Health Home State Plan Amendment

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Transmittal Number: IA-16-012 Supersedes Transmittal Number: IA-14-002 Approved Effective Date: Apr 1, 2016 Approval Date: Jul 20, 2016 Attachment 3.1-H Page Number: 1-49

Submission Summary

Transmittal Number:
Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

IA-16-012

Supersedes Transmittal Number:
Please enter the Supersedes Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

IA-14-002

☐ **The State elects to implement the Health Homes State Plan option under Section 1945 of the Social Security Act.**

Name of Health Homes Program:

IA-16-012 - Chronic Conditions Health Home - Managed Care Implementation

State Information

State/Territory name: **Iowa**

Medicaid agency: Iowa Medicaid Enterprise

Authorized Submitter and Key Contacts

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Proposed Effective Date

04/01/2016 (mm/dd/yyyy)

Executive Summary

Summary description including goals and objectives:
This State Plan Amendment is being submitted to update the description of how chronic condition health homes will operate under managed care as the State implements the 1915(b) Iowa High Quality Healthcare Initiative (Initiative).

The Health Home program enrolls Designated Providers to deliver personalized, coordinated care for individuals meeting program eligibility criteria. In return for the additional health home services to members, the Designated Provider is paid a monthly care coordination payment. Managed Care Organizations (MCOs) are responsible for: (i) developing a network of health homes; (ii) providing training, technical assistance, expertise and oversight to the health homes; (iii) identifying eligible members for enrollment; (iv) performing data analysis at the member level and program-wide to inform continuous quality improvement; (v) reimbursing providers; and (vi) attributing and enrolling members to a health home.

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2016	$ 0.00

	Federal Fiscal Year	Amount
Second Year	2017	$ 0.00

Federal Statute/Regulation Citation

Section 2703 of the PPACA

Governor's Office Review

- (●) **No comment.**
- ( ) **Comments received.**
  Describe:
- ( ) **No response within 45 days.**
- ( ) **Other.**
  Describe:

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Submission - Public Notice

Indicate whether public notice was solicited with respect to this submission.

- ( ) **Public notice was not required and comment was not solicited**
- ( ) **Public notice was not required, but comment was solicited**
- (●) **Public notice was required, and comment was solicited**

Indicate how public notice was solicited:

- [x] **Newspaper Announcement**

Newspaper	
Name:	

Newspaper	
Cedar Rapids Gazette Date of Publication: 03/09/2016 (mm/dd/yyyy) Locations Covered: Cedar Rapids, Eastern Iowa	
Name: Daily Nonpareil Date of Publication: 03/09/2016 (mm/dd/yyyy) Locations Covered: Council Bluffs, Western Iowa	
Name: Mason City Globe Gazette Date of Publication: 03/10/2016 (mm/dd/yyyy) Locations Covered: Central Iowa	
Name: Press-Citizen Date of Publication: 03/09/2016 (mm/dd/yyyy) Locations Covered: Iowa City, Eastern Iowa	
Name: Quad-City Times Date of Publication: 03/10/2016 (mm/dd/yyyy) Locations Covered: Eastern Iowa	
Name: Register Date of Publication: 03/09/2016 (mm/dd/yyyy) Locations Covered: Des Moines, Central Iowa	
Name: Sioux City Journal Date of Publication: 03/10/2016 (mm/dd/yyyy) Locations Covered: Sioux City, Western Iowa	
Name: Telegraph Herald Date of Publication: 03/08/2016 (mm/dd/yyyy) Locations Covered: Eastern Iowa	
Name:	

Newspaper	
Waterloo Curier	
Date of Publication: 03/10/2016 (mm/dd/yyyy)	
Locations Covered: Waterloo, IA - Eastern Iowa	

☐ **Publication in State's administrative record, in accordance with the administrative procedures requirements.**

Date of Publication:

(mm/dd/yyyy)

☐ **Email to Electronic Mailing List or Similar Mechanism.**

Date of Email or other electronic notification:

(mm/dd/yyyy)

Description:

☑ **Website Notice**

Select the type of website:

☑ Website of the State Medicaid Agency or Responsible Agency

Date of Posting: 03/04/2016 (mm/dd/yyyy)

Website URL: https://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization/federal-documents

☐ Website for State Regulations

Date of Posting:

(mm/dd/yyyy)

Website URL:

☐ Other

☐ **Public Hearing or Meeting**

☐ **Other method**

Indicate the key issues raised during the public notice period:(This information is optional)

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service Delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

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Submission - Tribal Input

☑ **One or more Indian health programs or Urban Indian Organizations furnish health care services in this State.**

☐ **This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**

☑ **The State has solicited advice from Tribal governments prior to submission of this State Plan Amendment.**

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner:

☑ **Indian Tribes**

Indian Tribes	
Name of Indian Tribe: Kickapoo Tribe Date of consultation: 03/12/2016 (mm/dd/yyyy) Method/Location of consultation: email	
Name of Indian Tribe: Meskwaki Tribe Date of consultation: 03/12/2016 (mm/dd/yyyy) Method/Location of consultation: email	
Name of Indian Tribe: Omaha Tribe Date of consultation: 03/12/2016 (mm/dd/yyyy) Method/Location of consultation: email	
Name of Indian Tribe: Ponca tribe Date of consultation: 03/12/2016 (mm/dd/yyyy) Method/Location of consultation: email	
Name of Indian Tribe: Prairie Band Potawatomi Nation Date of consultation: 03/12/2016 (mm/dd/yyyy) Method/Location of consultation: email	
Name of Indian Tribe: Santee Sioux Nation Date of consultation: 03/12/2016 (mm/dd/yyyy) Method/Location of consultation: email	
Name of Indian Tribe: Winnebago Tribe Date of consultation: 03/12/2016 (mm/dd/yyyy) Method/Location of consultation: email	

☐ **Indian Health Programs**

☐ **Urban Indian Organization**

Indicate the key issues raised in Indian consultative activities:

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service delivery**

Summarize Comments

Summarize Response

☑ **Other Issue**

Issues	
Issue Name: No issues were raised, no comments were received.	

Summarize Comments

Summarize Response

Issues	

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Submission - SAMHSA Consultation

☑ **The State provides assurance that it 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.**

Date of Consultation	
Date of consultation: 07/28/2011 (mm/dd/yyyy)	

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Health Homes Population Criteria and Enrollment

Population Criteria

The State elects to offer Health Homes services to individuals with:

☑ **Two or more chronic conditions**

Specify the conditions included:

☑ **Mental Health Condition**
☑ **Substance Abuse Disorder**
☑ **Asthma**
☑ **Diabetes**
☑ **Heart Disease**
☑ **BMI over 25**

Other Chronic Conditions	
Hypertension, BMI over 85 percentile for pediatric population.	

Additional description of other chronic conditions:

☑ **One chronic condition and the risk of developing another**

Specify the conditions included:

- ☑ **Mental Health Condition**
- ☑ **Substance Abuse Disorder**
- ☑ **Asthma**
- ☑ **Diabetes**
- ☑ **Heart Disease**
- ☑ **BMI over 25**

Other Chronic Conditions	
Hypertension, BMI over 85 percentile for pediatric population.	

Specify the criteria for at risk of developing another chronic condition:
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 can 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.

Additional description of other chronic conditions:

☐ **One or more serious and persistent mental health condition**

Specify the criteria for a serious and persistent mental health condition:

Geographic Limitations

☑ **Health Homes services will be available statewide**

Describe statewide geographical phase in/expansion. This should include dates and corresponding geographical areas that bring the program statewide.

If no, specify the geographic limitations:

○ **By county**

Specify which counties:

○ **By region**

Specify which regions and the make-up of each region:

○ **By city/municipality**

Specify which cities/municipalities:

○ **Other geographic area**

Describe the area(s):

Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the State will use to enroll eligible Medicaid individuals into a Health Home:

◉ **Opt-In to Health Homes provider**

Describe the process used:

Eligible individuals agree to participate in the health home at the initial engagement of the provider in a health home practice. A provider presents the qualifying member with the benefits of a health home and the member agrees to opt-in to health home services. The State or MCO may also attribute members to a health home. In either situation, the member will always be presented with the choice to opt-out at any time.

○ **Automatic Assignment with Opt-Out of Health Homes provider**

Describe the process used:

☐ **The State provides assurance that it will clearly communicate the opt-out option to all individuals assigned to a Health Home under an opt-out process and submit to CMS a copy of any letter or other communication used to inform such individuals of their right to choose.**

○ **Other**

Describe:

☑ **The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**

☑ **The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**

☑ **The State provides assurance that hospitals participating under the State Plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.**

☑ **The State provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each Health Homes enrollee will be claimed. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.**

☑ **The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

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Health Homes Providers

Types of Health Homes Providers

☑ **Designated Providers**

Indicate the Health Homes Designated Providers the State includes in its program and the provider qualifications and standards:

☑ **Physicians**

Describe the Provider Qualifications and Standards:

Physicians (Designated Practitioner):
The health home must have at least one MD/DO. The MD/DO must have an active Iowa license.

Nurses:
The HH must have Nurses to support the health home in meeting the provider standards and deliver health home services to qualified members. The nurse must be an RN or BSN with an active nursing license.

Health Coaches:
The HH must have a trained health coach to support the health home in meeting the provider standards and delivering health home services to qualified members.

☑ **Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards:

Physicians (Designated Practitioner):
The health home must have at least one MD/DO. The MD/DO must have an active Iowa license.

Nurses:
The HH must have Nurses to support the health home in meeting the provider standards and deliver health home services to qualified members. The nurse must be an RN or BSN with an active nursing license.

Health Coaches:
The HH must have a trained health coach to support the health home in meeting the provider standards and delivering health home services to qualified members.

☑ **Rural Health Clinics**

Describe the Provider Qualifications and Standards:

Physicians (Designated Practitioner):
The health home must have at least one MD/DO. The MD/DO must have an active Iowa license.

Nurses:
The HH must have Nurses to support the health home in meeting the provider standards and deliver health home services to qualified members. The nurse must be an RN or BSN with an active nursing license.

Health Coaches:
The HH must have a trained health coach to support the health home in meeting the provider standards and delivering health home services to qualified members.

☑ **Community Health Centers**

Describe the Provider Qualifications and Standards:

Physicians (Designated Practitioner):
The health home must have at least one MD/DO. The MD/DO must have an active Iowa license.

Nurses:
The HH must have Nurses to support the health home in meeting the provider standards and deliver health home services to qualified members. The nurse must be an RN or BSN with an active nursing license.

Health Coaches:

The HH must have a trained health coach to support the health home in meeting the provider standards and delivering health home services to qualified members.

☑ **Community Mental Health Centers**

Describe the Provider Qualifications and Standards:

Physicians (Designated Practitioner):
The health home must have at least one MD/DO. The MD/DO must have an active Iowa license.

Nurses:
The HH must have Nurses to support the health home in meeting the provider standards and deliver health home services to qualified members. The nurse must be an RN or BSN with an active nursing license.

Health Coaches:
The HH must have a trained health coach to support the health home in meeting the provider standards and delivering health home services to qualified members.

☐ **Home Health Agencies**

Describe the Provider Qualifications and Standards:

☑ **Other providers that have been determined by the State and approved by the Secretary to be qualified as a health home provider:**

☐ **Case Management Agencies**

Describe the Provider Qualifications and Standards:

☐ **Community/Behavioral Health Agencies**

Describe the Provider Qualifications and Standards:

☑ **Federally Qualified Health Centers (FQHC)**

Describe the Provider Qualifications and Standards:

Physicians (Designated Practitioner):
The health home must have at least one MD/DO. The MD/DO must have an active Iowa license.

Nurses:
The HH must have Nurses to support the health home in meeting the provider standards and deliver health home services to qualified members. The nurse must be an RN or BSN with an active nursing license.

Health Coaches:
The HH must have a trained health coach to support the health home in meeting the provider standards and delivering health home services to qualified members.

☐ Other (Specify)

☐ Teams of Health Care Professionals

Indicate the composition of the Health Homes Teams of Health Care Professionals the State includes in its program. For each type of provider indicate the required qualifications and standards:

☐ Physicians

Describe the Provider Qualifications and Standards:

☐ Nurse Care Coordinators

Describe the Provider Qualifications and Standards:

☐ Nutritionists

Describe the Provider Qualifications and Standards:

☐ Social Workers

Describe the Provider Qualifications and Standards:

☐ Behavioral Health Professionals

Describe the Provider Qualifications and Standards:

☐ Other (Specify)

☐ Health Teams

Indicate the composition of the Health Homes Health Team providers the State includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards:

☐ Medical Specialists

Describe the Provider Qualifications and Standards:

☐ **Nurses**

Describe the Provider Qualifications and Standards:

☐ **Pharmacists**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Dieticians**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Specialists**

Describe the Provider Qualifications and Standards:

☐ **Doctors of Chiropractic**

Describe the Provider Qualifications and Standards:

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Describe the Provider Qualifications and Standards:

☐ **Physicians' Assistants**

Describe the Provider Qualifications and Standards:

Supports for Health Homes Providers

Describe the methods by which the State will support providers of Health Homes services in addressing the following components:

1. **Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services,**
2. **Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines,**
3. **Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders,**
4. **Coordinate and provide access to mental health and substance abuse services,**
5. **Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care,**
6. **Coordinate and provide access to chronic disease management, including self-management support to individuals and their families,**
7. **Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services,**
8. **Coordinate and provide access to long-term care supports and services,**
9. **Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services:**
10. **Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate:**
11. **Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.**

Description:

- The State facilitates an MCO health homes work group to ensure training and communication alignment on key policy and operational issues between managed care and fee-for-service health home enrollees.
- A "kick-off" teleconference is held with key health home staff to help prepare them for the new program including introductions, education and resources on member identification, engagement and enrollment, PMPM claims submission work, PCMH standard goal setting, and IHIN connection efforts.
- Monthly collaborative learning network call is offered to all health home providers providing a regular forum to discuss key aspects of implementing a health home, share important news and activities, open discussion on current barriers or issues with a heavy focus on delivering the health home services. A Health Home clinic

spends 5- 10 minutes sharing an anonymous, challenging Member Case Study or experience of an adopted clinical process with the goal of sharing ideas and concepts to better coordinate or provide care in a health home setting.
- Distribution of a quarterly newsletter.
- Program designated website.
- Designated contact information to IME or MCO staff for member enrollment, billing and project management.
- Individualized technical assistance in connecting with state Health Information Exchange to report the quality measures.
- MCOs are contractually required to provide training, technical assistance, expertise and oversight to health homes and to perform data analysis at the member level and program-wide to inform continuous quality improvement. The State reviews and approves the MCO's methodologies and continually monitors for compliance.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.

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. Health Home Practices may contract with one or more MCOs to deliver services to managed care enrollees. To be enrolled as a Health Home with an MCO, the Health Home must first register with the State.

b. Practitioners operating within a Health Home Practice agree to adhere to the Health Home Provider Standards.
i. Health Home Practices may include but are not limited to primary care practices, Community Mental Health Centers, Federally Qualified Health Centers, and Rural Health Clinics.
ii. At a minimum, practices must fill the following roles:
• Designated Practitioner
• Dedicated Care Coordinator
• Health Coach

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.

Provider Standards

The State's minimum requirements and expectations for Health Homes providers are as follows:

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 DHS self-assessment and submit to the State at the time of enrollment in the program, if not already PCMH recognized/certified.
• Achieve PCMH Recognition/Certification, such as NCQA, other national accreditation, or another program recognized by the State 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,
- Coordinate with MCOs, TCM, CM and Service Coordinators for members that receive MCO, TCM, CM and Service Coordination activities.
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 and MCOs 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.

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Health Homes Service Delivery Systems

Identify the service delivery system(s) that will be used for individuals receiving Health Homes services:

☑ **Fee for Service**
☐ **PCCM**

○ **PCCMs will not be a designated provider or part of a team of health care professionals. The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments.**

○ **The PCCMs will be a designated provider or part of a team of health care professionals.**

The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**
Description:

☐ **Requirements for the PCCM participating in a Health Homes as a designated provider or part of a team of health care professionals will be different from those of a regular PCCM.**

If yes, describe how requirements will be different:

☑ **Risk Based Managed Care**

◉ **The Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals. Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be affected:**

☐ **The current capitation rate will be reduced.**

☑ **The State will impose additional contract requirements on the plans for Health Homes enrollees.**

Provide a summary of the contract language for the additional requirements:
MCOs are contractually required to meet the following requirements: (i) develop a network of health homes which meet the requirements established in the State Plan; (ii) provide training, technical assistance, expertise and oversight to health homes; (iii) identify eligible members for enrollment; (iv) perform data analysis at the member level and program-wide to inform continuous quality improvement; (v) reimburse providers according to a reimbursement methodology proposed by the Contractor and approved by the Agency; and (vi) and develop an incentive payment structure, for the Agency review and approval, that rewards health homes for performance based on quality and outcomes.

☐ **Other**

Describe:

○ **The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.**
Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Homes services.

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

The State intends to include the Health Homes payments in the Health Plan capitation rate.

○ **Yes**

☐ **The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:**

- **Any program changes based on the inclusion of Health Homes services in the health plan benefits**
- **Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)**
- **Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)**
- **Any risk adjustments made by plan that may be different than overall risk adjustments**
- **How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM**

☐ **The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services.**

☐ **The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found.**

○ **No**

Indicate which payment methodology the State will use to pay its plans:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Other Service Delivery System:**

Describe if the providers in this other delivery system will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers:

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

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Health Homes Payment Methodologies

The State's Health Homes payment methodology will contain the following features:

☑ **Fee for Service**

☑ **Fee for Service Rates based on:**

☑ **Severity of each individual's chronic conditions**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

The PMPM payment is a reflection of the added value provided to members receiving this level of care and will be risk adjusted based on the level of acuity assigned to each patient with no distinction between public or private health home providers. The health home provider will tier the eligible members into one of four tiers with a PMPM payment assigned to each tier.

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Other: Describe below.**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee-for-service rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

Tier Minutes Per Month Sum of Chronic Conditions
Tier 1 15 1-3
Tier 2 30 4-6
Tier 3 60 7-9
Tier 4 90 10 or more

Additional Tiering Information
Qualifying members as described in the Population Criteria Section of the document are automatically a Tier 1 member. To qualify for a higher tier, providers will use a State provided tier tool that looks at Expanded Diagnosis Clusters to score the number of conditions that are chronic, severe and requires a care team.

Reimbursement for Evaluation and Management (E/M) procedure code 99215 as of January 2012 was used as the base value for determining one hour of physician work. The count of major conditions serves as a proxy for the time (expressed in minutes in above table) and work required to coordinate patient care. PMPM time units of care coordination were determined for each tier utilizing best practice criteria for care coordination. The work of care coordination is divided between the physician and other members of the care coordination team; therefore, the following distribution of work in an optimally-functioning practice is as follows:
20% Physician
30% Care Coordinator

20% Health Coach
30% Office/Clerical

The fee-for-service rate for one hour of care coordination was calculated after discounting for the above work distribution over time (Care Coordinator and Health Coach are at 65% of the physician rate and office/clerical are at 30%).

☑ **Per Member, Per Month Rates**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

Patient Management Per Member Per Month Payment
This reimbursement model is designed to only pay for Health Home services as described in the six service definitions (Comprehensive Care Management, Care Coordination, Comprehensive Transitional Care, Health Promotion, Individual and Family Support, and Referral to Community and Social Services) may or may not require face–to-face interaction with a health home patient. However, when these duties do involve such interactions, they are not traditionally clinic treatment interactions that meet the requirements of currently available billing codes. The criteria required to receive a monthly PMPM payment is:
A. The member meets the eligibility requirements as identified by the provider and documented in the member's electronic health record (EHR).
B. The member has full Medicaid benefits at the time the PMPM payment is made.
C. The member has agreed and enrolled with the designated health home provider.
D. The Health Home provider is in good standing with IME and is operating in adherence with all Health Home Provider Standards.
E. The minimum service required to merit a Patient Management PMPM payment is that the person has received care management monitoring for treatment gaps defined as Health Home Services in this State Plan. The Health Home must document Health Home services that were provided for the member.
a. The health home will attest, monthly, that the minimum service requirement is met. The patient medical record will document health home service activity and the documentation will include either a specific entry, at least monthly, or an ongoing plan of activity, updated in real time and current at the time of PMPM attestation.

The patient management per member per month payment rate is posted at
http://www.ime.state.ia.us/Providers/healthhome.html
effective for services provided on or after July 1, 2012. The rates will be reviewed annually, and updated as needed based on evaluation and effectiveness of the program.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

☐ **Incentive payment reimbursement**

Provide a comprehensive description of incentive payment policies that the State will use to reimburse in addition to the unit base rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the incentives that will be reimbursed through the methodology, how the supplemental incentive payments are tied to the base rate activities, the criteria used to determine a provider's eligibility to receive the payment, the methodology used to determine the incentive payment amounts, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

☐ **PCCM Managed Care (description included in Service Delivery section)**

☑ **Risk Based Managed Care (description included in Service Delivery section)**

☐ **Alternative models of payment, other than Fee for Service or PM/PM payments (describe below)**

☐ **Tiered Rates based on:**

☐ **Severity of each individual's chronic conditions**

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Rate only reimbursement**

Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.
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 have the delivery of this care coordinated between the entities. Additionally, MCOs are contractually required to ensure non-duplication of payment for similar services; the State reviews and approves MCO non-duplication strategies and conducts ongoing monitoring to assure continued compliance.

☑ **The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule**

☑ **The State provides assurance that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.**

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Submission - Categories of Individuals and Populations Provided Health Homes Services

The State will make Health Homes services available to the following categories of Medicaid participants:

☑ **Categorically Needy eligibility groups**

Health Homes Services (1 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive Care Management

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.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
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.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Designated Practitioner

Description

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

Care Coordination

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

When the member receives care coordination from a TCM, CM or Service Coordinator, the Health Home must collaborate with TCM, CM, and Service Coordinators to ensure the care plan is complete and not duplicative between the two entitiies.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
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.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☑ **Nurse Care Coordinators**

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

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Health Promotion

Definition:
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.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

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.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name
Designated Practitioner and Health Coach

Description
Health Promotion services are the responsibility of the Health Coach role and Designated Practitioner role within the Health Home.

Health Homes Services (2 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

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

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

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
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.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☑ **Nurse Care Coordinators**

Description
Comprehensive Transitional Care services are the responsibility of the Dedicated Care Coordinator role and Designated Practitioner role within the health home.

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Individual and family support, which includes authorized representatives

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.

When the member receives care coordination from a TCM, CM or Service Coordinator, the Health Home must collaborate with TCM, CM, and Service Coordinators to ensure the care plan is complete and not duplicative between the two entitiies.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Health IT can assist care coordinators providing information that is culturally and linguistically appropriate for the patient, family and caregivers.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Health Coach

Description

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

Referral to community and social support services, if relevant

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.

When the member receives care coordination from a TCM, CM or Service Coordinator, the Health Home must collaborate with TCM, CM, and Service Coordinators to ensure the care plan is complete and not duplicative between the two entitiies.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.

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.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☑ **Nurse Care Coordinators**

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

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:
N/A

☑ **Medically Needy eligibility groups**

◉ **All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.**

○ **Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.**

○ **All Medically Needy receive the same services.**

○ **There is more than one benefit structure for Medically Needy eligibility groups.**

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Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement 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.

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.
Using Medicaid claims data, including MCO encounter data, the State-selected evaluator 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 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.

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.

Describe how the State will use health information technology in providing Health Homes services and to improve 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. 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.

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.

Quality Measurement

☑ **The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.**

☑ **The State provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.**

States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:

Evaluations

☑ **The State provides assurance that it will report to CMS information submitted by Health Homes 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.**

Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:

Hospital Admissions

Measure:
Hospital Admissions
Measure Specification, including a description of the numerator and denominator.
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 Sources:
Claims, including MCO encounter data
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Emergency Room Visits

Measure:
ER Visits
Measure Specification, including a description of the numerator and denominator.
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 Sources:
Claims, including MCO encounter data
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Skilled Nursing Facility Admissions

Measure:

Skilled Nursing Facility Admissions
Measure Specification, including a description of the numerator and denominator. 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 Sources: Claims, including MCO encounter data Frequency of Data Collection: ○ **Monthly** ○ **Quarterly** ◉ **Annually** ○ **Continuously** ○ **Other**

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

Hospital Admission Rates
Medicaid claims data, including MCO encounter 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.

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

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.

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.

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.

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.

Estimates of Cost Savings

☐ **The State will use the same method as that described in the Monitoring section.**

If no, describe how cost-savings will be estimated.
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.

(Continued under "Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.")

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 80 per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.