

BUILDING A RECOVERY-ORIENTED, INTEGRATED SYSTEM OF CARE FOR PERSONS WITH SERIOUS MENTAL ILLNESS

Rhode Island's Proposal for Medicaid Health Homes

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RI RECOGNIZES THE OPPORTUNITY

- Medicaid Health Homes (MHH):
 - An initiative included in the Patient Protection and Affordable Care Act (PPACA)
 - Outlined in Section 1945 of the Social Security Act, and,
 - Centers for Medicare and Medicaid Services (CMS)
November 16, 2010-Guidance to State Medicaid Directors
- Offers states the opportunity to provide Medicaid coverage, at an enhanced Federal Medicaid Participation Rate of 90-10 (FMAP) for comprehensive care coordination for individuals with chronic health conditions, giving emphasis to persons with serious mental illness.



HEALTH HOME SERVICES

- There are six (6) specific categories of service under Health Homes:
 - Comprehensive Care Management
 - Care Coordination
 - Health Promotion
 - Comprehensive Transitional Care
 - Individual and Family Support Services
 - Referral to Community and Social Support Services



COMPREHENSIVE CARE MANAGEMENT SERVICES

- **CMHO Specific Definition:** 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.

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 CMHO. Assessments may be conducted by a psychiatrist, registered nurse or a licensed and/or master's prepared mental health professional. 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 he staff person (s) and/or program to provide the treatment.

Based on the bio-psychosocial assessment, a goal-oriented, person centered care plan is developed, implemented and monitored by a multi-disciplinary team in conjunction with the individual served.



CARE COORDINATION


- **CMHO Specific Definition:** Care coordination is the implementation of the individualized treatment plan (with active involvement of the individual served) for attainment of the individuals' goals and improvement of chronic conditions. Care managers 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:
 - Assessing support and service needs to ensure the continuing availability of required services;
 - Assistance in accessing necessary health care; and follow up care and planning for any recommendations
 - Assessment of housing status and providing assistance in accessing and maintaining safe and affordable housing;
 - Conducting outreach to family members and significant others in order to maintain individuals' connection to services; and expand social network
 - Assisting in locating and effectively utilizing all necessary community services in the medical, social, legal and behavioral health care areas and ensuring that all services are coordinated; and
 - Coordinating with other providers to monitor individuals' health status, medical conditions, medications and side effects.



HEALTH PROMOTION

- **CMHO Specific 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. Health promotion services may be provided by any member of the CMHO health home team.

Health promotion activities place a strong emphasis on self-direction and skills development for monitoring and management of chronic health conditions. Health promotion assists individuals to take a self-directed approach to health through the provision of health education. Specific health promotion services may include, but are not limited to, providing or coordinating assistance with:

- Promoting individuals' health and ensuring that all personal health goals are included in person centered care plans;
 - Promotion of substance abuse prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and increased physical activity;
 - Providing health education to individuals and family members about chronic conditions;
 - Providing prevention education to individuals and family members about health screening and immunizations;
 - Providing self-management support and development of self-management plans and/or relapse prevention plans so that individuals can attain personal health goals; and
 - Promoting self direction and skill development in the area of independent administering of medication.
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COMPREHENSIVE TRANSITIONAL CARE

- **CMHO Specific Definition:** Comprehensive transitional care services focus on the transition of individuals from any medical, psychiatric, long-term care or other out-of-home setting into a community setting. Designated 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.

To facilitate timely and effective transitions from inpatient and long-term settings to the community, all health home providers will maintain collaborative relationships with hospital emergency departments, psychiatric units of local hospitals, long-term care and other applicable settings. In addition, all health home providers will utilize hospital liaisons to assist in the discharge planning of individuals, existing CMHO clients and new referrals, from inpatient settings to CMHOs. Care coordination may also occur when transitioning an individual from a jail/prison setting into the community.

Hospital liaisons, community support professionals and other designated members of the team of may provide transitional care services. The team member collaborates with physicians, nurses, social workers, discharge planners and pharmacists within the hospital setting to ensure that a treatment plan has been developed and works with family members and community providers to ensure that the treatment plan is communicated, adhered to and modified as appropriate.

INDIVIDUAL FAMILY AND SUPPORT SERVICES

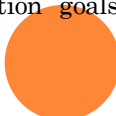
- **CMHO Specific Definition:** Individual and family support services are provided by community support professionals and other members of the health team to reduce barriers to individuals' care coordination, increase skills and engagement and improve health outcomes. Individual and family support services may include, but are not limited to:
 - Providing assistance in accessing needed self-help and peer support services;
 - Advocacy for individuals and families;
 - Assisting individuals identify and develop social support networks;
 - Assistance with medication and treatment management and adherence;
 - Identifying resources that will help individuals and their families reduce barriers to their highest level of health and success; and
 - Connection to peer advocacy groups, wellness centers, NAMI and Family Psycho-educational programs.
 - Individual and family support services may be provided by any member of the CMHO health home team.



REFERRAL TO COMMUNITY AND SOCIAL SUPPORT SERVICES

- **CMHO Specific Definition:** Referral to community and social support services provide individuals with referrals to a wide array of support services that will help individuals overcome access or service barriers, increase self-management skills and achieve overall health.

Referral to community and social support involves facilitating access to support and assistance for individuals to address medical, behavioral, educational, social and community issues that may impact overall health. The types of community and social support services to which individuals will be referred may include, but are not limited to:

- Primary care providers and specialists
 - Wellness programs, including smoking cessation, fitness, weight loss programs, yoga
 - Specialized support groups (i.e. cancer, diabetes support groups)
 - Substance treatment links in addition to treatment - supporting recovery with links to support groups, recovery coaches, 12-step
 - Housing (including Sober Housing)
 - Social integration (NAMI support groups, MHCA OASIS, Alive Program, Anchor Recovery Center, etc.)
 - Assistance with the identification and attainment of other benefits
 - State Nutrition Assistance Program (SNAP)
 - Connection with the Office of Rehabilitation Service and CMHO team to assist person with education/vocational rehabilitation goals
 - Assisting persons in their social integration and social skill building
 - Faith based organizations
 - Referral to community and social support services may be provided by any member of the CMHO health home team.
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RI RECOGNIZES THE OPPORTUNITY

- Research highlights particular obligation to ensure access to comprehensive healthcare for persons with SMI
 - Shorter life expectancy
 - Increased prevalence of metabolic syndrome
 - High rate of co-morbidities
- Goals of Health Home align with recovery-oriented systems of care




RECOGNIZING THE OPPORTUNITY

- Many supporting components of Health Home already in place in Rhode Island's community mental health system:
 - Every community hospital has a contract with one or more CMHOs to conduct emergency psychiatric assessments in ERs;
 - Long term relationships with local FQHCs, PC Practices including co-location and formal integrated care agreements
- Re-organized delivery system in 2009—
“Consumer Oriented System of care”, to tailor services to meet individual's needs.
- Opportunity to achieve budget savings, and continue system re-design.



RI'S MEDICAID HEALTH HOME PROPOSAL

- RI proposing to implement two statewide MHH programs:
 - Community Mental Health Organizations (\$12.7 in GR savings)
 - Comprehensive Evaluation Diagnosis Assessment Referral Re-evaluation Family Centers (CEDARRs) (\$1.3 in GR savings)
 - The CMHO Health Home will include:
 - 7 CMHOs est. in state statute in 1964
 - 2 of which are SAMHSA primary care/behavioral health integration Grantees
 - 2 specialty providers serving only adults with SPMI
 - Each CMHO health home will be responsible for establishing an integrated service network within its own geographic area and for coordinating service provision with other geographic areas.
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RI'S MEDICAID HEALTH HOME PROPOSAL

- Population to be served through CEDARRs Health Homes:
 - Children and Youth with Chronic Health Conditions
- Population to be served by CMHO Health Homes:
 - Individuals who are categorically eligible for RI Medical Assistance and who are diagnosed with a SPMI



CMHO MEDICAID HEALTH HOME PROPOSAL

- In 2010, CMHOs serve 7,490 persons w/ SPMI:
 - 35.5% - Medicaid eligible
 - 33.9% - Dually eligible (Medicaid/Medicare)
 - 14.4% - Medicare only
 - 5.5% - Other insurance
 - 10.7% - Uninsured
- In addition to those already enrolled in CMHO:
 - Eligible individuals presenting to an ER, or admitted to hospitals will be told about health homes and referred to the health home in their geographic area.




CMHO MEDICAID HEALTH HOME PROPOSAL

- In RI, all Medicaid-only individuals are auto-enrolled in Managed Care with BH-carve out for persons with SPMI
- RI's 1115 Global Medicaid Waiver will also allow for auto-assignment of individuals to a health home in his/her geographic area; however, persons are not bound by catchment areas, and can choose another eligible health home, if he/she wishes.
 - On 9/1/2011, DBHDDH sent letter to all CSP clients in RI BHOLD database:
 - Informed them of the Health Home Initiative,
 - Indicated which HH they were enrolled in,
 - Options for transitioning to different CMHO-HH



CMHO HEALTH HOME STANDARDS

CMHOs agree to:

- A psychiatrist to be assigned to the health home team;
 - 24/7 availability for individuals in need of referral/health home service;
 - Conduct wellness interventions based on individuals' level of risk;
 - Participate in any statewide learning sessions for health home providers;
 - Within 3 months of health home service implementation, have a contract or MOU with local hospital(s) for transitional care planning,
 - Agree to establish contracts or MOUs with FQHC and/or PCPs in the CMHOs area.
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CMHO HEALTH HOME STANDARDS

CMHOs agree to, cont...

- Convene internal health home team meetings with all relevant providers to plan and implement goals and objectives of practice transformation;
- Participate in CMS and state-required evaluation activities;
- Establish a process for receiving and accepting relevant information to coordinate care for HH participants a
- Develop reports on CMHO health home activities, efforts and progress in implementing health home services (e.g., monthly clinical quality indicators reports).
- Agree to participate in annual chart reviews to assess compliance.



THE CMHO HEALTH HOME TEAM

- The Medicaid Health Home Team who will provide the six (6) health home services must include:
 - A Master's Level Team Coordinator (1 FTE)
 - A Psychiatrist (0.5 FTE)
 - A Registered Nurse (2.5 FTE)
 - A Licensed and Master's prepared mental health professional (.5 FTE)
 - A Community Support Professional – Hospital Liaison (1 FTE)
 - Community Support Professionals (5.5 FTE)
 - A Peer Specialist (0.25 FTE) As the resource becomes available
 - Total of 11.25 FTEs per 200 clients
 - Department sets floor of 600 HH service hours across team with 200 clients
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THE CMHO HEALTH HOME TEAM

- Other health team members may include, but are not limited to:
 - primary care physicians,
 - pharmacists,
 - substance abuse specialists,
 - vocational specialists, and,
 - community integration specialists.



HEALTH INFORMATION TECHNOLOGY

- CMHOs at different stages in implementing certified EHRs;
- State will phase in use of HIT to support Health Homes;
- Medicaid MCOs will support CMHOs initially, in the delivery of health home services to the 35% enrolled in MCOs, by providing health utilization profiles
 - # Emergency Room Visits
 - Last ER Visit Date
 - Last ER Visit Primary Diagnosis
 - # Urgent Care Visits
 - PCP site and date of last PCP visit, etc.
- To the extent possible, similar profiles will be derived from the Medicaid data warehouse and other applicable sources for the remaining fee-for-service individuals who are dually eligible for Medicare and Medicaid.
- The state will work closely with the Centers for Medicare and Medicaid Innovation to obtain Medicare utilization and cost data.



PAYMENT METHODOLOGY

- The State will pay for services under this section on the basis of a cost-related case rate encompassing all health home services.
 - Proposed Case Rate for Health Home Services approximately \$442.00/client/month
 - Code for basic case management/CPST (had been reimbursed @ \$21.25/15 min) has been rolled into HH Case rate, with some exceptions:
 - CPST with SA and SEP modifiers may be still be billed as treatment
 - Codes for ACT I and II have been unbundled, with portion of funding rolled into HH rate, and new per diem of \$13.80 created (RI Consumer System of care/RICSOC) (had been reimbursed at \$52.69 and \$34.30/day, previously).
- Remaining **treatment** codes are under review by DBHDDH for adjustment/modification. Potential changes include, but not limited to:
 - MHPRR rate may be re-defined;
 - Maintaining CPST code for GOP and/or CNOM-funded clients



PAYMENT METHODOLOGY

- Providers will be required to collect and submit complete encounter data on a monthly basis utilizing standard Medicaid coding and units in an electronic format to be determined by BHDDH.
- BHDDH will utilize this data to:
 - develop recipient profiles
 - study service patterns, and
 - analyze program costs vs. services received by recipients for potential adjustments to the case rate as well as considering alternative payment methodologies.



HEALTH HOME CODING

- 1) STANDARD CONVENTIONS UTILIZED FOR MEDICAID BILLING SHOULD BE FOLLOWED WHERE AVAILABLE.
- 2) LOCAL MODIFIERS HAVE BEEN ADDED TO DIFFERENTIATE HEALTH HOME SERVICE.
- 3) X0500-X6, -X7 and -X8 SHOULD BE REPORTED IN **FIFTEEN (15) MINUTE UNITS. THE FIRST UNIT MUST LAST A FULL 15-MINUTES, ADDITIONAL UNITS DURING THE SAME ENCOUNTER SHOULD BE ROUNDED UP/DOWN AS APPROPRIATE.**
- 4) HEALTH HOME TELEPHONE CONTACTS SHOULD BE REPORTED IN **FIVE (5) MINUTE UNITS. THE FIRST UNIT MUST LAST A FULL 5-MINUTES, ADDITIONAL UNITS DURING THE SAME ENCOUNTER SHOULD BE ROUNDED UP/DOWN AS APPROPRIATE.**



HEALTH HOME ENCOUNTER CODING

- Capture HH encounters through following codes/intervals:
 - HH Face to Face Individual – 15 minute intervals
 - HH Group – 15 minute intervals
 - HH Collateral face to face – 15 minute intervals
 - HH Phone/Other – 5 minute intervals



QUALITY MEASURES

- Goal Based Quality Measures:
 - Improve care Coordination
 - Reduce Preventable Emergency Department (ED) Visits
 - Increase Use of Preventive Services
 - Improve Management of Chronic Conditions
 - Improve Transitions to CMHO Services
 - Reduce Hospital Readmissions
- Within each domain, are measures for:
 - Clinical care
 - Experience of Care
 - Quality of Care



Improve Care Coordination

Clinical Care:

- Care plan identifies physical and behavioral health needs
- Hospital-discharged patients are seen for appropriate outpatient follow-up care

Experience of Care: OEI

- Patient experience accessing physical health care

○ Quality of Care:

- CMHO clients discharged from hospitals are contacted by HH team within 48 hours.



REDUCE PREVENTABLE ED VISITS

○ Clinical Care:

- Percent of patients with one or more ED visits for any conditions named in NYU ED methodology, available at:
<http://wagner.nyu.edu/ld.lpsr/Index.html?p=61>
- Percent of patients with one or more ED visits for a mental health condition

○ Experience of Care: OEI

- Patients experience with accessing outpatient services, and satisfaction with those services.

○ Quality of Care:

- Hospital discharged patients are contacted and assisted in obtaining outpatient care to avoid future need for hospital ED



INCREASE USE OF PREVENTIVE SERVICES

○ **Clinical Care:**

- Smoking prevalence
- Substance abuse prevalence
- Prevalence of BMI > 25/obesity
- Adults current on recommended cancer screening

○ **Experience of Care: OEI**

- Patient experience with receiving primary care

○ **Quality of Care:**

- Patients with regular check-ups for physical health
- Smoking cessation counseling, referral, and treatment
- Substance abuse counseling, referral, and treatment
- Weight management counseling, referral



IMPROVE MANAGEMENT OF CHRONIC CONDITIONS

○ Clinical Care:

- Percentage of patients with diabetes (type 1 or type 2) who had HbA1c < 8.0%
- Percentage of patients identified as having persistent asthma & were appropriately prescribed medication (controller medication) during the measurement period
- Percentage of patients with a diagnosis of hypertension who have been seen for at least 2 office visits, w/blood pressure adequately controlled (BP < 140/90) during the measurement period
- Percentage of patients diagnosed with CAD with lipid level adequately controlled (LDL<100)



IMPROVE MANAGEMENT OF CHRONIC CONDITIONS

○ **Quality of Care:**

- Percent of patients screened within last 12 months for:
 - BMI
 - BP
 - HDL cholesterol
 - Triglycerides
 - HbA1c or FBG
- Percent of patients who are adherent to prescription medication for:
 - Asthma and/or COPD
 - CVD and Anti-hypertensive medication
- Percent using a statin who have history of CAD



IMPROVE TRANSITIONS TO CMHO SERVICES

○ **Clinical Care:**

- Hospital-discharged patients are seen for appropriate outpatient follow-up care at CMHO within 14 days

○ **Experience of Care: OEI**

- Patients' experience of care access

○ **Quality of Care:**

- Patients contacted by CMHO HH team member within 48 hours of discharge;
- Presence of Medication Reconciliation Form in patient's chart
- Presence of discharge summary in patient's chart



REDUCE HOSPITAL RE-ADMISSIONS

○ **Clinical Care:**

- Avoidance of re-admissions within 30 days for related-cause issue/diagnosis;

○ **Experience of Care: OEI**

- Patients' experience of care access

○ **Quality of Care:**

- Hospital-discharged patients are seen for appropriate outpatient follow-up care by a CMHO or other medical provider within 14 days.
- Hospital-discharged patients are contacted within 48 hours by CMHO HH team member, and assisted in obtaining outpatient care as indicated.



CHALLENGES

- In general, the biggest challenge is “flying the plane, while building it..”
 - CMS approved plan on 11/23/11.
 - State began implementation on 10/1/11:
 - Billing codes and protocols not finalized;
 - Reporting mechanisms not finalized;
 - Internal processes/policies at CMHOs under development;
 - Though Council convened numerous meetings throughout planning process, staff not fully educated to new model of service delivery.
 - Processes for data sharing with hospitals, FQHCs, and Health Plans not finalized



CHALLENGES

- Reporting & Tracking Services/Encounters:
 - Team of 200 clients to receive 600 hours HH services on average per month
 - Each client to receive one (1) hour/month of HH service (direct/indirect)
 - Each client to receive one (1) hour per quarter of face-to-face HH service
 - Team of 200 clients to receive 500 hours of treatment on average per month
 - Each client to receive minimum 1 hour of treatment per month



CHALLENGES

- Tracking Time of Staff on HH Team:
 - HH Team of 11.25 FTEs is supported by case rate of \$442.00/month. State has told CMS that at the 6 month mark, it will review assumptions regarding composition and FTE allocations to HH Team to determine if rate is sufficient or too high:
 - CMHOs developing processes for staff, including physicians, to track time dedicated to HH services.
- Clients who refuse to participate in HH initiative.
- Receiving timely data from other treating providers, hospitals, health plans, Medicare.
 - Confidentiality and 42 CFR



CHALLENGES

- No additional resources coming into system, and no financial incentive for other providers or facilities to work collaboratively
- Proving cost savings:
 - No baseline data from which to work
 - Other State initiatives that could take credit for cost savings:
 - Communities of Care
 - Dual eligibles under Managed Care
 - High cost case reviews

