STATE OF OKLAHOMA

COMPARISON OF EXISTING SERVICES AND DELIVERY MODELS WITH HEALTH HOME DEFINITIONS for MEMBERS WITH SMI/SED 07/20/14

CURRENT PRIMARY CARE AND BEHAVIORAL HEALTH CARE COORDINATION AND SERVICE DELIVERY	HEALTH HOME INTEGRATED PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES	AVOIDING DUPLICATION
PRIMARY CARE CASE MANAGEMENT (PCCM) Oklahoma's PCCM program is called SoonerCare Choice (SCC), in which each enrollee is linked to a Primary Care Provider (PCP). PCPs are usually physicians, physician group practices, or clinics (such as federally qualified health centers [FQHCs] and Indian, Tribal and Urban (I/T/U). The State also recognizes nurse practitioners, and physician assistants as PCPs. In SCC, members get to choose their own health care provider called the **Patient- Centered Medical Home (PCMH).** PCMHs are required to coordinate or provide all medically necessary primary and preventive services including referrals for specialty care**.** Members self-refer to behavioral health services and a formal PCMH referral document is not required for payment. The State sets the requirements for participation using a tiered method, which is based on the capabilities of the practice. PCMH responsibilities by tier level are:**Tier 1: Entry-Level Medical Home** 12 total requirements including coordinated primary care, open scheduling, immunizations, medications list, tests tracking, referral tracking, patient education, plus 24/7 telephone coverage by medical professional. **Tier 2:** - **Advanced Medical Home** Tier 1 requirements + 8 additional requirements consisting of: full time practice, inpatient tracking, hospital follow-up and enhanced access plus 3 optional of the following 6 criteria: practice healthcare team, after-visit follow up, adoption of evidence-based practice guidelines,	Team-based, whole-person orientation with ***explicit focus on the integration of behavioral health and primary care.*** The designated provider does not have to provide all the required services themselves, but must ensure the full array of services is available and coordinated to resolve duplication and gaps in care, **Oklahoma's Health Home (HH) model provides a behaviorally oriented, alternative community-based setting to receive intensive services and partner closely with primary care in an integrated manner.** **Core Team Members for Adults include:** • Consulting PCP (Physician or APRN that is embedded, or may be a partnership with multiple PCMHs, an FQHC or I/T/U facility); • Health Home Director; • Embedded nurse care manager (RN or LPN), • Licensed behavioral health team professionals, • Psychiatrist; • Behavioral health case managers; • Peer support specialists; • Wellness coaches. Core Team Members for Children: The needs of children with serious emotional disturbances in a HH model that also serves adults are different. (See Core Team Members for SED Children under TCM below) • HH Comprehensive Care Management, Care Coordination and Health Promotion Services include: Identification of High risk individuals; • Assessment of preliminary service needs using standardized tool; • Development of a person-centered care plan for each individual that coordinates and integrates all of his or her	The health home model may need multiple entities to collaborate to effectively manage an individual's comprehensive range of needs. However, the designated provider is fully responsible for the management of the member's care, with the goal to provide care coordination that leads to better overall health outcomes for the member. **Differentiated Services:** Building on Oklahoma's current statewide, managed care ("PCMH"), model each HH enrollee will be linked to a PCP. HH eligible members who are enrolled in SCC, and wish to maintain that established relationship (e.g. child that has a Pediatrician for asthma, family can have same PCP), can also receive HH services, with the PCMH-PCP becoming a "virtual" member of the HH team. Given that the primary care activities supported through the PCMH also constitute baseline foundational activities required of the Health Home for all Health Homes-eligible members, there is potential overlap in duties. However, the nature of the services provided by each entity would be clearly differentiated, in order to avoid duplication. For example, the **health home nurse care manager** will assume primary responsibility for "on the ground" care management/care coordination services such as: • Ensuring that a whole person plan is in place for the member; • Follow-up of necessary assessments, lab and imaging, and referral tracking, which will include documenting individual client care in electronic health

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medication reconciliation, mental health screening, and after-hours service. **Tier 3: Optimum Medical Home** Tier 1 and Tier 2 requirements + 1 additional requirement of health assessment tools. **BEHAVIORAL HEALTH CARE COORDINATION** PCPs are in the best position to identify the early warning signs of behavioral health disorders, and adequate treatment can be provided to members with mild to moderate behavioral health symptoms. PCPs may not feel comfortable or have much experience (or practice capacity for long term services and supports) to manage patients with complex mental health needs, including co-occurring substance abuse disorders, who are also known as "super-utilizers".[1] The State has a couple of programs (HANs, SHMP) that work in partnership with the PCMH to increase their capacity, and other separate services provided in specialty settings: TCM, CMHCs and PACT. **HEALTH ACCESS NETWORK (HAN)**	clinical and non-clinical healthcare related needs and services and goals; • Development of treatment guidelines; • Monitoring of health status; • Development and dissemination of reports; • Ensuring effective communication, coordination, and integration with PCMH practices in a bidirectional manner to provide high-quality and efficient care; • Ensuring appropriate and timely consultations and referrals that complement the aims of the PCMH practice; • Ensuring the efficient, appropriate, and effective flow of necessary patient and care information; • Effectively guiding determination of responsibility in co-management situations; • Having procedures to convene internal health home team meetings; • Providing crisis intervention services (includes mobile crisis (must be reachable 24/7) • Scheduling and arranging appointment times including arranging transportation if necessary • Providing health education specific to a member's chronic conditions; • Developing self-management plans with the individual; • Providing support for improving social networks and providing health-promoting lifestyle interventions, including but not limited to: substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and increasing physical activity; and • Assisting members to participate in the implementation of the comprehensive care plan and placing a strong emphasis on person-centered empowerment to understand	record (EHR) available for all team members; • Coordination with external primary care providers such as school-based and public health departments to ensure continuity; • Expecting patients/families to select a personal clinician and documenting the selection in HH records and ensuring that a child sees their PCP at least once annually; • Developing self-management plans with the individual; • Provide opportunities and activities for promoting wellness and preventing illness, • Develops and monitors individual care plans to promote adherence to medical treatment and guidelines; • Provides information to the PCMH on member's health care utilization; • 24/7 on call access (first point of contact) The **consulting PCMH (and HAN, if applicable**) could focus on: • Identification of individuals most appropriate for added HH support, using screening and assessment tools; • Assuring that HH enrollees receive care consistent with appropriate medical standards including providing anticipatory guidance regarding developmental and behavioral health for children, including education regarding the use of

[1] Some States have created super-utilizer programs (Community Care of North Carolina, Maine) to work in close partnership with primary care providers to enhance their capacity and provide

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(***Pilot Project that is geographically limited)*** Non-profit, administrative entities that work with PCMHs to coordinate and improve the quality of care for SCC members *with* complex health care needs including: ✓ Individuals enrolled in SHMP (*co-management*); ✓ Individuals with frequent emergency room utilization; ✓ Women enrolled in the Oklahoma Cares Program diagnosed with breast or cervical cancer; ✓ Pregnant women enrolled in the High Risk OB Program; and ✓ Individuals enrolled in the Pharmacy Lock-In Program • Develops a Care Management (CM) team with a full-time RN as leader; team composition will vary depending on the needs of its patients and the HAN-designed CM projects for its Affiliated Providers. Additional team participants could include pharmacists, behavioral health specialists, clinical social workers, or community health workers; • Establishes or utilizes a disease registry system, e.g. data warehouse, for high risk/high cost conditions afflicting members to track and provide early interventions from a population level; • At HAN option, may have a formal affiliation agreement /partnership at the community-level with traditional and non-traditional providers; • Offers patients access to all levels of care, including	and self-manage chronic health conditions. **In addition to the above, Health Promotion Services for All Children With SED include:** • Ensures that children have preventive health and appropriate medical follow-up; • Coordinates with other providers to monitor the child's health status, medical conditions, medications and side effects; • Assists in locating and arranging specialty evaluations as needed, in coordination with the child's PCMH/ PCP consultant; • Educating members regarding the importance of immunizations and screenings, child physical and emotional development; • Linking each child with screening in accordance with the EPSDT periodicity schedule; • Monitoring usage of psychotropic medications through report analysis and follow up with outliers; • Identification of children in need of immediate or intensive care management for physical health needs; • Providing opportunities and activities for promoting wellness and preventing illness, including the prevention of chronic physical health conditions; and • Include wellness goals in the comprehensive care plan **Other Health Promotion Activities Specific to Children in Foster Care:** • Collaborates with Child Welfare Staff to access medical	immunization and screenings; • Participating in treatment planning; • Consulting with team psychiatrist; • With team psychiatrist, monitoring prescribing to improve the use of psychotropic medications in children[2] • When onsite in a full- or part-time capacity, the PCMH provider may provide consultation to the practice team on consumers who have particularly complex needs or are unresponsive to treatment; • Consulting regarding specific consumer health issues; • Facilitating and enhancing information flow within the medical neighborhood (referrals for primary care coordination and with external specialty medical providers) • Notification to the HH, to the extent possible, when a member is admitted and discharged from a hospital. • Eligibility Issues (ensuring that the member does not have lapses in enrollment) for continuity of care • The HANs, where available, will help build linkages to other community and social supports, and to enhance coordination of medical care, ***The State will create set operational protocols for PCMHs/HANS and HHs that establish these clear guidelines as to which services are the PCMHs/HANs responsibility.***

[2] Children in foster care are not currently enrolled with the PCMH, however the State's 1115 demonstration allows them to optionally enroll. The goal is to have HH care coordinator link foster care child to PCMH.

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primary, outpatient, specialty, certain ancillary services, and acute inpatient care, within a community or across a broad spectrum of providers; • Coordinates with members' PCP when a member is admitted and discharged from a hospital, to the extent possible • Facilitates access to call center support for affiliated PCPs with 24 hours day/7 days / week voice-to-voice telephone coverage with immediate availability of an on-call medical professional.	history; • Helps locate a new provider in new setting as child transitions from home to foster placement; • Helps develop policies to improve psychotropic medication prescribing; may include second opinion utilizing HAN network provider; • Provide education to primary care about foster children's mental health needs including consultations with pediatric psychiatrist. ***With its partners (the medical neighborhood), HHs:*** • Collaborate with physicians, nurses, social workers, discharge planners, pharmacists, and other community system(s), including **HANs,** public health nurses, school nurses, and public human service agencies) to continue implementation of the comprehensive care plan with a specific focus on increasing members and family members' ability to manage care and live safely in the community, and shifts the use of reactive care and treatment to proactive health promotion and self-management; • Develop protocols for communication and coordination of patient care across providers (e.g., care coordination agreements or MOAs with regional hospitals or PRTFs; to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of HH participants; • Maintain a mutual awareness and collaboration to identify individuals seeking emergency department services that might benefit from connection with a HH; • Utilize hospitalization episodes to locate and engage members in need of HH services; • Perform the required continuity of care coordination between inpatient and outpatient care, including	**Non-Duplication of Services – MMIS Edits:** • Building on the state's PCMH foundation and infrastructure, the State will allow each HH enrollee to choose a PCP. • If eligibility data shows a HH eligible member is currently enrolled in a PCMH, the member will choose to either continue their existing relationship with their external, personal PCP at the PCMH, or to disenroll from the PCMH and have their primary physical care provided by the HH-PCP. If the HH-PCP is selected, the member will then be disenrolled from the PCMH panel. • No PCCM fee will be made to the PCMH (including HAN, if applicable) and a HH-PCP at the same time. **Non-Duplication of Services – Information Exchange:** When external partners have no HIT, information will be shared using traditional methods such as fax, telephone and/or email. The state will develop a communication document which will be sent by secure email or fax. A follow-up telephone call may be required. *The OHCA will provide guidance to PCMHs and HHs regarding documentation and services to support a Medicaid claim.* **Screenings and Assessments**: The HH is required to provide screenings and assessments; however separate payment will be made

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	establishment or reestablishment of community resources and necessary follow-up visits; • Coordinate with the hospital or PRTF upon discharge as soon as possible and avoid readmission. **<u>Ways Health Information Technology (HIT) will Link</u>** • Qualified HHs will be required to demonstrate a capacity to use HIT to link services, facilitate communication among team members and between the health team, the individual and family caregivers, and provide feedback to practices as feasible and appropriate. • HH providers will work with HIOs or the Direct project to access member data and to develop partnerships that maximize the use of HIT across providers. HH providers will utilize HIT to create, document, execute, and update the comprehensive, person-centered service plan for every member that is accessible to the interdisciplinary team of providers when external partners have the capability to receive structured, electronic records. • HH providers will also be encouraged to utilize HIT to monitor member outcomes; initiate changes in care and follow up on member testing, treatments, services and referrals. In addition, the System of Care (SOC) Wraparound teams will be required to access data from the Medicaid Management Information System (MMIS) in order to monitor use of psychotropic medications for children with SED and in foster care.	for physical health screenings and assessments outside of the PCCM or base fee, since these are direct services. (e.g., EPSDT screenings not included in PCMH PCCM fees).

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SOONERCARE HEALTH MANAGEMENT PROGRAM (SMHP) ***Population focus:*** SoonerCare Choice members who have chronic medical conditions. Health Coaches embedded at patient-centered medical home practices are working closely with the medical home team. Coaches may provide individual or group coaching services to members with chronic disease or at high risk for chronic disease. A health coach may be dedicated to a single practice or shared between more than one practice site. Health coaches use evidence-based concepts such as motivational interviewing and member-driven action planning principles to impart change in behaviors that impact chronic disease care. All SMHP services assist providers in better caring for high-risk members. OHCA projects that up to 75 PCMHs serving up to 100 members each may be selected for embedded health coach services. • •	**HH Services:** • Comprehensive Care Management; • Care Coordination; • Health Promotion; • Comprehensive Transitional Care/Follow-up • Patient and Family Support • Referral to Community and Social Support Services	**Member Choice of Programs - MMIS Edits:** . There will be no duplication of services and payments for similar services provided under other Medicaid authorities. If claims data shows HH eligible members are currently receiving SHMP services, the eligible member will receive written notification of their eligibility to either continue receiving SHMP, or to receive care coordination services through a HH. The notification will include an explanation of the benefits of participating in a HH as well as a list of HHs in their area from which they can choose. ***It was suggested that we add language to specify how the HH engagement/outreach team will help the prospective member make a decision about being enrolled in the Health Home.*** ***A draft might say:*** The designated HH team member will also contact members currently receiving SHMP to discuss and assist the member in choosing the best health plan. [Something like that]

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TARGETED CASE MANAGEMENT (TCM): The State Plan currently supports several varieties of TCM. Each variety has it's own financial model, fee(s)/rate(s), staffing ratio, staffing qualifications, minimum contact expectation, • **HI-TCM**: High Intensity TCM for Adults (Intensive) and Children (Wraparound). Caseloads generally lower (1:10 to 15) • **AR-TCM: At-Risk** TCM for children assessed as at - risk of abuse and neglect and in Child Welfare (CW) or Office of Juvenile Affairs (OJA) Custody **(**one contact per month) • **RC**–Resource Coordination is CM for individuals who may need mild-level or short-term interventions. Caseloads are usually 30-35 members. This type of TCM may apply to children who are receiving services in school-based settings pursuant to IFSP or IHSP and have a high-risk mental health condition, or as a step-down from HH wraparound level. • **DD-TCM:** TCM for members with Intellectual Disabilities or Related Conditions • **PH-TCM**; Public Health TCM for the following target groups: members 0-3 with Developmentally Disabilities; High risk pregnant women; and for First time mothers **TCM Services Include:** • Services to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services;	HH Care Coordination; Comprehensive Transitional Care/Follow-up, Patient and Family Support; and Referral to Community and Social Support Services • Conducts referrals, facilitating linkages, and follow-up; • Communicating with other providers and members/family enrollees; • Services are designed to streamline transition between hospital or PRTF discharge plan and the comprehensive care plan, reduce hospital and PRTF admissions and interrupt patterns of frequent emergency department use; • Transition may include transitions between service delivery models; including facilitating transition for individuals with serious behavioral health challenges who are aging out of foster care and to other independent living services; • Develops formalized contracts with hospitals; • The designated HH team member collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the comprehensive care plan with a specific focus on increasing members and family members' ability to manage care and live safely in the community, and shifts the use of reactive care and treatment to proactive health promotion and self-management. **Core Team Members for Children**: • Care Coordinator (Bachelor's Level) • Project Director (Clinical Supervisor who is a Licensed Behavioral Health Professional (LBHP or Registered Nurse); • Psychiatric Consultant (Physician or APRN) • Family Support Provider (FSP); • Youth Peer Support Specialist	**Health Home Integration** **MMIS Edits:** A care coordination fee (**G9002 and G9004 for PACT**) for adults and risk adjusted fees for children (**G9010** for Wraparound level and **G9009** for Service Coordination level) will be paid on behalf of each HH enrollee. HH CM will NOT have discrete program models that parallel historic TCM models. There will be no duplication of services and payments for similar services provided under other Medicaid authorities. If claims data shows HH eligible members are currently receiving any TCM, the member would have a choice as to which type of care coordination service would better meet their needs ❖ **HI-TCM** HI-TCM requirements will convert to HH requirements. If claims data shows eligible HH enrollees are receiving HI-TCM, they would receive written notification that includes an explanation of the benefits of participating in a HH as well as a list of HHs in their area from which they can choose. HHs can no longer bill the codes that were used in TCM. (T1016, T1017) ❖ **AR-TCM** AR-TCM requirements for members with SED will convert to HH requirements. If claims data shows a HH eligible child also receives AR-TCM services, the child-serving agency will receive notification of the child's eligibility and the benefits of participating in HHs. If the child is enrolled, the HH will become the

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• Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educ., social or other services; • Development (and periodic revision of a specific care plan that is based on the information collected through the assessment (needs based serve planning) or a plan based on the wraparound facilitation model that identifies and builds on the strength of the child and family to determine/create an integrated and individualized treatment plan; • Monitoring and follow-up activities: • Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. These activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals; • Referral and related activities: To help an eligible individual obtain needed services including activities that help link an individual with: • Medical, social, educational providers; or other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual; • Assure adequate and appropriate range of services are provided to the individual to include: linkages with the mental health system • Linkages with needed supports, and coordination of the various system components.	• Administrative Support Staff **Other Community Partners:** Other Team members include natural and professional supports, or representatives from other systems interacting with the child/family such as: • PCP Consultant (Physician or APRN); • Representatives of Child-serving systems such as CW or OJA; • School personnel; • LBHP clinicians; • Law Enforcement, Courts; • Tribal Partners; • Paraprofessional support workers; • Substance Abuse Agencies; and • HAN network provider, if applicable ***Intensive Care Coordination: Wraparound Approach:*** The Wraparound approach is a form of intensive Care coordination for children with SED. It provided by the HH for children will provide a single point of accountability for ensuring that medically necessary services and supports are accessed, coordinated, and delivered in a: • Strength based, • Individualized, • Family driven, • Youth guided, and • Ethnically, culturally and linguistically relevant manner.	single point of accountability, and the child will have all of their behavioral, physical, social and long term care needs coordinated by the Health Home. The child serving agencies can no longer bill the code (G9012) that was used in AR-TCM for children with SED. **Reimbursement to Optional SED Team Members** • Case managers of the child-serving agencies (CW OJA) will be defined as part of the HH team, along with other professional and natural supports. Agencies will no longer be able to bill for AR-TCM for children with SED. The successful transition of the former AR-TCM benefit by HHs will require close collaboration among the Health Home, families, child serving case managers and other professional supports, • Professional team members (e.g., psychiatrist, child welfare, OJA workers may bill for participation in HH team conferences. (HCPC G9007) for government providers, or (CPT 99366) for private providers. The rate paid to government providers will be based on the costs and calculations used in the AR-TCM rates. • Payment to natural supports may flow through the HH base rate. **Member Choice of Programs** ❖ **RC** If claims data shows eligible HH enrollees are

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	The comprehensive, person-centered care plan is developed through a wraparound care planning process. The Wraparound "Facilitator" (or care coordinator) organizes, convenes, and coordinates this process consistent with System of Care (SOC) values. This will result in a comprehensive care plan that is individualized for the child and family. Care coordination in the wraparound process is designed to facilitate a collaborative relationship among the child with SED, the family and all systems involved. The Care Coordinator ensures that the wraparound process is organized and integrated across all child-serving systems (e.g., schools, child welfare, juvenile justice, substance abuse) to enable the child to remain in his/her own home community. Ensures that children in Child Welfare or Juvenile Justice Custody are linked to a PCP.	receiving RC pursuant to IFSP or IHSP in a school setting, the child (or parent/guardian) would receive written notification that includes an explanation of the benefits of participating in a HH as well as a list of HHs in their area from which they can choose. The member will have a choice as to which (HH or SC-TCM from qualifying school-based case manager) would better meet their needs. ❖ **DD-TCM** Members eligible for both DD-TCM and health home services are given choice as to which care management/ care coordination services would best meet their needs (e.g., they could enroll in health homes and stay in waiver, but only for non-care management/ care coordination services). The DD provider will not be able to bill for TCM if the member chooses HH. Members cannot be eligible for both. • **PH-TCM** Members have choice of programs that best meet their needs. ***The State will create set operational protocols among agencies to clearly define steps, guidelines and responsibilities for communication and coordination for children that are referred for HH services.***
COMMUNITY MENTAL HEALTH CENTER (CMHC) SUPPORT SERVICES ***Population focus*:** Consumers with serious mental illness (SMI) or Children with Serious Emotional Disturbance	• Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered HH services; • Coordinate and provide access to high-quality healthcare services informed by evidence-based clinical practice	**Non-Duplication of Services -** **MMIS Edits:** A care coordination fee (**G9002)** will be paid on behalf of each HH enrollee. There will be no duplication of

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(SED) • Has embedded behavioral health team members, including psychiatrist; • Holds regular team meetings addressing practice function; • Provide Behavioral health assessment (and periodic reassessment) to determine the need for any medical, educational, social or other services; • Provides a plan of care focusing on the individual's mental health barriers; • Crisis intervention; • Provides Psychiatric Consultation (not a Medicaid covered service, except by Telemedicine) • Provide health education specific to an individual's chronic condition; • Coordinates and provides access to preventive mental and substance abuse services; • Provides peer support; • Identify a course of action for the member to respond to the assessed needs. • Member has 24/7 access; • Outreach and Engagement (not a Medicaid covered service) Systems of Care: CMHCs that sponsor - Systems of Care (SOC) Teams for children provide services and supports that are guided by the needs, strengths and culture of the child and family, developed through a wraparound care planning process consistent with SOC values. In addition to wraparound planning, services include mobile response, intensive in-home services and flex funds. . **Health Information Technology:** All CMHCs utilize an	guidelines; • Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders; • Coordinate and provide access to mental health and substance abuse services; • Coordinate and provide access to chronic disease management, including self-management support to individuals and their families; • Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services; ; Individual and family support services assist individuals in accessing services that will reduce barriers and improve health outcomes, with a primary focus on increasing health literacy, the ability of the member to self-manage their care and facilitate participation in the ongoing revision of their comprehensive care plan. *For adults with SMI and children with SED*, these services include, but are not limited to: • Teaching individuals and families self-advocacy skills; • Attending appointments with individuals and families when necessary to offer support and coaching; • Providing peer and family support groups; • Corresponding to requests for peer support in a variety of settings; • Modeling and teaching how to access various community resources; Assisting with obtaining and adhering to medications and other prescribed treatments; and • Identifying resources for individuals to support them in attaining their highest level of health and functioning in their	services and payments for similar services provided under other Medicaid authorities – CMHC requirements for the following services will convert to become HH requirements, and CMHCs will no longer be able to separately bill: • Treatment planning (H0031 H0032) • Medication management (H0034); • Peer Support (H2015); • Individual and Family Support (T1027) Primary care consultation will be included in the rate and not separately payable by the State. The member cannot be enrolled in PCMH and HH at the same time. **Screenings and Assessments**, **Outreach and Engagement** • The HH is required to provide screenings and assessments; however separate payment will be made of the PCCM fee or base fee for physical health assessments since these are direct services. (e.g., EPSDT screenings not included in PCMH fee) • **Outreach and engagement** (Case Finding) - HHs will receive a PMPM billed as a FFS code (**G9001**) once a month. The case finding PMPM is only available for the first three months after a patient has been attributed to a given health home and this PMPM is intended to cover the cost of outreach and engagement. Once a patient has been assigned a care manager and is enrolled in the health home program the case finding fee will no longer be

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electronic medical record (EMR) and are in the process of upgrading to an ONC-certified electronic health record (EHR).	families and in the community, including transportation to medically necessary services	reimbursable.
PROGRAMS OF ASSERTIVE COMMUNITY TREATMENT (PACT) ***Population focus*:** Consumers with SMI (most expensive) A PACT is an evidence-based model that must be a self-contained clinical program that assures the fixed point of responsibility for providing treatment, rehabilitation and support services. The PACT team shall use an integrated service approach to merge clinical and rehabilitation staff expertise, such as psychiatric, substance abuse, employment, within one service. CMHCs or OU Tulsa Community Health sponsors PACT teams. Teams that minimally consist of: • Team Lead (LBHP); • Nurse Care Manager (RN or LPN); • Certified Behavioral Health Case Managers; • Other LBHPs; • Substance abuse treatment specialist; • Employment specialist; • Peer Recovery Support Specialists; and • Administrative support staff. The team conducts/provides:	• Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered HH services; • Coordinate and provide access to high-quality healthcare services informed by evidence-based clinical practice guidelines; • Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders; • Coordinate and provide access to mental health and substance abuse services; • Coordinate and provide access to chronic disease management, including self-management support to individuals and their families; • Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;	**Non-Duplication of Services – MMIS Edits:** A care coordination fee (**G9004)** will be paid on behalf of each HH enrollee. There will be no duplication of services and payments for similar services provided under other Medicaid authorities. PACT services that meet the definition of HH services will be converted to HH requirements and current PACTs will no longer be able to separately bill: • Treatment planning (H0031 H0032) • Medication management (S5185; T1502) • TCM (T1017) **Screenings and Assessments** The HH is required to provide screenings and assessments; however separate payment will be made physical health assessments outside of the PCCM fee or base fee, since these are direct services. (e.g., EPSDT screenings not included in PCMH fee). • Payment will no longer be made for PACT screening code (T1023) but will be allowed as outreach and engagement code (G9001) **Current PACT component services that may be separately billable:**

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• Initial Assessment; • Comprehensive Assessments; • Treatment Planning and Review; • Comprehensive treatment, rehabilitation and support; • Crisis intervention; • Symptom assessment, management and individual supportive therapy; • Medication prescription administration, monitoring and documentation; • Individual, Family, Group Therapy; • Psychosocial Rehabilitation; • Medication Training and Support; • Peer Support;		Separate payment will also be made for: Office Visits by Psychiatrist; Individual, family and group therapy Individual and Group Psychosocial Rehab Mobile Crisis Intervention by LBHP
TRANSITIONAL CASE MANAGEMENT (CM) **Population focus:** Children with SED ***Transitional CM*** *Children with SED* and residing in a hospital or PRTF are eligible for transitional case management. Oklahoma's State Plan specifies that the Inpatient Psych under 21 benefit is an all-inclusive rate. Therefore, FFP is not payable until the date that an individual leaves the institution, is enrolled with the community case management provider, and receiving medically necessary services in a community setting. ***Discharge Planning (included in per diem for inpatient psychiatric services – under 21)*** The individual plan of care must be recovery focused, trauma informed, and specific to culture, age and gender and includes:	**HH Services:** **Comprehensive Transitional Care/Follow-up** • • Focuses on the movement of individuals from any medical/psychiatric inpatient or other out-of-home setting into a community setting, and between different service delivery models; • Participates in hospital and Psychiatric Residential Treatment Facility (PRTF) discharge processes ○ Such activities include services to begin the care planning team process, and engaging the family and parent advocate and working with the receiving school system.	**Differentiated Services –** **Non-Duplication of Services -** In addition to a PCCM fee, a risk-adjusted base care coordination fee (**G9010 for Wraparound level and G9009 for Service Coordination Level**) will be paid on behalf of each HH enrollee. There will be no duplication of services and payments for similar services provided under other Medicaid authorities. **Transitional Care Coordination:** • If psychiatric residential or other long-term placement is needed, the child will be assigned a care coordinator ***while still in placement*** and the HH is eligible for payment for services that are beyond the scope of discharge planning activities. . The facility must include transitional care services by the HH in the plan of care. The HH care coordinator must have a system to work with the facility discharge planner, in order to provide

CURRENT PRIMARY CARE AND BEHAVIORAL HEALTH CARE COORDINATION AND SERVICE DELIVERY	HEALTH HOME INTEGRATED PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES	AVOIDING DUPLICATION
• Plan for discharge, all of which is developed to improve the child's condition to the extent that the inpatient care is no longer necessary; • Specific discharge and after care plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, after care plans will include referral to medication management, out-patient behavioral health counseling and case management to include the specific appointment date(s), names and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the member into their family school, and community.		continuity, avoid duplication and to ensure a smooth transition. • The State will amend the State Plan Psychiatric Hospital Under 21 Benefit page to describe that the State will directly reimburse the HH for services provided under arrangement[3]. The State will pay the **G9009** applicable rate while the child is still in placement **for a period not to exceed 90 days (or a shorter period specified by the Medicaid Agency) and during the last 14 days prior to discharge from an institutional or community stay of less than 90 consecutive days**. **MMIS Edits:** • **Transitional TCM** - will convert to a HH service and will no longer be billable by the community case management provider.
PARTIAL HOSPITALIZATION PROGRAM (PHP)//DAY TREATMENT (site based programs that occur separate from regular classroom) **Population focus:** Children with SED Non-residential treatment programs for children that require treatment for less than 24 hours a day, (e.g., they do not require hospitalization in an inpatient setting). However, they need more intensive and comprehensive services than they can receive in an outpatient setting. **Team includes:** • Licensed Behavioral Health Professionals; (LBHPs);		**Differentiated Services – Non-Duplication of Services -** In addition to a PCCM fee, a base care coordination fee will be paid on behalf of each HH enrollee. There will be no duplication of services and payments for similar services provided under other Medicaid authorities. Children and youth meeting medical necessity requirements for coverage of a PHP comprise two groups: • Those members who are discharged from an inpatient hospital treatment program, and • The PHP is in lieu of continued inpatient treatment; or

[3] See CMCS Informational Bulletin, November 28,2012, available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-11-28-12.pdf

CURRENT PRIMARY CARE AND BEHAVIORAL HEALTH CARE COORDINATION AND SERVICE DELIVERY	HEALTH HOME INTEGRATED PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES	AVOIDING DUPLICATION
• Behavioral Health Rehabilitation Specialists (BHRS), • Certified Alcohol and Drug Counselors; (CADCs) • Nurse; **Bundled hourly rate includes:** • Assessment, diagnostic and treatment plan services for mental illness and/or substance abuse disorders; • Service Plan Development and review; • Individual/Group /Family Counseling; • Substance abuse specific services; • Drugs and biological furnished for therapeutic purposes; • Behavioral health rehabilitation training and education; • Care Coordination of behavioral health services provided by certified behavioral health case managers; • A nursing assessment must be completed within 24 hours of admission • A separately billable exam and medical history must be coordinated with the PCP. **Non-Covered Services** • Meals • Transportation • Academic Instruction		as a less restrictive alternative to inpatient treatment. • If a HH member also requires structured PHP services while enrolled in HHs, the services provided by each entity would be differentiated in order to avoid duplication. Role of HH Care Coordinator: • Initiates an evaluation or assessment if needed; • Assembles all interested parties through a wraparound planning process to participate as members of the child's team; • Crisis Management 24/7; • Monitoring of Psychotropic Medications; • Discharge Planning. Role of PHP Case Manager: • Ensures that education needs are adequately met so that child can make a successful transition back to home school; • Participates in treatment planning development and review (team conferences) **Screenings and Assessments**; • If a HH member is discharged from an inpatient hospital, the PHP must incorporate the hospital comprehensive assessment into the service being provided by the PHP provider PHP provider will not duplicate services (e.g. completing another nursing or behavioral health assessment) provided by the HH team. The PHP provider will incorporate the assessments conducted by the HH team. **Reimbursement for PHP:**

STATE OF OKLAHOMA

COMPARISON OF EXISTING SERVICES AND DELIVERY MODELS WITH HEALTH HOME DEFINITIONS

for MEMBERS WITH SMI/SED 07/20/14

CURRENT PRIMARY CARE AND BEHAVIORAL HEALTH CARE COORDINATION AND SERVICE DELIVERY	HEALTH HOME INTEGRATED PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES	AVOIDING DUPLICATION
		• The State will amend the State Plan for PHP services\ to convert the case management/care coordination to HH services.