

## **REQUEST FOR INFORMATION (RFI)**

### **Maine Department of Health and Human Services**

### **“Stage B” Health Homes for Adults with Serious Mental Illness (SMI) and Children with Serious Emotional Disturbance (SED)**

#### **Purpose and Objective**

This document is a request for comments regarding certain aspects of the Maine Department of Health & Human Services’ (the Department’s) Value Based Purchasing (VBP) Strategy, focusing on:

The Department’s plans to take advantage of Section 2703 of the Affordable Care Act, establishing Health Homes to serve MaineCare and Medicare-Medicaid dual enrollees (both children and adults) with significant mental health and co-occurring needs.

For more information on the Department’s Value Based Purchasing Strategy, see:

<http://www.maine.gov/dhhs/oms/vbp>.

Response to this RFI is voluntary. The State is seeking information that may be of use for future policy development. Any individual or entity may respond to the RFI, including but not limited to individuals, social service organizations, advocacy organizations, mental health providers, primary care providers, hospitals and health systems. This RFI, and responses to it, does not in any way obligate the State, nor will it provide any advantage or disadvantage to respondents in potential future applications or Requests for Proposals for competitive procurement. Respondents are responsible for all costs associated with the preparation and submission of responses to this RFI.

All responses to this RFI are public.

#### **Request for Information Schedule**

**Posting:** April 25, 2013

**Deadline for Questions:** 5:00 PM Eastern Standard Time, May 3, 2013

**Answers Published:** 5:00 PM Eastern Standard Time, May 17, 2013

**Final submission date:** 5:00 PM Eastern Standard Time, June 14, 2013

#### **Background and Goals**

On August 26, 2011, the Department announced its value-based purchasing strategy to achieve the right care for the right cost through three primary goals:

## 1. Strengthen Primary Care

- *Health Homes*: building off Maine’s multi-payer Patient Centered Medical Home (PCMH) Pilot, the Department is taking advantage of Section 2703 of the Affordable Care Act to better coordinate care for individuals with chronic conditions (in Stage A) and individuals with significant behavioral health needs (in Stage B).
- *Primary Care Provider Incentive Program (PCPIP)*: the Department is evaluating the current PCPIP program to better incent improvement, align with quality measures from other purchasers, and emphasize the reduction of inappropriate Emergency Department (ED) use.

## 2. Improve Transitions of Care

- *Emergency Department (ED) Collaborative Care Management Project*: MaineCare continues to convene hospital EDs and surrounding community supports across the state to better coordinate care for MaineCare members with high utilization of the ED.
- *MaineCare’s Health Homes Initiatives*: A primary goal of Maine’s Health Homes is to improve patient transitions of care between inpatient settings, specialty care, residential and institutional facilities, and/or their homes.

## 3. Create Accountable Communities, a shared savings Accountable Care organization (ACO) model to incent groups of qualified and willing providers to improve health outcomes and reduce avoidable costs for an assigned MaineCare member population.

This RFI seeks to receive input on Stage B of MaineCare’s Health Homes initiative, serving adults with Serious Mental Illness (SMI) and Children with Serious Emotional Disturbance (SED).

## Health Homes

Section 2703 of the Affordable Care Act establishes the “State Option to Provide Health Homes for [Medicaid] Enrollees with Chronic Conditions.” This option encourages states to develop a Health Homes program, under which the State may receive a 90% federal match for two years, to provide Medicaid beneficiaries that have two or more chronic conditions and/or a serious mental illness, the following services:

- Comprehensive care management
- Care coordination
- Comprehensive transitional care from inpatient to other settings
- Individual and family support
- Referral to community and social support services
- Health promotion
- Use of health information technology

Health Homes are designed to promote comprehensive, coordinated, and patient-centered care to individuals with complex conditions and health care needs. The service builds on and aligns with Maine's work in the development of multi-payer Patient-Centered Medical Homes.

Maine is pursuing the development of the Health Home option in two stages:

### **Stage A: Health Homes for Individuals with Chronic Conditions**

Stage A of the Health Homes Initiative creates Health Homes for individuals with chronic health conditions who do *not* have significant mental health needs. This Health Home option was implemented on January 1, 2013. The Health Home model under Stage A consists of a designated patient-centered medical home practice (the "Health Home practice") that partners with a Community Care Team (CCT) to jointly provide Health Home services to eligible MaineCare members. CCTs coordinate with the Health Home Practice and broader community to provide intensive care management to the practices' highest need patients. Additional information about Maine's Stage A Health Home model can be found at <http://www.maine.gov/dhhs/oms/vbp/health-homes/>.

### **Stage B: Health Homes for Individuals with Serious Mental Health Needs**

Maine's consideration of Stage B Health Homes began with the recognition that the integration of physical and behavioral health care is a critical feature of a high-performing system of care for individuals with significant mental health and co-occurring service needs. Recent research has highlighted that individuals with serious mental illness die at a much younger age; have much higher health care costs than other MaineCare members, and often have difficulty accessing and/or maintaining linkages with or relationships with primary care. In the interest of both good health and better management of resources, integrated care makes sense. Many providers and consumer organizations around the state have been working to provide more integrated care to MaineCare members, across both physical and community mental health care settings. MaineCare would like to expand this work through Stage B of Health Homes.

Community providers in Maine already provide services similar to the core Health Home services delineated in Section 2703 of the ACA through Community Integration for Adults, Targeted Case Management (TCM) for children with serious emotional disturbance, and through Stage A Health Home practices and Community Care Teams. The Department's goal in the development of Health Homes for individuals with serious mental health and co-occurring disorders is to build on existing resources and infrastructure, maintain consumer choice, and at the same time promote the delivery system transformation needed to improve health outcomes and lower cost.

### **Maine's Vision for Integrated Services through Stage B Health Homes**

The Department issued an RFI regarding its Value-Based Purchasing strategy, including its plan to implement Health Homes, in November, 2011. Questions specifically pertaining to the Health Homes model solicited respondents' feedback regarding their interest and capacity in providing Health Home services, as well as respondents' thoughts on suitable models and partnerships to provide Health Home

services. Many behavioral health organizations as well as some of the hospital system respondents indicated their belief that mental health organizations would be the most appropriate Health Home for members with serious and persistent mental illness.

This feedback, along with further discussions with leadership within the Department, lead the Department to determine that a separate Health Homes model with a specific emphasis on mental health/co-occurring expertise would be most beneficial to individuals with SMI and SED.

MaineCare will support integrated behavioral health care for adults with SMI and children with SED through the implementation of Stage B Health Homes. Similar to Stage A:

- Stage B Health Homes will consist of partnerships between primary care and CCTs;
- CCTs in Stage B will coordinate with community-based and social service organizations in order to address the full spectrum of members' needs, including physical health, housing, educational and vocational supports, etc.

In contrast to Stage A, the Stage B Community Care Team must demonstrate specific expertise in serving individuals with SMI and/or SED. Furthermore, while in Stage A of the Health Home initiative the primary point of access for the majority of individuals in Health Homes is the primary care practice, in Stage B the primary access point for the majority of individuals with SMI and SED will be through the Stage B CCT.

Stage B Health Homes will consist of qualified organizations with mental health and co-occurring expertise that partner with primary care providers to deliver Health Home services. Stage B Health Homes will integrate with and not duplicate services currently offered to Mainecare members. Using the flexibility and scope of a 2703 State Plan Amendment (SPA), MaineCare will work with new and existing qualified providers to develop more integrated, more coordinated, and more comprehensive service systems across the state.

Adults with serious mental illness and children with serious emotional disturbance are eligible to receive services through a Stage B Health Home. Individuals with both Medicare and full Medicaid eligibility (dual eligibles) who meet eligibility criteria may also receive these services if they choose to. MaineCare members may choose not to participate in Health Home services.

Stage B Health Homes commit to delivery system transformation. In order to promote the provision of seamless, integrated services with a common locus of care coordination and accountability, the Department is proposing that Stage B Health Homes integrate the services described in Section 17.04-1 Community Integration for adults and Section 13.03(A) Targeted Case Management Services for Children with SED into the service structure of the Health Home. Accordingly, providers who elect to become a Stage B CCT will no longer deliver services under Section 17.04-1 Community Integration (CI) for adults or Section 13.03(A) Targeted Case Management Services (TCM) for Children with SED if they are also providing Health Home services to those populations. Stage B CCT services will take the place of Community Integration for Adults and Targeted Case Management for children's behavioral health for eligible members who choose to receive services through these organizations. Stage B CCT Providers may continue to deliver other mental health services, including those in Section 17.04 2 -9, Section 65 Behavioral Health Services, and TCM services offered to other populations within Chapter II, Section 13 of the MaineCare Benefits Manual.

We recognize that for some providers, capacity to transition to a new service delivery model may be limited. In order to support consumer choice and minimize any disruption in services, community mental health providers that choose not to participate in the Health Home model may continue to offer Section 17.04-1 and/or Section 13.03(A) services. For providers that choose to participate in this new service, we anticipate a period of time for capacity-building and system transition.

CCT providers who currently participate in Stage A of Health Homes may provide both Stage A and Stage B CCT services if they meet the qualifications for both services.

For more information about Health Homes generally, see the Center for Medicare and Medicaid Services' (CMS) State Medicaid Directors' letter regarding Health Homes at <https://www.cms.gov/smdl/downloads/SMD10024.pdf>, and the Center for Health Care Strategies' Health Homes fact sheet at [http://www.chcs.org/usr\\_doc/Health\\_Homes\\_Fact\\_Sheet.pdf](http://www.chcs.org/usr_doc/Health_Homes_Fact_Sheet.pdf).

## **Response Content**

The Department is seeking *detailed, specific, targeted, and actionable* feedback on the following topics:

- 1. Provider Standards and Requirements**
- 2. Payment Models**
- 3. Integration of Physical and Behavioral Health**
- 4. Core Components**
- 5. Performance Measures**
- 6. Rights of Recipients**
- 7. Data Sharing and Data Analytics**
- 8. Member Assignment and Consumer Choice**
- 9. Other**

### **Provider Standards and Requirements**

Minimum requirements for Stage B CCTs may include:

1. Extensive expertise in care management/care coordination for adults and/or children with serious mental health/serious emotional disturbance and co-occurring disorders
2. Demonstrated capacity to provide the six core Health Home services:
  - a. Comprehensive care management
  - b. Care coordination and health promotion
  - c. Comprehensive transitional care from inpatient to other settings

- d. Individual and family support
  - e. Referral to community and social support services
  - f. Use of health information technology, as feasible and appropriate
3. Partnerships with primary care providers that ensure that specific medical screening and primary care services, consistent with current professional standards of care, are provided to all Stage B Health Home members in an integrated, coordinated, and seamless fashion
  4. An Electronic Health Record
  5. Identified clinical and administrative leadership
  6. Participation by leadership and key clinical staff in any and all educational or training opportunities provided by the Department related to the Stage B Health Homes initiative.

In addition to a set of requirements that must be met at the outset of participation, Stage B Health Homes will also commit to full implementation of Stage B Health Home Core Standards within a specified time after implementation. Core Standards will be further defined and quantified, and may include standards regarding:

1. Team-based care
2. Population risk stratification and management
3. Integrated and consumer-driven care planning for each individual served
4. Enhanced access to care
5. Behavioral-physical health and wellness integration
6. Inclusion of consumers and families in implementation and quality improvement
7. Formalized discharge/transition procedures with area hospitals, emergency rooms, crisis services, corrections/juvenile justice facilities, and residential treatment facilities
8. Connection to and collaboration with community resources and social support services
9. Commitment to reducing unnecessary healthcare spending, reducing waste, and improving cost-effective use of healthcare services
10. Integration and use of Health Information Technology (HIT) into care

#### Questions

1. Providers: Describe your overall level of interest in becoming a Stage B Health Home, including capacity to meet minimum requirements. For each of the required Health Home services listed above at Provider Standards and Requirements, (2)(a) through (e), indicate:
  - a. Your capacity to provide the service;
  - b. Whether you would provide the service within your organization or would partner with other organizations;
  - c. If you do not currently have the capacity to provide the service, what resources and assistance you would require to develop the capacity.
  
2. How should “extensive expertise” in mental health services be demonstrated? Options to consider include:
  - a. Adherence to standards that would be developed specifically for the Stage B Health Home Model (describe);
  - b. Accreditation specific to community behavioral health from nationally-recognized accrediting organizations such as JCACO, COA and/or CARF;
  - c. Maine mental health services licensure;
  - d. Combination/Other (describe).
  
3. What minimum capacity of health information technology/electronic health records should a Stage B Health Home entity have to become a Health Home for these populations? If you are a mental health/behavioral health provider, describe your current capacity, including any products/tools in this area specifically designed for behavioral health.
  
4. Please provide any additional comments or suggestions regarding the requirements for providers of this service.

### **Payment Models**

The Department is currently exploring payment options to support Stage B Health Homes. As with Stage A Health Homes, these payment options may include individual per member, per month payments to both the Health Home practice and the Stage B CCT.

### Questions

1. Are there payment models emerging for integrated behavioral health that support more coordinated care and better outcomes?

2. What is the capacity of current community mental health providers to adapt to new models of payment, especially models that may require some data capacity and quality measurement?
3. Should payment be tiered to reflect varying levels of need?
4. How can payment be structured to better integrate and improve access to primary care for MaineCare members with serious mental health needs?

### **Integration of Physical and Behavioral Health**

Stage B Health Homes must have the ability to ensure that specific medical screening and treatment services, consistent with current professional standards of care, are provided to each assigned member by assuring that comprehensive care coordination services are provided in collaboration with primary care. Integrating this care may mean co-location, in-house primary care capacity, and/or close linkages to a primary care provider.

### Questions

1. If you are a provider, describe the current level of integration of primary care and mental health services at your organization. “Mental health services” here means that you are able to meet the needs of adults with a serious mental illness and/or children with serious emotional disturbance. Would your level of integration be categorized as:
  - a. Full integration (both primary care and mental health services are delivered on site via integrated care plan);
  - b. Co-location (primary care is available at the mental health care site through partnering arrangements with other providers, or mental health care is available at the primary care site; care plans are coordinated);
  - c. Collaboration (the mental health or primary care site partners with and refers to local providers to obtain mental health or primary care services for members; care plans are separate).

Please provide any additional detail on your organization’s integration efforts.

2. Mainecare Stage A Health Homes requires the partnership of designated Health Home/Patient-Centered Medical Home practices with designated CCTs to deliver Health Home services. However, we recognize that in Stage B, consumers may not currently receive primary care services through a Health Home/PCMH practice. Community mental health organizations may serve a population that receives care at many different primary care practices. Consumers with serious mental health and co-occurring disorders may also have trouble accessing primary care, especially in rural areas.

- a. What kinds of partnership structures should MaineCare consider in Stage B in order to best support patient choice while promoting the Health Home/Patient-Centered Medical Home primary care model?
3. What non-reimbursement tools/supports could assist you and/or your organization to better integrate behavioral and primary care in order to more effectively serve people with serious mental health and co-occurring disorders (may include telepsychiatry or psychiatric consultation, changes in licensing, resolution of privacy concerns, additional training, etc.)?

### **Core Components**

MaineCare will require that Stage B Health Home services be delivered via a team-based model that provides comprehensive care and promotes good use of existing resources and expertise. In Stage A, that team consists of the Health Home practice plus a CCT. CCTs in Stage A are required to have at minimum a CCT Manager, a Medical Director, and a Clinical Leader. Review of emerging Health Home models in other states that focus on individuals with serious behavioral health needs indicates that these requirements vary, and may include Nurse Care Managers, Clinical Care Managers such as LCSWs who are accountable for overall care management and care coordination, and/or Health Home Specialists who are non-licensed staff that support Care Managers and provide care coordination. States may also require a Medical Director, and incorporate Peer Support Specialists, Vocational Specialists, and other staff.

### Questions

1. What are the critical staff components for the Stage B Community Care Team? What kind of flexibility should be permitted in team composition? What can we learn from Assertive Community Treatment teams or Wraparound services in the state, and how could these models be incorporated into the Stage B model?
2. What kind of capacity and models exist for Peer Support in Maine? How could/should Peer Supports be integrated into the Stage B model? Please describe any promising models being implemented in Maine, including staff qualifications, if available.
3. What kinds of additional staff training or expertise might be required for Stage B Health Home staff, particularly entry level or bachelor's level staff, and does this training currently exist?

### **Performance Measures**

MaineCare will require Stage B Health Homes to be accountable for the quality of care using standards and measures specified by the Department and CMS through the 2703 authority. These measures shall track mental health and functional status as well as physical health processes and outcomes.

### Questions

1. What specific measures would you recommend the Department use to evaluate:
  - a. Quality
  - b. Access?
  - c. Consumer experience of care?
  - d. Improved health and wellness (including functional status and quality of life)?
2. What specific health indicators and/or processes are particularly important in assessing the health of adults and/or children with SMI/SED and co-occurring disorders?
3. Please indicate which measures are already in use in integrated settings and whether they have been endorsed locally or nationally (e.g. SAMHSA's National Outcome Measures, Maine Health Management Coalition's Pathways to Excellence (PTE) measures<sup>1</sup>, CAHPS, NCQA, etc.). Indicate if a measure has yet to be developed. Explain how the measures proposed represent a comprehensive indication of the overall quality of care delivered.
4. How should data in support of these measures be collected?
5. Are there Maine-based behavioral health measures currently in place (through APS, in connection with the AMHI consent decree, etc.) that could or should be leveraged for Stage B Health Home quality measurement? Are there current processes or reporting requirements that should *not* be incorporated into the model, or those that would be redundant?

### **Rights of Recipients**

The development of Stage B Health Homes will need to align with the Rights of Recipients of Mental Health Services, the Health Insurance Portability and Accountability Act of 1996, and 42 CFR Part 2, regarding the privacy of substance use disorder information, as applicable.

### Questions

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<sup>1</sup> See [www.getbettermaine.org](http://www.getbettermaine.org).

Describe any potential conflicts or considerations in managing these varied requirements in an integrated, team-based environment.

1. Provide any thoughts, concerns or input on how to ensure that consumer rights, specifically regarding choice, grievances/appeals, and privacy protections are fully recognized.
2. Generally, how can Stage B Health Homes, through design, core components, peer support, or other means promote/enhance consumer rights, consumer involvement, and a consumer-directed approach to care?

### **Data Sharing and Analytics**

The Department is exploring how to share timely claims data with Stage B Health Homes, including the development of utilization reports that can help identify the need for enhanced care coordination and other interventions.

#### Questions

1. What data would participating providers require to better enable them to improve the value of care under this initiative, and how frequently should this data be provided?
2. What methods for data sharing will enable providers to easily access and analyze the data?
3. If you are a provider, describe the analytic capacity your provider organization would require to become part of a Stage B Health Home Team, and the resources you currently possess to achieve this capacity.

### **Member Assignment and Consumer Choice**

The process of enrolling MaineCare members is important in order to appropriately calculate payment, track utilization, and accurately measure quality and performance. As in Stage A of Health Homes, the Department plans to assign members to Stage B Health Homes based on the services they currently use. Consumers will also receive written information and outreach that notifies them of this new service. Consumers may always change to another service provider and/or opt out of services.

#### Questions

1. Describe the mechanisms necessary to ensure consumer choice, access to services, and seamless transitions.
2. Identify key considerations in providing education and outreach to members about the new service and possible channels or methods to ensure full communication with members about Stage B Health Homes.

#### Other

Please provide any other additional *detailed, specific, targeted, and actionable* feedback on these or other components of the Department's Stage B Health Home model.

## Procedures and Instructions

All submissions, questions, concerns or communications regarding this RFI should be emailed to: [kitty.purington@maine.gov](mailto:kitty.purington@maine.gov).

### Questions

The Department will accept and provide answers to questions that seek clarification regarding the content of this RFI. The Department does not anticipate that it will be able to provide answers regarding detailed plans for the initiative beyond the information currently provided, as the responses to this RFI will play a large role in determining those plans.

### Responses

Email an electronic copy of your responses in Microsoft Word format to [kitty.purington@maine.gov](mailto:kitty.purington@maine.gov) using the subject line: "Value Based Purchasing RFI." Include the attached cover sheet, Attachment A, with your response.

**Responses are to be submitted using the outline sequence in this RFI, by the deadline stated in the schedule above.** Respondents may respond to as many or as few of the components of the RFI as they choose. It is the respondent's sole responsibility to ensure that their submission is received at the proper email address.

Respondents are responsible for all costs associated with the preparation and submission of responses to this RFI.

**Attachment A: Stage B RFI Cover Sheet**

Organization/ Name of Respondent: \_\_\_\_\_

Parent Organization (if applicable): \_\_\_\_\_

Contact Person:

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Please check all boxes which describe the respondent:

- Independent individual respondent
  - MaineCare consumer
  - Parent/guardian of consumer
  - Health care practitioner
  - Other: \_\_\_\_\_
- Provider (check all that apply):
  - Provider of Community Integration Services
  - Provider of Targeted Case Management
  - Provider of peer services
  - Hospital or system-owned/affiliated mental health provider
  - Independent non-profit MH provider
  - Independent for-profit MH provider
  - Primary care provider
  - MaineCare Health Home
  - Community Care Team
  - Hospital or health care system
  - FQHC
- Other: \_\_\_\_\_
  - Tribal Organization
  - Consumer Advocacy Organization
  - Other Advocacy Organization
  - Other: \_\_\_\_\_