Anthem is committed to supporting the Virginia Department of Medical Assistance Services' (the Department) goals to establish health homes to reduce fragmentation in care, enhance access to services that address the holistic service needs of members, increases service coordination and care management, facilitates transitions in care, promotes self-care and health promotion, as well as links to community services and supports. The management of the full behavioral health benefit (Option B) for Anthem BHH members supports a holistic approach to care as well as the full integration of primary and behavioral health services.

Anthem is experienced in establishing health homes. We have established PPACA Section 2703 health homes consistent with CMS approved State Plan Amendment in New York (January 1, 2012), Washington (July 1, 2013), and Kansas (July 1, 2014) for broad populations covering a number of chronic conditions. We are also working with health homes in States in which we manage Medicaid benefits but in which State approved health homes do not directly involve the MCOs in the administration of the health home program, including West Virginia, Maryland, and Wisconsin. Support and consultation is provided in other states, which are in various stages of planning and development, including California, Kentucky, and Tennessee. Thus, while health home programs are a relatively new service model promoting a holistic focus and coordinating of care across the service delivery system, Anthem has been an active leader in the implementation of health homes across the country.

A Behavioral Health Home is defined as integrated, person-centered services, with close coordination and collaboration with physical and behavioral *service delivery system* aimed at individuals with serious mental illness/serious emotional disturbance and at risk of complex, chronic physical health conditions – fueled by exchange of health information, evidence-based practices and care coordination. Health homes are intended to improve outcomes by reducing fragmented care and promoting patient-centered care.

In Virginia, we are implementing a version of Behavioral Health Homes, entitled Enhanced Care Coordination (ECC), as a component of the Commonwealth Coordinated Care demonstration. Based on this early work, we offer the following proposal to the State.

I. Establish a pilot Behavioral Health Home based on the ECC model
II. Structure a partnership with a specific CSB and a FQHC in the geographical-vicinity to collaborate to provide a Behavioral Health Home for identified members with a primary focus on the core health home services. Establish an agreement with a community-based behavioral health services organization (CSB) to establish an integrated Behavioral Health Home offering physical and behavioral health services (co-located) as well as care coordination, care management, health promotion with linkages to community services and supports. CSB and FQHC Partners have been identified and planning meetings executed.
III. Develop a robust pilot/demonstration Health Home which will most-likely be located in the Greater Richmond Area.

Health Home Services

At the core of health home services are the activities of a care coordinator who engages the member in developing a health services plan broadly defined to address physical and behavioral health issues as well as socio-economic issues related to housing, employment, social connections, and meaningful

community participation. Traditional health services including physician primary care services, specialty services including psychiatric services, test and procedures, emergency services and facility/inpatient services are all covered per established benefit levels.
The core health home services as defined by CMS include:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care
- Individual and family support (includes Auth Rep)
- Referral to community and social support services
- HIT to link services, as feasible and appropriate

A core requirement is that the Health Home provides a community-based care manager to *engage* the member in health services, to serve as a link between physical and behavioral health professionals as well as coordinating with specialists and facilitating continuity in services during transitions between service environments. The care manager addresses barriers to service access, *promotes self-care and active member participation in decision-making* regarding health status and condition management. The member is provided information about his or her condition(s) and tools and techniques to manage the condition(s) which may include diet and exercise, medication adherence and monitoring of health condition; such as, a person with diabetes monitoring blood sugar levels.

A field based care manager is thus a valuable resource to Anthem Care Coordinators who can be positioned to interact with community-based care managers in facilitating availability and authorizations of identified services and supports, monitor member service utilization, monitor for condition concordant services, and identify gaps in services.

The care manager who may be a person with background and education in nursing, social work, psychology or other health and human service fields examples of the types of activities the care manager may engage as part of the core services include:

- Coordinate behavioral health and medical care including linking/referring to specialty establish a person-centered care plan based on a biopsychosocial assessment
- Develop safety plans; advanced directives
- Provide individual and family supports
- Health promotion, helping individuals to maintain health
- Facilitate collaboration between physical and behavioral health providers
- Follow/monitor treatment for acute illness
- Engage in medication reconciliation
- Coordinate with other specialty treatment providers
- Monitor ED and Inpatient admissions to ensure transitions in care are coordinated
- engage patients in self-care regarding chronic conditions
- Facilitate palliative care, end of life decisions and supports, family engagement, pain management
- Collaborate with primary care and specialty providers on a routine basis regarding current medical status, progress made to date in stabilizing/improving chronic conditions, and modifying treatment plan to address newly identified needs/issues.

- Ensure that all serious behavioral health/medical issues are reported immediately and assist consumer to access relevant treatment providers.
- Ensure that treating BH practitioners are aware of current prescribed medications, & preferred packaging/administration methods.
- Assist members to utilize effective decision making & problem-solving skills in managing their medical conditions and general health.
- Assist the consumer to develop a crisis support plan for behavioral health and medical needs.
- Collaborate with MCO CM on a regular basis to keep MCO apprised of member's status.
- Assist consumer to monitor and maintain Medicaid eligibility.
- Actively support/assist consumer to transition between levels of care, to include proactively assisting with transitional planning and follow-up with appointments upon discharge
- Linking, referring and facilitating access to community based services to ensure stability, and closely monitoring progress.

A second core requirement of this ECC based care model is the co-location of a medical RN within the CSB to provide both member support and provider care manager consultation to promote and ensure improved clinical outcomes in members assigned to the pilot. Key functions of the RN position will include the following:

- Facilitate bidirectional exchange of information between the PCP office and CSB Health home
- Integrate separate BH and medical care plans into to a single holistic plan of care.
- Collaborates with the care coordinator/CM as necessary to ensure the implementation of holistic plan of care
- Serve as the medical "link" between the member, the PCP office and care manager.
- Provide on-site medication reconciliation services
- Reinforce medical instructions in the presence of the CM
- Provide condition based education to members within the pilot.
- Provide on-site condition based training to CM managers
- Co-leads clinical rounding with the BH CM to ensure the delivery of holistic plans of care
- Facilitates Medical appointments
- Reinforce medical instructions given at appointment with CM present
- Ensure continuity following member receipt of care in medical setting: ED, acute medical hospitalization

A third core component of this ECC based model of care with RN onsite support is telephonic RN supervision by PCPs within the participating FQHC. This FQHC-CSB RN relationship will foster both the bidirectional flow of clinical information and clinically indicated referrals.

Anthem Philosophy of Health Home Services

Anthem promotes Health Homes with a holistic orientation that recognizes the importance of integrating primary and behavioral health services while coordinating linkages to long-term community services and supports. Member choice and person-centered services are emphasized. Health homes are responsible to assign a care manager to each health home member to facilitate engagement, self-care, and coordination between health service providers, as well as community based services and supports. A health home ensures a holistic approach addressing physical and behavioral health issues, by developing and implementing a person-centered service plan that addresses physical and mental health as well as community services and supports. The health home uses technology to promote coordination

of health services, incorporates standardized protocols and best practices, and uses information systems to automate reminders for predictable and expected service activities. It engages members in preventive health services and monitors the member's response to interventions.

A Behavioral health home may be defined to include more than one organization to ensure that a team of health professionals are available to address the health service needs of the individual. Significant to the Health Home is a community-based care manager. For example, Anthem's initial activities in Virginia include building linkages and memorandum of understanding between Community Service Boards and Federal Qualified Health Centers as well as a co-located care manager. This place-of-service represents a setting in which an individual usually seek services, feels comfortable in the setting, and has a greater likelihood of participating in a holistic approach to their health service needs.
A provider organization builds on their current relationship with a member through education; outreach and engagement of individuals identified with multiple chronic conditions or a serious mental illness.

Anthem facilitates this process by:

- enrolling Members (meeting criteria for health homes) in health homes that meet provider qualifications and reflect member choice
- sharing clinical information with health home regarding service utilization and acuity risk scores
- monitoring and supporting members by identifying gaps in services
- engaging in ongoing quality improvement to enhance member experience

A significant aspect of health homes is to engage in activities that evolve the health services delivery system. The premise is to move from a focus on acute episodes of care to the importance of engaging the individual over the long term to address current and emerging health service needs.

Move From	Move To
Admit/discharge	Engagement/follow-up
Acute—in-the-moment focus	Long-term care
Specific presenting condition	Holistic—mind and body
Compliance	Adherence
Physician decision-making	Shared decision-making
Passive patient	Active/engaged individual
Episodic documentation	Registries, alerts and reminders

Move From	Move To
File audits, episodic events	Outcomes — clinical, financial and consumer
Disease coping	Disease management and health behaviors
Individual providers	Service team
Volume financial model (FFS)	Value-based financial model (shared risk)

Care Coordination reflects activities to promote continuity and consistency of services provided for a member. The care manger's role is one across time in assisting an individual to manage a chronic condition(s). The care manager promotes collaborations among and between health service providers to promote consistency in a treatment approach as well as to minimize duplication of tests, images, and service interventions and evaluate prescriptions for counter-indicators related to co-occurring conditions. The care manager evaluates continuity of services and consistency of prescribing between physicians. For example, person placed on medications by PCP are changed by hospitalists when person enters hospital; or new prescriptions by specialists for person when in the hospital are not known by PCP, who then changes the prescription.

Establishing effective and efficient coordination through partnering with health home care managers will reduce duplication of efforts while also enhancing overall care coordination and care management that includes the member as an active participant. The following table outlines roles and responsibility for the community-based care manager and Anthem's Care Coordinator to clarify these roles.

Health Home Provider Responsibility	Anthem Responsibility
Acuity Low/Mild **Service mix: Low intensity/Low frequency—periodic**	
• Completing a biopsychosocial assessment leading to a patient-centered treatment plan inclusive of safety issues and an Advance Directive, housing, employment/education, interpersonal relations • Outpatient physical and behavioral health services • Health promotion and prevention (immunizations, screening for health risks including behavioral health) • Providing information on smoking, alcohol use/abuse, nutrition, and exercise • Chronic condition education, self-care plan, monitoring condition (for example, mood scale, HbA1c, blood pressure)	• Provider supports and education—chronic care model, disease/condition guidelines • Provider incentives for care that is compliant with clinical practice guidelines • Monitoring completion of health screening/wellness exams • Monitoring standard of care for chronic conditions • Monitoring for duplication of test and procedures • Monitoring ED visits and inpatient admissions • Providing utilization information to HH • Initiate and supporting development of community supports and services such as supportive housing, transportation, employment, and other community-based servcies
Acuity Mid/Moderate **Service mix: Moderate intensity/Moderate frequency—bi-weekly, monthly**	
All the above, plus: • Acute episodic outpatient services • Occasional ED admissions—care transition services from ED to outpatient • Coordination between PCP and behavioral health • Coordination with medical specialists • Medication reconciliation • Coordinating family supports/social supports • Community referrals	All the above, plus: • Education and support • Post-Hospitalization Stabilization Program for Members transitioning from inpatient care to home • Monitoring of Member utilization of multiple Providers • Monitoring of pharmacy utilization • Monitoring of frequency of contacts by community-based case manager • Service Coordinator interactions with community-based case manager within the health home
Acuity High/Complex **Service mix: High intensity/High frequency—bi-weekly, weekly**	
All the above, plus: • Intensive case management • Pain management • Adjusting treatment protocol as indicated	All the above, plus: • Service Coordinator actively engaged with community-based case manager within the health home to monitor Member engagement and participation in intervention plan

Behavioral Health Home Population

Behavioral health homes consistent with "*A Healthy Virginia*" are proposed to be offered to adults (21+) with a serious mental illness as well as with specific co-morbid serious and chronic health conditions.

Diagnostic groups to include:

- Schizophrenia and other psychotic disorders
- Major depressive disorders
- Bipolar disorders

Serious Medical Conditions

- Hypertension
- Asthma
- Diabetes
- Cancer
- Hypercholesterolemia
- Heart Disease
- Arthritis
- COPD
- Obesity

The following methodology will be applied in order to identify the appropriate members eligible for enrollment in the Anthem Behavioral Health Home.

To be enrolled in an Virginia Mental Health -Health Home pilot, a Medicaid consumer must meet <u>at least ONE of the four pathways during the research time period*</u>[1]:

1. Medicaid Mental Health Claims History

A. 6 or more visits with one or more of the following Mental Health codes (MCO or Magellan)

99605, 99606, 99607	Pharmacological Management
H0004	Counseling & Therapy (Ind)
H0004	Counseling & Therapy (Grp)
S9484	Crisis Intervention
S0201	Partial Hospitalization
H0035	Community Psychiatric Support Tx (Ind)
H0036	Community Psychiatric Support Tx (Grp)

Virginia has many other Medicaid mental health services such as Residential treatment service, targeted case management, Intensive outpatient etc. managed by Magellan which may be important to include in the eligibility criteria for the health home population. Recommend including additional mental health services that are available (covered) and typically utilized by individuals with SMI in Virginia to capture all eligible individuals.

AND

B. One or more Medicaid claims containing a primary mental health diagnoses listed in attached excel sheet – tab 1 **(Diagnosis Codes**)

2. High Mental Health pharmaceutical use defined as:

A. Received 6 or more prescriptions during the research time period from the following drug classes or lists (one prescription = 1 month of medications) – See attached excel sheet – tab 2 **Meds** (includes all the below categories)

OR

B. Received any office administered antipsychotic medication ("J code injectable") – See attached excel sheet – tab 3 **J Codes**

AND In addition to 2A OR 2B, the enrollee must have **BOTH**:

C. One or more Medicaid claims containing a primary mental health diagnoses listed in attached excel sheet – tab 1 (**Diagnosis Codes**)

AND

D. Meets the cost threshold of greater than or equal to the average total Medicaid cost of the SPMI overall population ($10,471)

3. History of Hospital Inpatient Admission

A. The member has had 1 or more inpatient psychiatric hospitalizations in one calendar year, two or more inpatient hospitalizations within 90 days, or has readmitted to an inpatient psychiatric hospital within 30 days of discharge.

AND

B. Has had one or more Medicaid claims containing a primary mental health diagnoses listed in attached excel sheet – tab 1 (**Diagnosis Codes**)

AND

B. Has had Medicaid claims (Medical & BH) during the research period of at least the average total cost of SPMI overall population ($10,471)

4. History of Emergency Room Use

A. Has had 4 or more visits to a hospital emergency department for **any** primary diagnosis

AND

B. One or more Medicaid claims containing a primary mental health diagnoses listed in attached excel sheet – tab 1 (**Diagnosis Codes**)

AND

C. Has had Medicaid claims (Medical & BH) during the research period of at least the average total cost of SPMI overall population ($10,471)

We plan to develop a virtual Behavioral Health Home in partnership with a geographically-desirable and -proximate Community Service Board (CSB) and Federally Qualified Health Center (FQHC) leveraging the Enhanced Care Coordination (ECC) model we currently have in place under the Commonwealth Coordinated Care (CCC) program for our Medicare-Medicaid Plan (MMP). Additionally, the plan will co-locate a medical RN within the CSB who will function to medically support members and to ensure medical-BH collaboration and integration of care plans. Using health care analytics and claims data, individuals will be identified meeting aforementioned diagnostic criteria and matched with a CSB/FQHC for enrollment in our behavioral health home. Letters will be sent to the member introducing the member to the health home program and services.

Quality Management and Outcomes

The behavioral health home is intended to increase access to physical health services as well as lead to less fragmentation and increase collaboration between health services providers. Importantly, behavioral health homes seek to engage the member in self-care through development of a personalized health services plan that is holistic and reflective of the member's health and recovery goals. Quality factors consider engagement and access of health services reflecting that the member receives health services including health promotion, self-care and health maintenance addressing the member's chronic health condition(s).

Outcomes reflect on expected program goals including:

1. Increased PCP visits during the pilot year
2. Reduced hospital admissions
3. Reduced 30 day readmissions
4. Reduced emergency department service utilization
5. Improved health status
6. Increased member and provider satisfaction

Summary

Anthem appreciates the opportunity to work with the Department on the implementation of behavioral health homes, recognizing many of the logistical and operational factors to be addressed in establishing a pilot program. Our experiences in working with other states in launching a health program reflects the importance of approaching this program from a system transformation perspective engaging community health services organizations in a learning community to establish the knowledge, skills and practice orientation that responds to the member in a holistic manner, moves to a team-based approach, and views health services over the long-term engaging the member as an active participant in his or her health and recovery.

Appendices

1. An overview of the Anthem Behavioral Health Homes service delivery model, including implementation of each of the six core services, separately.

Anthem's Behavioral Health Home Pilot is being established in collaboration with a Community Service Board and FQHC. A Behavioral Health Home defines a team to providers who will provide a holistic approach in addressing physical and behavioral health needs and in the provision of enhanced care coordination that includes core health home services. Team members include:

- Medical RN
- Psychiatrists
- Care Coordinator
- Peer Support Specialist

In addition, other health professionals may serve as part of the health services team such as:

- Behavioral Health Professional
- Pharmacist
- Physical Therapists
- Occupational Therapists
- Dieticians
- Optometrist
- Dentist
- Podiatrist
- PCP from the participating FQHC
- Medical Specialists appropriate to the chronic health conditions experienced by the member

The Health Plan may supplement these roles in collaborating with the health Home partner (CSB) to address the comprehensive needs of the member. The Care Coordinator may be a nurse or a social worker who takes the lead in establishing a health action plan (HAP). The HAP addresses acute and long term health goals encompassing chronic health conditions as well as behavioral health conditions incorporating self-care and natural supports.

A medical RN is also a critical role to ensure that health and wellness activities are completed, medication reconciliation is conducted, and acute episodes of care are addressed. Our program design is to include a co-located RN to facilitate the integration of physical and behavioral health services; informing the appropriateness of the Health Action Plan and working with the care coordinator to establish collaborative care between specialists.

The Care Manager provides any of the following six core services to members assigned to the Health Home Partner (HHP).

Comprehensive Care Management

Goal: Provide coordination and collaboration with all team members to promote continuity and consistency of care and minimize duplication of services. Comprehensive care management includes a comprehensive health-based needs assessment to determine the member's physical, behavioral health, and social needs, and the development of a Health Action Plan (HAP). The

following activities are examples of the services that may be included in the provision of Comprehensive Care Management. These activities are documented in the member's care record.

Scenario: A member is identified and approved as a HH eligible participant following program eligibility criteria. The HHP accesses Patient360 via the provider portal to perform a comprehensive review of the member's utilization of benefits and services.

Additional activities may include:

- Reviewing health care utilization data available via Anthem's portal
  - Comparing utilization of services to evidence based guidelines related to diagnoses
  - Comparing utilization of services to standards of care that are age/gender specific
  - Reviewing access to services for trends (ER utilization, PCP visits, hospitalizations, pharmacy use)
  - Reviewing authorizations and claims to gather information on all rendering providers.
- Comparing Anthem's portal information to the member information contained in the HHP health record and updating as appropriate
- Outreaching to the member (calls, letters, emails, and face to face visits)
- Once contact is made with the member, establish rapport, verifying the utilization information that has been gathered , obtain any necessary release of information
- Requesting records from associated providers as needed
- Scheduling and completion of the assessment
- Working with the member to determine health goals based upon gaps in care or other needs identified during the assessment and/or subsequent meetings
- Developing the HAP and providing copies to the member and all providers

<u>Care Coordination</u>

Goal: Provide care coordination that is timely, addresses needs, improves chronic conditions, and assists in the attainment of the member's goals. Initial efforts include ensuring that medical visits are obtained based on best practice, for example if there has not been a medical visit in the past year, ensure an appointment is scheduled and kept. Likewise, if a psychiatric contact is needed ensure this is completed. Provide for ongoing contacts with these health service professions to ensure health and wellness activities are completed. The following activities are examples of the services that may be included in providing Care Coordination and should be documented in the member's care record.

Scenario: As part of the assessment and consultation with the primary care physician it was determined that member should be seen by a dermatologist. The Care Coordinator will assist the member by researching dermatologists available in Anthem's network using the member portal. The Care Coordinator will review the provider options with the member, educate the member about transportation benefits, and assist the member to schedule an appointment and transportation. The Care Coordinator may accompany the member to the appointment and assist in helping the member to understand the information presented. The Care Coordinator will follow up with the member after the appointment to confirm understanding and receipt of new medications or self- care management. The Care Coordinator will provide an update to the PCP or other providers about the new treatment as prescribed by the dermatologist.

Additional activities may include:

- Supporting adherence to treatment recommendations, engaging members in chronic condition self-care, and encouraging continued participation in HH care
- Ongoing activities to achieve the goals listed on the member's HAP
- Monitoring Emergency Department (ED) and in-patient admissions and associates follow up care needs
- Coordination and collaboration with other providers to monitor the member's conditions, health status, medications and side effects, referral for LTSS, and locating non-Medicaid resources
- Engaging members and family/support persons/guardians in decisions, including decisions related to pain management, palliative care, and end-of life decisions and supports
- Creating and promoting linkages to other agencies, services, and supports, assisting in scheduling appointments, and providing follow-up support after appointments

Health Promotion

Goal: Assessment of members understanding of their health conditions, health literacy, and motivation to engage in self-management. Health Promotion includes linking members to educational resources that focus on smoking cessation, diabetes, asthma, hypertension, recovery, and/or other health conditions. HHPs will assist members as they learn to manage their own health and mitigate complications related to their conditions in the prevention or development of other chronic conditions. The co-located RN's role will reinforce an integrated medical and BH care plan. The following activities are examples of the services that may be included in providing Health Promotion and should be documented in the member's care record.

Scenario: The Care Coordinator reviews health information (available on the provider portal or through records received by a rendering provider) for a member and identifies a possible gap in diabetes care. The Care Coordinator received care records from the PCP and confirmed the diagnosis of diabetes but the member denies this diagnosis. The Care Coordinator refers the member to the RN who meets with the member to discuss the diagnosis, shares the health information received from the PCP or other providers that confirms the diagnosis, and explains the meaning of the information. The RN helps the member understand next steps in maintaining good health, how to utilize their benefits to manage their health care, and offers other resources that may provide additional support for diabetes management.

Examples of activities include:

- Encouraging and supporting healthy ideas and behaviors through the sharing of health promotion materials (Ameritips or use of the member portal), training/classes, support groups or other activities
- Engaging members, family members/support persons, and guardians in making health services decisions using decision-aids or other methods that assist the member to evaluate the risks and benefits of recommended treatment (Self-Advocacy)
- Providing health education and coaching to members, family members/support persons, and guardians about chronic conditions and ways to manage health conditions
- Helping to identify and share opportunities to participate in health education classes, seminars, or health fairs

- Implementing motivational interviewing techniques to verify member understanding of self-care, assess their level of motivation to improve their overall health, and meeting the member where they are to provide education related to self- care management
- Encourages member to complete wellness checks as appropriate for their conditions
- Assists the member in understanding their benefits and how to access the services and supports they are eligible to receive

Comprehensive Transitional Care

Goal: Comprehensive care coordination and timely follow up care for each HH member transferred from one caregiver or site of care to another. The HHP will perform a review of all medications to ensure continuity of care for continuing medications and appropriate initiation of new medications and share relevant information to all providers and pharmacies as needed. The medication reconciliation and the following associated transitional care activities are examples of the services that may be included in providing Comprehensive Transitional Care and should be documented in the member's care record.

Scenario: The HHP is notified or becomes aware of an inpatient admission, ER visit, or other transitional care event. Examples of activities may include:

- Calling the member or the facility to obtain details of the admission/event
- Requesting a discharge summary from the facility and confirming PCP/specialists have received a copy as appropriate
- Working with the discharge planner at the facility to schedule follow up visits (within 72 hours of discharge for behavioral health follow up appointments and within 7 days of discharge for physical health follow up appointments)
- Ensuring transportation is arranged if needed
- Offering to attend follow up appointments if the member needs assistance
- Reconciling medications
- Providing medication education and notifying all rendering providers of reconciled medication list
- Updating the HAP if needed
- Determining the need to update a comprehensive assessment (if the members condition indicates a substantial change in health)
- Determining updates in needs assessment related to waiver service, LTSS supports/services (if applicable), change in Person Centered Support Plan (if applicable), home modifications, durable medical equipment needs, home health needs, therapy needs/appointments, home safety modifications, offer assistance to family/other supports, provide referrals to community service providers if indicated
- Confirming member understanding of follow up and/or self- care related to the inpatient stay or ER visit
- Visit to the RN who will review the hospital discharge instructions, reconcile medications and ensure the information is communicated to the PCP.
- **Follow member progress at least once weekly after discharge to ensure attendance at follow up appointments, medication adherence, self- are, etc. Weekly follow up should occur for 30 days post discharge.**

Individual and Family Support

Goal: Increase the member's, family/support persons and guardians understanding of the effect(s) of the health condition on the member's life and improve adherence to an agreed upon treatment plan with the ultimate goal of improved overall health and quality of life. The following activities are examples of the services that may be included in providing Individual and Family Supports and should be documented thoroughly in the members' care record.

Scenario: The Care Coordinator visits the member and their family. The Care Coordinator facilitates a discussion about the member's Health Action Plan and how the family members might be able to help the member be successful in meeting these goals. As an example, the members Health Action Plan goal may be to lower their LDL cholesterol by avoiding fried foods. The family member may work at a restaurant and routinely brings home leftover fried foods. The discussion could focus on how to show love in another way, how avoiding bringing these foods home supports the member's goal, available educational opportunities that strengthen member self-care and family support, and whether there are alternative food choices that would be healthier options.

Examples of activities include:

- Completing screening tools or questionnaires with the member and family/support persons that help identify gaps in self-care knowledge, environmental risks, personal safety, management of finances, etc.
- Offering information to the member and family/support persons about community resources such as support groups, educational seminars, health fairs or other activities that are available online, via phone, or in person
- Ensuring member and family/support persons understanding of and appropriate use of all Medicaid benefits, waiver benefits, or other services

Referral to Community and Social Support Services

Goal: Provide referrals to community supports and services includes long-term care, mental health and substance use services, housing, transportation, and other community and social services needed by the member. The following activities are examples of the services that may be included in providing Referral to Community and Social Supports and should be documented thoroughly in the member's care record.

Scenario: The Care Coordinator arrives at the member's home for a scheduled visit. The member appears disheveled and is having difficulty walking. During the visit the Care Coordinator asks the member if they are having difficulty in walking. The member states that it has become difficult to walk without having the support of holding onto items throughout the home and self-care has become more difficult as well. The member states there are no family members in the area to assist and they don't have the income to pay for a helper. The Care Coordinator compiles a list of the members needs and begins the process of identifying, explaining and managing referrals to resources that may be available to assist the member.

Examples of activities include:

- Completing or following up on referrals to community supports and services as needed

- Assisting the member in advocating for access to care by helping to complete paper work and/or applications, making phone calls
- Identifying and establishing natural supports if services providers are unavailable in the member's community
- Assisting the member in establishing and maintaining relationships with community services providers, e.g., Home and Community Based Services (HCBS) providers, faith-based organizations, food pantries, meals on wheels, home health, utility assistance
- Providing comprehensive explanations of all options for managing needs so member can make informed choices

2. Process for monitoring involvement by the member and Health Home Partner.

Anthem's Health Home Case Managers and the Outreach Care Specialist aid in the development and delivery of health home services in conjunction with the HHPs. Our staff is available for consult and offers guidance on assessment of physical and behavioral health conditions. Our Case Managers can be present to help coordinate services as well as HAP delivery upon request of the HHP. Our staff reviews submitted HAPs for completeness and member participation by reviewing the goals, objectives, and also the signature page. If a HAP is submitted without a signature page to help indicate member participation, we reach out to the HHP for resolution.

Information our staff collects for/prior to HAP completion with the Health Home Partner:

- Verification of eligibility; HH enrollment; any other health insurance present;
- Verification of assigned HHP; check HIPAA and responsible person(s) information; recent hospitalizations and notes; if there is a guardian/DPOA and paperwork is not on file, we request a copy prior to the visit to be faxed in and sent to the appropriate department for retention.
- Check HEDIS alerts; number of Emergency Room and Inpatient visits; any behavioral health authorizations in place; gather provider and pharmacy addresses and phone numbers; diagnoses; Waiver information; recent prescriptions from pharmacy claims along with prescribing physician; labs info if applicable.
- Verify/document assigned LTSS Service Coordinator; Physical Health Case Management or Behavioral Health CM; check medication list; alternate contact information; documentation of possible guardian information.
- Documentation from recent inpatient stays; as applicable - discharge date, discharge meds, discharge instructions, etc.

How our staff assist in completing a HAP with the HHP:

- Load of the Adult/Pediatric initial assessments and Health Risk Assessments into the iPad to complete while attending the HAP visit. If our Nurse Case Managers are completing the HAP, this will also be loaded into the iPad.
- Provision of support if the HHP Care Coordinator has questions regarding aspects of the HAP
- Provision of education and assistance to families as needed to help to identify gaps/barriers, etc. along with assistance with troubleshooting and goal setting as needed.
- Address HEDIS alerts if applicable.
- An e-mail is sent to the member's LTSS Service Coordinator, Physical Health case manager, or Behavioral Health case manager advising them of the member's HH enrollment, who the assigned HHP is, and if there is an assigned care coordinator. Contact information for the

HHP is provided and the Service Coordinator or Case Manager is advised of the date and time of the face to face meeting and sent an invite to attend.

Ongoing monitoring and support of the HHP includes regular monthly meetings with the HHP to identify challenges, barriers, and success in carrying out the HH program and services as well as reviewing member engagement and service utilization.

3. CMS Core measures for health homes

CMS Required Core Quality Measures			
Measure Title	**Measure Definition**	**Numerator**	**Denominator**
1. Adult Body Mass Index (BMI) Assessment	Percentage of members 18-74 years of age who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to the measurement year	Body mass index documented during the measurement year or the year prior to the measurement year	Members 18-74 of age who had an outpatient visit
2. Ambulatory Care-Sensitive Condition Admission	Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 populations under age 75 years.	Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years	Total mid-year population under age 75
3. Care Transition – Transition Record Transmitted to Health care Professional	Care transitions: percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.	Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care
4. Follow-Up After Hospitalization for Mental Illness	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit,	An outpatient visit, intensive outpatient encounter, or partial hospitalization (refer to Table FUH-C in the original measure documentation for codes to identify visits) with a mental	Members 6 years of age and older discharged alive from an acute inpatient setting (including acute

CMS Required Core Quality Measures			
Measure Title	**Measure Definition**	**Numerator**	**Denominator**
	an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.	health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.	care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December of the measurement year
5. Plan- All Cause Readmission	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	Count the number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination	Count the number of Index Hospital Stays for each age, gender, and total combination
6. Screening for Clinical Depression and Follow-up Plan	Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented.	Total number of patients from the denominator who have follow-up documentation	All patients 18 years and older screened for clinical depression using a standardized tool
7. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received the following: • Initiation of AOD treatment. • Engagement of AOD treatment.	"Initiation of AOD Dependence Treatment: Members with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis.	Members 13 years of age and older as of December 31 of the measurement year with a new episode of AOD during the intake period, reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators.
8. Controlling High Blood	The percentage of patients 18–85 years of age who had a	The number of patients in the denominator whose most	Patients 18-85 with hypertension.

CMS Required Core Quality Measures			
Measure Title	**Measure Definition**	**Numerator**	**Denominator**
Pressure	diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.	recent, representative BP is adequately controlled during the measurement year. For a member's BP to be controlled, both the systolic and diastolic BP must be <140/90mm Hg.	A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the first six months of the measurement year.
See: Core Set of Health Care Quality Measures for Medicaid Health Home Programs Technical Specifications and Resource Manual for Federal Fiscal Year 2013 Reporting (CMS March 2014)			