth.org](http://www.crisphealth.org).

**15. On p. 6, in Provider Standards, there is mention made of contractual arrangements between the Health Home provider and “appropriate service providers, of comprehensive, integrated services.” Are we correct in interpreting this to mean that contracts are required between the Health Home and these other providers? Furthermore, is the SPA stating that coordination with providers is limited to just those providers with whom the Health Home has a formal contract?**

While the State expects that most Health Homes will provide services directly, Health Home providers may choose to subcontract the delivery of their Health Home services to another entity, contingent upon Department approval of the contract. Health Homes will be expected to regularly communicate and collaborate with medical and community support providers that serve their participants in order to coordinate care and support their participants, and they will be expected to develop clear protocols for this. However, there is no requirement that the Health Home develop formal contracts with these entities.

**16. It would be very helpful if the Department could assist MCOs and Health Homes by developing a common protocol for collaboration. Is this a possibility?**

As mentioned above, the Department is in the process of developing provider manuals which will include guidance on a wide range of issues, as well as common templates and protocols for things like MCO/Health Home collaboration.

## **Questions/Comments relating to children in the Health Home**

**17. We are concerned that the State Plan Amendment does not adequately address the unique needs of children in the Health Homes, with services and evaluation measures designed for adult recipients. An**

**independent SPA designed specifically for this population would be preferable. Is that something the Department will consider?**

The Department has received several comments stating that the Health Home program appears to be designed primarily with adult participants in mind, rather than children and youth. We acknowledge this challenge, which is a direct reflection of guidance from the Centers for Medicare and Medicaid Services (CMS) yet we feel that this is a workable model for achieving the goals of a HH for children and adolescents.. The State is unable to offer Health Home services to individuals with SPMI without extending the same services to children with SED, and these must be launched simultaneously if we wish to collect the enhanced federal match funds for the program, which makes the program a fiscally feasible option for the state. For that reason, we cannot have two separate Health Home programs implemented at different times if we wish to receive these matching funds for the full 2 years.

Additionally, the goal of the Health Home initiative, as directed by CMS, is to improve health outcomes and patient experience of care while reducing healthcare costs *among individuals with chronic conditions*. This objective is, by nature, best suited for adult participants, rather than children and youth whose conditions are generally not yet considered chronic. For that reason, the Department has strived to create a program within the Health Home design that will benefit children with SED. To this end, we have shifted the focus in many of the Health Home services to more appropriately meet the needs of the child and youth population, emphasizing prevention rather than treatment of chronic conditions, and including extensive care coordination with schools, Department of Juvenile Services (DJS) and other agencies that interact with these participants and their families.

Regarding evaluation of the program—the measures included in the SPA were largely the result of direction from CMS and generally target the adult population of the program. However, The Department is in the process of considering additional measures that may better capture outcomes among children and youth, and appreciate the feedback on this point provided by stakeholders.

**18. Can you please explain the rationale in limiting the child eligibility criteria to those with SED receiving PRP services? We feel there are other criteria and provider types that may be more appropriate to receive and deliver health home services.**

The decision to provide Health Home services to children and youth with SED, and to serve them through Psychiatric Rehabilitation Program providers was made with consideration of the existing PMHS services for children and youth. DHMH initiated a planning process to consider the pros and cons of providing HH services to children and adolescents under Mental Health Case Management and the simultaneous use of a 1915(i) SPA to provide intensive care coordination. Based on a number of policy and cost considerations, this approach was not taken. However, a 1915(i) SPA for children and adolescents will be submitted shortly with the expectation that these youth and families receive high quality somatic coordination and wellness services not unlike those required by the Health Home proposal

**19. Are children with SED who are participating in MT/ACT services eligible for Health Home services?**

Pending CMS approval, children participating in MT/ACT services will be eligible for Health Home services so long as they are not receiving 1915(i) waiver services or Mental Health Targeted Case Management services.

**20. Children and youth with SED often have periods when they are well and periods when they are not. Unlike adults with SPMI, PRP usage for these children tends to be of short duration. Can you provide clarity on when a child would be discharged?**

If a Health Home participant has been discharged from PRP, MT, or OTP services due to stabilization of their condition and the decision that that level of care is no longer necessary, they may continue to receive Health Home services from their own Health Home for up to 6 months after this point. This is intended to ease their transition into a less intensive level of care, and assist the participant in increasing their ability to self-manage or connect with additional supports. This is contingent upon the individual and provider continuing to meet all other criteria, such as Medical Assistance eligibility and the minimum monthly provision of Health Home services.

In the case of a child or youth with SED who may go in and out of PRP services due to varying levels of wellness, this 6-month period would serve to provide some continuity between services. A child could continue to receive Health Home services for 6 months following discharge from the PRP, and if they are re-enrolled with the PRP at a date past the 6 months, they will simply be re-activated in eMedicaid as well. This would allow the Health Home provider to access the individual's participant file and resume their tracking, review, and reporting.

**21. Because criteria for youth PRP and adult PRP are quite different, youth in PRPs typically are discharged upon turning 18 due to not meeting the adult criteria for PRP services. Discharge of a youth from a Health Home upon turning 18 has the potential to do serious harm, and set back previous gains. What is your plan for youth turning 18 years of age?**

Upon turning 18, unless a youth is eligible for PRP services based on SPMI medical necessity criteria they will be discharged from the Health Home following the 6-month transition period mentioned above. During these 6 months, Health Home staff will focus on connecting the youth and their family to additional resources and supports. We recognize that the Health Home proposal does significantly highlight the broader needs of the Transition-aged youth population and does little in itself to address these needs. As a result, MHA has decided to consider policy initiatives and strategies in conjunction with its SAMHSA funded HTI project and other projects for young adults to improve the young adult transition. There is an overriding priority on prompt submission of the HH proposal to CMS which these other more complex and budget sensitive issues should not delay.

**22. There needs to be more clarity on how the Health Home program will provide the specialized care coordination needed by children, such as care coordination with the school system, mental health providers, and other agencies like DSS and DJS. Additionally, there should be references to EPSDT.**

The SPA has been updated to more clearly state the importance of EPSDT and collaboration with schools and other child-serving agencies and organizations in the Health Home. The Department will provide additional guidance to Health Homes through provider manuals specific to each Health Home type, addressing the unique needs of each population. These will be distributed and reviewed during provider training sessions prior to the launch of the Health Home program.