



U.S. Department of Health and Human Services  
Assistant Secretary for Planning and Evaluation  
Office of Disability, Aging and Long-Term Care Policy

## **MEDICAID HEALTH HOMES IN OHIO:**

### **REVIEW OF PRE-EXISTING INITIATIVES AND STATE PLAN AMENDMENT FOR THE STATE'S FIRST HEALTH HOMES UNDER SECTION 2703 OF THE AFFORDABLE CARE ACT**

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<b>Ohio's Health Home Program at a Glance</b>	
<b>Health Home Eligibility Criteria</b>	Serious and Persistent Mental Illness (SPMI), Serious Mental Illness (SMI), or Serious Emotional Disturbance (SED)
<b>Qualifying Conditions</b>	Beneficiaries who meet the state definition for SPMI, SMI, or SED
<b>Enrollment*</b>	10,312
<b>Designated Providers</b>	Community Behavioral Health Centers (CBHCs)
<b>Administrative/ Service Framework</b>	The health homes program is a joint effort between Ohio Medicaid and the Ohio Department of Mental Health and Addiction Services (MHAS). MHAS oversees the state's behavioral health system; funding for behavioral health services is channeled from the state to the county, where local mental health and addiction boards are responsible for managing behavioral health services through contracting with provider agencies, including CBHCs, for the provision of behavioral health services.
<b>Required Care Team Members</b>	<ul style="list-style-type: none"> <li>• Health home team leader</li> <li>• Embedded primary care clinician</li> <li>• Care manager</li> <li>• Qualified health home specialist</li> </ul>
<b>Payment System</b>	Per member per month (PMPM) care management fee
<b>Payment Level</b>	Site-specific and based on costs, ranging from \$270-\$400 PMPM
<b>Health Information Technology (HIT) Requirements</b>	HIT requirements are phased-in over 2 years. The only initial requirement is that health homes be able to receive utilization data electronically. Within 1 year of being designated a health home provider, the CBHC must adopt an electronic health record (EHR). Within 2 years, it must demonstrate that the EHR is used to support all health home services. Furthermore, the CBHC must participate in Ohio's statewide Health Information Exchange when it becomes available in their region.
* January 2014 data provided to the Centers for Medicare and Medicaid Services' Health Home Information Resource Center.	

## Introduction

Ohio's Section 2703 Health Home State Plan Amendment (SPA) was approved by the Centers for Medicare and Medicaid Services (CMS) on September 17, 2012, with an effective date of October 1, 2012. The state offers health home services to beneficiaries with serious and persistent mental illness (SPMI), and to children with serious emotional disturbance (SED) who receive care through qualifying Community Behavioral Health Centers (CBHCs). The approved SPA targets five counties (Butler, Adams, Scioto, Lawrence, and Lucas), though the state intends to expand health home services statewide in a subsequent phase. This expansion was scheduled to begin October 1, 2013,<sup>1</sup> drawing upon lessons learned during the initial phase of implementation, but was later delayed due to concerns from the mental health community about the proposed rules regarding enrollment criteria and reimbursement.<sup>2</sup>

The health homes program is a joint effort between Ohio Medicaid and the Ohio Department of Mental Health and Addiction Services (MHAS), the latter of which was created on July 1, 2013 through a merger between the Department of Mental Health and the Department of Alcohol and Drug Addiction Services. MHAS oversees the state's behavioral health system, which is organized into three tiers. Funding for behavioral health services is channeled from the state to the county, where local mental health and addiction boards are responsible for planning, developing, managing, and evaluating behavioral health services within their respective jurisdictions. These boards contract with provider agencies, including CBHCs, for the provision of behavioral health services.<sup>3</sup> As of April 2013, there were six certified health homes operating in 20 clinic sites in the five designated counties.<sup>4</sup>

## Implementation Context

In January 2011, Governor John Kasich created the Office of Health Transformation (OHT)<sup>5</sup> to oversee reforms to the administration, financing, and delivery of health care services for Medicaid beneficiaries.<sup>6</sup> Medicaid health homes have been implemented alongside a number of broader health care system reforms, including managed care expansion and performance improvement plans and the creation of a State Health Care Innovation Plan (through the State Innovation Model Design Grant award) for increasing access to patient-centered medical care and reforming the payment system for public and private health insurers.

### ***Managed Care***

Ohio Medicaid provides coverage to categorically needy families and children, the aged, blind, or disabled, and individuals who qualify for certain limited benefits. These include Medicare beneficiaries who receive only Medicare premium assistance, working age persons with disabilities who "buy-in" to Medicaid, and those who receive services under the State Family Planning Waiver. The program covers roughly 2.2 million

Ohioans, 1.6 million of whom are enrolled in managed care.<sup>7</sup> Individuals receiving long-term care, who are dually eligible for Medicaid and Medicare, and who qualify as medically needy are excluded from managed care. In January 2012, the state announced its plans to restructure its managed care program, and to renegotiate its contracts with managed care plans (MCPs) operating in the state. As part of this restructuring, the state reduced the number of service regions from eight to three and combined coverage for the categorically needy populations in each region. Under the terms of the new managed care contracts, plans are now required to develop quality improvement incentives for the providers they contract with, and meet certain performance standards in order to receive the full capitation payment from the state.<sup>8</sup> Behavioral health services are carved out and reimbursed on a fee-for-service basis. As of July 1, 2013, five plans have contracted with Ohio Medicaid to provide services.<sup>9</sup>

The state is also pursuing managed care reforms for beneficiaries who are dually eligible for Medicaid and Medicare. In December 2012, the state entered into a Memorandum of Understanding (MOU) with CMS, as part of a three-year demonstration that will test a new managed care model for the state's 182,000 dually eligible beneficiaries. Under this MOU, the state and CMS will contract with Integrated Care Delivery System plans to coordinate and oversee the provision of all services for this population, including physical, behavioral, and long-term services and supports (LTSS).<sup>10</sup> In May 2014, the program will be implemented in seven regions covering 29 counties, and will enroll an estimated 115,000 people.

In June 2013, the state was awarded a Balancing Incentive Payment Program grant to restructure its LTSS system, with the ultimate goal of shifting care for this population into home and community settings. The state designated the 12 Area Agencies on Aging as the lead agencies in the statewide Aging and Disability Resource Network, which will oversee a No Wrong Door/Single-Entry Point system for screening, referral, and support navigation functions for people who need long-term care. The timeline for implementation has not been finalized, but it is anticipated that full implementation will be completed by September 2015.<sup>11</sup>

### ***Care Delivery Reform Initiatives***

Ohio has taken a number of steps to expand the medical home model. In June 2010, the state legislature passed Ohio House Bill 198, which created the Patient-Centered Medical Home (PCMH) Education Advisory Group and the PCMH Education Pilot.<sup>12</sup> The pilot is focused on advancing medical and nursing curricula to include the PCMH principles of care delivery. It involves 50 practice sites, all of which are affiliated with a medical or nursing school. Some of the stated goals of the program are to facilitate the adoption of the medical home model, develop the primary care physicians' workforce within Ohio, improve health care quality and reduce costs, and create learning sites where clinicians in training can experience working in the PCMH model. The Education Advisory Group provides assistance and advice on implementation of the pilot, and direct technical assistance to pilot sites is provided by the American Academy of Family Physicians.

Ohio Medicaid is also participating in several federal demonstrations and projects, including the Comprehensive Primary Care Initiative (CPCI), the Community-based Care Transitions Program, and the State Innovation Model Planning grant. The CPCI is a multi-payer initiative involving Medicare, Medicaid, and private insurers. Participating primary care practices receive technical assistance and resources to improve patient quality of care, implement care management for high-need patients, and coordinate care with other providers.<sup>13</sup> The Care Transitions Program is testing models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. Grantees received a two-year award from CMS, which may be extended annually until the end of the five-year demonstration project. Seven entities in Ohio received grants, two of which will cover health home counties: The Southwest Ohio Community Care Transitions Collaborative<sup>14</sup> and the Southern Ohio Care Transitions Project.<sup>15</sup> Both grants involve partnerships between Area Agencies on Aging, county mental health boards, hospitals, primary care providers (PCPs), and other community-based organizations. The funding will support implementation of a Care Transitions Intervention program for patients diagnosed with heart failure, heart attack, pneumonia, or multiple chronic conditions. The program provides coaching, medication reconciliation, chronic disease management, and referrals for patients following discharge from a participating hospital.

In February 2013, the state also received a six-month State Innovation Model Planning grant from CMS, which builds on the state's other ongoing initiatives, including health homes.<sup>16</sup> The goal for this planning period will be to develop a framework for making medical homes available to the majority of Ohio residents and implementing episode-based payment systems across Medicaid, Medicare, and the commercially insured.<sup>17</sup>

## **Implications for the Ohio Section 2703 Medicaid Health Homes Evaluation**

Several of the initiatives described in the preceding section have implications for both the implementation and evaluation of the state's health homes program, particularly those related to managed care and care transitions. It is not yet clear how health homes will be integrated or aligned with these initiatives. Many of these details are still being developed and may change over the course of the evaluation. Given the range of initiatives underway, it may be difficult to identify a "health home effect" on the identified outcomes. However, because health homes are being offered initially in only five counties, it may be possible to identify an appropriate comparison group for all or part of the evaluation period.

The state is using this initial phase of health home implementation to test different models of care. Participating CBHCs have differing levels of experience with providing integrated care and infrastructure in place to support health home implementation. For example, two health homes are co-located with PCPs, while the rest must coordinate

entirely with off-site providers. Important early evaluation activities will be documenting the baseline structures and processes in place and identifying changes made as a result of health home implementation. Because of the anticipated expansion, analyses also will need to control for participant and provider time in the program.

## **Population Criteria and Provider Infrastructure**

Ohio offers health homes services to categorically eligible beneficiaries who meet the state definition of SPMI, which includes persons with SPMI, serious mental illness (SMI), or SED.<sup>18</sup> Medically needy beneficiaries are excluded from the health homes option. Qualified CBHCs operating in one of the five designated counties are eligible to apply to be health homes. The care team and their respective role are explicitly defined in the SPA, and will at a minimum include:

- A Health Home Team Leader, who provides administrative and clinical leadership, as well as oversight of health home services.
- An Embedded Primary Care Clinician, who assists with provision of health home services, provides consultation to other team members, and provides direct care.
- A Care Manager, who provides and coordinates all care management services.
- A Qualified Health Home Specialist, who assists the Care Manager with all health home services.

Each health home will determine and assemble the appropriate number of full-time equivalents required to meet service requirements and must participate in technical assistance provided by the state. This assistance includes the Health Homes Learning Community, a learning collaborative established to support health home implementation, and other activities, which may be supplemented by health home team calls.

### ***Enrollment***

Medicaid beneficiaries receiving services at a qualifying CBHC are engaged and enrolled in the health home by that CBHC. Beneficiaries have the ability to opt-out or enroll with another health home provider. Hospitals, specialty providers, MCPs, or other providers may refer Medicaid beneficiaries to participating health homes, which are responsible for determining whether those clients meet the criteria. The state also notifies eligible beneficiaries through mail and through public education campaigns conducted in partnership with advocacy groups such as NAMI-Ohio and the Ohio Empowerment Coalition.

## Service Definitions and Provider Standards

Service definitions are reproduced in Table 2. The role that each care team member plays in the provision of these services is explicitly described in the SPA, with the Team Leader, Embedded Primary Care Clinician, and Care Manager each playing a part. Qualified Health Home Specialists support the Care Manager in care coordination, health promotion, individual and family support services, and referral to community and social support services. Ohio has also established broad standards that CBHCs must meet before qualifying as health homes, relating primarily to their certification, care structures, processes, and relationships with other providers and MCPs.

In order to qualify as a health home, CBHCs must:

- Be certified by the Ohio Department of Mental Health as eligible to provide Medicaid-covered community mental health services.
- Provide all health home services as necessary and appropriate for beneficiaries.
- Meet state requirements related to integration of physical and behavioral health, including achievement of accreditation from a state-approved certification body such as the Joint Commission or National Committee for Quality Assurance.
- Establish a partnership and a referral/coordination process with specialty providers, inpatient facilities, and MCPs in the service area.
- Support the delivery of person-centered care as defined by the state.
- Have the capacity to receive electronic data from a variety of sources to facilitate service provision.
- Maintain a comprehensive and continuous quality improvement program capable of collecting and reporting data on utilization and health outcomes, and be able to report this data to the state or its designee.
- Participate in the Medicaid Health Homes Learning Community.
- Be a current eligible provider in the Ohio Medicaid Program, and have the capacity to serve health home-eligible Medicaid individuals in the designated service area.

The SPA also includes clear expectations for MCPs. MCPs are required to establish a partnership with the CBHC health home in their service area and develop written policies and procedures that address the way these organizations exchange information and share care management responsibilities. MCPs must also develop a transition plan for each member receiving health home services. Additionally, MCPs are expected to perform ongoing identification of the plan's members who may benefit

from health home services and assist them with selecting and enrolling in a health home, if they so choose. MCPs must track which members are receiving health home services, and are required to integrate all information transmitted by the health home or the state regarding a member into the MCP's system. MCPs must also participate in transitional care activities with the health home and integrate results from the health homes quality measures into their quality improvement program. Finally, MCPs, like health homes, must participate in the Medicaid Health Homes Learning Community. The state monitors MCPs to ensure that they are actively supporting the CBHC health homes.

## **Use of Health Information Technology**

Ohio decided to phase-in requirements related to the use of health information technology over two years. The only initial requirement is that health homes be able to receive utilization data electronically from a variety of sources, including clinical patient summaries and notifications regarding a patient's admission to or discharge from an inpatient facility. Within one year of being designated a health home provider, the CBHC must adopt an electronic health record (EHR). Within two years, it must demonstrate that the EHR is used to support all health home services. Furthermore, the CBHC must participate in Ohio's statewide Health Information Exchange when it becomes available in their region.

CBHCs receive quarterly utilization profiles on each health home beneficiary, which underpins the provision of all health home services. Providers are required to develop internal processes to act on and disseminate patient utilization data, and use this patient data to update care plans and establish necessary relationships with other providers to ensure care coordination. Providers must also be able to take patient summary information and format it in a useful way for the client.

## **Payment Structure**

Payment levels for health home services are site-specific, and are based on the state's Uniform Cost Report Requirements, which considers staffing costs, the indirect costs related to health homes service provision, and the estimated health homes caseload. These case rates vary in practice from about \$270 to just over \$400 per month.

Providers must submit claims to receive payments, and may do so only if a health home service is rendered during the billing month for a given individual. Only one claim may be submitted per individual per month. The monthly case rate covers all health home service components, and is made in addition to the community behavioral health treatment services reimbursed under existing Medicaid payment mechanisms.

This rate determination methodology is in effect only for the providers targeted in the initial SPA. For health homes approved in the next phase of implementation, the state is developing a different rate which has yet to be determined.<sup>19</sup>

## **Quality Improvement Goals and Measures**

Ohio has identified eight goals for its health homes program. In addition to reporting the core health home measures selected by CMS, the state will also report on 26 performance measures, which are detailed in Table 3 below. Measures will be generated from claims data, as well as data from vital statistics and patient experience surveys.

## **Evaluation Measures and Methods**

The evaluation measures and methodology described in the SPA are reproduced in Table 4 below. Ohio will use annual HEDIS data to evaluate inpatient admission, readmission, emergency department visits, and skilled nursing facility admissions. The 26 performance measures will be used to evaluate clinical outcomes and for quality improvement. Assessment of processes and lessons learned will be conducted through the Medicaid Health Homes learning collaboratives, which will elicit and analyze feedback on implementation successes and challenges and review evaluation data and reports. To estimate cost savings, Ohio intends to use a pre/post design with a comparison group. Savings will be evaluated by comparing per member per month (PMPM) costs for a baseline period and the evaluation period for health home enrollees with those for similar beneficiaries with SPMI who are not enrolled in health homes, with further adjustment for individual and geographic characteristics.

<b>TABLE 1. Target Population and Designated Providers--Ohio</b>	
<b>SPA Approval (Effective Date)</b>	September 17, 2012 (October 1, 2010)
<b>Designated Provider(s)</b>	CBHCs
<b>Health Home Team Composition</b>	<ul style="list-style-type: none"> <li>• Health home team leader</li> <li>• Embedded primary care clinician</li> <li>• Care manager</li> <li>• Qualified health home specialist</li> </ul>
<b>Target Population</b>	Beneficiaries who meet the state definitions for SPMI, SMI, or SED

<b>TABLE 2. Health Home Service Definitions--Ohio</b>	
<b>Care Coordination</b>	Care coordination is the implementation of the single, integrated care plan. With a person-centered focus, the CBHC will facilitate and direct the coordination, communication, and collaboration which is necessary for the individual to demonstrate progress on the goals/actions of the care plan and achieve optimal health outcomes. This will include, but not be limited to, the following: providing assistance to the consumer in obtaining health care; performing medication management and reconciliation; tracking tests and referrals with the necessary follow-up; sharing the crisis plan, assisting with and coordinating prevention, management and stabilization of crises and ensuring post-crisis follow-up care is arranged and received; participating in discharge planning; and making referrals to community, social and recovery supports. The CBHC-HH will be required to assist the individual with making appointments and validating that the services were received.
<b>Comprehensive Care Management</b>	Comprehensive care management begins with the identification of eligible individuals. The health home will be responsible for identifying individuals with SPMI who are currently affiliated with the health home site. SPMI individuals without a CBHC affiliation or a routine source of health care may be identified through referral from another provider or an administrative data review and connected to a CBHC-HH to begin the comprehensive care management process. The next step is for the CBHC to engage the eligible individual and his/her family by explaining the benefits of participation and receiving health home services, and the right to opt-out of HH services. The health home will complete a comprehensive assessment of the individual's physical health, behavioral health, long-term care and social needs. The assessment must account for the cultural and linguistic needs of the individual and use relevant comprehensive data from a variety of sources, including the individual/family, caregivers, medical records, team of health professional, etc. At a minimum, the CBHC-HH will reassess the individual at least once every 90 days. Based on the health assessment, the CBHC health home will assemble a team of health professionals, and establish and negotiate roles and responsibilities for each member of the team, including the accountable point of contact. The health home will develop and continuously update a single care plan that will include prioritized goals and actions with anticipated timeframes for completion and will reflect the individual's preferences. Prior to implementation of the care plan, a communication plan must be developed to ensure that routine information exchange, collaboration, and communication occurs between the team members, providers, and the individual/family. The CBHC-HH will frequently and routinely monitor the care plan to determine adherence to treatment guidelines and medication regimes, barriers to care, or any clinical and nonclinical 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.

**TABLE 2 (continued)**

<b>Health Promotion</b>	Health promotion services are intended to equip the individual/family with relevant knowledge and skills which will: increase his/her understanding of diseases/conditions identified in the assessment, promote self-management, and improve quality of life and daily functioning. This may be accomplished through the following examples: education about wellness and healthy lifestyle choices; provision of or referrals to evidence-based wellness programs; and connections to peer supports. A focus of health promotion will be to support and engage the individual and the family in the development, implementation and monitoring of the care plan. By empowering the individual and promoting self-advocacy, there will be an increased ability to be proactive in the self-management of existing conditions, increase the utilization of preventative services, and accessing care in appropriate settings.
<b>Comprehensive Transitional Care</b>	Comprehensive transitional care services are designed to ensure continuity of care and prevent unnecessary inpatient readmissions, emergency department visits and/or other adverse outcomes, such as homelessness. The CBHC-HH will develop arrangements with inpatient facilities, emergency departments and residential facilities for prompt notification of an individual's admission and/or discharge to/from a hospital emergency department, inpatient unit or residential facility. The CBHC-HH will coordinate and collaborate with inpatient facilities, hospital emergency departments, residential facilities and community partners to ensure that a comprehensive discharge plan and/or transition plan, and timely and appropriate follow-up is completed for an individual who is transitioning to/from different levels and settings of care. The CBHC-HH will conduct and/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.
<b>Individual and Family Support Services</b>	The CBHC-HH will offer and/or arrange for on-site and off-site community and social support services through effective collaborations with social service agencies and community partners. The CBHC-HH 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-HH will assist the consumer in making appointments, validate the service was received, and complete any follow-up as necessary.

<b>TABLE 3. Goal-Based Quality Measures--Ohio</b>	
<b>Improve Cardiovascular Care</b>	<u>Clinical outcome measures:</u> <ul style="list-style-type: none"> <li>• Cholesterol management for patients with cardiovascular conditions</li> <li>• Controlling high blood pressure</li> </ul>
<b>Improve Care Coordination</b>	<u>Experience of care measures:</u> <ul style="list-style-type: none"> <li>• SAMHSA National Outcome Measures (NOMs): general satisfaction with care, access to care, quality and appropriateness of care, participation in treatment, cultural competence</li> </ul> <u>Quality of care measures:</u> <ul style="list-style-type: none"> <li>• Timely transmission of transition record</li> <li>• Reconciled medication list received by health home</li> </ul>
<b>Improve Diabetes Care</b>	<u>Clinical outcome measures:</u> <ul style="list-style-type: none"> <li>• Comprehensive diabetes care: HbA1c level</li> <li>• Comprehensive diabetes care: LDL-C screening</li> </ul>
<b>Improve Care for Persons with Asthma</b>	<u>Clinical outcome measures:</u> <ul style="list-style-type: none"> <li>• Use of appropriate medications for people with asthma</li> </ul>
<b>Improve Health Outcomes for Persons with Mental Illness</b>	<u>Clinical outcome measures:</u> <ul style="list-style-type: none"> <li>• Proportion of days covered of medication</li> </ul> <u>Experience of care measures:</u> <ul style="list-style-type: none"> <li>• NOMs as listed above</li> </ul> <u>Quality of care measures:</u> <ul style="list-style-type: none"> <li>• Follow-up after hospitalization for mental illness</li> <li>• Annual assessment of BMI, glycemic control, and lipids for people with Schizophrenia who were prescribed antipsychotics</li> <li>• Screening for clinical depression and follow-up plan</li> <li>• Annual assessment of BMI, glycemic control, and lipids for people with Bipolar Disorder who were prescribed mood stabilizers</li> </ul>
<b>Improve Preventative Care</b>	<u>Clinical outcome measures:</u> <ul style="list-style-type: none"> <li>• Percent of live births weighing less than 2,500 grams</li> </ul> <u>Quality of care measures:</u> <ul style="list-style-type: none"> <li>• Prenatal and post-partum care</li> <li>• Adult BMI assessment</li> <li>• Weight assessment and counseling for nutrition and physical activity for children/adolescents</li> <li>• Adolescent well-care visits</li> <li>• Adults' access to preventive/ambulatory health services</li> <li>• Appropriate treatment for children with upper respiratory infections</li> <li>• Annual dental visit, age 2-21</li> <li>• Annual dental visit, age 22 and older</li> </ul>
<b>Reduce Substance Abuse</b>	<u>Quality of care measures:</u> <ul style="list-style-type: none"> <li>• Initiation and engagement of alcohol and other drug dependence treatment</li> <li>• Smoking and tobacco use cessation</li> </ul>
<b>Improve Appropriate Utilization/Site of Care</b>	<u>Clinical outcome measures:</u> <ul style="list-style-type: none"> <li>• Ambulatory care-sensitive condition hospitalization rate</li> <li>• Inpatient and emergency department utilization rate</li> <li>• All-cause readmission</li> </ul>

<b>TABLE 4. Evaluation Methodology--Ohio</b>	
<b>Hospital Admission Rates</b>	The state will use claims data and HEDIS methods to calculate admission rates for general hospital/acute care, inpatient alcohol and other drug services, and inpatient mental health services discharges. It will also use this data to calculate the number of inpatient stays that were followed by an acute readmission for any diagnosis within 30 days.
<b>Chronic Disease Management</b>	The state will use claims data to calculate performance measures to monitor the management of the following chronic diseases and conditions: heart disease, hypertension, obesity, diabetes, asthma, schizophrenia, bipolar disorder, and alcohol and other dependence.
<b>Coordination of Care for Individuals with Chronic Conditions</b>	The state will use claims data to determine whether health homes received a reconciled medication list at the time of discharge and to monitor whether transition records were transmitted to health homes within 24 hours of a discharge.
<b>Assessment of Program Implementation</b>	The state has selected 26 performance measures that will be used to evaluate clinical outcomes and for the purposes of quality improvement.
<b>Processes and Lessons Learned</b>	The state will develop Medicaid Health Home Learning Communities as an ongoing quality improvement effort. The Learning Communities will elicit feedback to understand any operational barriers of implementing health home services, review evaluation data and reports, and review relevant program feedback to determine which elements of the health home service delivery are working and which are not.
<b>Assessment of Quality Improvements and Clinical Outcomes</b>	The state has selected 26 performance measures that will be used to evaluate clinical outcomes and for the purposes of quality improvement.
<b>Estimates of Cost Savings</b>	Changes in PMPM costs will be evaluated over time for the 2 distinct SPMI populations--those enrolled in health homes and those not enrolled in health homes. The latter group will serve as the control. The PMPM costs for both groups will be calculated for each year of implementation and compared to costs in an unspecified baseline period. Actual costs (those generated for the health home population) will be compared to expected costs (those generated for the control group) to determine program savings associated with the health homes initiative. Findings will be adjusted for populations and geographic characteristics. Dual eligible enrollees will be evaluated separately.

## Endnotes

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18. State definitions are detailed in 5122-29-33 health home service for persons with serious and persistent mental illness. Available from: <http://codes.ohio.gov/oac/5122-29-33>.
19. Ohio Department of Mental Health and Addiction Services Memorandum. August 14, 2013. Available from: <http://mha.ohio.gov/Portals/0/assets/Planning/Medicaid/Health%20Home%20update%20081413.pdf>.

This paper is an attachment to the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation (ASPE) report “***Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Annual Report - Year Two***”. The full report is available at: <http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.cfm>.

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# EVALUATION OF THE MEDICAID HEALTH HOME OPTION FOR BENEFICIARIES WITH CHRONIC CONDITIONS: Annual Report - Year Two

## Files Available for This Report

### Full Report (including state appendices)

Executive Summary: <http://aspe.hhs.gov/daltcp/reports/2014/HHOption2es.cfm>  
HTML: <http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.cfm>  
PDF: <http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.pdf>

### Alabama appendix only

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