MEDICAID MODEL DATA LAB

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Health Home Services Forms (ACA 2703)
Page: 1-10

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Transmital Numbers (TN) and Effective Date

Please enter the numerical part of the Transmital Numbers (TN) in the format YY-0000 where YY = the last two digits of the year for which the document relates to, and 0000 = a four digit number with leading zeros. The dashes must also be entered. State abbreviation will be added automatically.

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Effective Date

07/01/2012

[redacted]

Attachment 3.1-H

Page 1

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

☑ Health Home Services

How are Health Home Services Provided to the Medically Needy?

Same way as Categorically Needy

i. Geographic Limitations

Statewide Basis

If Targeted Geographic Basis,

ii. Population Criteria

The State elects to offer Health Home Services to individuals with:

☑ Two chronic conditions
☑ One chronic condition and the risk of developing another
☐ One serious mental illness

from the list of conditions below:

☑ Mental Health Condition
☑ Substance Use Disorder
☑ Asthma
☑ Diabetes
☑ Heart Disease
☑ BMI Over 25
☑ Other Chronic Conditions Covered?

Description of Other Chronic Conditions Covered.

Hypertension, BMI over 85 percentile for pediatric population.

At risk can be defined as documented family history of a verified heritable condition in a category described above, a diagnosed medical condition with an established co-morbidity to a condition in a category described above, or a verified environmental exposure to an agent or condition known to be causative of a condition from a category described above. Providers will follow the guiding principles posted at the departments website http://www.ime.state.ia.us/. The guiding principles use USPSTF guidelines to identify at risk conditions. All at risk conditions must be documented in the patient's medical record at the time the member is enrolled in the program.

In order to avoid duplication of services, members currently receiving Targeted Case Management (TCM) Case Management (CM) as a Home and Community Based Waiver Service, or service coordination from a DHS social worker will shift the delivery of this care to their health home practice.

iii. Provider Infrastructure

☑ Designated Providers as described in §ection 1945(h)(5)

A health home practice will serve as a Designated Provider and may include multiple sites when those sites are identified as a single organization or medical group that shares policies and procedures and electronic systems across all of their practice sites.

a. Each Health Home Practice is registered with the State and provided a state assigned health home provider ID.
b. Practitioners operating within a Health Home Practice agree to adhere to the Health Home Provider Standards (listed in Section V below).
i. Health Home Practices may include but are not limited to primary care practices, Community Mental Health Centers, Federally Qualified Health Centers, and Rual Health Clinics.
ii. At a minimum, practices must fill the following roles:
- Designated Practitioner
- Dedicated Care Coordinator
- Health Coach
- Clinic support staff

Each role is linked to specific health home services in section IV below.

c. The Health Home Practice coordinates, directs, and ensures all clinical data related to the member is maintained within the member's medical records. The use of Health Information Technology (HIT) is the required means of facilitating these processes

☐ Team of Health Care Professionals as described in §ection 1945(h)(6)

☐ Health Team as described in §ection 1945(h)(7), via reference to §ection 3502

iv. Service Definitions

Comprehensive Care Management

Service Definition

Managing the Comprehensive Care for each member enrolled in the health home includes at a minimum:
- Providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
- Developing and maintaining a Continuity of Care Document (CCD) for all patients, detailing all important aspects of the patient's medical needs, treatment plan, and medication list.
- Implementing a formal screening tool to assess behavioral health (mental health and substance abuse) treatment needs along with physical health care needs.

Comprehensive Care Management services are the responsibility of the Designated Practitioner role within the Health Home.

Ways Health IT Will Link

By the provider maintaining an electronic system with standards/protocols for tracking patient referrals, and using the Health Information Network (HIN) to exchange health records, comprehensive care management can be more easily achieved.

Providers shall establish an electronic system (as part of their EHR system) that supports evidenced based decisions.

Care Coordination

Service Definition

Care Coordination includes assisting members with medication adherence, appointments, referral scheduling, understanding health insurance coverage, reminders, transition of care, wellness education, health support and/or lifestyle modification, and behavior changes.
Coordinate, direct, and ensure results are communicated back to the health home. The use of HIT is the recommended means of facilitating these processes that include the following components of care:
- Mental health/ behavioral health
- Oral health
- Long term care
- Chronic disease management
- Recovery services and social health services available in the community
- Behavior modification interventions aimed at supporting health management (e.g., obesity counseling and tobacco cessation, health coaching)
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

The Care Coordinator role is responsible for ensuring these services are performed with the assistance of the entire the Health Home team.

Ways Health IT Will Link

The establishment of an EHR system will assist care coordinators with maintaining a comprehensive medication list, allow providers access to evidenced based decisions and assist with referral protocols.

Health IT can assist care coordinators providing and disseminating wellness education, informative tracks, and resources that supports lifestyle modification and behavior changes.

Health Promotion

Service Definition

Ways Health IT Will Link

Health Promotion includes coordinating or providing behavior modification interventions aimed at supporting health management, improving disease outcomes, disease prevention, safety and an overall healthy lifestyle.
Use of Clinical Decision Support within the practice workflow.
Implementation of a formal Diabetes Disease Management Program.
Health Promotion services are the responsibility of the Health Coach role and Designated Practitioner role within the Health Home.

The establishment of an EHR system will assist care coordinators with maintaining a comprehensive medication list, allow providers access to evidenced based decisions and assist with referral protocols.

Health IT can assist care coordinators providing and disseminating wellness education, informative tracks, and resources that supports lifestyle modification and behavior changes.

Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)

Service Definition

Comprehensive Transitional Care from inpatient to other settings includes the services required for ongoing care coordination. For all patient transitions, a health home shall ensure the following:
• Receipt of updated information through a CCD.
• Receipt of information needed to update the patients care plan (could be included in the CCD) that includes short-term transitional care coordination needs and long term care coordination needs resulting from the transition.

The Designated Provider shall establish personal contact with the patient regarding all needed follow up after the transition
Comprehensive Transitional Care services are the responsibility of the Dedicated Care Coordinator role and Designated Practitioner role within the health home.

Ways Health IT Will Link

The establishment of an EMR system will assist care coordinators with maintaining a comprehensive medication list, allow providers access to evidenced based decisions and assist with referral protocols.

Health IT can assist care coordinators providing wellness education and information that supports lifestyle modification and behavior changes.

Individual and Family Support Services (including authorized representatives)

Service Definition

Individual and Family Support Services include communication with patient, family and caregivers in a culturally appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives.
Activities could include but are not limited to:
• Advocating for individuals and families,
• Assisting with obtaining and adhering to medications and other prescribed treatments.
• Increasing health literacy and self management skills
• Assess the member's physical and social environment so that the plan of care incorporates areas of needs, strengths, preferences, and risk factors.

Individual and Family Support services are the responsibility of the Health Coach role within the health home.

Ways Health IT Will Link

Health IT can assist care coordinators providing information that is culturally and linguistically appropriate for the patient, family and caregivers.

Referral to Community and Social Support Services

Service Definition

Referral to Community and Social Support Services includes coordinating or providing recovery services and social health services available in the community, such as understanding eligibility for various health care programs, disability benefits, and identifying housing programs.

Referral to Community and Social Support services are the responsibility of the Dedicated Care Coordinator role within the health home.

Ways Health IT Will Link

By maintaining an electronic system with standards/protocols for tracking patient referrals, and using health IT to exchange health records, comprehensive care management can be more easily achieved.

v.Provider Standards

To enroll as a health home practice, Designated Providers must sign an agreement attesting adherence to the below standards:

1. Recognition/Certification –
a. HH Providers must adhere to all federal and state laws in regard to HH recognition/certification.
b. Comply with standards specified in the Iowa Department of Public Health rules. Those rules will likely require National Committee for Quality Assurance (NCQA) or other national accreditation.
c. Until those rules are final, providers shall meet the following recognition/certification standards:
• Complete the TransforMed self-assessment and submit to the State at the time of enrollment in the program.
• Achieve NCQA or other national accreditation within the first year of operation
d. Exception applied for Health Homes past the first year where an application has been submitted and pending ruling. The Health Home must prove application submission status on demand and the State may terminate health home enrollment if recognition/certification status has not be achieved within 2 years of operation.
2. Personal provider for each patient
a. 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.
3. Continuity of Care Document (CCD)
a. Update a CCD for all eligible patients, detailing all important aspects of the patient's medical needs, treatment plan and medication list. The CCD shall be updated and maintained by the health home provider.
4. Whole Person Orientation
a. Provide or take responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life, acute care, chronic care, preventive services, long term care, and end of life care.
5. Coordinated/Integrated Care
a. Dedicate a care coordinator, defined as a member of the Health Home Provider, responsible

for assisting members with medication adherence, appointments, referral scheduling, tracking follow-up results from referrals, understanding health insurance coverage, reminders, transition of care, wellness education, health support and/or lifestyle modification, and behavior changes.
b. Communicate with patient, and authorized family and caregivers in a culturally-appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives.
c. Monitor, arrange, and evaluate appropriate evidence-based and/or evidence-informed preventive services.
d. Coordinate or provide:
• Mental health/behavioral health
• Oral health
• Long term care
• Chronic disease management
• Recovery services and social health services available in the community
• Behavior modification interventions aimed at supporting health management (Including but not limited to, obesity counseling, tobacco cessation, and health coaching)
• Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
e. Assess social, educational, housing, transportation, and vocational needs that may contribute to disease and/or present as barriers to self management.
f. Maintain system and written standards/protocols for tracking patient referrals.
6. Emphasis on Quality and Safety
a. Demonstrate use of clinical decision support within the practice workflow.
b. Demonstrate use of a population management tool, (patient registry) and the ability to evaluate results and implement interventions that improve outcomes overtime.
c. Demonstrate evidence of acquisition, installation and adoption of an electronic health record (EHR) system and establish a plan to meaningfully use health information in accordance with the Federal law.
d. When available, connect to and participate with the Statewide Health Information Network (HIN).
e. Each health home shall implement or support a formal diabetes disease management Program. The disease management program shall include:
• The goal to improve health outcomes using evidence-based guidelines and protocols.
• A measure for diabetes clinical outcomes that include timeliness, completion, and results of A1C, LDL, microalbumin, and eye examinations for each patient identified with a diagnosis of diabetes.
• The Department may choose to implement subsequent required disease management programs anytime after the initial year of the health home program. Based on population-specific disease burdens, individual Health Homes may choose to identify and operate additional disease management programs at anytime.
f. Each Health Home shall implement a formal screening tool to assess behavioral health (mental health and substance abuse) treatment needs along with physical health care needs.
g. Provide the Department outcomes and process measure reporting annually.
7. Enhanced Access
a. Provide for 24/7 access to the care team that includes, but is not limited to, a phone triage system with appropriate scheduling during and after regular business hours to avoid unnecessary emergency room visits and hospitalizations.
b. Monitor access outcomes such as the average 3rd next available appointment and same day scheduling availability.
c. Use of email, text messaging, patient portals and other technology as available to the practice to communicate with patients is encouraged.

vi. Assurances

☑ A. The State assures that hospitals participating under the State plan or a waiver of such plan will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

☑ B. The State has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

☑ C. The State will report to CMS information submitted by health home providers to inform the evaluation and Reports to Congress as described in section 2703(b) of the Affordable Care Act, and as described by CMS.

vii. Monitoring

A. Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications.

An event tracking method is currently in place to identify potentially avoidable hospital readmissions using Medicaid claims data. The event method tracks events rather than individuals. After the index admission (first admission), readmission events are calculated for periods of 7 days, 14 days, and 30 days.

B. Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications.

Using Medicaid claims data the University of Iowa Public Policy Center will calculate two types of control groups for the Medicaid enrollees that join a Health Home. First, enrollees in the Health Home will be their own controls through a pre- and post-program comparison. This analysis will compare the costs PMPM costs for the year prior to entering the program to the PMPM costs for the first six months, first year and first 18 months of the program. We will continue to calculate the PMPM costs on an every six month basis. Limitations to this method are more thoroughly discussed in the evaluation plan.
In addition, we will attempt to match each enrollee who has been in the Health Home for at least one year with an enrollee that is not in a Health Home but has been enrolled in Medicaid for one year. By controlling for factors such as age, gender, and type of chronic condition in the match we are able to lessen the bias that may exist between the two groups. However, we will also use propensity scoring to adjust the regression on PMPM cost. With these two methods the PMPM cost changes due to the Health Home should be measurable in a way that provides the least bias.

C. Describe the State's proposal for using health information technology in providing health home services under this program and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

A key building block to the successful use of HIT for the coordination of care across the continuum will be the ability to exchange health information across the care givers. Iowa eHealth is implementing a state-wide health information Network (HIN) in CY2012. IME will need to continue to support the effort to make the exchange available to health home providers.
Collaboration will continue between the health home project team and the State Medicaid HIT project team.
The HIT team will be responsible for monitoring the rate of adoption and meaningful use of EHRs within the Iowa Medicaid provider community. HIT will also be responsible for monitoring and reporting on the progress of the creation of the statewide HIN.

As part of the minimum requirements of an eligible provider to operate as a health home, the following relate to HIT:
• Demonstrate use of a population management tool, (patient registry) and the ability to evaluate results and implement interventions that improve outcomes overtime.
• Demonstrate evidence of acquisition, installation and adoption of an electronic health record (EHR) system and establish a plan to meaningfully use health information in accordance with the Federal law.
• When available, connect to and participate with the Statewide Health Information Network (HIN).
• Provide for 24/7 access to the care team that includes but is not limited to a phone triage system with appropriate scheduling during and after regular business hours to avoid unnecessary emergency room visits and hospitalizations.
• Encourage providers to utilize email, text messaging, patient portals and other technology as available to communicate with patients.

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As technology matures and access to the HIN increases, the requirements will be periodically reviewed to be more specific and set the appropriate level of service required to be a health home.

[redacted]

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

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viii. Quality Measures: Goal Based Quality Measures

Please describe a measureable goal of the health home model that will be operationalized utilizing measures within the domains listed below. The measures may or may not be tied to the services depending on the goal. If the measure is tied to a service, please complete the service-based quality measure section. If the measure is tied to a goal, please complete the goal-based measure section.

Goal 1:

Change patient behavior to increase the use of preventative services, and increase awareness of appropriate chronic condition management.

Clinical Outcomes

Measure

(NQF 038) Increase use of preventive services

Data Source

Claims

Measure Specification

The numerator and denominator specifications of this measure are based off National Quality Forum (NQF) specifications. The State will inform Health Home providers of the detailed specifications of this measure prior to the start of each reporting period.

How Health IT will be Utilized

Provider standards require the use of clinical decision support within the practice workflow, which will ideally be part of the practices EHR solution or patient registry software to assist providers in consistently reaching quality goals.

Experience of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

(NQF 055) Improve diabetes managementDilated eye exam (annual by optometrist or ophthalmologist)

Data Source

Claims

Measure Specification

The numerator and denominator specifications of this measure are based off National Quality Forum (NQF) specifications. The State will inform Health Home providers of the detailed specifications of this measure prior to the start of each reporting period.

How Health IT will be Utilized

Provider standards require the use of clinical decision support within the practice workflow, which will ideally be part of the practices EHR solution or patient registry software to assist providers in consistently reaching quality goals.

Goal 2:

N/A

Clinical Outcomes

Measure

(NQF 062) Improve diabetes management: Micro albumin (annual)

Data Source

Claims

Measure Specification

How Health IT will be Utilized

The numerator and denominator specifications of this measure are based off National Quality Forum (NQF) specifications. The State will inform Health Home providers of the detailed specifications of this measure prior to the start of each reporting period.

Provider standards require the use of clinical decision support within the practice workflow, which will ideally be part of the practices EHR solution or patient registry software to assist providers in consistently reaching quality goals.

Experience of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

(NQF 056)Improve diabetes management: Foot exam (annual)

Data Source

Claims

Measure Specification

The numerator and denominator specifications of this measure are based off National Quality Forum (NQF) specifications. The State will inform Health Home providers of the detailed specifications of this measure prior to the start of each reporting period.

How Health IT will be Utilized

Provider standards require the use of clinical decision support within the practice workflow, which will ideally be part of the practices EHR solution or patient registry software to assist providers in consistently reaching quality goals.

Goal 3:

N/A

Clinical Outcomes

Measure

(NQF 0064) Improve diabetes management: Proportion with HgA1c less than

Data Source

Claims

Measure Specification

The numerator and denominator specifications of this measure are based off National Quality Forum (NQF) specifications. The State will inform Health Home providers of the detailed specifications of this measure prior to the start of each reporting period.

How Health IT will be Utilized

Provider standards require the use of clinical decision support within the practice workflow, which will ideally be part of the practices EHR solution or patient registry software to assist providers in consistently reaching quality goals.

Experience of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

(NQF 013) Improve diabetes management: Proportion with LDL less than 100

Data Source

Claims

Measure Specification

The numerator and denominator specifications of this measure are based off National Quality Forum (NQF) specifications. The State will inform Health Home providers of the detailed specifications of this measure prior to the start of each reporting period.

How Health IT will be Utilized

Provider standards require the use of clinical decision support within the practice workflow, which will ideally be part of the practices EHR solution or patient registry software to assist providers in consistently reaching quality goals.

Goal 4:

Transform provider practices by the adoption of the patient centered medical home model to improve the population health of members.

Clinical Outcomes

Measure

(CHIPRA 10)Well Child visits in the first 15 months of life

The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life.

No well-child visits
One well-child visit
Two well-child visits
Three well-child visits
Four well-child visits
Five well-child visits

Data Source

claims

Measure Specification

The numerator and denominator specifications of this measure are based off CHIPRA measure specifications. The State will inform Health Home providers of the detailed specifications of this measure prior to the start of each reporting period.

How Health IT will be Utilized

Provider standards require the use of clinical decision support within the practice workflow, which will ideally be part of the practices EHR solution or patient registry software to assist providers in consistently reaching quality goals.

Experience of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

(CHIPRA 21) Follow-up care for children prescribed ADD medication
The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

Data Source

Claims

Measure Specification

The numerator and denominator specifications of this measure are based off CHIPRA measure specifications. The State will inform Health Home providers of the detailed specifications of this measure prior to the start of each reporting period.

How Health IT will be Utilized

Provider standards require the use of clinical decision support within the practice workflow, which will ideally be part of the practices EHR solution or patient registry software to assist providers in consistently reaching quality goals.

Goal 5:

N/A

Clinical Outcomes

Measure

(CHIPRA 13) Annual Dental Visit

Data Source

Claims

Measure Specification

The numerator and denominator specifications of this measure are based off CHIPRA measure specifications. The State will inform Health Home providers of the detailed specifications of this measure prior to the start of each reporting period.

How Health IT will be Utilized

Provider standards require the use of clinical decision support within the practice workflow, which will ideally be part of the practices EHR solution or patient registry software to assist providers in consistently reaching quality goals.
Provider standards require the use of clinical decision support within the practice workflow, which will ideally be part of the practices EHR solution or patient registry software to assist providers in consistently reaching quality goals.

Experience of Care

Measure

N/A

Data Source

N/A

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Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

(NQF 031) Breast cancer screening

Data Source

Claims

Measure Specification

The numerator and denominator specifications of this measure are based off National Quality Forum (NQF) specifications. The State will inform Health Home providers of the detailed specifications of this measure prior to the start of each reporting period.

How Health IT will be Utilized

Provider standards require the use of clinical decision support within the practice workflow, which will ideally be part of the practices EHR solution or patient registry software to assist providers in consistently reaching quality goals.

Goal 6:

N/A

Clinical Outcomes

Measure

(NQF 032) The percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer

Data Source

Claims

Measure Specification

The numerator and denominator specifications of this measure are based off National Quality Forum (NQF) specifications. The State will inform Health Home providers of the detailed specifications of this measure prior to the start of each reporting period.

How Health IT will be Utilized

Provider standards require the use of clinical decision support within the practice workflow, which will ideally be part of the practices EHR solution or patient registry software to assist providers in consistently reaching quality goals.

Experience of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

NQF 041
Percentage of patients aged 6months and older who received an influenza immunization

Data Source

Claims

Measure Specification

The numerator and denominator specifications of this measure are based off National Quality Forum (NQF) specifications. The State will inform Health Home providers of the detailed specifications of this measure prior to the start of each reporting period.

How Health IT will be Utilized

Provider standards require the use of clinical decision support within the practice workflow, which will ideally be part of the practices EHR solution or patient registry software to assist providers in consistently reaching quality goals.

Goal 7:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

[redacted]

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

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ix. Evaluations

A. Describe how the State will collect information from health home providers for purposes of determining the effect of this program on reducing the following (include the data source and frequency of data collection):

i. Hospital admissions

Description

HEDIS specifications for categorizing hospital admissions will be used along with inpatient costs for the period before and after implementation of the program for enrollees who have a Health Home and those that do not.).

Data Source

Claims

Frequency of Data Collection

12 months

ii. Emergency room visits

Description

HEDIS specifications for determining an emergency room visit will be used along with ER costs for the period before and after implementation of the program for enrollees who have a Health Home and those that do not.

Data Source

Claims

Frequency of Data Collection

12 months

iii. Skilled Nursing Facility admissions

Description

SNF admissions will be tracked in the claims data and assessed individually to determine the reason for admission and the costs. We anticipate that there will be very few SNF admissions as this population will encompass many enrollees who are young, functional, and chronically ill.

Data Source

Claims

Frequency of Data Collection

12 months

i.

B. Describe how the State will collect information for purposes of informing the evaluations, which will ultimately determine the nature, extent and use of this program, as it pertains to the following:

Hospital admission rates

Medicaid claims data will be assimilated to determine hospital admission rates in categories established through NCQA HEDIS specifications. Rates and costs will be compared for the pre- and post-program period for enrollees in a Health Home and those not in Health Home.

ii. Chronic disease management

Clinical data received from providers on health home enrollees will provide the best picture for this evaluation.

iii. Coordination of care for individuals with chronic conditions

Clinical data received from providers on health home enrollees will provide the best picture for this evaluation.

iv. Assessment of program implementation

This will consist of a review of program administrative costs, reported patient outcomes, and overall program cost savings and patient surveys.
A formative evaluation that details the process of implementation and the challenges experienced and adaptations that were made will be undertaken.

v. Processes and lessons learned

An evaluation that includes provider and patient input on the health home program will inform the state on ways to improve the process.

As more successful health homes are identified via clinical data and claims data, implementation guidelines and suggestions will be documented and trained to further promote success statewide.

vi. Assessment of quality improvements and clinical outcomes

An evaluation that includes provider and patient input on the health home program will inform the state on ways to improve the process.

An evaluation of the clinical data shared by providers will allow the state to adjust the clinical outcome measures to ensure the optimal results and continued improvement.

vii. Estimates of cost savings

Population: There are two populations of interest within this program, those who enter Medicaid and the Health Home at the same time and those who have been in Medicaid for a period of time and then enter the Health Home. Cost savings will be estimated for both groups utilizing a PMPM basis, however, the comparison groups for the populations will differ.
Cost savings methodology: Regression analyses will be utilized to determine the expected PMPM for enrollees in the Health Home assuming the Health Home were not in place. For those newly enrolled in Medicaid and the Health Home we will utilize a control group of new enrollees who have opted not to enter the Health Home or to whom the Health Home is not available. The groups will be matched on chronic conditions, age, gender, race, eligibility type (including whether they are dual eligible) and rural/urban area. In this case, the actual PMPM costs for those in the Health Home will be compared to those not in the Health Home to determine cost savings. "Average PMPM cost in Year 1 for those in Health Home minus average PMPM costs in Year 1 for those not in Health home times the number of enrollee months in a Health Home" will provide an estimate of cost savings in Year 1. Application of the savings amount to estimated enrollee months in Health Home for Years 2 and 3 should provide future savings estimates.
Those enrolled for some time in the Medicaid program prior to enrolling in the Health Home will serve as their own controls and also have a separate control group. PMPM costs for the period up to 24 months prior to enrolling in the Health Home will be used to establish a PMPM trend line in the period before enrolling in the Health Home. In addition, a separate trend line will be established for the 24 months prior to the beginning of the Health Home program for those who have not enrolled in the program either because they refused to participate or because there is not a Health Home in their area. We will match the groups on chronic conditions, age, gender, race, eligibility type (including whether they are dual eligible) and rural/urban area. The cost savings will be estimated with the following formula: Estimated PMPM costs based on PMPM trend line in the period prior to enrolling in the Health Home minus Actual PMPM costs after enrolling in Health Home. The resulting estimated PMPM reduction will be adjusted for the comparison group of those not enrolled in the Health Home by subtracting the PMPM estimate found through the following formula: Estimated PMPM costs after initiation of the Health Home program based on the PMPM trend line in the period prior to initiation of the Health Home program minus actual PMPM costs after initiation of the Health Home program. This adjustment ensures that the Health Home program effects are singled out from other more general cost effects of changes in the Medicaid program, providers or patients that are not related to the Health Home.
Limitations: There may be a propensity for enrollees who have the most to gain from the Health Home to enroll earlier than those with less to gain. Essentially, those who are sicker may enroll earlier and the reduction in costs accounted by the Health Home may be greater than for later enrollees. This would cause the savings estimates for future years to be overstated. To adjust for this possible overstatement a sensitivity analysis will be performed to provide a confidence interval around the savings estimate. Enrollees who are dual eligible in Medicare and Medicaid may be difficult to include in these analyses. We will separate the data for the dual eligible group and analyze them separately as a check on our estimates.

Page

[redacted]

Attachment 3.1-H

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

☐ Health Home Services

i. Geographic Limitations

If Targeted Geographic Basis,

ii. Population Criteria

The State elects to offer Health Home Services to individuals with:

☐ Two chronic conditions
☐ One chronic condition and the risk of developing another
☐ One serious mental illness

from the list of conditions below:

☐ Mental Health Condition
☐ Substance Use Disorder
☐ Asthma
☐ Diabetes
☐ Heart Disease
☐ BMI Over 25
☐ Other Chronic Conditions Covered?

Description of Other Chronic Conditions Covered.

iii. Provider Infrastructure

☐ Designated Providers as described in §ection 1945(h)(5)

☐ Team of Health Care Professionals as described in §ection 1945(h)(6)

☐ Health Team as described in §ection 1945(h)(7), via reference to §ection 3502

Attachment 3.1-H
Page 1

Effective: 7-1-12 Approved: 6-7-12

iv. Service Definitions

Comprehensive Care Management

Service Definition

Ways Health IT Will Link

Care Coordination

Service Definition

Ways Health IT Will Link

Health Promotion

Service Definition

Ways Health IT Will Link

Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)

Service Definition

Ways Health IT Will Link

Individual and Family Support Services (including authorized representatives)

Service Definition

Ways Health IT Will Link

Referral to Community and Social Support Services

Service Definition

Ways Health IT Will Link

v.Provider Standards

vi. Assurances

☐ A. The State assures that hospitals participating under the State plan or a waiver of such plan will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

☐ B. The State has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

☐ C. The State will report to CMS information submitted by health home providers to inform the evaluation and Reports to Congress as described in section 2703(b) of the Affordable Care Act, and as described by CMS.

vii. Monitoring

A. Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications.

B. Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications.

C. Describe the State's proposal for using health information technology in providing health home services under this program and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

[redacted]

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

viii. Quality Measures: Goal Based Quality Measures

Please describe a measureable goal of the health home model that will be operationalized utilizing measures within the domains listed below. The measures may or may not be tied to the services depending on the goal. If the measure is tied to a service, please complete the service-based quality measure section. If the measure is tied to a goal, please complete the goal-based measure section.