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Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, Secretary

TO: Health Home providers  
FROM: Behavioral Health Unit, Office of Health Services, DHMH  
DATE: March 7, 2014  
RE: Health Home Update- intake and service options

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The Department would like to inform Health Home providers of recent changes to the intake portion of eMedicaid's Health Home system, as well as an update impacting Health Home service provision and claims. Please see below for details, and contact [dhmh.healthhomes@maryland.gov](mailto:dhmh.healthhomes@maryland.gov) with any questions.

Health Home Participant Intake Requirements

The eMedicaid participant intake process previously required providers to report baseline values for Glucose Tolerance Test (GTT) and Lipid Density Profile (LDL) measures if the Health Home participant had a diagnosis of Diabetes or High Blood Pressure. However, because these diagnostic measures are not medically appropriate for all participants, providers may now leave these fields blank when completing the intake screen. Blood pressure and other measures are still required in order to complete an intake. Providers should **not** be entering placeholder values for any of these measures.

Population Health Management

Care management at both the individual and population level is an integral part of the Health Home model. At the population level, this includes monitoring population health status and service use to determine adherence to or variance from treatment guidelines. This involves developing and reviewing a health monitoring and analysis report evaluating the entire population of a Health Home based on a particular treatment guideline, and identifying whether each individual has met the guideline in question. For example, a provider may use the service to identify whether each Health Home enrollee is at variance with a guideline of HbA1c levels of less than 8.0%.

These findings should then initiate appropriate follow up services for participants, such as specialist referrals or health education. Acceptable guidelines to use for this purpose must be healthcare performance measures, including process and outcomes measures, which are endorsed or utilized by a national healthcare accrediting body, or a state or federal government.

Such an activity is considered a billable Health Home service for every participant included in the report, assuming the following guidelines are met:

1. The service must be delivered by the Health Home Director, Health Home Care Manager, or the Physician/Nurse Practitioner Consultant.
2. The monitoring service must be done for the provider's entire population of Health Home participants, unless the guideline used is specific to a sub-population based on age (18 years and older or under 18 years) or gender (male or female), such as mammogram

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frequency for adult women. The provider may report the PHM activity as a service for all participants reviewed in the report.

3. The monitoring service must focus on at least one treatment guideline, and must identify whether or not each Health Home member included is at variance with the guideline(s).
4. Because of the unique nature of this population-based service, providers do not need to document the service in the client's individual record; however, a printed copy of the monitoring report must be signed and dated by one or more Health Home staff (Care Manager, HH Director, MD/NP Consultant), evidencing that he or she reviewed the report, and this document must be maintained in a central file available for audit at any time. The report can be developed manually or through an HIT care management tool. The service must be noted in eMedicaid as well, as detailed below.
5. This service is considered a group service; only one group service can be billed per month.

These services must be reported using the "Population Health Management activity" check box under the Comprehensive Care Management service category in eMedicaid. You must enter the date the report was reviewed, as well as a brief description of the guideline used. Providers who have been performing these activities in accordance with the requirements above may report services delivered in the months of December, January, February and on an ongoing basis.

#### 30-day Claims Deadline

During the early stages of enrollment, the Department will not penalize providers for claims submitted past the 30-day deadline. As providers become familiar with the Health Home reporting and billing systems, the Department expects this deadline to be met.