The Commonwealth of Massachusetts
Executive Office of Health and Human Services
One Ashburton Place, Room 1109

DEVAL L. PATRICK
Governor

JOHN POLANOWICZ
Secretary

June 2013

To Interested Parties:

The Affordable Care Act (Federal Healthcare Reform) established an opportunity for states to develop "Health Homes" as a way to improve integrated and coordinated care to Medicaid enrollees. The federal government has established certain requirements that must be met for Health Homes – including the services that must be delivered, types of providers that may deliver the services, and individuals that may be eligible – but it allows states flexibility in designing their Health Home benefit.

Massachusetts intends to implement a statewide Health Homes project for MassHealth Members with Serious Emotional Disturbance (SED) and Serious and Persistent Mental Illness (SPMI). Under the Health Homes initiative, designated providers will provide care as Health Homes, if they choose to apply and meet qualifications. The Executive Office of Health and Human Services, Office of Medicaid (EOHHS) is issuing this Request for Information (RFI) to help inform the agency's efforts to develop these Health Homes. This initiative is part of broader developments under way in Massachusetts to move away from payer-based to provider-based care management.

The purpose of this RFI is to elicit information from interested parties on the design and implementation of the Health Homes Initiative. Interested parties include behavioral health and primary care providers, professional organizations, managed care organizations, academicians, and advocates. EOHHS is particularly interested in hearing from behavioral health and primary care providers regarding any programmatic and operational features that EOHHS should consider incorporating into the programs design.

EOHHS is seeking responses to the specific questions listed in the attached RFI. Instructions for responding are provided in **Section IV** of the RFI. Responses are due no later than **July 12, 2013 at 3:00 PM.**

Respondents need not answer every question in this RFI, but should feel free to respond to as many as they feel are appropriate.

Thank you for taking the time to respond to this request.

Sincerely,

Julian J. Harris, M.D., M.B.A., M.Sc.
Medicaid Director

COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Office of Medicaid
One Ashburton Place, 11th floor
Boston, MA 02108

MASSACHUSETTS HEALTH HOMES INITIATIVE

REQUEST FOR INFORMATION

June 2013

Document Number: 13MEEHSMAHEALTHHOMESRFI

I. INTRODUCTION

A. Federal Framework for Health Homes

Massachusetts plans to pursue an opportunity under Section 2703 of the Affordable Care Act (ACA) to develop a Health Home benefit. The Medicaid program in Massachusetts, known as MassHealth, is administered by the Executive Office of Health and Human Services (EOHHS).

The state has some flexibility in designing a Health Home benefit but there are federal requirements, including the services that must be delivered, types of providers that may deliver the services, and MassHealth Members that may be eligible.

Designated Health Home providers will deliver six services to eligible Members:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care;
- Patient and family support;
- Referral to community and social support services; and
- Use of health information technology, as feasible and appropriate.

Participating states receive a federal financial participation rate of 90% for the first eight quarters that Health Home services are available to a specific group of eligible individuals. We expect that all MassHealth Members with SED and SPMI, including those enrolled in managed care and those dually eligible for Medicaid and Medicare or commercial insurance would be eligible for Health Home services as medically necessary.

B. Health Homes in Massachusetts

Through Health Homes, MassHealth aims to strengthen its mental health centers and Community Service Agency (CSA) providers in order to improve integrated care. Massachusetts Health Home providers will improve coordination of care for individuals with complex needs and high costs, as part of the broader MassHealth initiative to improve care for its population.

Massachusetts is developing a Health Homes approach that is well coordinated and aligned with other health care reform and cost control measures. In particular, we expect that there will be strong connections between Health Homes and the Primary Care Payment Reform (PCPR) Initiative.[1]

[1] Information on the Primary Care Payment Reform Initiative is available at http://www.mass.gov/eohhs/gov/newsroom/masshealth/providers/primary-care-payment-reform-initiative.html

The proposed focus is to designate Health Homes to deliver the six Health Homes services to adults with Serious and Persistent Mental Illness (SPMI) and to children with Serious Emotional Disturbance (SED). The Health Home providers will likely be MassHealth contracted mental health centers and CSAs that serve MassHealth youth with SED in the Children's Behavioral Health Initiative (CBHI)

Research indicates that persons served by the public mental health system experience lower life expectancy, in part due to a lack of access to physical health care.[2] Massachusetts aims to integrate primary and behavioral health care in order to improve access to primary health care for individuals with behavioral health conditions.

II. MASSACHUSETTS' VISION FOR HEALTH HOMES

A. Population Criteria

The Massachusetts Health Home project is aimed at members with SPMI or SED. MassHealth's Health Home definition of SPMI is in development, and is informed by definitions in current state programs and those used by other states' Health Home programs. For members under the age of 21, MassHealth will use CBHI's definition of SED.[3] For members over the age of 21, MassHealth is considering the following definitional structure:

1. MassHealth members who are determined eligible for DMH services (which incorporates functional criteria), **OR**
2. Meeting certain utilization criteria during a calendar year, e.g.:
    - Hospitalization for behavioral health disorders (excluding hospitalizations solely for substance use) or suicide and intentional self-inflicted injury, or
    - Three or more emergency department visits for behavioral health disorders (excluding substance use) or suicide and intentional self-inflicted injury **OR**
3. Having claims for specific diagnoses, such as schizophrenia or major depression, bipolar and paranoid disorders (details of specific diagnoses are still to be determined).

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[2] Morbidity and Mortality in People with Serious Mental Illness, National Association of State Mental Health Program Directors, Medical Directors Council; Editors: Parks, Svendsen, Singer, Foti, Technical Writer: B. Mauer. October 2006

[3] The SED definition in contracts with providers: "A behavioral health condition that meets the definition set forth in the Individuals with Disabilities Act (IDEA), 20 U.S.C. § 1401(3)(A)(i) and its implementing regulations or the definitions set forth in regulations governing the Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States Department of Health and Human Services, 58 Fed. Reg. 29422-02 (May 10, 1993), as currently drafted and subsequently amended."

EOHHS estimates that the following numbers of MassHealth members are in each category. The two groups are mutually exclusive, and the categories within each group are hierarchical:

Population Group	N
Group 1: Children receiving CBHI services[a,b]	**40,000**
• *Intensive care coordination (ICC) and/or family support & training services*	*8,500*
• *Other CBHI services*	*31,500*
Group 2: Members meeting SPMI criteria[c]	**156,400**
Adults (age >21)	143,600
Children/Youth (age 21 and under; not part of Group 1)	12,900
For all ages:	
• *Functional criteria (DMH eligibility)[d]*	*16,000*
• *Behavioral health hospitalization[d]*	*11,400*
• *3 or more behavioral ED visits[d]*	*1,300*
• *Diagnostic (SPMI DxCG HCC based on claims) criteria[e]*	*127,700*
Total (unduplicated)[g]	**196,400**

Numbers may not sum to totals because of rounding
[a] Defined as children who received any CBHI service between 1/1/09 and 6/30/11
[b] Classified into two mutually exclusive categories and arranged in a hierarchical order (e.g., children who received both ICC and other CBHI services are only classified in the ICC category)
[c] Classified into four mutually exclusive categories and arranged in a hierarchical order (e.g., members with both a behavioral health hospitalization and with the SPMI DxCG HCC are only classified in the behavioral health hospitalization category)
[d] Based on eligibility and claims/encounter data between 1/1/2010 and 12/31/2010
[e] Based on the presence of SPMI in DxCG HCCs in CY 2009 and CY 2010

B. Geographic Scope

MassHealth plans to implement the Health Homes project statewide.

C. Providers

Under the Health Homes initiative, Massachusetts is considering allowing providers that function as MassHealth contracted mental health centers, qualified hospital-licensed health centers, and community service agencies to offer integrated and coordinated care as Health Homes, if they choose to apply and meet qualifications.

1. MassHealth Contracted Mental Health Centers

MassHealth contracted mental health centers are required to offer a wide range of services for all age groups, including:[4]

- Intake services
- Evaluation and diagnostic services
- Treatment planning services
- Diagnostic and treatment services, which MassHealth regulations[5] further specify as:

  (1) diagnostic services;
  (2) psychological testing;
  (3) long-term therapy;
  (4) short-term therapy;
  (5) individual therapy;
  (6) couple therapy;
  (7) family therapy;
  (8) group therapy;
  (9) medication visit;
  (10) case consultation;
  (11) family consultation;
  (12) crisis intervention/emergency services;
  (13) after-hours telephone service; and
  (14) home visits

- Emergency services, including provision for 24 hour a day, seven day a week clinic coverage for evaluation, diagnosis and disposition for a client's presenting crisis, including short-term intervention and referral
- Referral services

Clinics must provide multi-disciplinary staff, including a board-certified or -eligible psychiatrist and at least two other mental health professionals (psychologist, psychiatric social worker, psychiatric nurse, psychiatric nurse mental health clinical specialist, licensed mental health counselor, licensed alcohol and drug counselor, other licensed practitioners). A facility that provides just behavioral health services – such as a community mental health center – or one that provides additional medical services – such as a community health center – may be a MassHealth contracted mental health center. MassHealth intends to designate as Health Homes those clinics able and willing to upgrade their capabilities to include Health Home services for individuals of all ages with SPMI or SED. As clinics evolve toward more integrated and coordinated care, they may choose to take part in PCPR as well.

[4] Department of Public Health Regulations (105 CMR 140.520) specify adequacy standards for each of these services.
[5] 130 CMR 429.421(B)

2. Hospital-Licensed Health Centers

   Hospital-licensed health centers operate under a hospital's license, but are not physically attached to a hospital. Hospital-licensed health centers are required by MassHealth regulations to offer at least two of the following three services:[6]

   - Pediatric Services;
   - Internal Medicine; and
   - Obstetrics/Gynecology.

   In addition, hospital-licensed health centers are required to offer:

   - Health education;
   - Medical Social Services; and
   - Nutrition Services.

   In order to become a Health Home, a hospital-licensed health center would need to meet certain criteria of providing outpatient behavioral health services and having experience dealing with the population of members with SPMI. In developing the Health Homes benefit, MassHealth will need to define these criteria. One standard may be to require hospital-licensed health centers to be able to provide the same services that MassHealth contracted mental health centers are required to be able to provide (see above).

3. Community Service Agencies

   Massachusetts developed the CBHI, a system of screening and treatment for members with SED. One CBHI service, Intensive Care Coordination (ICC), is targeted case management that offers many Health Home services to individuals with SED. Intensive Care Coordination is offered by 32 CSAs to MassHealth Standard and CommonHealth Members. ICC services include:

   - A care planning team that assesses needs for any medical, educational, social, therapeutic or other services;
   - Development of a person-centered individual care plan;
   - A care coordinator to work with the member, family and care team to achieve the goals of the care plan;
   - Referral to and monitoring and coordination of available services; and
   - Development of a transition plan when the member has achieved the goals of the individual care plan.

   The Health Homes project aims to strengthen each CSA's ability to offer Health Home services. CSAs may choose to become Health Home designated providers by

[6] 130 CMR 410.413

adding care coordination for physical conditions to its services and meeting other Health Home qualifications.

If a CSA chooses not to become a Health Home designated provider, the CSA may still be considered part of a Health Home team for a designated Health Home provider, such as a MassHealth contracted mental health center.

For members with SED who do not have a medical need for ICC, Health Home services will be offered through designated MassHealth contracted mental health centers.

D. Health Home Services

MassHealth is in the process of defining the six Health Home services. Preliminary definitions are as follows:

1. Comprehensive care management

   Comprehensive care management activities generally include frequent patient contact, clinical assessment, and communication with treating clinicians in coordination with a licensed professional as well as medication review and reconciliation and medication adjustment by protocol by a licensed professional. A critical component of comprehensive care management is developing and maintaining an integrated care plan, including medical and behavioral health goals of the member, which delineates the roles and responsibilities of the care team. For children, the integrated care plan includes non-medical services and supports that are essential to the child's behavioral health, such as services provided by schools and state agencies, as well as other formal and informal supports.

2. Care coordination and health promotion

   Care coordination and health promotion includes tracking and assisting patients as they move across care settings and coordinating services with other service providers, including behavioral health, specialty care, inpatient care, social services, natural community supports and long-term care providers. The service also includes ensuring that the exchange of patient information among providers across settings keeps the care team informed of members' health status and whereabouts; developing referral and information-sharing protocols with relevant providers, which stipulate access expectations and include plans for problem solving and coordination; patient empowerment strategies, including motivational interviewing or other interventions; patient education about relevant health promotion strategies. In this program, MassHealth intends to emphasize close coordination among the Health Home, mental health providers, substance abuse treatment providers, and the primary care team. For children, care coordination includes linkages to non-medical services and supports in the community, including schools, juvenile courts, and other formal and informal supports.

3. Comprehensive transitional care, including appropriate follow-up, from inpatient to other settings

   Comprehensive transitional care includes having mechanisms in place to receive information from other providers and payers about a member's movement across settings of care, including visits to the emergency department, or admissions or discharges from inpatient facilities; having protocols in place to exchange patient information with the relevant hospitals or other providers to support discharge planning; having mechanisms to reach out to patients to ensure follow-through on discharge planning. For children, transitional care must include transitions to and from non-medical out of home placements such as foster care, as well as transition from child-serving systems to adult-serving systems for adolescents approaching or of transitional age.

4. Patient and family support, including authorized representatives

   Patient and family support includes providing family and group-based services, including education and training; support for patients and families in identifying goals and priorities; connecting patients and their families with peer support and community members with relevant lived experience. For children, availability of caregiver peer support ("family partners") is an essential element of patient and family support. For older adolescents and young adults, peer support is a highly recommended element of patient and family support.

5. Referral to community and social support services, if relevant

   Referral to community and social support services includes forming connections with relevant community resources, including other state agencies or non-governmental organizations; creating information-sharing protocols with community-based organizations where appropriate; including interactions with community and social support services in the integrated care plan and care team as necessary.

6. Use of health information technology to link services as feasible and appropriate

   Use of health information technology may involve connection to the statewide Health Information Exchange; use of an electronic medical record system; analyzing claims data provided by managed care organizations, or other use of relevant technology.

E. Provider Standards

Massachusetts is considering requiring the following standards for a provider to enroll as a Health Home provider. They would have to:

- Be enrolled in the Massachusetts Medicaid program and adhere to Medicaid program requirements;
- Be a MassHealth contracted mental health center, a CSA, Community Mental Health Center, or a hospital-licensed health center;
- Actively utilize or have the capacity to build in utilization of Massachusetts' Statewide Health Information Exchange;

- Either directly provide, or subcontract for the provision of, Health Home services. The Health Home provider remains responsible for all Health Home program requirements, including services provided by the contractor;
- Ensure each patient has an ongoing relationship with a personal provider, physician, nurse practitioner or physician assistant who is trained to provide first contact, continuous and comprehensive care, where both the patient and the provider/care team recognize each other as partners in care. This relationship is initiated by the patient choosing the Health Home;
- Maintain and update an integrated care plan for all eligible patients, detailing all important aspects of the patient's behavioral health and medical needs, treatment plan and medication list;
- Complete status reports to document clients' outstanding needs with regards to housing, employment status, education, custody, etc.;
- Agree to participate in CMS and state-required evaluation activities;
- Agree to develop required reports describing Health Home activities, efforts, and progress in implementing Health Home services;
- Have a strong, engaged leadership personally committed to and capable of leading the provider through the transformation process and sustaining transformed processes;
- Agree to convene regular, ongoing and documented internal Health Home team meetings to plan and implement goals and objectives of practice transformation.

F. Payment methodology

MassHealth is in the process of developing a payment methodology. At this point, MassHealth is considering a risk-adjusted per-member per-month payment for Health Home services, with a quality incentive payment.

G. Interaction with Other Programs

MassHealth must actively manage the intersection of the Health Homes program with other programs that include care coordination or care management activities in order to ensure that these programs are aligned and to avoid double-paying for services. Relevant programs include:

1. Primary Care Payment Reform

   MassHealth's plan is that a provider may simultaneously be enrolled as a member's PCPR participant and as a Health Home, and payments to the provider for that member will be adjusted to reflect any overlap in Health Home and PCPR services. If, however, a member selects a Health Home that is not her primary care clinician (PCC), the Health Home retains primary responsibility for care management services, and the PCC's role is limited to coordinating with the Health Home in the provision of primary care services.

2. Children's Behavioral Health Initiative

   MassHealth envisions that the Health Home services will apply to members not receiving ICC services, and will provide continuity for children who do not have a medical need for ICC. MassHealth also is investigating the possibility of building upon the existing ICC and Family Support and Training services to include coordination with primary care so that services provided by CSAs could be construed as another element of the Health Homes initiative.

3. Community Based Flexible Supports (CBFS)

   EOHHS, including MassHealth and DMH, is committed to ensuring alignment between DMH Case Management and the CBFS program. Most CBFS providers are also MassHealth contracted mental health centers, and we will work with CBFS providers that would like to become health homes. DMH will work with CBFS providers that do not apply to become health homes to ensure that they appropriately coordinate with their clients' health homes.

4. Department of Mental Health Case Management

   EOHHS, including MassHealth and DMH, is committed to ensuring alignment between DMH Case Management and Health Homes. We envision that a member may receive both DMH Case Management services and Health Home services (through Health Home providers such as DMH or MassHealth contracted mental health centers), with the DMH case manager maintaining a higher level oversight over a care plan that includes responsibilities for the Health Home. The Health Home responsibilities, as opposed to the DMH case manager responsibilities, would include more day-to-day management of the care plan and management of physical and behavioral health conditions.

5. Care management programs from managed care entities (MCOs, ICOs, SCO, MBHP)

   MassHealth plans to release specific guidance to managed care plans for how their care managers should work with Health Homes, including provision of data, coordination of the integrated care plan, and processes for defining roles and responsibilities.

H. Attributing Members to Health Home Panels

MassHealth will associate members with the Health Home with which they enroll for billing and reporting purposes. Health homes will submit claims for services provided to eligible MassHealth members.

I. Quality Measures

MassHealth is in the process of determining which quality metrics might be appropriate for this program. A preliminary set of quality measures is attached as **Attachment 2**.

III. QUESTIONS FOR RESPONSE

EOHHS requests responses to the following questions. We encourage all interested parties to provide comments and suggestions for consideration. Please refer to **Section IV** for an explanation of EOHHS' confidential treatment of trade secrets or commercial or financial information identified as such by the respondent.

1. Respondent characteristics

a. If you provide services, what kind of direct services do you provide?

b. If you provide services, how would you describe the population you serve, and how many people do you serve annually?

c. If you do not provide services, what is your role in the health care system?

2. Health Homes clinical delivery model

a. The ACA defines Health Home services at a broad level, and MassHealth has refined the definitions in Section D of this RFI. Will Health Homes services as defined be beneficial for the population you treat (including, if applicable, special populations such as children, homeless individuals, individuals involved in the criminal justice system, and individuals with co-morbidities)? How should Health Homes services be modified or further specified (e.g., specifying frequency of or mechanism used for services)?

b. Should MassHealth define the licensure level, staffing ratios, or credentials of members of the Health Home team? If so, how?

c. Which services are most important for a Health Home to provide on a 24/7/365 basis? Examples may include phone counseling, access to a peer support, or access to a prescriber who can provide medication management.

d. There may be a subset of the Health Home population who could be considered "high risk" in that they have higher service needs and distinct utilization patterns from other Health Homes eligible members. Members may be defined as high risk based on functional impairment, utilization criteria, other chronic conditions, involvement with state agencies, or other facts. Should MassHealth define standards for identifying "high risk members" within the Health Homes eligible population? If we do define "high risk members" separately, what additional services would they require?

e. Please rank order these healthcare needs identifying 1-3 highest priority needs. Then please comment on each of these needs re: current state and how Health Homes can address this need.

   (1) Need for afterhours access to a clinician with prescribing ability

   (2) Need for afterhours access to clinician for crisis de-escalation

(3) Need for coordination and communication between primary care, behavioral health and other providers/caregivers and the patient (and in the case of children, the family) on the development and implementation of an integrated care plan

(4) Need for updating and communicating changes in care plans based on acute and other occurrences, such as hospitalizations and ED visits

(5) Need for patient-centeredness (or in the case of children, family-driven care) in developing the integrated care plan which may decrease patient adherence with the care plan;

(6) Need for the care plan to incorporate community supports, including peer supports or other resources, or in the case of children and adolescents, failure of the plan to include schools and other community supports including informal supports, and failure to include caregiver peer support ("Family Partners") when needed

(7) Need for resources and strategies to maximize adherence to treatment and engagement of persons served

(8) Need for the care plan to integrate substance abuse treatment

(9) Need for sufficient use and functionality of information technology to facilitate coordination of care across settings

(10) For children and adolescents, need for more appropriate child oriented protocols, standards, and payment provisions that recognize the multiple caregivers and collaterals involved in the child's care.

(11) Others?

f. Are group services, possibly convened by family partners and/or peer specialists for children and families, a valuable component of a new Health Home service?

g. EOHHS seeks to support providers in their ability to connect Health Home participants to both natural (such as a trusted friend, or peer) and formal (such as a provider or state agency) supports. How can EOHHS best support providers in this task, including helping providers connect to the Department of Public Health's substance abuse treatment resources?

3. Member outreach

a. MassHealth members will be notified of their eligibility for Health Home services, and if they so choose to join, will need to actively enroll with a qualified Health Home provider. How can MassHealth design a member outreach strategy to ensure that qualified members who will benefit from Health Home services will learn about and choose to enroll in a Health Home?

b. What role should other stakeholders, including managed care organizations, behavioral health providers, primary care providers, or community groups play in member outreach?

4. **Providers**

    a. Given MassHealth's intent that Health Homes serve to better integrate behavioral health and medical care for members with SPMI (adults) and SED (children and adolescents), should other types of providers be eligible to become Health Homes?
    b. Are the provider standards listed appropriate?
    c. What support would Health Homes require from MassHealth to better integrate with primary care and provide Health Homes services?

5. **Payment**

    a. For MassHealth members enrolled in managed care, should Health Home services be provided (and paid for) by managed care entities, or should Home Health services be provided to such managed care enrollees as a wrap service that MassHealth pays for directly?
    b. What factors or models should MassHealth consider when designing the payment structure for this program?

6. **Data Sharing/EOHHS Responsibilities**

    a. What data would providers need to obtain from EOHHS and/or managed care entities to in order to provide Health Homes services most effectively? Why?
    b. What capabilities should the state require of providers with respect to information sharing and information technology? Should the state require participation in the MassHIway, the state-wide health information exchange? Why or why not?
    c. How can EOHHS facilitate better information sharing through the Health Homes program?

7. **Quality Measures**

    a. The Centers for Medicare and Medicaid Services (CMS) recently proposed a recommended core set of health care quality measures for assessing the Health Home service delivery model (**Attachment 2**). What measures would you add or delete from this list? Should we include surveys that measure patient experience?
    b. We are considering quality measures related to the following goals: improve coordination and integration of care, improve behavioral health care, improve access to outpatient behavioral health care, increase health promotion and prevention, improve chronic disease management, reduce hospital admissions, and reduce emergency room visits. What are your thoughts about these goals? Are any missing or should any be removed?
    c. Should Health Homes quality measures be limited to those endorsed by the National Quality Forum?

8. **Health Information Technology**

    a. If you are a provider, what is your usage of EHR and ability/interest in connecting with the Statewide HIE?

    b. What concerns or barriers do you foresee in communicating across health care settings?

9. **Intersections with PCPR, the Duals Initiative, CBHI, managed care entities, DMH, and case management programs**

    a. What issues do you foresee for Health Homes interacting with other care management and care coordination services available from MassHealth, the Department of Mental Health, and managed care entities?

    b. One suggestion for the Health Home benefit for children and families is to allow families to choose between Intensive Care Coordination (ICC) and Family Support and Training (FS and T) that are currently offered in a Community Services agency (CSA) or an expanded Health Home benefit with the CSA that includes those services and the coordination with primary care for children with co-morbid conditions such as obesity or asthma. Should the Health Home benefit remain with the CSA or should the benefit follow the family when they transition from a Community Service Agency to other outpatient behavioral health programs?

    c. Would you support the inclusion of peer specialists for older adolescents and young adults as part of the Health Home model? How should peer specialists be integrated into CSA's and Mental Health Centers?

    d. What is the best way to incorporate Health Home services into the current service array of Community Based Flexible Supports (CBFS) to improve coordination with the client's primary care provider and other health care providers? What strategies could EOHHS employ to avoid duplicating services between CBFS and health homes?

    e. How might Health Homes intersect with the Program for Assertive Community Treatment (PACT) teams?

10. **Member Protections**

    What member protections (notifications, feedback mechanisms, etc.) should be in place for the Health Homes program?

IV. RFI RESPONSE INSTRUCTIONS

A. RFI Response Instructions

EOHHS requests that RFI responses be submitted by **July 12, 2013, by 3:00 p.m.** Eastern Time. Responses should be submitted in one of the following ways:

- By e-mail (preferred) to: louis.delena@state.ma.us
- In writing to:
  Lou DeLena, Procurement Coordinator
  Executive Office of Health and Human Services
  One Ashburton Place, 11th Floor
  Boston, MA 02108

Parties interested in responding to this RFI should prepare a typewritten response that includes a cover sheet that states the respondent's name, organization, address, telephone number, e-mail address, and affiliation or interest (e.g., current or potential contractor, community member, provider, advocacy organization). Responses may be submitted either electronically or in hard copy, double-sided, single-spaced pages. (Parties responding in hard copy should submit **one original and three copies** of their response.) Questions should be answered in order of appearance and numbered according to the RFI question number. Respondents are invited to respond to any or all of the RFI questions; please respond to as many as you feel are appropriate. Responses, including any attachments thereto, should be clearly labeled and referenced by name in the RFI response. No part of the response can be returned. Receipt of RFI responses will not be acknowledged.

B. Additional Information

1. Electronic Distribution

   This RFI has been distributed electronically using the Commonwealth Procurement Access and Solicitation System (Comm-PASS). Comm-PASS is an electronic mechanism used for advertising and distributing the Commonwealth of Massachusetts' procurements and related files. No individual may alter (manually or electronically) the RFI or its components except those portions intended to collect the respondent's response. Interested parties may access Comm-PASS at the following address: http://www.comm-pass.com.

   Questions specific to Comm-PASS should be made to the Comm-PASS Help Desk comm-pass@osd.state.ma.us.

2. RFI Amendments

   Interested parties are solely responsible for checking Comm-PASS for any addenda or modifications that are subsequently made to this RFI. The Commonwealth and its subdivisions accept no liability and will provide no accommodation to interested parties who fail to check for amended RFIs.

3. Use of RFI Information

   Information is being solicited in this RFI to assist EOHHS in the development and implementation of the Health Homes initiative. EOHHS reserves the right to accept or reject, in part or in full, any information contained in or submitted in response to this RFI. The RFI is not binding on EOHHS and shall not obligate EOHHS to issue a

procurement that incorporates any RFI provisions or responses. Responding to this RFI is entirely voluntary, will in no way affect EOHHS' consideration of any proposal submitted in response to any subsequent procurement, and will not serve as an advantage or disadvantage to the respondent in the course of any procurement that may be issued. Responses to this RFI become the property of the Commonwealth of Massachusetts and are public records under the Massachusetts public records law, M.G.L. c. 66, § 10 and c. 4, § 7, cl. 26, regarding public access to such documents. However, information provided to EOHHS in its response to this RFI and identified by the respondent as trade secrets or commercial or financial information shall be kept confidential and shall be exempt from disclosure as a public record (see M.G.L. c. 4, § 7, cl. 26). This exemption may not apply to information submitted in response to any subsequent procurement.

ATTACHMENT 1:

ACRONYMS USED IN THE RFI

ACA	Affordable Care Act
CBHI	Children's Behavioral Health Initiative
CBFS	Community-Based Flexible Support
CMS	Centers for Medicare and Medicaid Services
CSA	Community Service Agency
DMH	Massachusetts Department of Mental Health
DPH	Massachusetts Department of Public Health
EHR	Electronic Health Record
EOHHS	Massachusetts Executive Office of Health and Human Services
FS & T	Family Support and Training
HIE	Health Information Exchange
ICC	Intensive Care Coordination
ICO	Duals Integrated Care Organization
MBHP	Massachusetts Behavioral Health Partnership
MCO	Managed Care Organization
PACE	Program for All-inclusive Care for the Elderly
PCPR	Primary Care Payment Reform
PCC	Primary Care Physician
RFI	Request for Information
SCO	Senior Care Options
SED	Serious Emotional Disturbance
SPMI	Serious and Persistent Mental Illness

ATTACHMENT 2:

CMS QUALITY MEASURES FOR ASSESSING THE HEALTH HOME SERVICE DELIVERY MODEL

(Document begins on the following page)

NQF #	Measure Title	Measure Description	Numerator/Denominator	Alignment with Other CMS Programs
N/A	**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	**Numerator Description** Body mass index documented during the measurement year or the year prior to the measurement year **Denominator Description** Members 18-74 of age who had an outpatient visit	Medicaid Adult Core Set, HEDIS
N/A	**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 population under age 75 years.	**Numerator Description** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years **Denominator Description** Total mid-year population under age 75	
648	**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.	**Numerator Description** 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 **Denominator Description** 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	Medicaid Adult Core set

NQF #	Measure Title	Measure Description	Numerator/Denominator	Alignment with Other CMS Programs
0576	**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 intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.	**Numerator Description** 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 health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. **Denominator Description** Members 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December of the measurement year	Children's Core Set, Medicaid Adult Core Set, HEDIS
1768	**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.	**Numerator Description** Count the number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination **Denominator Description** Count the number of Index Hospital Stays for each age, gender, and total combination	Adult Core set, HEDIS

2

NQF #	Measure Title	Measure Description	Numerator/Denominator	Alignment with Other CMS Programs
0418	**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	**Numerator Description** Total number of patients from the denominator who have follow-up documentation **Denominator Description** All patients 18 years and older screened for clinical depression using a standardized tool	PQRS, CMS QIP, Medicare Shared Savings Program, Medicaid Adult Core set, Meaningful Use 2

NQF #	Measure Title	Measure Description	Numerator/Denominator	Alignment with Other CMS Programs
0004	**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.	**Numerator Description** 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. Engagement of AOD Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted. **Denominator Description** 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.	Meaningful Use 1 and 2, Medicaid Adult Core set, HEDIS

NQF #	Measure Title	Measure Description	Numerator/Denominator	Alignment with Other CMS Programs
0018	**8. Controlling High Blood Pressure**	The percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.	**Numerator Description** The number of patients in the denominator whose most 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. **Denominator Description** Patients 18-85 with hypertension. 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.	Million Hearts, Medicaid Adult Core set, Meaningful Use 2, ACO Measure