Ohio Medicaid Health Homes: Review of Certification Standards & Phase 2 Payment Rate Changes Webinar FAQs

This document contains a brief summary of key questions posed during the National Council for Behavioral Health's Ohio Health Home Learning Community webinar held on March 26, 2014. It is not intended to substitute for official state regulation or in-depth review of primary source materials from OhioMHAS, Ohio Medicaid or HSAG, referenced within this document. For information on Health Homes in Ohio, visit http://mha.ohio.gov/Default.aspx?tabid=536 Further questions may be directed to the state at healthhomes@mha.ohio.gov, or to the National Council at Ohio-TTAC@thenationalcouncil.org.

CPST Reimbursement:

If disenrollment from a Health Home occurs within 3 days, can the client receive CPST services after the disenrollment date if it falls within same month as they were enrolled in the Health Home?

A: Due to the overlap between the health home service and CPST, the health home may bill for only CPST OR the monthly health home case rate in a single month. The only exception to this is the first month of a client's enrollment. If the health home monthly claim has already been billed and paid and the patient voluntarily disenrolls and opts to receive CPST, then the health home should void the health home claim and begin billing for the provided CPST service.

Electronic Health Record:

With respect to electronic health record requirements, what are continuity of care records?

A: Meaningful Use requirements for all EHRs will have requirements for continuity of care record. The continuity of care record (CCR) is a patient health summary standard. It aims to improve continuity of care, reduce medical errors and ensure a minimum standard of secure health information transportability. CCR contains patient demographics, insurance and healthcare provider information, medication lists, allergies, diagnoses, problem list and recent medical procedures and treatment (AAFP.org). Under the meaningful use of EHR technology, a certified EHR system must be able to receive documents formatted in either the Continuity of Care Record or the Continuity of Care Document standard and display them in a human-readable format (SearchHealthIT.com). Provider receives discharge information/record from a hospital (example). Transition to additional provider and/or additional services – the ability to share basic patient health summary information and such documentation electronically reflects continuity of care record.

What is the current status of health information exchange (HIE) and regional extension centers?

A: CliniSync is Ohio's statewide health information exchange (HIE) created by the nonprofit Ohio Health Information Partnership that now is connecting 141 hospitals and their employed physicians throughout Ohio. CliniSync is actively transmitting results and reports from hospitals to physician practices. More than 50 hospitals plus 1,200 independent physicians are "live" on the network and another 1,000 independent physicians are waiting for their hospitals to be fully integrated so they can receive results and reports.

CliniSync supports the ability to electronically exchange clinical data for purposes of care coordination not only among hospitals and primary care providers, but all members of the medical neighborhood including behavioral health, long-term care, other medical specialists and commercial labs. A recently published white paper, Consulting in Cyberspace, provides a more in-depth view of health information exchange services available in Ohio at *http://www.clinisync.org/images/stories/Clinisync/CliniSyncWhitePaper2014_.pdf*

Currently, nine behavioral health organizations are sending or receiving clinical data electronically through CliniSync, including one of Ohio's first wave health homes. Numerous behavioral health organizations are actively engaged in discussions with CliniSync, including a very large community behavioral health group in the Northeast portion of the state. CliniSync is also providing HIE support to participants of Ohio's Screening, Brief Intervention and Referral to Treatment (SBIRT) grant, a best practice initiative to improve the identification and treatment of substance misuse at an early stage.

In 2010, The Ohio Health Information Partnership (The Partnership) received $14.8 million in federal HITECH funds to create CliniSync's infrastructure and an additional $28 million to provide support for 6,000 primary care physicians to adopt electronic health records (EHRs) and achieve Meaningful Use through a Regional Extension Center (REC) Program. Ohio has been recognized by the Office of the National Coordinator for Health IT (ONC) as a national leader for their REC programs and we currently have the highest participation rates in the country. In terms of Medicaid and Medicare EHR incentive dollars, Ohio providers have received 21,941 payments in the amount of $972.5 million.

The Central Ohio Health Information Exchange (COHIE) was one of seven regional partners that supported the Regional Extension Center (REC) program for providers in the Central Ohio area. While that one partner in Central Ohio no longer offers REC services, the Ohio Health Information Partnership has contracted with at least 10 consultants all over the state to continue to provide services under what is called a "No Cost Extension" from the Office of the National Coordinator for HIT. The REC grant was slated to conclude February 2014; however, Ohio was the first REC in the country to be awarded a non-cost extension to their program until February 2015. With the extension, The Partnership centralized support for primary care- focused REC services and began a complimentary program, CliniSyncPLUS, for specialists and other providers. For more information about our CliniSyncPLUS program, see *http://www.clinisync.org/images/stories/MU2_for_Physicians_CliniSyncPlus.pdf*

Although there has been significant interest and numerous discussions to bring health plans into the CliniSync HIE to support Ohio's exchange payer exchange requirements for the Medicaid Behavioral Health Home program, at this time a standard method for exchange has not been adopted among health plan participants. CliniSync strongly recommends use of ONC-endorsed interoperability standards for this type of connectivity. These standards are currently being deployed among leading market EHR vendors to support eligible hospitals and providers in achieving Meaningful Use through the Medicare and Medicaid EHR Incentive Programs.

Does my organization need to get state approval of EHR vendors?

A: The Partnership is not a state agency and does approve EHR vendors. The Office of the National Coordinator for Health IT (ONC) does certify EHR products for compliance with Stage 1 and Stage 2 Meaningful Use standards. These programs are referred to as the 2011 certification program (Stage 1) and the 2014 (CEHRT) certification program (Stage 2). A list of EHR products that have been certified under these programs is available at http://oncchpl.force.com/ehrcert. For vendors who support providers not eligible for Meaningful Use, ONC published guidance that strongly encourages those vendors to adopt common interoperability standards: http://healthit.gov/sites/default/files/generalcertexchangeguidance_final_9-9-13.pdf

Must the State Board of Pharmacy approve the process even if a provider has capability of submitting Rx electronically using a certified EHR?

A: That is correct in Ohio. Ohio Administrative Code requires prior approval by the Ohio Board of Pharmacy (OBOP) of all electronic prescription transmission systems intended for use in Ohio. Historically, the OBOP's requirements and certification process have been independent of ONC's national certifying programs; however, OBOP has worked extensively over the past few years to streamline its approval process and align efforts with DEA certification requirements for prescribing of controlled substances. The Partnership and OBOP participated in Ohio's ePrescribe Task Force that published a white paper on this topic in August 2012 available at http://www.clinisync.org/public/images/stories/e-Prescribe_White_Paper_Final_8_15_12.pdf

Health Home Certification Requirements:

Does the state require a specific FTE % for the RN Case Manager?
A: No, there is not a specific FTE % requirement in the OhioMHAS certification rule for the RN care manager position.

Does the RN Case Manager requirement pertain to each Health Home provider or each Health Home team within a provider (if applicable)?
A: Each OhioMHAS certified Health Home service provider must include at least one RN Care Manager within their overall health home program. The provider is not required to have an RN Care Manager on every Health Home team unless the patient mix indicates that is appropriate.

Is the Health Home certification for an individual provider or within the county? For example, may a provider with multiple county sites provide Health Home services in a non-Phase 2 county?
A: Although the OhioMHAS Health Home service Certification applies to all of a provider's service locations, a provider may only provide and be paid by Medicaid when the health home service is provided by a health home team member "based" at a co-located/fully integrated setting located within the Centers for Medicare and Medicaid Services (CMS)approved geographic regions (counties) .

Can a provider with multiple sites within a county (some offering co-located primary care, some not) provide Health Home services at the sites without co-located services, using mobile staff?
A: See response to previous question. It is important to also keep in mind that the co-located/fully integrated requirement is there to ensure an integrated and inter disciplinary team approach with ease of access to primary care.

Eligibility for Health Home Services:

Note: *The Ohio Medicaid Health Home Enrollee Methodology criteria are available here:* http://mha.ohio.gov/Default.aspx?tabid=601 *under "Health Home Enrollment Resources."*

Where can I find the revised diagnosis code list?
A: See the diagnosis list on the Ohio MHAS web site at this address: http://mha.ohio.gov/Default.aspx?tabid=601

If a Health Home enrollee is incarcerated, are they still eligible to receive services from the Health Home for coordination and support during incarceration?
A. Per CMS policy, State Medicaid programs and participating providers may not receive federal funding for services delivered to persons who are considered incarcerated at the time of service. This policy is operationalized in MITS by denying any service claims submitted

listing the place of service as 09. Please reference the BH MITS BITS dated February 8, 2013 along with the OMA memo dated January 2, 2013 for further details. Health home services provided to a Health Home enrollee before or after the incarceration period may be eligible for Medicaid reimbursement. Providers are accountable for and must ensure that the accurate HIPAA compliant place of service codes are used when submitting claims.

Enrollment:

How does the state plan to share a list of potential Health Home clients with certified HH providers?
A: Providers certified by OhioMHAS as a Health Home service provider and who have executed a business associate agreement with the state will have access to a secure web portal sponsored by OhioMHAS where they can review and download lists of health home eligible clients identified by the state.

How will multiple mental health providers in the same county coordinate the same prospective client list provided by the state?
A: See the response to the question above. Once an individual is enrolled in a health home that enrollment information will be available in MITS associated with that particular client. Any CPST services rendered to actively enrolled health home members will be denied. So it is advisable for mental health providers to check for health home enrollment as part of the regular eligibility checking process.

Will current agency clients who are listed in the portal HAVE to be enrolled in a Health Home to receive services?
A: Health home service providers are expected to discuss the benefits and consequences of receiving the health home service with current clients who meet the enrollment criteria. If the client consents, then yes, they are to be enrolled and provided the service. If the client does not wish to enroll into the health home, then they will continue to have access to all medically necessary Medicaid covered services except health home.

Will managed care organizations (MCOs) have a role/What role will MCOs have in to enroll Health Home clients?
A: Medicaid managed care plans are required to develop coordination agreements with health homes with whom they share clients in common. MCPs are required to share data with health homes about clients served in common and also make referrals of clients that they believe would benefit from the health home service. Most Ohio MCPs allow existing health homes to have access to their on line patient medical summaries. Likewise, health homes are required to collaborate with MCPs regarding clients served in common. One example is sharing care plans and integrating MCP representatives into care plan meetings. MCPs get daily data files including the enrollment of any of their members in a Health Home.

Is it possible to find out ahead of time how many clients you currently have that would be eligible for the Health Home under the new eligibility criteria?
A: Prior to July 1, 2014, OhioMHAS will share a de-identified data file listing key information about the potentially eligible health home population. This information is intended to inform agencies considering health home certification of the potentially eligible population in their area of the state. The state is not able to share person identified eligibility information prior to approval of a provider as a Health Home and the execution of the business associate agreement with the state. So to assess the potential eligibility of your agency's current caseload, we recommend using the criteria outlined in the rule to evaluate your current client eligibility potential.

Will non-Health Home providers have similar access to a list of eligible clients?
A: No. Person identified datasets are considered protected health information (PHI) and will only be shared with those health home service providers who have a business associate agreement with the state. Health home service providers may only use the provided PHI for health home purposes.

Can only Phase 2 certified Health Homes market services to the "unconnected" list of clients?
A: No. Both Phase 1 and Phase 2 health home providers may market health home services to clients who meet the eligibility criteria, regardless of whether or not those clients have a current connection with your or any other mental health agency. However, only Ohio MHAS certified health homes will have access to the list of eligible clients.

For persons enrolled in MyCare (dual eligibles) and eligible for the Behavioral Health Home at CMH, the MCOs contract with the Behavioral Health Homes for coordination and services - correct?
A: Yes, My Care Ohio Plans will be responsible for health home services for any recipients enrolled in My Care Ohio and health homes. My Care plans will delegate the complete care management responsibility to health homes for any enrollees they share in common. Therefore, Health Homes must submit their claims for health home services to My Care plans. In fact, all specialty MH and AoD Medicaid services (CPST, counseling, partial hospitalization, crisis, MH assessment, pharm management; case management, medication somatic/medication assisted treatment, lab urinalysis, outpatient detox, IOP, methadone administration and office administered medications) are "carved in" to the responsibility of My Care Ohio plans for any dual eligibles receiving those services. So if your behavioral health organizations are serving Medicare/Medicaid dual eligibles and you are located in a My Care region, then you should consider pursuing a contract with the My Care plans in your area. You may suggest that providers check out our My Care Ohio pages on the Ohio Medicaid web site which is here:
http://medicaid.ohio.gov/PROVIDERS/ManagedCare/IntegratingMedicareandMedicaidBenefits.aspx

Health Home Rate (Phase 2):

What are the rates for Phase 2 of the Health Home program?
A: The state has proposed in its revised regulations for Phase 2 base rates of $188 (Adult) and $169 (Child) per month.

Can the state-established Health Home base rate adjust up or down?
A: Yes. After 6 months, the base rate will be adjusted based on "relative risk scores" of the caseload enrolled in each health home. Beginning in month 7, providers will see an adjustment to the base rate based on the relative medical/clinical "risk" of their enrollees compared to the caseload of other health homes. Those providers whose caseload has higher medical and clinical risk may see a percentage increase while those with caseloads with less medical/clinical risk may see a percentage decrease in the base rate. The risk scoring methodology to be used is called the "Chronic Illness and Disability Payment System" or CDPS. This model has been used by US Medicaid programs since 1996 and was updated in 2008 to include pharmaceutical experience. "CDPS plus RX" is the risk scoring methodology currently used by Ohio Medicaid to calculate managed care plan payment rates for the aged, blind and disabled population.

Since this is a case rate, rather than a capitated (PMPM) rate, does this mean that if a person is enrolled in the Health Home, that the agency automatically receives the payment rate, or does a service submission have to be submitted to obtain payment?
A: Health Home providers are required to submit data and a Medicaid claim for every client served during the month in order to receive the case rate payment for that client. The submission of a health home claim represents documentation that the provider rendered health home care coordination activities to that individual during that month unlike a PMPM "capitated rate" health homes bear no financial risk for the cost of other medically necessary services and may bill for non-health home services (except CPST) delivered to health home enrollees.

When do savings have to be demonstrated in order to achieve a rate adjustment?
A: Ohio Medicaid plans to begin using an outcomes adjustment to the base rate payment beginning in year 4 of health home participation based on the achievement of desired outcome measures in the previous year. Health home outcome and performance measures will be collected at the end of each year, but outcome based rate adjustments are not planned until year 4.

Phase 2 Implementation Issues:

Which counties will be included in Phase 2 of the Ohio Health Home?
A: Providers in the following counties are eligible to apply for Phase 2 of the Ohio Health Home program:

- *Cuyahoga*

- *Erie*
- *Franklin*
- *Hamilton*
- *Portage*
- *Summit*

My organization applied to be a Health Home in Phase 1 but our application was held pending rule revision. Do I need to reapply? Will any changes in application procedure apply to my organization?
A: No, organizations that have already submitted health home certification applications that are currently on file with the OhioMHAS Bureau of Licensure and Certification will not be required to reapply. However, those organizations will be required to complete a brief certification application checklist whereby the organization attests that it is compliant with the changes to the health home service rule. The certification application checklist will be available on the OhioMHAS website in the near future.

What are criteria for an expedited application?
A: The OhioMHAS Bureau of Licensure and Certification will review certification applications for completeness and compliance in the order that they are received. There is no criterion for an expedited application.