CMS-10434 OMB 0938-1188

Approval Notice

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

Date: 12/15/2017

Head of Agency: Barbara Sears

Title/Dept : Director

Address 1: 50 West Town Street

Address 2:

City : Columbus

State: OH

Zip: 43215

MACPro Package ID: OH2017MS0003O

SPA ID: OH-17-0042

Subject

Approval Notification

Dear Barbara Sears

This is an informal communication that will be followed with an official communication to the State's Medicaid Director.

The Centers for Medicare and Medicaid Services (CMS) is pleased to inform you that we are recommending approval for your request for

Approval

Reviewable Unit	Effective Date
Health Homes Intro	12/31/2017
Health Homes Population and Enrollment Criteria	12/31/2017
Health Homes Geographic Limitations	12/31/2017
Health Homes Services	12/31/2017
Health Homes Providers	12/31/2017
Health Homes Service Delivery Systems	12/31/2017
Health Homes Payment Methodologies	12/31/2017
Health Homes Monitoring, Quality Measurement and Evaluation	12/31/2017

Increased Geographic Coverage

( ) Yes

(•) No

Increase in Conditions Covered

( ) Yes

(•) No

Ohio is not entitled to an enhanced FMAP percentage for this SPA.

Sincerely,

Ruth Hughes

ARA

Approval Documentation

Name	Date Created	Type
No items available		

Package Information

Package ID OH2017MS0003O
Program Name Health Homes date extension 12-17
SPA ID OH-17-0042
Version Number 2
Submitted By Gregory Niehoff
Package Disposition
Priority Code P3

Submission Type Official
State OH
Region Chicago, IL
Package Status Approved
Submission Date 11/17/2017
Approval Date 12/15/2017 5:37 PM EST

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | OH2017MS0003O | OH-17-0042 | Health Homes date extension 12-17

Not Started | In Progress | Complete

Package Header

Package ID OH2017MS0003O
Submission Type Official
Approval Date 12/15/2017
Superseded SPA ID N/A

SPA ID OH-17-0042
Initial Submission Date 11/17/2017
Effective Date N/A

State Information

State/Territory Name: Ohio
Medicaid Agency Name: Ohio Department of Mediciad

Submission Component

- (•) State Plan Amendment
- (•) Medicaid
- ( ) CHIP

Submission Type

- (•) Official Submission Package
- ( ) Draft Submission Package

Allow this official package to be viewable by other states?

- (•) Yes
- ( ) No

Key Contacts

Name	Title	Phone Number	Email Address
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SPA ID and Effective Date

SPA ID OH-17-0042

Reviewable Unit	Proposed Effective Date

Reviewable Unit	Proposed Effective Date
Health Homes Intro	12/31/2017
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Executive Summary

Summary Description Including Goals and Objectives

This SPA supersedes Ohio SPA TN 17-0021, and simply extends the end date of this program to June 30, 2018.

This State Plan Amendment continues Medicaid health homes for beneficiaries who meet the State's definition of serious and persistent mental illness (SPMI) - which includes adults with serious mental illness (SPMI) and children with serious emotional disturbance (SED) - in the following Ohio counties: Butler County, Adams County, Scioto County, Lawrence County, and Lucas County. Health home services included in this SPA were originally implemented with SPA TN 12-0013 and included the aforementioned counties. There are currently six approved Health Homes operating in these counties.

Ohio's Community Behavioral Health Centers (CBHCs) are eligible to apply to become Medicaid health homes for Medicaid beneficiaries with SPMI/SED. The goals of Ohio's CBHC health homes for Medicaid beneficiaries with SPMI are as follows: improve the integration of physical and behavioral health care; lower the rates of hospital emergency department (ED) use; reduce hospital admissions and readmissions; reduce healthcare costs; decrease reliance on long-term care facilities; improve the experience of care, quality of life and consumer satisfaction; and improve health outcomes. Moreover, the State expects to achieve better care coordination and management of health conditions as well as increase the use of preventive and wellness management services.

Dependency Description

Description of any dependencies between this submission package and any other submission package undergoing review

N/A

Disaster-Related Submission

This submission is related to a disaster

- ( ) Yes
- (•) No

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2018	$12726000
Second	2019	$0

Federal Statute / Regulation Citation

Section 1945 of the Social Security Act, Section 2703 of the Affordable Care Act

Governor's Office Review

- ( ) No comment
- ( ) Comments received
- ( ) No response within 45 days
- (•) Other

Describe The State Medicaid Director is the Governor's designee.

Authorized Submitter

The following information will be provided by the system once the package is submitted to CMS.

Name of Authorized Submitter Gregory Niehoff

Phone number 6147523588

Email address gregory.niehoff@medicaid.ohio.gov

Authorized Submitter's Signature Gregory Niehoff

☑ I hereby certify that I am authorized to submit this package on behalf of the Medicaid Agency.

Submission - Public Comment

MEDICAID | Medicaid State Plan | Health Homes | OH2017MS0003O | OH-17-0042 | Health Homes date extension 12-17

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Package Header

Package ID OH2017MS0003O

SPA ID OH-17-0042

Submission Type Official

Initial Submission Date 11/17/2017

Approval Date 12/15/2017

Effective Date N/A

Superseded SPA ID N/A

Name of Health Homes Program

Health Homes date extension 12-17

Indicate whether public comment was solicited with respect to this submission.

○ Public notice was not federally required and comment was not solicited

◉ Public notice was not federally required, but comment was solicited

○ Public notice was federally required and comment was solicited

Indicate how public comment was solicited:

☐ Newspaper Announcement

☐ Publication in state's administrative record, in accordance with the administrative procedures requirements

☐ Email to Electronic Mailing List or Similar Mechanism

☐ Website Notice

☐ Public Hearing or Meeting

☑ Other method

Name of method:	Date:	Description:
Continued dialogue with stakeholders	9/28/2017	ODM has continued to engage extensively with stakeholders throughout the development of the State's behavioral health redesign. This extension of the Health Homes end date from 12/31/17 to 6/30/18 is proposed as part of the larger redesign project, and stakeholders were involved in the decision and approved it.

Upload copies of public notices and other documents used

Name	Date Created	Type
email re dialogue w stakeholders re HH extension	10/27/2017 1:13 PM EDT	PDF

Upload with this application a written summary of public comments received (optional)

Name	Date Created	Type

Name	Date Created	Type
No items available		

Indicate the key issues raised during the public comment period (optional)

- [ ] Access
- [ ] Quality
- [ ] Cost
- [ ] Payment methodology
- [ ] Eligibility
- [ ] Benefits
- [ ] Service delivery
- [ ] Other issue

Submission - Tribal Input

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Name of Health Homes Program

Health Homes date extension 12-17

One or more Indian health programs or Urban Indian Organizations furnish health care services in this state

- ( ) Yes
- (•) No

Submission - Other Comment

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SAMHSA Consultation

Name of Health Homes Program

Health Homes date extension 12-17

- [x] The State provides **assurance** that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Date of consultation
12/1/2011

Health Homes Intro

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System-Derived

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 Homes date extension 12-17

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

This SPA supersedes Ohio SPA TN 17-0021, and simply extends the end date of this program to June 30, 2018.

This State Plan Amendment continues Medicaid health homes for beneficiaries who meet the State's definition of serious and persistent mental illness (SPMI) - which includes adults with serious mental illness (SPMI) and children with serious emotional disturbance (SED) - in the following Ohio counties: Butler County, Adams County, Scioto County, Lawrence County, and Lucas County. Health home services included in this SPA were originally implemented with SPA TN 12-0013 and included the aforementioned counties. There are currently six approved Health Homes operating in these counties.

Ohio's Community Behavioral Health Centers (CBHCs) are eligible to apply to become Medicaid health homes for Medicaid beneficiaries with SPMI/SED. The goals of Ohio's CBHC health homes for Medicaid beneficiaries with SPMI are as follows: improve the integration of physical and behavioral health care; lower the rates of hospital emergency department (ED) use; reduce hospital admissions and readmissions; reduce healthcare costs; decrease reliance on long-term care facilities; improve the experience of care, quality of life and consumer satisfaction; and improve health outcomes. Moreover, the State expects to achieve better care coordination and management of health conditions as well as increase the use of preventive and wellness management services.

General Assurances

- [x] The state provides **assurance** that eligible individuals will be given a free choice of Health Homes providers.
- [x] The states provides **assurance** that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- [x] 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.
- [x] 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.
- [x] 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.
- [x] 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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System-Derived

- ( ) Health Homes services will be available statewide
- (•) Health Homes services will be limited to the following geographic areas

Specify the geographic limitations of the program

- (•) By county

Health Homes services will be provided in a geographic phased-in approach

By region

By city/municipality

Other geographic area

Specify which counties:

1. Adams
2. Butler
3. Lawrence
4. Lucas
5. Scioto

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

- [x] Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- [ ] Medically Needy Eligibility Groups

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
- [x] One serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition

The State targets Health Homes services to individuals with:
- One or more serious and persistent mental health conditions
- The poorest health outcomes resulting from their co-morbidity and complex health conditions

Specify the criteria for a serious and persistent mental health condition: Health home services for individuals with a serious and persistent mental health condition will be targeted to those with a demonstrated need for health home services based on the combination of a history of uncoordinated care (as evidenced by high inpatient hospitalization use or high emergency department use or high community psychiatric supportive treatment use) and serious mental illness (as evidenced by a serious mental health diagnosis or high mental health service utilization or high mental health pharmacy use).

To accomplish this, Ohio has used Medicaid claims data (including a review of diagnosis codes, pharmaceutical use, inpatient hospital admissions, and Emergency room utilization) to select the eligible pool of health home enrollees. The precise selection criteria has been reviewed and revised multiple times through discussions with Ohio MHAS and their stakeholders and approved by Medical directors of Ohio Medicaid and Ohio MHAS. Ohio will allow other consumers who lack sufficient Medicaid claims history to be enrolled if the health homes determine that they meet similar medical need and clinical diagnostic criteria. Ohio will retrospectively review these enrollments to confirm the medical need for health home services.

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

Describe the process used

Ohio will employ a two-prong approach to enroll eligible Medicaid beneficiaries with SPMI to health homes based upon consumer choice.

Referral and assignment to Health Homes provider with opt-out

Other (describe)

1. Eligible Medicaid beneficiaries will be identified using the claims data research described above. Health homes will be provided with the list of eligible health home enrollees and will perform outreach to them to orient them to the benefit of enrolling into a health home. This will include both individuals with and without a service history with that community behavioral health center. The beneficiary will be afforded the choice to enroll, and, if so, the health home they choose will document and retain the beneficiary's informed consent. Additionally, should beneficiaries desire to receive health home services from another health home provider they will be able to do so. Eligible Medicaid beneficiaries with SPMI who are currently being served at a CBHC that is not a health home will have the option of receiving health home services at one of the CBHC health home sites in their targeted geographical region.

2. Those beneficiaries who lack sufficient Medicaid claims history or who present in the hospital ED, or who are admitted as an inpatient and appear to meet the criteria for health home services may be referred to a health home provider in their geographic area. Similarly, referrals to health homes may come from specialty providers, primary care providers, managed care plans or other sources in the community. For these new referrals, eligibility for health home services will be determined at the CBHC health home using the state-defined criteria. Ohio Medicaid will perform look behind audits of these enrollees to assure that they do meet the state defined criteria. Outreach and community partnerships are supported by CBHC health homes who are required to notify other treatment providers about health home services and encourage their participation in care coordination efforts. Beneficiaries must consent to enrollment and health homes will document their informed consent and keep it on file. Health homes must also comply with timely disenrollment should a beneficiary request such.

Health Homes Providers

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System-Derived

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

Clinical Practices or Clinical Group Practices

Rural Health Clinics

Community Health Centers

Community Mental Health Centers

Describe the Provider Qualifications and Standards

Community behavioral health centers (CBHCs) will serve as designated providers for individuals with SPMI and deliver services through a multi-disciplinary team of health care professionals, including at least one nurse care manager on staff at each health home. CBHC will be required to meet state-defined qualifying core elements that assure coordination of comprehensive medical, behavioral, long-term care and social services that are timely, quality driven and integrated. CBHC health homes will be required to demonstrate the integration of behavioral health and primary care services by providing health care services rendered by primary care clinicians who are embedded or co-located with the community behavioral health provider. Integration of behavioral and primary health care must be in place for a period of at least six months prior to the CBHC enrolling as an SPMI Health Home. A health home must provide a minimum level of medical screening

and treatment services consistent with current professional standards of care. CBHC health homes will be required to establish written agreements with primary care practices that support bi-directional, integrated care. Additionally, CBHC health homes are required to establish partnerships and coordinate with other health care resources to address identified client needs, which include, but are not limited to: hospitals, medical service providers, specialists (including OB/GYNs and substance abuse treatment specialists), long-term care service and support providers, managed care plans and other providers as appropriate to meet beneficiaries' needs.

- [ ] Home Health Agencies
- [ ] Case Management Agencies
- [ ] Community/Behavioral Health Agencies
- [ ] Federally Qualified Health Centers (FQHC)
- [ ] Other (Specify)

- [ ] Teams of Health Care Professionals
- [ ] Health Teams

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

Each CBHC health home must have established a health home team led by a dedicated Care Manager who will provide health home services, and coordinate and facilitate beneficiaries' access to services in accordance with a single, integrated care plan. The CBHC must also identify other health care team members necessary to comprehensively and holistically meet the beneficiaries' needs, including the previously mentioned requirement to employ at least one nurse care manager. While the composition of the team of health care professionals is flexible and is expected to change as the needs of the health home beneficiary change over time, the health home team provides consistency and continuity of care for the beneficiary. Medical leadership is essential to systematically implement standards of quality care. Clinical personnel with experience in Patient Centered Medical Home transformation shall espouse the expertise of change improvement science (e.g., IHI's Breakthrough Series Model) to drive enhanced system performance leading to improved clinical outcomes. To that end, both the Embedded Primary Care Clinician and the staff RN are integral to the success and demonstration of integrated care in CBHC health homes. The Embedded Primary Care Clinician assesses, monitors and consults on the routine, preventive, acute and chronic physical health care needs of clients.. Requiring each health home to have at least one nurse care manager on staff assures that there is a medical professional to provide consultation on the overall care management and care coordination of the health home service, including overall management and coordination of the consumer's integrated care plan, comprehensive assessment, and case review. This requirement also assures continuity of care between the health home and ancillary physical health, behavioral health and social services providers.

Core CBHC health home team members and roles: Health Home Team Leader: Provides administrative and clinical leadership and oversight to the health home team and monitors provision of health home services. A key function of the Team Leader role is to champion for health home services and motivate and educate other staff members. The Health Home Team Leader must possess a strong health management background and an understanding of practice management, data management, and managed care. The Health Home Team Leader must also have training and experience in quality improvement. The Health Home Team Leader will monitor and facilitate clinical processes and components of Health Homes, which include but are not limited to: consumer identification and engagement; completion of comprehensive health and risk assessments; development of care plans; scheduling and facilitation of treatment team meetings; provision of health home services; monitoring consumer status and response to health coordination and prevention activities; and development, tracking and dissemination of outcomes. The additional clinical and administrative duties will include hiring and training of staff, providing feedback regarding staff performance, conducting performance evaluations, providing direction to staff regarding individual cases, and monitoring overall team performance and plan for improvement.

Embedded Primary Care Clinician: Participates in the provision of health home services including identification of consumers, assessment of service needs, care plan development, development of treatment guidelines, and monitoring of health status and service use. The Embedded Primary Care Clinician will provide education and consultation to the health home team and other team members regarding best practices and treatment guidelines in screening and management of physical health conditions as well as engage with, and act as liaison between, the treating primary care provider and the team. The Embedded Primary Care Clinician will also meet with Care Managers individually to review challenging and complex cases as needed. The Embedded Primary Care Clinician role may be filled by any of the following professionals: primary care physicians, internists, family practice physicians, pediatricians, gynecologists, obstetricians, Certified Nurse Practitioners with a primary care scope of practice, Clinical Nurse Specialists with a primary care scope of practice, and Physician Assistants. It is strongly preferred that the Embedded Primary Care Clinician also functions as the treating primary care clinician whenever possible and may hold dual roles on the health home team.

Care Manager: Is accountable for overall care management and care coordination and able to both provide and coordinate all health home services. A single care management record will be agreed to and shared by all team professionals and patient case reviews will be conducted on a regular basis. The Care Manager will be responsible for overall management and coordination of the beneficiary's care plan which will include both medical/behavioral health (including substance abuse), long-term care, and social service needs and goals. Care Managers can utilize Qualified Health Home Specialists in the provision of some components of health home services. Care Managers must have the necessary credentials and skills to be able to conduct comprehensive assessments and treatment planning. Care Managers will have formal training as well as practical experience in behavioral health and possess core and specialty competencies and skills in working with the SPMI population. Care Managers will also need to demonstrate either formal training or a strong knowledge base in chronic physical health issues and physical health needs of the SPMI population and must be able to function as a member of an inter-disciplinary team. Finally, Care Managers must be knowledgeable and experienced in community resources and social support services for the SPMI population.

Qualified Health Home Specialist: Assists and supports Care Managers with care coordination, referral/linkage, follow-up, family/consumer support and health promotion services and may include Peer Support Specialists as well as other health professionals or credentialed personnel with commensurate experience.

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 supported providers of Health Homes services in addressing the above components through a technical assistance contract which has subsequently ended. The State continues to provide technical assistance on an as-needed basis.

Other Health Homes Provider Standards

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

A community behavioral health center (CBHC) must meet state defined core requirements in order to qualify as a provider of health home services for individuals with serious and persistent mental illness (SPMI). CBHCs will be the only provider type recognized by the State as eligible to provide Health Home services for persons with SPMI. The State will contract with the approved CBHC Health Home for the provision of, and payment for, Health Home services. Unless otherwise indicated, CBHCs must meet the following minimum requirements prior to providing health home services:

Be certified by the Ohio Department of Mental Health and Addiction Services as eligible to provide the following covered community mental health services: pharmacological management, mental health assessment, behavioral health counseling and therapy, and community psychiatric support treatment.

Provide all of the following health home services as necessary and appropriate for beneficiaries: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family supports, referral to community and social support services, and the use of health information technology to support the delivery of health home services.

A health home provider shall demonstrate integration of physical and behavioral health care for a minimum of six months prior to the date of application by:
1. Having an ownership or membership interest in a primary care organization where primary care services are fully integrated and embedded; or
2. Entering into a written integrated care agreement which is a contract, memorandum of understanding, or other written agreement with a primary care provider for co-located bi-directional coordinated care at each health home site. For the purposes of this rule, when the health home service is co-located in a primary care setting, it is subject to the provisions of this rule and the primary care setting must be identified and reported to the department. The department reserves the right to visit primary care settings where the health home service is co-located.
a. Provide preventive and chronic primary care services, ensuring that specific medical screening and treatment services consistent with medical standards of care are provided to health home enrollees on-site;
b. Participate in care coordination and care management activities (e.g. integrated care plan development, contributing to the assessment, participating in health home team meetings, etc.) with the health home provider; and
c. Contribute to a shared medical record and/or an integrated care plan maintained by the health home provider

A health home provider shall demonstrate integration of physical and behavioral health care by achieving one of the following:
1. Successful implementation of accrediting body integrated physical health/primary care standards during the next accreditation survey process following Ohio department of mental health and addiction services certification as a health home provider in which the provider is eligible in accordance with its accrediting body policies and procedures to undergo a review of its integrated physical health/primary care services:
a. Integrated behavioral health/primary care or health home core program accreditation by the commission on accreditation of rehabilitative facilities; or
b. Primary physical health care standards by the joint commission behavioral health care accreditation program, or primary care medical home or behavioral health home certification by the joint commission; or
c. Integrated behavioral health and primary care supplement standards by the council on accreditation; or
d. Equivalent accreditation or certification approved by the Ohio department of mental health and addiction services; or
2. Within eighteen months:
a. Level one patient-centered medical home recognition by the national committee for quality **assurance**; or
b. Patient-centered specialty practice recognition by the national committee for quality **assurance**; or
c. Equivalent recognition approved by the Ohio department of mental health and addiction services.

A health home provider shall also ensure that specific medical screening and treatment services, consistent with current professional standards of care, are provided to the Health Home consumer by directly providing the service on-site or assuring the service is provided through a written agreement with a primary care provider.

A health home provider shall also identify a single point of contact for each MCP who shall work with the MCP on activities such as the following: informing the MCP of CBHC Health Home Care Management Team meetings, collaborating on the development of the assessment and care plans, facilitating data exchange with the MCP.

If a health home provider does not have an ownership or membership interest in a primary care organization where primary care services are fully integrated and embedded, the health home provider shall enter into a written integrated care agreement with a primary care provider for co-located, bi-directional coordinated care at each health home site.

Each health home provider shall establish effective partnerships and referral/coordination processes with specialty providers, inpatient facilities, and managed care plans that support the delivery of health home services.
1. The CBHC must establish a partnership and a referral/coordination process with specialty providers and inpatient facilities. At a minimum, the referral/coordination process must address the roles of the CBHC and the partnering provider in coordinating and managing care for the consumer, including any necessary follow up with the consumer. The process shall include how and what type(s) of information will be exchanged in a HIPAA compliant manner between the CBHC and the partnering specialty provider or inpatient facility.

2. The CBHC must establish partnerships with managed care plans in the service area and develop written policies and procedures that include the following:
a. Delineating roles and responsibilities between the Health Home and the Managed Care Plan in order to avoid duplication or gaps in the delivery of health home services and to assure that the needs of the individuals are being met;
b. Notifying the MCP of referrals received by the CBHC for the MCP's members, and of any MCP member who is currently receiving health home services. The CBHC Health Home will collaboratively develop a transition plan with the MCP for any plan member that will receive health home services in order to prevent unnecessary duplication of, and avoid gaps in services.
c. Forming a Care Management team that includes the CBHC Health Home core team, the health home enrollee, the enrollee's family/supports, the enrollee's primary care provider, and other providers, as appropriate, and the enrollee's managed care plan in order to effectively manage the enrollee's needs.
d. Working collaboratively with the MCP to ensure all of the member's needs identified in the CBHC health home care plan are met. Ensure that the care plan is accessible to the MCP and providers involved in managing the enrollee's health care.
e. Requesting care coordination supports from the MCP, if needed.
f. Collaborating with the MCP's designated single point of contact on such activities as the following: exchanging information about the plan's member, soliciting input to the development of the care plan, participating in Health Home team meetings, and assuring access to services that are outside the scope of the CBHC.
g. Ensuring that if the CBHC has direct ownership of a primary care provider/practice that it seeks a contract with the MCPs in the service area for the provision of primary care services. If the CBHC has a co-located relationship with a primary care provider for the provision of primary care services, the CBHC shall encourage the provider to seek a contract with the MCPs in the service area.
h. Ensuring that the CBHC's collaborative care agreements are primarily with primary care providers who are contracted with the MCPs in the service area. Ensure that any established partnerships and referral/coordination processes with specialists and inpatient facilities, if applicable, also include those contracted with the MCPs in the service area. The CBHC shall work with the MCP to understand how credentialing may impact partnering providers who do not have current contracts with the MCPs in the service area. The CBHC shall also:
i) Provide a list of primary care providers and specialists/inpatient facilities to the MCP, for which the CBHC has integrated care agreements and referral/coordination processes, respectively. The CBHC shall refer to the plan's panel of providers when assisting the enrollee in obtaining necessary health care.
ii) Collaborate with the MCP to ensure that the enrollee's selected/assigned PCP has a current, collaborative care agreement with the CBHC. If the enrollee requests a change to the selected PCP, the CBHC shall inform the MCP so that the plan's existing process to change the PCP is promptly initiated.
i. Providing timely notification of all inpatient facility discharges and residential setting transitions to the managed care plan in order to ensure adequate and timely provision of follow up care. The CBHC Health Home will ensure that a discharge/transition plan is in place prior to the enrollee's discharge or transition. The CBHC will work with the MCP to ensure that post discharge services are prior authorized, if appropriate, and provided by the plan's contracted providers. The CBHC must ensure that the discharge/transition plan is integrated into the plan of care and communicated to the Care Management Team.

j. Having the capacity to send electronic data to MCPs and to produce ad hoc reports to more effectively coordinate care.

A health home provider must support the delivery of person-centered care by providing:

1. Expanded, timely access to services provided by the health home provider;

2. Orientation of the patient to health home services;
The CBHC must provide the patient, family and caregivers with verbal information and/or written materials in a manner that is appropriate for the patient's needs and includes the following: an overview of health home services and how the consumer will benefit from the services; the ability to decline the services or terminate participation in the program; and how the patient, family and caregivers may participate in the delivery of health home services.

3. Services that are delivered to the patient/family in a culturally and linguistically appropriate manner;
The CBHC must assess the racial and ethnic diversity of the population served and ensure that patients receive care in a way that is compatible with their cultural needs. The CBHC must record all special communication needs of the consumer in the care plan and the provision or related services offered to the consumer (e.g., identification of a hearing impairment and provision of sign language services). The CBHC must attempt to recruit and retain staff who are representative of the demographic(s) of the population served.

4. A multi-disciplinary team based approach for the delivery of Health Home services through the ongoing use of an established team of members defined by the state;

5. A single, integrated, person-centered care plan that coordinates all of the clinical and non-clinical needs;
The single integrated care plan must identify the consumer's needs (as identified in the comprehensive assessment), goals, interventions, and expected outcomes. The CBHC must provide an opportunity for the patient, family members, caregivers, and providers to offer input to the care plan. The care plan must be reviewed no less frequently than once a quarter and updated as appropriate.

6. The ability to track tests and referrals for health care services, and coordinate follow up care as needed;
The CBHC must track lab and imaging tests until results are available. For any abnormal results that are identified, the CBHC must coordinate the notification to the patient and any necessary follow up with the prescribing provider. The CBHC must also track all referrals for health care services, including referrals to specialists or community agencies. The CBHC must validate that the service was received and perform any necessary follow up.

7. Point of care reminders for patients about services needed for preventive care and/or management of chronic conditions using patient information and clinical data. The CBHC must incorporate the use of evidence based clinical guidelines and data of its population into patient care processes that proactively identifies and engages patients who are lacking critical services for conditions that are relevant to the population.

Health home providers must have the capacity to receive electronic data from a variety of sources to facilitate care management, care coordination, and comprehensive transitional care. At a minimum, this may include clinical patient summaries, medication profiles, and real-time notifications of a patient's admission to, or discharge from, an emergency department or inpatient facility.

A health Home provider must maintain a comprehensive and continuous quality improvement program capable of collecting and reporting data on utilization and health outcomes, and the ability to report to the State or its designee.

Each health home provider must participate in the Medicaid Health Homes Learning Community.

A health home provider must serve as a current eligible provider in the Ohio Medicaid Program.

Each health home provider must have the capacity to serve Medicaid individuals who are eligible to receive health home services in the designated service area.

Each CBHC health home will determine, assemble and maintain appropriate Health Home Team FTEs that are necessary to provide health home services and achieve the necessary health home outcomes.

CBHC health home team members must consist of:
Health Home Team Leader:

Minimum qualifications:
1. Licensed independent social worker, professional clinical counselor, independent marriage and family therapist, registered nurse with a master of science in nursing, certified nurse practitioner, clinical nurse specialist, psychologist or physician.
2. Supervisory, clinical and administrative leadership experience.
3. Health management experience, and competence in practice management, data management, managed care and quality improvement.
Responsibilities:
1. Provide administrative and clinical leadership and oversight to the health home team, and monitor provision of health home service.
2. Monitor and facilitate consumer identification and engagement, completion of comprehensive health and risk assessments, development of integrated care plans, scheduling and facilitation of treatment team meetings, provision of health home service, consumer status and response to health coordination and prevention activities, and development, tracking and dissemination of outcomes.

Embedded Primary Care Clinician:
Qualifications:
Primary care physician, internist, family practice physician, pediatrician, gynecologist, obstetrician, certified nurse practitioner with primary care scope of practice, clinical nurse specialist with primary care scope of practice, or physician assistant.
Responsibilities:
1. Provide health home service including identification of consumers, assessment of service needs, development of integrated care plan and treatment guidelines, and monitor health status and service use.
2. Provide education and consultation to the health home team and other team members regarding best practices and treatment guidelines in screening and management of physical health conditions as well as engage with, and act as a liaison between, the treating primary care provider and the team.
3. Meet individually as needed with care managers to review challenging and complex cases.
4. It is preferred, but not required, that the embedded primary care clinician also functions as the treating primary care clinician and thus may hold dual roles on the health home team.

Care Manager:
Minimum qualifications:
1. Licensed social worker, independent social worker, professional counselor, professional clinical counselor, marriage and family therapist, independent marriage and family therapist, registered nurse, certified nurse practitioner, clinical nurse specialist, psychologist or physician.
2. Possess core and specialty competencies and skills in working with persons with SPMI, including assessment and treatment planning.
3. Demonstrate either formal training or a strong knowledge base in chronic physical health issues and physical health needs of persons with SPMI and be able to function as a member of an inter-disciplinary team.
4. Knowledge of community resources and social support services for persons with SPMI.
Responsibilities:
1. Accountable for overall care management and care coordination, and both provide and coordinate all of the health home service.
2. Responsible for overall management and coordination of the consumer's integrated care plan, including physical health, behavioral health, and social service needs and goals.
3. Conduct comprehensive assessments and develop

Qualified Health Home Specialist:
Minimum qualifications:
Pharmacist, licensed practical nurse; qualified mental health specialist with a four-year degree, two-year associate degree or commensurate experience; wellness coach; peer support specialist; certified tobacco treatment specialist, health educator or other qualified individual (e.g., community health worker with associate degree).
Responsibilities:
Assist with care coordination, referral/linkage, follow-up and consumer, family, guardian and/or significant others support and health promotion services.

The CBHC will be required to maintain documentation in the care plan in order to demonstrate that Health Home services are being delivered in accordance with program rules and requirements. The CBHC must be compliant with the provider standards in order to maintain a designation as a Health Home provider.

Name	Date Created	Type
No items available		

Health Homes Service Delivery Systems

MEDICAID | Medicaid State Plan | Health Homes | OH2017MS0003O | OH-17-0042 | Health Homes date extension 12-17

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

- [x] 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

Ohio will employ both the Ohio Medicaid fee-for-service delivery system, and risk based managed care under the Ohio Medicaid Managed Care delivery system.

The contract between the State and the Medicaid MCPs will require that each MCP performs the following activities to support the CBHC Health Home:
1. Establishes a partnership with the CBHC Health Home and develops written policies and procedures in order to avoid gaps or duplication in the delivery of health home services.

2. Develops a transition plan timely and in collaboration with the CBHC Health Home for each plan member that will receive Health Home services. The transition plan should confirm the start date for Health Home services and identify the member's primary care provider, the data/information that will be transferred to the CBHC Health Home, and the single point of contact designated for the CBHC Health Home.

3. Performs ongoing identification of the plan's members who have a diagnosis of SPMI and could benefit from receiving Health Home services. The MCP will contact these eligible members, educate the members about the benefits of receiving Health Home services, assist them in selecting a Health Home, and facilitate the referral to the selected Health Home.

4. Transmission of information and reports (e.g., clinical patient summaries, approved prior authorizations, IP/ED notifications) to the health home in order to assist with the delivery of health home services;

5. Establishes and maintains a mechanism to track the plan's members who are receiving Health Home services.
6. Integrates all information/data transmitted by the CBHC Health Home or the State related to a member's receipt of Health Home services into the MCP's systems, such as member services, utilization management, etc.

Remaining narrative is provided in separate attachment via e-mail.

☐ Other

☐ Other Service Delivery System

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | OH2017MS0003O | OH-17-0042 | Health Homes date extension 12-17

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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)
- [x] Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

- [x] Tiered Rates based on
  - [ ] Severity of each individual's chronic conditions
  - [ ] Capabilities of the team of health care professionals, designated provider, or health team
  - [x] Other

Describe below

Cost-based rates are dependent upon whether the recipient is a child or an adult.

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

n/a

Provide a comprehensive description of the policies the state will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

A. Effective for dates of service from July 1, 2014 through June 30, 2018, health home services are reimbursed using a monthly case rate based on cost information provided in accordance with guidance in 2 CFR 200 or the Medicare Provider Reimbursement Manual, Part 1, as applicable to the health home depending on its organizational type. The only allowable costs that can be reported are the costs related to the provision of services to Medicaid Health Home enrollees for the Health Home submitting cost information.

Providers must submit claims in order to receive case rates for health homes services. A claim can be submitted if any of the health home service components are rendered during the billing month to an enrolled individual as long as the services performed are directly linked to the goals and actions documented in the single person-centered integrated care plan for each health home enrollee. Only one claim per individual will be reimbursed per calendar month.

The health home must provide the following information for the purposes of determining the monthly case rate:

1. Medicaid Health Home Enrollee Caseload is based on the estimated population to be served by the health home.

2. Medicaid Dedicated Health Home Staffing Costs. For each required team member dedicated to Medicaid health home enrollees, the following staffing information must be provided for the home team member role (health home team leader, embedded primary care clinician, care manager, and qualified health home specialist):

a. Professional credentials. Credentials are determined by the health home

and must align with staff roles and requirements as described in Attachment 3.1-A.

b. Staffing ratios. Staffing ratios are established by the State for the health home to meet the need of the population being served.

c. Number of full-time equivalent employees (FTEs). The number of FTEs is equal to the projected monthly caseload divided by the staffing ratio for each team member role.

d. Annual salary. The annual salary includes both direct and indirect service costs for Medicaid Health Homes enrollees services associated with each team member role, including time allocated to activities such as the provision of clinical supervision, documentation, oversight, and quality assurance when a team member has a primary or significant responsibility for such activities.
e. Annual staffing costs. The annual staffing cost for each team member role is equal to the annual salary multiplied by the number of FTEs.

3. Indirect Costs Related to the Provision of Health Home Services of Medicaid Enrollees.

a. The only indirect costs that can be reported are those related to the provision of Health Homes services for Medicaid enrollees.

b. Indirect costs must be identified, allocated, and reported using the uniform cost reporting principles in accordance with 2 CFR 200 or the Medicare Provider Reimbursement Manual Part 1, as applicable to the health home depending on its organizational type.

c. For purposes of rate setting, indirect costs must be reported on an estimated annual basis.

B. Calculation of the monthly case rate. The monthly case rate is equal to the following:
1. The Medicaid Dedicated Health Home Staffing Costs for each team member role added to the Indirect Costs Related to the Provision of Health Home Services of Medicaid Enrollees equals the Medicaid Health Homes enrollee total annual cost. The PMPM Medicaid Health Homes enrollee cost is calculated as follows:
a. Divide the Medicaid Health Homes enrollee total annual cost by the caseload; then
b. Divide the result of the calculation in paragraph (B)(1)(a) of this rule by twelve.
c. The resulting calculated monthly case rate is reduced by ten percent. This monthly case rate is effective until June 30, 2018.

C. The provider's cost will be reviewed annually to determine whether it is necessary to rebase the case rate, based on the information from the provider's actual costs for the prior year.

D. Providers will be required to report all budgeted and actual costs associated with health home services on the uniform cost report.

E. Health home service payments are not subject to cost reconciliation.

F. Health home service payments will not result in any duplication of payment or services between Medicaid programs, services, or benefits (i.e. managed care, other delivery systems including waivers, any future health homes, and other state plan services).

The monthly case rates are published on the Department's Community Mental Health Agency fee schedule. Rates and fees can be found by accessing the agency's website at http://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates/SchedulesandRates.aspx

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 Health home service payments will not result in any duplication of payment or services between Medicaid programs, services, or benefits (i.e. managed care, other delivery systems including waivers, any future health homes, and other state plan services).

☑ 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

Comprehensive care management begins with identification of individuals potentially eligible to receive health home services. ODM will identify individuals who, based on claims review, appear to meet the eligibility criteria described in detail above. Health homes may review this list of eligible individuals and outreach to them for health home enrollment. Health homes may also pursue enrollment of other individuals who are not included on the state defined list of eligibles if they determine that they also meet the state defined criteria. Health home eligible individuals may be identified through referral or an administrative data review and connected to a CBHC health home to begin the comprehensive care management process. The next step is for the CBHC to engage the eligible individual and his/her family. The health home must document the consumer's informed consent specific to enrollment in the health home service prior to enrollment; informed consent shall include:
1. A description of the health home service, benefits and drawbacks of enrollment in the health home service, including the relationship between the health home service and other services, particularly other care coordination services (e.g. CPST, MCP care management, AoD case management),
2. The consumer's ability to opt out of enrollment in the health home service;
3. Orient consumers by discussing the benefits of active participation;
4. Within 30 days of enrollment in the health home service, conduct a comprehensive assessment of the individual's physical health, behavioral health (i.e., mental health disorders, substance abuse disorders, and developmental disabilities), long-term care (e.g. assistance with activities of daily living, functional status, self-care capability), and social service needs (e.g. financial assistance, housing, family or support system dynamics), incorporating relevant information from screening tools, medical records, the consumer and his/her family, guardian and/or significant others, other providers, health home team members, and other sources as applicable; develop a team of health care professionals to deliver health home service based on the consumer's needs; establish and negotiate roles and responsibilities, including the accountable point of contact;
5. Within 60 days of enrollment in the health home service, develop a single, person-centered, integrated care plan that addresses and coordinates all of a consumer's clinical and non-clinical needs, and includes prioritized goals and actions with anticipated time frames for completion and reflects the individual's preferences; implement and monitor the integrated care plan to determine adherence to treatment and medication regiment; identify, and to the extent possible, remove barriers to care, or any clinical and non-clinical issues that may impact the individual's health status or progress in achieving the goals and outcomes outlined in the integrated care plan;
6. At least once every 90 days:
a. Reassess the consumer and update the comprehensive assessment as needed based upon the results of the reassessment. The reassessment may be based upon clinical interviews with the consumer and/or guardian and review of data or other information (e.g. progress notes, test results, reports from health home and other providers, etc.), and comparing the most recent data with the data collected at earlier assessments.
b. Review the integrated care plan, and update it when indicated by the results of the reassessment;
7. Develop a communication plan to ensure that routine information exchange (clinical consumer summaries, medication profiles, updates on consumer progress toward meeting goals), collaboration, and communication occurs between the team members, providers, payers, and the consumer and the consumer's family, guardian, and/or significant others; and
8. Develop a crisis management and contingency plan in collaboration with the consumer and the family, guardian, and/or significant others.
Role of Team Members in Comprehensive Care Management:
The Health Home Team Leader, the Embedded Primary Care Clinician, and the Care Manager will participate in the comprehensive care management activities and the comprehensive care management service components will be delegated among the health home team members as follows:
The health home Team Leader will be responsible for initially screening all new referrals, tracking and facilitating transfer/transition of new cases on to the health home team. The Team Leader will also be responsible for reviewing the list of new cases with the entire team during regular team meetings and assigning each health home enrollee to a designated Care Manager and Qualified Health Home Specialist based on the individual's preferences, needs and staff availability.
The other team members can also help identify and facilitate transition of new cases to the team in collaboration with the Team Leader. A licensed clinician Care Manager will be responsible for a designated caseload, completion of the CBHC's standardized health risk assessment, as well as the CBHC's comprehensive health assessment and care plan including a crisis plan with input from other team members.
The Care Manager will support and engage the individual and family in the assessment process and the development of care plan which will include the prioritization of goals.
The Embedded Primary Care Clinician will be responsible for reviewing the assessment and health data and formulating goals/interventions for physical health care which will be included in the care plan. The Care Manager will provide specific interventions for managing chronic diseases identified in the assessment and care plan under the supervision of the Team Leader and in consultation with the primary care clinician.
All members of the health home team will routinely monitor the enrollee's symptoms and functioning, and conduct ongoing assessment of the enrollee's needs. The Team Leader will review and monitor timeliness and quality of assessments and care plans, and ensure that health home enrollees receive comprehensive care management service. The Team Leader and Embedded Primary Care Clinician may also complete some components of the comprehensive assessments and care plans and provide specific care management interventions.
The CBHC health home will frequently and routinely monitor the care plan to determine adherence to treatment guidelines and medication regimes, barriers to care, or any clinical and non-clinical issues that may impact the individual's health status or progress in achieving the goals and outcomes outlined in the care plan. As part of the monitoring, the CBHC and team of health professionals are expected to adhere to the communication plan when providing updates and progress reports on the individual.
The methods of health home services delivery will consist of: service delivery to the beneficiary and may include other individuals who will assist in the beneficiary's treatment; service delivery may be face-to-face, by telephone, and/or by video conferencing; service delivery may be in individual, family or group

format; and service delivery is not site specific and the health home services should be provided in locations and settings that meet the needs of the health home beneficiary.

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

The State will require that participating health homes must have an operational Electronic Health Record (EHR) system in place to support the delivery of CBHC health home services. In recognition of the varying levels of EHR (i.e., electronic medical records, registries, etc.) utilized by CBHC health homes, the State will initially require that CBHC health homes are able to receive utilization data electronically from a variety of sources. The data will, at a minimum, include clinical patient summaries (e.g., diagnosis, medication profiles, etc.) and notifications of a patient's admission to, or discharge from, an emergency department or inpatient facility. At the time of enrollment as a Health Home the CBHC must implement and actively use in clinical services an electronic medical record product certified by the Office of the National Coordinator for Health Information Technology (ONC). This must be evidenced by at least one of the following:
1. Submission of a minimum of forty per cent of prescriptions electronically;
2. Receiving structured laboratory results;
3. Utilizing continuity of care records;
4. Participating in an Ohio regional extension center program; or
5. Participating in an Ohio health information exchange.

Health homes must also comply with the following requirements:
1. Within twenty-four months, demonstrate an electronic health record is used to support all health home services, and
2. Participate in the statewide health information exchanges when established.

Following enrollment of beneficiaries into health homes and as part of initial Comprehensive Care Management activities, CBHCs will receive electronic health utilization profiles on health home beneficiaries. CBHC health homes will also be required to develop internal processes in order to act on and disseminate the data and demonstrate how electronic data will be utilized to continue ongoing Comprehensive Care Management services. The state will provide utilization profiles to each health home on a regular schedule.

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists

Description

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)

Care Coordination

Definition

1. Implement the integrated care plan;
2. Assist consumer in obtaining health care, including primary, acute and specialty medical care, mental health, substance abuse services and developmental disabilities services, long-term care and ancillary services and supports;
3. Perform medication management, including medication reconciliation;
4. Track tests and referrals, and follow-up as necessary;
5. Coordinate, facilitate and collaborate with the consumer, team of health care professionals and other providers, and the consumer's family, guardian and/or significant others;
6. Share the crisis management and contingency plan, assist with and coordinate prevention, management and stabilization of crises and ensure post-crisis follow-up care is arranged and received;
7. Assist consumer in obtaining referrals to community, social and recovery supports, making appointments and confirming that the consumer received the service(s);
8. Provide clinical summaries and consumer information along with routine reports of integrated care plan compliance to the team of health care professionals, including the consumer and the consumer's family, guardian and/or significant others consistent with the communication plan.

The CBHC health home will be required to assist the individual with making appointments and validating that the services were received by the individuals. Although care coordination requires participation of all health home team members in implementation of the care plan, the Care Manager will have the lead care

coordinator role across all providers and settings. The Embedded Primary Care Clinician may have a lead role for the coordination of physical health care needs and communication with the treating primary care clinician and medical specialists as appropriate. The Team Leader will take the lead for developing general care coordination and communication protocols for use with external and internal providers. The Team Leader will also serve as the universal point of contact and care coordinator for all consumers on the team and be the back-up for the Care Manager and Qualified Health Home Specialist. The Care Manager will utilize Qualified Health Home Specialists in coordinating some aspects of the care plan such as referrals to specialists, implementation of discharge plan, accessing housing and other community resources, and obtaining entitlements. The Care Manager will also need to coordinate with other team members such as the nurse on medication management and reconciliation, tracking of labs and results of consults. The methods of health home services delivery will consist of; service delivery to the beneficiary and may include other individuals who will assist in the beneficiary's treatment; service delivery may be face-to-face, by telephone, and/or by video conferencing; service delivery may be in individual, family or group format; service delivery is not site-specific and the health home services should be provided in locations and settings that meet the needs of the health home beneficiary.

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

The State will require that participating health homes must have an operational Electronic Health Record (EHR) system in place to support the delivery of CBHC health home services. In recognition of the varying levels of EHR (i.e., electronic medical records, registries, etc.) utilized by CBHC health homes, the State will initially require that CBHC health homes are able to receive utilization data electronically from a variety of sources. The data will, at a minimum, include clinical patient summaries (e.g., diagnosis, medication profiles, etc.) and notifications of a patient's admission to, or discharge from, an emergency department or inpatient facility. At the time of enrollment as a Health Home the CBHC must implement and actively use in clinical services an electronic medical record product certified by the Office of the National Coordinator for Health Information Technology (ONC). This must be evidenced by at least one of the following:

1. Submission of a minimum of forty per cent of prescriptions electronically;

2. Receiving structured laboratory results;

3. Utilizing continuity of care records;

4. Participating in an Ohio regional extension center program; or

5. Participating in an Ohio health information exchange.

Health homes must also comply with the following requirements:

1. Within twenty-four months, demonstrate an electronic health record is used to support all health home services, and

2. Participate in the statewide health information exchanges when established.

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists

Description

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)

Health Promotion

Definition

1. Provide education to the consumer and the consumer's family, guardian and/or significant others that is specific to the consumer's needs as identified in the assessment;
2. Assist the consumer in acquiring symptom self-monitoring and management skills so that the consumer learns to identify and minimize the effects of the chronic illnesses that negatively impact his/her daily functioning;
3. Provide or connect the consumer and the consumer's family, guardian and/or significant others with services that promote a healthy lifestyle and wellness

through the use of evidence-based, evidence-informed, best, emerging, and/or promising practices;
4. Actively engage the consumer and the consumer's family, guardian and/or significant others in developing, implementing and monitoring the integrated care plan;
5. Connect supports including self-help/self-management and advocacy groups;
6. Manage consumer population through use of clinical and consumer data to remind consumers about services needed for both preventive and chronic care;
7. Promote positive behavioral health and lifestyle choices; and
8. Provide education to the consumer and the consumer's family, guardian and /or significant others about accessing care in appropriate settings.

Health promotion can be provided by any member of the health home team. The Care Manager, as the accountable point of contact has the lead responsibility for providing or arranging for health promotion services based on the identified needs in the assessment and goals in the care plan. All members of the team will be able to educate clients and families regarding the primary condition and chronic diseases and teach self-management skills. The Embedded Primary Care Clinician will provide education on physical health and preventive care as needed. Other health promotion services such as tobacco cessation and treatment may be provided by a Care Manager or Qualified Health Home Specialist with specialized training or Tobacco Treatment Specialist certification. Care Managers and Qualified Health Home Specialists with peer background will co-lead Chronic Disease Self-Management Programs (CDSMP), Wellness Management and Recovery (WMR), and Wellness Recovery Action Plans (WRAP) groups. The Team Leader will have the responsibility for reviewing patient data and developing health promotion programming and resources with input from the team. The Team Leader will also provide direct training or arrange ongoing in-service training for Care Managers and Qualified Health Home Specialists in evidence-based health promotion interventions and monitor provision of health promotion services. The methods of health home services delivery will consist of; service delivery to the beneficiary and may include other individuals who will assist in the beneficiary's treatment; service delivery may be face-to-face, by telephone, and/or by video conferencing; and service delivery may be in individual, family or group format; service delivery is not site specific and the health home services should be provided in locations and settings that meet the needs of the health home beneficiary.

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

The State will require that participating health homes must have an operational Electronic Health Record (EHR) system in place to support the delivery of CBHC health home services. In recognition of the varying levels of EHR (i.e., electronic medical records, registries, etc.) utilized by CBHC health homes, the State will initially require that CBHC health homes are able to receive utilization data electronically from a variety of sources. The data will, at a minimum, include clinical patient summaries (e.g., diagnosis, medication profiles, etc.) and notifications of a patient's admission to, or discharge from, an emergency department or inpatient facility. At the time of enrollment as a Health Home the CBHC must implement and actively use in clinical services an electronic medical record product certified by the Office of the National Coordinator for Health Information Technology (ONC). This must be evidenced by at least one of the following:

1. Submission of a minimum of forty per cent of prescriptions electronically;

2. Receiving structured laboratory results;

3. Utilizing continuity of care records;

4. Participating in an Ohio regional extension center program; or

5. Participating in an Ohio health information exchange.

Health homes must also comply with the following requirements:

1. Within twenty-four months, demonstrate an electronic health record is used to support all health home services, and

2. Participate in the statewide health information exchanges when established.

EHR supports for Health Promotion involves CBHCs use of electronically received health utilization profiles that connect clients with necessary social supports via phone, fax or web- based commensurate with providers capacity and referral source requirements.

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists

  Description

  Behavioral Health Professionals or Specialists

- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [x] Nurses

  Description

  Nurses

- [x] Medical Specialists

  Description

  Medical specialists

- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners

- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

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

Definition

Coordinate and collaborate with providers;
Facilitate and manage care transitions (e.g., inpatient-to-inpatient, residential, community setting(s) to prevent unnecessary inpatient admissions, inappropriate emergency department use and other adverse outcomes such as homelessness;
Conduct or facilitate effective clinical hand-offs that include timely access to follow-up post discharge care in the appropriate setting, timely receipt and transmission of a transition/discharge plan from the discharging entity, and medication reconciliation. A clinical hand-off is the transfer of care and responsibility from the outgoing clinician/provider to the oncoming clinician/provider and includes verbal and written communication to relay vital information about the consumer and his/her anticipated needs.

The Care Manager will be the accountable team member for providing comprehensive transitional care service including the development and coordination of a discharge and transition plan. However, other members of the health home team will provide input in the development and assist with the implementation of the discharge and transition plan. The Care Manager is responsible for exchanging or facilitating exchange of medical records such as the care plan, crisis plan, list of current medications, the most recent psychiatrist note and any other medical documents necessary to facilitate continuity of care during a crisis, hospitalization, incarceration or admission to a residential program. Hospital treatment team meetings will be attended by the Care Manager whenever possible or another team member if the Care Manager is not available. Qualified Health Home Specialists will assist with physical discharge process, assisting the client with returning home and community and linking the client to follow-up appointments. The Care Manager will review the discharge records including after-care plan and medications, update care plan accordingly, coordinate with other team members including family, psychiatrist, the hospital liaison worker, nurse and pharmacist and re-engage and re-orient the consumer to the community-based care. The Team Leader will track team clients in crisis, hospitalized or incarcerated, conduct case reviews, review discharge/transition plans, monitor warm hand-off and smooth transition of clients back to community. The methods of health home services delivery will consist of; service delivery to the beneficiary and may include other individuals who will assist in the beneficiary's treatment; service delivery may be face-to-face, by telephone, and/or by video conferencing; and service delivery may be in individual, family or group format; service delivery is not site specific and the health home services should be provided in locations and settings that meet the needs of the health home beneficiary.

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

The State will require that participating health homes must have an operational Electronic Health Record (EHR) system in place to support the delivery of CBHC health home services. In recognition of the varying levels of EHR (i.e., electronic medical records, registries, etc.) utilized by CBHC health homes, the State will initially require that CBHC health homes are able to receive utilization data electronically from a variety of sources. The data will, at a minimum, include clinical patient summaries (e.g., diagnosis, medication profiles, etc.) and notifications of a patient's admission to, or discharge from, an emergency department or inpatient facility. At the time of enrollment as a Health Home the CBHC must implement and actively use in clinical services an electronic medical record product certified by the Office of the National Coordinator for Health Information Technology (ONC). This must be evidenced by at least one of the following:

1. Submission of a minimum of forty per cent of prescriptions electronically;

2. Receiving structured laboratory results;

3. Utilizing continuity of care records;

4. Participating in an Ohio regional extension center program; or

5. Participating in an Ohio health information exchange.

Health homes must also comply with the following requirements:

1. Within twenty-four months, demonstrate an electronic health record is used to support all health home services, and

2. Participate in the statewide health information exchanges when established.

EHR supports for Comprehensive Transitional Care involve CBHCs use of electronically received health utilization profiles, which the notify CBHC health home about inpatient hospital admissions. The State will also make health home assignment information available to any Medicaid provider through the secure provider web portal. Providers will be able to access the portal to determine if consumers are enrolled in a health home.

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists

Description

Behavioral Health Professionals or Specialists

- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [x] Medical Specialists

Description

Medical specialists

- [ ] Physicians

- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Individual and Family Support (which includes authorized representatives)

Definition

Provide expanded access to and availability of services; Provide continuity in relationships between consumer, family, guardian and/or significant others with physician and care manager; Outreach to the consumer and his/her family, guardian and/or significant others, and perform advocacy on the consumer's behalf to identify and obtain needed resources such as medical transportation and other benefits for which he/she may be eligible; Educate the consumer in self-management of his/her chronic condition:
1. Facilitate further development of daily living skills;
2. Assist with obtaining and adhering to medication and other prescribed treatments;
3. Provide interventions that address symptoms and behaviors, and assist the health home consumer in eliminating barriers to seeking or maintaining education, employment or other meaningful activities related to his or her recovery-oriented goal; Provide opportunities for the family, guardian and/or significant others to participate in assessment and integrated care plan development, implementation and update; Ensure that health home service is delivered in a manner that is culturally and linguistically appropriate; Provide assistance in identifying and accessing needed community supports including self-help, peer support and natural supports, i.e. individual resources as identified by and available to the consumer which are independent from formal services, e.g. a relative, teacher, clergy member, etc.; Promote personal independence and empower the consumer to improve his/her own environment; Include the consumer's family, guardian and/or significant others in the quality improvement process including but not limited to, surveys to capture experience with health home service, establishment of a consumer and family advisory council; and Allow the consumer and his/her family, guardian and/or significant others access to the electronic health record or other clinical information.

Clients will be served by a constant core team to assure continuity of relationship and support. CBHC health home sites are expected to provide expanded and enhanced access to staff and services for support and client-centered care. Provision of peer support will be provided by the Qualified Health Home Specialist with peer specialist qualification. Care Managers and Qualified Health Home Specialists will also assist and link clients to natural supports, advocacy organizations, and support or self-help groups in their communities. The methods of health home services delivery will consist of; service delivery to the beneficiary and may include other individuals who will assist in the beneficiary's treatment; service delivery may be face-to-face, by telephone, and/or by video conferencing; and service delivery may be in individual, family or group format; service delivery is not site specific and the health home services should be provided in locations and settings that meet the needs of the health home beneficiary.

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

The State will require that participating health homes must have an operational Electronic Health Record (EHR) system in place to support the delivery of CBHC health home services. In recognition of the varying levels of EHR (i.e., electronic medical records, registries, etc.) utilized by CBHC health homes, the State will initially require that CBHC health homes are able to receive utilization data electronically from a variety of sources. The data will, at a minimum, include clinical patient summaries (e.g., diagnosis, medication profiles, etc.) and notifications of a patient's admission to, or discharge from, an emergency department or inpatient facility. At the time of enrollment as a Health Home the CBHC must implement and actively use in clinical services an electronic medical record product certified by the Office of the National Coordinator for Health Information Technology (ONC). This must be evidenced by at least one of the following:
1. Submission of a minimum of forty per cent of prescriptions electronically;
2. Receiving structured laboratory results;
3. Utilizing continuity of care records;
4. Participating in an Ohio regional extension center program; or
5. Participating in an Ohio health information exchange.

Health homes must also comply with the following requirements:
1. Within twenty-four months, demonstrate an electronic health record is used to support all health home services, and
2. Participate in the statewide health information exchanges when established.

EHR supports for Individual & Family Support Services will involve CBHCs' use of electronically received health utilization profiles that, auto-generate communications sent to patients and family members of next appointment and establishment of a "tickler" system (e.g., e-mail, postcard, phone call) to remind clients to schedule routine exam (dental exam, vision checks, medical test such as lab work, physical exam, mammogram, etc.). CBHCs will also be encouraged to develop internet capacity for information about wellness, promotional information, and supports access to services.

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses

Description

Behavioral Health Professionals or Specialists

- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Referral to Community and Social Support Services

Definition

1. Provide referrals to community/social/recovery support services; and
2. Assist the consumer in making appointments, confirm that the consumer attended the appointment, and determine the outcome of the visit and any needed follow-up.

The CBHC health home will offer and/or arrange for onsite and offsite community and social support services through effective collaborations with social service agencies and community partners. The CBHC health home will identify and provide referrals to community, social, or recovery support services such as maintaining eligibility for benefits, obtaining legal assistance, and housing. The CBHC health home will assist the consumer in making appointments; validate the service was received; and complete any follow up as necessary. Care Managers will be responsible for identifying non-clinical services and needs that require referrals to community and social supports during the comprehensive assessment with input from individual and family and other team members. However, Qualified Health Home Specialists will largely initiate referrals to community resources and social supports, assist with the completion of paperwork, ensure that needed services, resources and supports are acquired and provide status reports and updates to the team. The Team Leader will monitor team's referral process for community and social supports identify/compile community resources and assist with complex cases. The methods of health home services delivery will consist of; service delivery to the beneficiary and may include other individuals who will assist in the beneficiary's treatment; service delivery may be face-to-face, by telephone, and/or by video conferencing; and service delivery may be in individual, family or group format; service delivery is not-site specific and the health home services should be provided in locations and settings that meet the needs of the health home beneficiary.

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

The State will require that participating health homes must have an operational Electronic Health Record (EHR) system in place to support the delivery of CBHC health home services. In recognition of the varying levels of EHR (i.e., electronic medical records, registries, etc.) utilized by CBHC health homes, the State will initially require that CBHC health homes are able to receive utilization data electronically from a variety of sources. The data will, at a minimum, include clinical patient summaries (e.g., diagnosis, medication profiles, etc.) and notifications of a patient's admission to, or discharge from, an emergency department or inpatient facility. At the time of enrollment as a Health Home the CBHC must implement and actively use in clinical services an electronic medical record product certified by the Office of the National Coordinator for Health Information Technology (ONC). This must be evidenced by at least one of the following:

1. Submission of a minimum of forty per cent of prescriptions electronically;
2. Receiving structured laboratory results;
3. Utilizing continuity of care records;
4. Participating in an Ohio regional extension center program; or
5. Participating in an Ohio health information exchange.

Health homes must also comply with the following requirements:

1. Within twenty-four months, demonstrate an electronic health record is used to support all health home services, and
2. Participate in the statewide health information exchanges when established.

EHR supports for Referral to Community & Social Support Services will involve CBHCs' use of electronically received health utilization profiles that connect clients with necessary social supports via phone, fax or web- based commensurate with providers capacity and referral source requirements.

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians

Description

Behavioral Health Professionals or Specialists

- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

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

No change from 17-0021. Flow charts for adult and child scenarios are provided.

Name	Date Created	Type
HH Child Scenario Flow Chart	6/6/2017 3:07 PM EDT	
HH Adult Scenario Flow Chart	6/6/2017 3:07 PM EDT	

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | OH2017MS0003O | OH-17-0042 | Health Homes date extension 12-17

Not Started | In Progress | Complete

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Superseded SPA ID OH-17-0021
System-Derived

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

Health homes will be implemented in targeted geographic areas across the State. Changes in per member per month (PMPM) costs will be evaluated over time for the two distinct SPMI populations, those enrolled in health homes and those not enrolled in health homes. Those not enrolled in health home will serve as the control group. The PMPM costs for the two SPMI populations will be calculated using a baseline period prior to health home implementation. The PMPM costs will then be calculated for each health home program year, which will be referred to as the projection year. The trend between the two periods for the control group will be calculated and applied to the baseline value for the health home population, producing the expected costs for the health home population absent the influence of the health homes initiative. The actual projection year costs will be compared to the expected costs for the health home population to determine program savings associated with the health homes initiative. Monthly case rates paid to the health homes will be removed from program savings to determine the net savings to the health homes program. For the above described cost savings calculation, all Medicaid services will be included within the PMPM costs, which includes long term care and support services. To ensure the most accurate comparison between the baseline period and the projection period, the same data collection methods will be used for both years, such as using the same amount of claims run-out. To ensure the most appropriate comparison between the control group and the health home population, adjustments will be made to account for differences in population characteristics and geographic influences on the mix of services that could impact the trends, where appropriate. Enrollees with both Medicare and Medicaid coverage, will be evaluated separately. Savings will be calculated to the extent that the necessary Medicare data is made available to Ohio for the calculation.

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 require that participating health homes must have an operational Electronic Health Record (EHR) system in place to support the delivery of CBHC health home services. In recognition of the varying levels of EHR (i.e., electronic medical records, registries, etc.) utilized by CBHC health homes, the State will initially require that CBHC health homes are able to receive utilization data electronically from a variety of sources. The data will, at a minimum, include clinical patient summaries (e.g., diagnosis, medication profiles, etc.) and notifications of a patient's admission to, or discharge from, an emergency department or inpatient facility. At the time of enrollment as a Health Home the CBHC must implement and actively use in clinical services an electronic medical record product

certified by the Office of the National Coordinator for Health Information Technology (ONC). This must be evidenced by at least one of the following:
1. Submission of a minimum of forty per cent of prescriptions electronically;
2. Receiving structured laboratory results;
3. Utilizing continuity of care records;
4. Participating in an Ohio regional extension center program; or
5. Participating in an Ohio health information exchange.

Health homes must also comply with the following requirements:
1. Within twenty-four months, demonstrate an electronic health record is used to support all health home services, and
2. Participate in the statewide health information exchanges when established.

CBHC health homes will also be required to develop internal processes in order to act on and disseminate the data and demonstrate how data will be utilized to continue ongoing Comprehensive Care Management services. Medicaid utilization profiles will be supplied by the state to the CBHC health home on a regular basis. In the delivery of Care Coordination services, all CBHC health homes will be required to use utilization data and information supplied by the State to develop /update the integrated care plan, establish relationships with treatment providers (e.g., hospital, LTC, Rx), share information with other providers to facilitate their treatment of clients, conduct medication management and reconciliation, connect clients with necessary social supports, utilize lab portals to retrieve or develop auto-generated letters that notify PCPs of lab values. CBHC health homes will also be required to develop and utilize tracking systems (e.g., track women who are recommended to have a mammogram) to identify delivered and needed services that links to Care Management Plan. In addition, the CBHC health home must have the ability to take patient summary info and place it in formats that are useful for the client. If available, develop a unified care plan electronically. If the client chooses not to receive primary care services at the CBHC health home site, then the CBHC must demonstrate how primary care is integrated at the CBHC site.

EHR supports for Health Promotion involves CBHCs' use of electronically received health utilization profiles that connect clients with necessary social supports via phone, fax or web- based commensurate with providers capacity and referral source requirements.

HIT supports for Comprehensive Transitional Care involve CBHCs' use of electronically received health utilization profiles from the State, which notify CBHC health home as soon as possible about inpatient hospital admissions.

EHR supports for Individual & Family Support Services will involve CBHCs' use of electronically received health utilization profiles that, auto-generates communications sent to patients and family members of next appointment and establishment of a "tickler" system (e.g., e-mail, postcard, phone call) to remind clients to schedule routine exam (dental exam, vision checks, medical test such as lab work, physical exam, mammogram, etc.). CBHCs will also be encouraged to develop internet capacity for information about wellness, promotional information, and supports access to services.

EHR supports for Referral to Community & Social Support Services will involve CBHCs' use of electronically received health utilization profiles that connect clients with necessary social supports via phone, fax or web- based commensurate with providers capacity and referral source requirements.

Quality Measurement and Evaluation

- [x] 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
- [x] 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
- [x] 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
- [x] The state provides **assurance** that it will track avoidable hospital readmissions and report annually in the Quality Measures report

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