

TN - Submission Package - TN2016MH0003O - (TN-16-004) - Health Homes

Summary Reviewable Units Versions Approval Notice RAI News **Related Actions**

CMS-10434 OMB 0938-1188

Health Homes Intro

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Package Header

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Submission Type	Official	Initial Submission Date	10/12/2016
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Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

Health Link

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

Tennessee provides Health Home services to adults with serious mental illness (SMI) and children with Serious Emotional Disturbance (SED). The goal of the Health Home program is to meet the needs of these beneficiaries by:

1. Improving the quality of care that beneficiaries receive during the management of their illnesses.
2. Improving efficiency and decreasing the cost of care that beneficiaries receive by improving coordination of care between beneficiaries, their behavioral and physical health providers, and their social supports.
3. Improving the overall beneficiary experience of care.

In Tennessee's Health Home model, a Health Home will consist of a care coordination team embedded in a qualifying provider type. At the core of the care coordination team will be a clinical care coordinator and a case manager, with access to therapeutic staff on site or by affiliation. The Health Home will be responsible for enrolling all beneficiaries attributed to it, and meeting their needs by providing them with Health Home activities, as defined in this document, as they require. In order to receive a per member per month payment (PMPM), Health Homes must perform and submit claims for at least one of these activities for a beneficiary each month. We refer to this as an activity payment.

The State contracted Managed Care Organizations (MCOs) will have responsibility for beneficiary eligibility for Health Homes, attribution of beneficiaries to Health Homes, and payments to Health Homes. MCOs will respond to indications (claims-based or non-claims based) that an enrollee has met Health Home population criteria, attribute them to a Health Home provider following a pre-set algorithm, and communicate this to the new beneficiaries (including communicating their ability to opt out or switch providers). The MCOs will receive the claims made by providers for Health Home activities performed for beneficiaries, process these, and pay out corresponding per member per month payments in a timely manner. In addition, the MCOs will use data submitted by providers (claims and non-claims based) to track performance on quality and efficiency metrics. Assessment of these metrics will be used by the MCOs to make quarterly cost and quality performance reports for providers, pay annual outcome-based payments to high performing providers, and will be used by the State in aggregate to support overall program evaluation and monitor progress towards the program goals.

General Assurances

- The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Geographic Limitations

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- Health Homes services will be available statewide
- Health Homes services will be limited to the following geographic areas
- Health Homes services will be provided in a geographic phased-in approach

Health Homes Population and Enrollment Criteria

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Categories of Individuals and Populations Provided Health Homes Services

The state will make Health Homes services available to the following categories of Medicaid participants

Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups

Medically Needy Eligibility Groups

Mandatory Medically Needy

Medically Needy Pregnant Women

Medically Needy Children under Age 18

Optional Medically Needy (select the groups included in the population)

Families and Adults

Medically Needy Children Age 18 through 20

Medically Needy Parents and Other Caretaker Relatives

Aged, Blind and Disabled

Medically Needy Aged, Blind or Disabled

Medically Needy Blind or Disabled Individuals Eligible in 1973

Health Homes Population and Enrollment Criteria

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Population Criteria

The state elects to offer Health Homes services to individuals with:

- Two or more chronic conditions
- One chronic condition and the risk of developing another
- One serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition:

Health Home eligibility is established by meeting at least one of the following three categorical criteria:

Category 1 -- Diagnosis. This criterion is met if a beneficiary has received at any point during the previous 6 months a diagnosis or code for a condition (so for newly diagnosed as well as previously diagnosed conditions) such as:

Schizophrenia;
Bipolar disorder;
Attempted suicide or self-injury;
Homicidal ideation.

Category 2 - Diagnosis and utilization in combination. This criterion is met if a beneficiary experiences (a) one or more behavioral health-related inpatient admission, crisis stabilization unit admission (18 or above), ED admission (18 or below)* or residential treatment facility admission during the previous 3 months; and (b) a diagnosis for a condition such as:

Major depression;
Other depression;
Adjustment reaction;
Anxiety;
PTSD;
Substance use;
Psychosomatic disorders;
Conduct disorder;
Emotional disturbance of childhood and adolescence;
Somatoform disorders;
Personality disorder;
Other mood disorders;
Psychosis;
Abuse and psychological trauma;
Personal history of other mental and behavioral disorders;
Catatonic disorder due to known physiological condition;
Other specified mental disorders due to known physiological condition;
Other specified nonpsychotic mental disorders;
Nonpsychotic mental disorder, unspecified;
Psychological and behavioral factors associated with disorders or diseases classified elsewhere;
Mental disorder, not otherwise specified.

*As Crisis Stabilization Units (CSUs) are limited to individuals aged 18 and above in Tennessee, permitting children to enter through ED utilization with a qualifying diagnosis ensures that beneficiaries of all ages can be included in the program through this Category for continuity of care.

For each of the diagnoses listed above for Category 1 and Category 2, there are specific ICD-9 and ICD-10 codes.

Category 3: Provider documentation of functional need and medical necessity will be determined by the Health Home provider and verified by the MCO to be eligible for enrollment. Functional need is defined as aligning with what the State of Tennessee has set out as the mental health targeted case management medical necessity criteria, effective March 1, 2016 (adults) and April 1, 2016 (children). [Note that the Health Home program will be replacing mental health targeted case management.]

Health Homes Population and Enrollment Criteria

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Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home:

- Opt-In to Health Homes provider
- Referral and assignment to Health Homes provider with opt-out
- Other (describe)

Describe the process used:

Enrollees may contact their MCO directly to see if they are eligible to enroll. In addition, the MCO will run claims analyses monthly to determine if individuals meet the criteria. The MCO will notify eligible individuals and assign them to an MCO-selected provider. The notice will describe Health Home (HH) services and include information describing the opt out process, how to select another HH provider, and give contact information for the HH provider and the MCO.

The assigned provider must have the beneficiary complete a consent form in order to complete enrollment into the program and provide services. All activity payments are only dispersed when the provider completes qualifying HH activities. A provider can be paid a maximum of one HH activity payment per month. Member enrollment in the program has to be documented by the provider, and should indicate that the individual has received information explaining the HH program and has consented to receive services (noting the effective date of enrollment).

MCOs and providers will engage in active outreach to enroll individuals in the program who meet the criteria based on provider referral (provider documentation that the criteria are met) or claims review. MCOs assign eligible beneficiaries to a qualifying HH provider according to the following hierarchical criteria:

- A provider providing the greatest number of outpatient behavioral health treatment services;
- A provider with the most recent mental health targeted case management visit;
- The attributed primary care provider (PCP), if the PCP is a HH provider;
- To an acceptable HH provider (MCOs may make this decision based on previous performance of provider, geography / proximity to the beneficiary, etc.)

If a beneficiary opts out, they will be removed from the panel of their assigned provider and enter inactive status. Provided they continue to meet program eligibility requirements, they will be able to opt back in to the program by notifying their MCO, or presenting for treatment and care coordination at a qualifying provider and completing the consent form again with a new effective date.


As a central component of the program is coordination of Behavioral Health (BH) care, if a beneficiary does not receive any BH related treatment for six months, they will be removed from their assigned HH provider's panel for payment purposes, and become inactive within the program. Without this BH related treatment, the coordination provided may become duplicative of coordination the beneficiary receives through membership in a PCMH program. The beneficiary may begin to receive services again following a qualifying BH treatment. Provider eligibility for activity payment likewise resumes at this occurrence.

If a provider, following multiple contacts and good-faith efforts, is unable to contact a beneficiary assigned to their panel for enrollment, the beneficiary's MCO will be able to reassign them to another provider which may be able to better engage the beneficiary after six months. The MCO will provide the beneficiary and the original HH provider all appropriate notice and information.

Beneficiaries will become ineligible for the program if they lose TennCare eligibility or receive another care coordination service that substantially duplicates those services provided through the HH program. Beneficiaries may become ineligible if their MCO or provider assesses them as no longer benefiting from HH membership, meeting medical necessity criteria, or as making little to no progress in meeting targeted goals for 6 months. This is a

discretionary process and members may remain in the program for more than 6 months without demonstrated progress if the beneficiary, MCO, and provider believe that there are additional steps that can be taken to support the beneficiary. Additionally, an individual may later become eligible again (and re-enroll) if need for the HH services changes.

- The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Homes benefit or to change Health Homes providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individuals of the Health Homes benefit and their rights to choose or change Health Homes providers or to elect not to receive the benefit.

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Health Homes Providers

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Types of Health Homes Providers

Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

Physicians

Describe the Provider Qualifications and Standards

Provider must have at least 250 attributed Health Home beneficiaries. For other requirements to qualify, please see "Other Health Homes Provider Standards" section.

Clinical Practices or Clinical Group Practices

Describe the Provider Qualifications and Standards

Provider must have at least 250 attributed Health Home beneficiaries. For other requirements to qualify, please see "Other Health Homes Provider Standards" section.

Rural Health Clinics

Describe the Provider Qualifications and Standards

Rural health clinics, including those serving fewer than 250 attributed Health Home beneficiaries, may potentially be permitted to be designated as Health Homes in rural areas or counties where there would not otherwise be a Health Home. For other requirements to qualify, please see "Other Health Homes Provider Standards" section.

Community Health Centers

Describe the Provider Qualifications and Standards

Provider must have at least 250 attributed Health Home beneficiaries. For other requirements to qualify, please see "Other Health Homes Provider Standards" section.

Community Mental Health Centers

Describe the Provider Qualifications and Standards

Provider must have at least 250 attributed Health Home beneficiaries. For other requirements to qualify, please see "Other Health Homes Provider Standards" section.

Home Health Agencies

Case Management Agencies

Community/Behavioral Health Agencies

Federally Qualified Health Centers (FQHC)

Describe the Provider Qualifications and Standards

Provider must have at least 250 attributed Health Home beneficiaries. For other requirements to qualify, please see "Other Health Homes Provider Standards" section.

Other (Specify)

Teams of Health Care Professionals

Health Teams

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

The State has elected to designate as its vehicle for delivering Health Home services providers, including CMHCs, FQHCs, and other organizations that have been certified by the State as meeting a set of enumerated qualifications, such as the employment and/or identification of specified care team members, and that are under contract with MCOs to provide Health Home services. MCOs under contract with the State will be responsible for ensuring access to Health Home services through such qualified providers.

Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to 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
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. 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

Description

The State will support providers of Health Homes services concerning the above listed components by:

Providing training support for Health Home staff. This training support will include in-person and technology-enabled coaching; statewide and regional meetings, webinars, and/or teleconferences; as well as the development of Learning Collaboratives across the state that will assist providers to become Health Homes and to participate in quality improvement activities designed to improve outcomes for the beneficiaries.

Delivering quarterly cost and quality performance reports to Health Home providers. These reports will be sent by the MCOs and will show provider performance on a set of metrics developed in consultation with stakeholders, compared to a provider's previous performance as well as performance compared to their peers in Tennessee. The State, and/or a vendor acting on behalf of the State, and the MCOs will work with providers to understand how to interpret their reports and improve their performance.

Launching a web-based Care Coordination Tool that Health Home staff will be trained on and required to use to access their attributed Health Home beneficiary information such as ADT feeds (admission, discharge, transfer notifications), gaps in care alerts, and beneficiary risk scores for purposes of beneficiary outreach.

Supporting the development of health information technology capabilities in Health Home organizations through the development of DIRECT messaging and continuity of care document receipt and transmission capabilities.

Developing a Health Home program provider manual to provide clear guidance to both MCOs and Health Home providers. One component of the manual will be a description of the six Health Home service areas (comprehensive care management, care coordination, health promotion, transitional care, patient and family support, referral to social supports), and the activities required of providers that correspond to them. In addition, the manual will outline minimum requirements for payment, procedures for claims, details on the quality and efficiency measures that providers will be accountable for, ongoing requirements for continued provider eligibility for the program, and monitoring protocols to ensure that required Health Home activities are being performed.

Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

To join and remain part of the model, a Health Home provider must meet State-specific standards, listed below:

- a) Meet the Provider Qualifications and Standards of a Health Home provider as described in this State Plan: maintaining status as a Health Home provider in Year 2 onwards will be subject to ongoing performance and quality review.
- b) Provide the eleven CMS-required Health Home service activities listed earlier in this document.
- c) Make an explicitly stated commitment to collaboration with primary care provider(s) (and demonstrate this by providing subsequent documentation of collaboration agreement with PCP).
- d) Adopt use of the State Care Coordination Tool.
- e) Have a documented plan to progress toward CMS e-prescribing requirements by October 2017 (including exchange of medication history).
- f) Employ the following personnel:
 - One individual, designated as point of contact for the Health Home
 - A lead clinical care coordinator(s) who, as part of a care team, is to coordinate with medical professionals. This role is to be filled by a Registered Nurse, licensed to practice in Tennessee. (Non-lead clinical care coordinators shall have a bachelor's degree, or an RN or LPN, licensed to practice in Tennessee.)
 - Case manager(s), who, as part of a care team, act as the primary point of contact for patient family relationship. All case managers shall have, at a minimum, a bachelor's degree or an RN, licensed to practice in Tennessee.

g) The Health Home shall have the capability to provide community-based mental health services onsite (i.e. on staff or through affiliation), with either:

- A psychiatrist with a license to practice in Tennessee, or
- A primary care physician, licensed to practice in Tennessee, and a psychologist, licensed to practice in Tennessee, or
- A primary care physician, licensed to practice in Tennessee, and a licensed master's level mental health professional whose master's degree is tied to mental health practice (or related subjects). The mental health professional may be: a psychological examiner or senior psychological examiner; licensed master's social worker with 2 years of mental health experience or licensed clinical social worker; marital and family therapist; nurse with a master's degree in nursing who functions as a psychiatric nurse; professional counselor; or if the person is providing service to service recipients who are children, any of the above educational credentials plus mental health experience with children. The appropriate license must be an active Tennessee license.

h) The Health Home shall enable employed and affiliated personnel to engage in continuous learning, including through participation in relevant seminars, webinars, training programs, and Learning Collaborative activities.

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No items available	

Health Homes Service Delivery Systems

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Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- Fee for Service
- PCCM
- Risk Based Managed Care

The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals

- Yes
- No

Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be avoided

- The current capitation rate will be reduced
- The State will impose additional contract requirements on the plans for Health Homes enrollees

Provide a summary of the contract language for the additional requirements

The State's managed care contracts will be amended to reflect the requirements for provision of Health Home services for those adult members with SMI or those child members with SED who meet the population criteria for Health Homes.

Through its contracts, the State will require MCOs to provide Health Home services according to the standards set by the State. These standards include requiring Care Coordinators to involve the member, the member's family or legally appointed representative, PCP, and care coordinators, in Health Home activities and continuing Health Home services until a member no longer qualifies on the basis of medical necessity or refuses treatment.

The Health Home is a team of professionals associated with a mental health clinic or other behavioral health provider who provides whole-person, patient-centered, coordinated care for an assigned panel of members with behavioral health conditions. Members who would benefit from Health Home services will be identified based on diagnosis, health care utilization

patterns, or functional need. They will be identified through a combination of claims analysis and provider referral.

Health Home professionals will use care coordination and patient engagement techniques to help members manage their healthcare across the domains of behavioral and physical health, including:

- Comprehensive care management (e.g., creating care coordination and treatment plans);
- Care coordination (e.g., proactive outreach and follow up with primary care and behavioral health providers);
- Health promotion (e.g., educating the patient and his/her family on independent living skills);
- Transitional care (e.g., participating in the development of discharge plans);
- Patient and family support (e.g., supporting adherence to behavioral and physical health treatment)
- Referral to social supports (e.g., facilitating access to community supports including scheduling and follow through)

Payments for Health Home services are included in the capitation payments paid to the MCOs by the State.

Other

Other Service Delivery System

Health Homes Payment Methodologies

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Payment Methodology

The State's Health Homes payment methodology will contain the following features

- Fee for Service
- PCCM (description included in Service Delivery section)
- Risk Based Managed Care (description included in Service Delivery section)
- Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

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Assurances

- The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.
Describe below how non-duplication of payment will be achieved In order to avoid the duplication of payment for similar services, the State has undertaken to review programs and placement settings which offer their beneficiaries care coordination which substantially resembles the care coordination provided for beneficiaries in the Health Home program. When there is evidence of the potential for significant overlap, a beneficiary in such a program or placement setting who is also eligible for the Health Home program will have their eligibility for the Health Home program suspended for the duration of their tenure in the duplicative program or placement setting.
- The State meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), 1902(a)(30)(A), and 1903 with respect to non-payment for provider-preventable conditions.
- The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.
- The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Health Homes Services

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Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition

1. Create, update, and monitor the progress of a comprehensive person-centered care plan, following an assessment of the patient's behavioral and physical health needs. For beneficiaries that do not have a recent comprehensive care plan on record (within the last 6 months) with the attributed provider, this is the first activity required to be completed within 30 days of patient enrollment. Comprehensive care management can be conducted on or off site. The plan should address the patient's behavioral health treatment needs, and care coordination and social services (including assisting with referrals to address housing needs, financial education and/or planning, education and training on the transportation benefit including bus passes) needs, including protocols for treatment adherence and crisis management, incorporating input from:
 - the patient;
 - the patient's social support;
 - the patient's primary and specialty care providers (within 90 days of enrollment with the Health Home).
2. Track and make Health Home service improvements based on quality outcomes distributed in reports from MCOs and through ongoing assessment. These quality outcomes include member-level healthcare screenings, inpatient readmissions, and chronic illness treatment, which will help drive the services provided to the beneficiary.
3. Identify highest risk patients on a continuous basis, supported by the Care Coordination Tool, and align Health Home provider organization to focus resources and interventions. The Care Coordination Tool will assign individualized risk scores to each beneficiary within the Health Home program. This will allow the Health Home to better develop appropriate care management plans for each beneficiary and to target beneficiaries on their panel with specific care management needs.
4. Meet CMS e-prescribing requirements (from year 2 of the program).

Providers are expected to offer an integrated suite of services, by coordinating all services offered. While this section is organized by six Health Home services, it is anticipated that all services will work in collaboration to meet the needs of the beneficiary and aid in the beneficiary's progress towards recovery.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

1. The Care Coordination Tool's gaps in care function will support care and treatment plan creation in multiple ways including the existence of care and treatment plan gaps in care and the ability to input care / treatment plan goals and elements as gaps in care, which the case manager or care coordinator can close as goals are met.
2. DIRECT messaging could be a secure mechanism for Health Home providers to transmit care and treatment plan documents to and from PCPs.
3. Health Home providers who have EHR capabilities will be able to store key elements of the care / treatment plans in the EHR for easy access.
4. MCO will provide claims-based reporting to Health Home providers on an ongoing basis to help them track and act on clinical quality outcome measures and identify highest risk patients.

Scope of service

The service can be provided by the following provider types

Behavioral Health Professionals or Specialists

Description

Behavioral Health Professionals or Specialists may provide the service.

Nurse Practitioner

Description

Nurse Practitioners may provide the service.

Nurse Care Coordinators

Description

Nurse Care Coordinators may provide the service.

Nurses

Description

Nurses may provide the service.

Medical Specialists

Physicians

Description

Physicians may provide the service.

Physician's Assistants

Pharmacists

Social Workers

Description

Social Workers may provide the service.

- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

Provider Type	Description
Case Managers	Case Managers may provide the service.

Care Coordination

Definition

1. Supports scheduling and reduces barriers to adherence for medical appointments, including in-person accompaniment to some appointments (other services can be provided in-person or remotely).
2. Arrange consultations with PCP to understand significant changes in medical status, and translate into care plan.
3. Proactive outreach with PCP regarding specific gaps in care.
4. Follow up with other behavioral health providers or clinical staff as needed to understand additional behavioral health needs, and translate into care plan.
5. Participate in patient's physical health treatment plan as developed by their primary care provider, as necessary.
6. Facilitate and participate in regular interdisciplinary care team meetings with PCMH / PCP when possible.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

1. DIRECT messaging and continuity of care document capability could allow Health Home providers to easily share and communicate patient information with other providers and support care coordination efforts.
2. The Care Coordination Tool's risk stratification function will allow providers to identify and focus high-intensity resources on the neediest patients.
3. Health Home providers could use patient web portals or secure emails to enable and streamline scheduling and follow-up activities.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

Description

Nurse Practitioners may provide the service.

Description

Nurse Care Coordinators may provide the service.

Description

Nurses may provide the service.

Description

Social Workers may provide the service.

Provider Type	Description
Case Managers	Case Managers may provide the service.

Health Promotion

Definition

Provide educational opportunities through face-to-face individual or group sessions, recordings posted on web sites or through mailings that focus on:

1. Early intervention and risk reduction strategies to avoid complications of disability and chronic illness.
2. Prevention and treatment of substance abuse.
3. Self-care training, including self-examination.
4. Need for clear understanding of how to take medications and the importance of coordinating all medications.
5. Understanding the difference between emergent, urgent, and routine health conditions.
6. The significance of the individual's role in his overall health and welfare, and available resources.
7. For caregivers, the significance of their role in the overall health and welfare of the beneficiary, and available resources.
8. Education of the patient and his/her family on independent living skills with attainable and increasingly aspirational goals. Education can be provided on or off site.
9. Participation in practice transformation training and learning collaboratives at which best practices on a variety of topics, including health promotion, will be disseminated.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

1. The Care Coordination Tool's gaps in care function could allow providers to track the performance of patient and family education activities, ensuring all patients are receiving sufficient support.
2. Providers could attend training remotely via teleconferencing or other technologies to improve skills and knowledge without sacrificing large amounts of time and resources.

Scope of service

The service can be provided by the following provider types

Behavioral Health Professionals or Specialists

Nurse Practitioner

Description

Nurse Practitioners may provide the service.

Nurse Care Coordinators

Description

Nurse Care Coordinators may provide the service.

Nurses

Description

Nurses may provide the service.

Medical Specialists

Physicians

Physician's Assistants

Pharmacists

Social Workers

Description

Social Workers may provide the service.

Doctors of Chiropractic

Licensed Complementary and alternative Medicine Practitioners

Dieticians

Nutritionists

Other (specify)

Provider Type	Description
Case Managers	Case Managers may provide the service.

Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

1. Receive Admission/Discharge/Transfer (ADT) notifications from hospitals for the patient and continue ongoing use of the Care Coordination Tool.
2. Participate in development of discharge plan for each hospitalization, beginning at admission to support patient's transition. This includes emergency rooms, inpatient residential, rehabilitative, and other treatment settings. This service can be provided off site.
3. Develop a systemic protocol to assure timely access to follow-up care post discharge that includes at a minimum all of the following:

Receipt of a summary of care record from the discharging entity;

Medication reconciliation;

Reevaluation of the care plan to include and provide access to needed community support services;

A plan to ensure timely scheduled appointments.

4. Establish relationships with hospitals, residential settings, rehabilitation settings, other treatment settings, and long term services and supports providers to promote a smooth transition if the patient is moving between levels of care and back into the community.
5. Provide additional high touch support in crisis situations when other resources are unavailable, or as an alternative to ED / crisis services.
6. Communicate and provide education to the patient, the patient's social supports and the providers that are located at the setting from which the person is transitioning, and at the setting to which the individual is transitioning.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

1. The Care Coordination Tool will serve as a portal for Health Home providers to receive ADT notifications about their patients, allowing them to participate in discharge planning.
2. DIRECT messaging and continuity of care document capability could allow Health Home providers to easily share and communicate patient information and discharge plans with other providers involved in a beneficiary's care.

Scope of service

The service can be provided by the following provider types

Behavioral Health Professionals or Specialists

Description

Behavioral Health Professionals or Specialists may provide the service.

Nurse Practitioner

Description

Nurse Practitioners may provide the service.

Nurse Care Coordinators

Description

Nurse Care Coordinators may provide the service.

Nurses

Description

Nurses may provide the service.

Medical Specialists

Physicians

Physician's Assistants

Pharmacists

Social Workers

Description

Social Workers may provide the service.

Doctors of Chiropractic

Licensed Complementary and alternative Medicine Practitioners

Dieticians

Nutritionists

Other (specify)

Provider Type	Description
Case Managers	Case Managers may provide the service.

Individual and Family Support (which includes authorized representatives)

Definition

1. Provide high-touch in-person support to ensure treatment and medication adherence (including medication reconciliation, medication management for specialty medications, medication drop-off, help arranging transportation to appointments).
2. Provide caregiver counseling or training to include, skills to provide specific treatment regimens to help the individual improve function, obtain information about the individual's disability or conditions, and navigation of the service system.
3. Identify resources to assist individuals and family support members in acquiring, retaining, and improving self-help, socialization and adaptive skills.
4. Check-ins with patient (on or off site) to support treatment adherence.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

1. The Care Coordination Tool's risk stratification function will allow providers to identify and focus high-intensity resources on the neediest patients.
2. Health Home providers could use patient web portals or secure emails, or smart phone applications to enable and streamline scheduling and follow-up activities.

Scope of service

The service can be provided by the following provider types

Behavioral Health Professionals or Specialists

Nurse Practitioner

Nurse Care Coordinators

Nurses

Medical Specialists

Physicians

Physician's Assistants

Pharmacists

Social Workers

Description

Social Workers may provide the service.

Doctors of Chiropractic

Licensed Complementary and alternative Medicine Practitioners

Dieticians

Nutritionists

Other (specify)

Provider Type	Description
Case Managers	Case Managers may provide the service.

Referral to Community and Social Support Services

Definition

1. Identify and facilitate access to community supports (food, shelter, clothing, employment, legal, entitlements, and all other resources that would reduce barriers to help individuals in achieving their highest level of function and independence), including by providing referrals, scheduling appointments, and following up with the patient, their relevant caregivers, and these community supports. Services can be provided on or off site.
2. Communicate patient needs to community partners.
3. Provide information and assistance in accessing services such as: self-help services, peer support services; and respite services.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

1. The Care Coordination Tool's care plan function could allow providers to track activities related to community supports, ensuring all patients are receiving sufficient support.
2. DIRECT messaging and continuity of care document capability could allow Health Home providers to easily share and communicate patient information with community partners.

Scope of service

The service can be provided by the following provider types

Behavioral Health Professionals or Specialists

Nurse Practitioner

Description

Nurse Practitioners may provide the service.

Nurse Care Coordinators

Description

Nurse Care Coordinators may provide the service.

Nurses

Description

Nurses may provide the service.

Medical Specialists

Physicians

Physician's Assistants

Pharmacists

Social Workers

Description

Social Workers may provide the service.

Doctors of Chiropractic

Licensed Complementary and alternative Medicine Practitioners

Dieticians

Nutritionists

Other (specify)

Provider Type	Description
Case Managers	Case Managers may provide the service.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | TN2016MH00030 | TN-16-004 | Health Link


Package Header

Package ID	TN2016MH00030	SPA ID	TN-16-004
Submission Type	Official	Initial Submission Date	10/12/2016
Approval Date	4/28/2017	Effective Date	1/1/2017
Superseded SPA ID	N/A		

Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

See attached diagrams.

Name	Date Created	
Health Homes Patient Flow Slides	10/10/2016 5:16 PM EDT	

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | TN2016MH0003O | TN-16-004 | Health Link

Package Header

Package ID	TN2016MH0003O	SPA ID	TN-16-004
Submission Type	Official	Initial Submission Date	10/12/2016
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Superseded SPA ID	N/A		

Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates

Medicaid claims information will be used to calculate PMPM total cost of care (TCOC) figures for Health Home target population members belonging to each practice, on an annual basis. Historic Medicaid claims data using a three-year base period will be employed to determine the PMPM TCOC for these individuals in the period before program launch. A growth rate will be trended forward on this baseline figure to permit comparison between projected PMPM costs in the absence of the program, and the actual PMPM costs following program launch. The growth rate will be adjusted to reflect both the medical inflation rate and a minimum savings rate.

The PMPM will include all care (professional, inpatient, outpatient, pharmacy, ancillary), with all costs above \$100,000 per year being truncated. However, certain services will be excluded from the calculation (due to lack of consistent offering), including dental services, transportation services, nursery (including NICU), and other costs as determined by the State (e.g. spend after 90 days in a nursing facility, first month of life, etc.)

For the purposes of calculating TCOC, patients that have been enrolled with a practice(s) for less than 9 months of the performance period are excluded.

Describe how the state will use health information technology in providing Health Homes services and to improve 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)

The State will use health information technology in the following ways to support Health Home services:

- 1) Developing a Care Coordination Tool that Health Homes will be able to use to access patient information such as ADT feeds (admission, discharge, transfer) from hospitals, gaps in care, and patient risk scores for purposes of patient outreach
- 2) Supporting the development of health information technology capabilities in Health Home organizations

MCOs will:

- 1) Monitor Health Home activities through existing billing and claims processes, including administering payment as needed
- 2) Provide claims-based reporting to Health Home providers on an ongoing basis to help them track and act on clinical quality outcome measures
- 3) Generate and maintain up to date Health Home patient registry including all relevant data fields

Health Homes Monitoring, Quality Measurement and Evaluation

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Quality Measurement and Evaluation

- The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state
- The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals
- The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS
- The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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