Health Home State Plan Amendment

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

Transmittal Number: WV-14-0009 Supersedes Transmittal Number: Proposed Effective Date: Jul 1, 2014 Approval Date: Attachment 3.1-H Page Number:

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.
WV-14-0009

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.

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

Name of Health Homes Program:
WV Health Homes for Individuals with Bipolar Disorder at Risk for Hepatitis Type B and C

State Information

State/Territory name: **West Virginia**
Medicaid agency: WV Department of Health and Human Resources, Bureau for Medical

Authorized Submitter and Key Contacts

The authorized submitter contact for this submission package.

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Proposed Effective Date

07/01/2014 (mm/dd/yyyy)

Executive Summary

Summary description including goals and objectives:
West Virginia's State Plan Amendment (SPA) is health delivery model targeted for the treatment of members with bipolar disorder who are at risk for Hepatitis B and/or Type C (HH-BD/H). The Health Home model is person-centered, primary care-based, behavioral health integrated. and case-managed by an interdisciplinary team.
Goals of this Health Home SPA include improving the health care experience, improving the health of populations, reducing per capita costs of health care, and promoting the integration of behavioral health into primary care.
Objectives include a reduction in emergency department use, hospital admissions and re-admissions, health care costs, reliance on long-term care facilities, and improving the health care experience, quality and outcomes for the individual and providers.

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2015	$ 3422074.00
Second Year	2016	$ 3422074.00

Federal Statute/Regulation Citation
Affordable Care Act, Section 2703,Section 1945

Governor's Office Review

No comment.

Comments received.
Describe:

No response within 45 days.

Other.
Describe:
Not Required.

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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:

Newspaper Announcement

Publication in State's administrative record, in accordance with the administrative procedures requirements.
Date of Publication:
01/01/2014 (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:

01/01/2014 (mm/dd/yyyy)

Website URL:

http://www.dhhr.wv.gov/bms/Pages/default.aspx

Website for State Regulations

Date of Posting:

01/01/2014 (mm/dd/yyyy)

Website URL:

Other

Public Hearing or Meeting

Date	Time	Location
Jan 24, 2014	1:30 PM	2428 East Kanawha Blvd. Charleston, WV 25301
Jan 22, 2014	4:00	Beckley, WV
Jan 21, 2014	4:00 PM	Huntington, WV

Other method

Other	
Name: Webinar Date: 03/06/2014 (mm/dd/yyyy) Description: The Bureau hosted a webinar to present the SPA information and solicit questions/comments. Interested parties were notified of the date/time by email.	

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 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

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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: 02/23/2012 (mm/dd/yyyy)	
Date of consultation: 09/06/2012 (mm/dd/yyyy)	
Date of consultation: 06/13/2013 (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	

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	
Bipolar Disorder ; Hepatitis Type B and/or Type C	

Specify the criteria for at risk of developing another chronic condition:
Evidence published indicates that individuals with Bipolar Disorder represent a patient population at high risk for: statistically high mortality rates compared to the general medical population; developing comorbid medical diseases because of lifestyle; substance abuse; having Hepatitis Type B and/or C. These individuals have a pattern of poor treatment compliance.
Prescription psychotropic medication costs for individuals with Bipolar Disorder in West Virginia average over $30,000 per year, per individual. If the individual concurrently suffers from Hepatitis Type C and is receiving the most current treatment, yearly prescription medical costs can easily exceed $100,000 per individual before other medications or other health care costs are considered. For the reasons noted, targeted treatment of this population meets the needs of West Virginians and is highly aligned with the three main goals to: improve the experience of care, improve the health of our population, and to reduce per capita health care costs.

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:
Wayne, Cabell, Putnam, Kanawha, Raleigh, and Mercer

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:

Automatic Assignment with Opt-Out of Health Homes provider

Describe the process used:
Claims based information for automatic assignment based on prior relationship with Health Home provider or, in the absence of relationship, Health Home that is geographically closest to patient. Patient notification completed by mail and by health home for options including opting out.

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:
WV Medicaid enrolled licensed health care practitioner

Clinical Practices or Clinical Group Practices

Describe the Provider Qualifications and Standards:
WV Medicaid enrolled licensed health care practitioner or group

Rural Health Clinics

Describe the Provider Qualifications and Standards:
WV Medicaid enrolled licensed rural health clinic

Community Health Centers

Describe the Provider Qualifications and Standards:
WV Medicaid enrolled licensed community health center

Community Mental Health Centers

Describe the Provider Qualifications and Standards:
WV Medicaid enrolled licensed community mental health center

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:

WV Medicaid enrolled licensed community or behavioral health agency

Federally Qualified Health Centers (FQHC)

Describe the Provider Qualifications and Standards:

WV Medicaid enrolled licensed federally qualified health centers

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 will provide support to providers using a variety of media. Specific programs will be developed and determined based on feedback from providers and identification of needs. This will include face to face training on the requirements and expectations of the SPA, including outreach, assessment, documentation, invoicing, and reporting. Scenarios will be used to illustrate the expectations for care coordination and other health home services.

A website has been set up to provide additional information about the SPA and will include access to recorded training webcasts as well as provider manual and FAQ's.Providers will have a specific APS Healthcare trainer consultant assigned to their agency in which they may request training and/or technical assistance. The APS Healthcare trainer consultant will be on the provider's site at least one time every twelve months providing training based upon the findings of a record review and certification audit. The findings of these reviews will be analyzed to determine a training plan for all Health Home Providers.

The State will provide support to providers using a variety of media. This will include face to face training on health home requirements and expectations for all providers prior to the effective date of the SPA, including outreach, assessment, documentation, invoicing and reporting.

A learning community of health home participants will be set up to allow for regular sharing of experiences among health homes providers and teams. Qualitative information about program implementation will be collected through this community. and Lessons learned will be harvested through the health home learning community.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.

West Virginia's provider infrastructure will include a designated primary care physician or advanced practice nurse practitioner, working with multidisciplinary teams in a variety of possible settings: primary care and solo medical practices; comprehensive community behavioral health centers with a primary care service base; providers who serve special populations; academic medical centers; other entities meeting established qualifications.

Provider Standards

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

1. Health home providers must enroll or be enrolled in the WV Medicaid program and agree to comply with all Medicaid program requirements.

2. Care coordination and the other five health home services, as identified by CMS, will be provided to all health home enrollees by an interdisciplinary team of providers. As described in the Provider Infrastructure section above, each health home will define its multidisciplinary team in a manner that assures capacity to provide or arrange for the six defined health home services. However, at minimum, each team shall include a primary care provider (physician or advanced practice nurse), a licensed behavioral health specialist, a registered nurse, and a care manager (who could be the nurse or the behavioral health specialist for persons with SMI). Each team shall include an individual who is designated as a care coordinator but who may also fill other roles. The care manager leads the health home team and is accountable for assuring that patient needs are identified and that an integrated care plan is developed and coordinated for each enrollee and is carried out by assuring access to medical and behavioral health care services and community social supports as defined in the care plan. Additional members of the health home team may include physicians, physicians' assistants, nurses, nurse practitioners, pharmacists,

social workers, mental health workers, health educators, community health workers, and others, dependent on the delivery model of the health home.
Specific qualifications for the required team member roles are as follows:
• Provider---MD, DO, or Advanced Practice Nurse licensed in the state of WV;
• Behavioral Health Specialist ---Masters prepared individual licensed in the state of WV in counseling, psychology, or social work;
• Nurse---Registered Nurse licensed in the state of WV;
• Care Manager---Registered Nurse or licensed Behavioral Health Specialist. Certification as a Case Manager is desirable and required within 18 months of provider designation as a health home;
• Care Coordinator---Licensed Registered Nurse or Bachelor's Degree in a social science with some applicable patient care or counseling experience. Completion of a care coordination training program is required within 12 months of provider designation as a health home.
The health home provider must identify the means for care plan documentation, communication, and integration across the various service delivery components of the health home.
Health home providers can either directly provide or subcontract for the provision of health home services. The health home provider remains responsible for all health home program requirements, including services performed by the subcontractor. The health home provider is required to describe the methods and processes for providing the health home services. Where contractual relationships are to be used, the health home provider must demonstrate that formal written agreements are in place at the time health home services are initiated.
3. Health home providers are expected to establish a medical neighborhood of local community providers that will serve as referral providers for various medical, behavioral health, and facility services, and as applicable to managed care, the medical neighborhood must include providers that are part of the contracted network of the managed care entity. At minimum, each health home must either include provision of behavioral health services or must establish a formal partnership with a behavioral health entity in order to assure appropriate access to a range of behavioral health services for all of its health home enrollees. Services will be available 24 hours a day/7 days a week. Hospitals that are part of a health home neighborhood must have procedures in place for referring any eligible individual with chronic conditions who seek or need treatment in a hospital emergency department to a health home or other facility based settings to ensure coordination of all aspects of transitional care for current and eligible recipients. Documentation describing the medical neighborhood and hospitals' referral commitment must be provided.
4. Health home providers must demonstrate their ability to perform each of the following functional requirements. This includes documentation of the processes used to perform these functions and the methods used to assure service delivery takes place in the described manner.
• Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services.
• Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines.
• Coordinate and provide access to preventive and health promotion services, including the promotion of mental and emotional well-being and the prevention of substance abuse.
• Coordinate and provide access to mental health and substance abuse services.
• Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings.
• Coordinate and provide access to chronic disease management, including self-management support to individuals and their families.
• Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services.
• Coordinate and provide access to long-term care supports and services.
• 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.
• 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.
• 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.

5. The health home provider must use an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act, and which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers. Providers may also access the The West Virginia Health Information Network (WVHIN), which is an interactive network.

6. As a condition of being a designated provider, the health home must agree not to refuse enrollment of eligible potential health home enrollee referred by Bureau for Medical Services (BMS).
7. As a condition of being a designated provider, the health home is subject to all audit and monitoring systems currently in place for Bureau for Medical Services programs. Documentation of health home services for enrollees is subject to audit by a Bureau for Medical Services contractor. In addition, the provider understands that BMS will monitor outcome measures and the provider is subject to discontinuation of designation as a health home if measures are not reported as required, or if anticipated outcomes are not achieved.
8. Health Home provider qualifications will initially be assessed and approved by the DHHR Bureau for Medical Services. Once a provider gains Health Home provider status, the provider record in the State's MMIS will include this designation. Subsequent Health Home provider recertification, conducted by APS Healthcare, will occur within thirteen months of the Health Home designation anniversaries. APS Healthcare is an approved Quality Improvement Organization (QIO) under contract with the Bureau for Medical Services to provide utilization management for certain Medicaid-covered services, including prior approval for inpatient hospital admission.

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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:

- [x] **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:

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:

☐ **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.

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.

Reimbursement will only be made for health home services not covered by any other available Medicaid reimbursement options. The criteria required for receiving a monthly PMPM reimbursement is:

a) The member meets health home eligibility criteria and is so flagged in the MMIS;

b) The member is enrolled as a health home member with the health home provider billing for the service reimbursement;

c) At least one of the core health home services has been provided during the previous month and documented in the member's medical record.

By submitting the basic or intense health home service code for reimbursement, the provider is attesting to the fact that at least one of the six health home services has been provided during the month.

The following steps are used to determine the rates:

1. The State will use West Virginia wage specific data obtained from the Bureau for Labor Statistics (BLS) for each Health Home designated multidisciplinary team professional.
2. Salary will be adjusted for fringe benefits and assigned at a rate of 40 percent of the average BLS annualized salary for each wage classification.
3. The fringe adjusted annual salary is converted to an hourly rate per wage classification assuming 2,080 work hours.
4. The hourly rate for each wage classification is adjusted for each multidisciplinary team member's level of participation in the health home team for each payment tier by dividing the team members assigned level of participation by the total assigned monthly participation for the health home team for each payment tier.
5. The monthly health home team level of participation assigned to Tier One services is two hours PMPM and eight hours PMPM for Tier Two services for individuals with Bipolar disorder and at risk for Hepatitis C. Health home participation levels will vary based on each targeted health home condition.
6. The tiered PMPM rate will equal the sum of hourly rates for each health home multidisciplinary team member that has been adjusted for fringe benefits and participation level.

As part of review of rates and potential adjustments, the composition of the health home team, as well as, estimated levels of participation of each team memeber will be revisited with appropriate bureau clinical and administrative staff to ensure appropriate changes are taken into consideration in calculating any rate revisions.

Payment for Health Home services under the State Plan will not duplicate payments made to public agencies or private entities under other program authorities for the same purpose. Medicaid will be the payer of last resort. Unless specifically notes otherwise in the plan, the state developed rate is the same for both governmental and private providers. Providers will be reimbursed at the lesser of the provider's usual and customary billed charge or the Bureau for Medical Services (Bureau) fee schedule. Rates will be published on the Bureau's website at: www.dhhr.wv.gov/bms

Two Level System: Payment will be made on a per member per month (PMPM) basis for each health home enrollee. Basic and Intensive Health Home Services comprise the two-level system.

Health Home Service Level I: The basic Level I health home service code is intended to cover the provision of all of the six health home services, as determined to be appropriate to meet the member needs. At the time of enrollment, the Health Homes requests prior authorization of the Level I service for each enrollee through a web-based prior authorization system managed by APS Healthcare. Both at initial

enrollment and at the time of each service request, APS Healthcare verifies the person's Medicaid eligibility. Payment will be made based on the presence of the Health Home attribute in the member's MMIS record, the member's Medicaid eligibility during the service month, a prior authorization in the MMIS including the service month and the submission for payment through the MMIS of the service code for Health Home Services: Level I. The benefit package for all Health Home enrollees includes eligibility for services covered by the basic health home code.
Health Home Service Level II: A second health home level of service, Level II, is available for those health home enrollees determined to require more intense service for a period. Health Homes request prior authorization of the Level II intensive service through the same web-based prior authorization system managed by APS Healthcare. At the time of a request for Level II service, APS Healthcare will conduct verification of the HH member's Medicaid eligibility. Each Medicaid member whom qualifies for Level II Health Home service will receive a one-month authorization. Authorization is based on clinical information presented by the Health Home provider, including hospitalizations, ER utilization, assessment scores, and clinical judgment documenting a deterioration of the enrollee's condition and crisis situation requiring stabilization. Payment will be made based on the presence of the Health Home attribute in the member's MMIS record, the member's Medicaid eligibility during the service month, a prior authorization in the MMIS including the service month and the submission for payment through the MMIS of the service code for Health Home Services: Level II.

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.
There will be a contractual agreement with Health Home Providers and other providers, such as waiver services providers and targeted case management providers, regarding non-duplication of similar benefits. In addition, Bureau for Medical Services does periodic retrospective reviews for these services.

☑ **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:
Comprehensive Care Management is the development, implementation, and ongoing reassessment of a comprehensive individualized patient-centered care plan for each member. The care plan design will be developed with input from the interdisciplinary team of providers on the basis of information obtained

from a comprehensive risk assessment that identifies the member's needs in areas including: medical, mental health, substance abuse/misuse, and social services. The comprehensive risk assessment will also include mental health and substance abuse screenings using standardized tools. HH Providers will be required to update the clinical/medical/social data received during an assessment at least every four months.

The individualized care plan will include integrated services to meet the member's behavioral health, rehabilitative, long term care, and social service needs, as indicated. The care plan will be developed with input from the interdisciplinary team of providers; identify the primary care physician, other health and behavioral health care providers, Care Manager, and other health team providers directly involved in the individual's care; and also identify community networks and supports needed for comprehensive quality health care. The Care Manager is a member of the team and responsible for the maintenance of the care plan document and ensures the client receives a copy of the initial care plan and any time that changes are made. Goals and timeframes for improving the member's health, overall health care status and identified interventions will be included in the care plan, as well as schedules for plan assessment and update. Comprehensive care management will assure that the member or legal health representative is an active team member in the care plan's development, implementation and assessment and is informed and in agreement with plan components. Member's family and other recognized supports will be involved in the member's care as requested by the member.

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

Penetration of HIT adoption in WV is variable at the current time, although a growing number of providers are adopting EHR's in response to the federal incentive program and BMS has partnered with the WV Regional Extension Center to further promote the use of HIT within the Medicaid provider community. Providers will be expected to demonstrate a commitment to the use of HIT by all members of the Health Home team, as part of the application to serve as a Health Home. At minimum, a certified EHR is required at the primary care site; the EHR is expected to document the elements of an individual care plan for each Health Home member. The use of HIT is also encouraged in the identification of individuals who are at highest risk and in need of more intense care management services; this will be done through analysis of population level reports of member characteristics and utilization patterns. This may also be done through electronic responses to a health risk assessment tool. To facilitate communication about care coordination and care management activities, various systems are being explored; however, none is expected to be in place prior to SPA implementation.

As the use of HIT and the implementation of a statewide health information exchange evolve, it is anticipated that the use of HIT to support all of the health homes services will also evolve.

Scope of benefit/service

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

Behavioral Health Professionals or Specialists

Description

Initial assessment and care plan development will be conducted in a face to face encounter. Follow up services may be conducted via telephone or telehealth modalities.

Nurse Care Coordinators

Description

Under the supervision of the primary care physician or advanced nurse practitioner, the nurse care coordinator supervises and facilitates the coordination of health care to the member. Initial assessment and care plan development will be conducted in a face to face encounter. Follow up services may be conducted via telephone or telehealth modalities.

Nurses

Description

Under the supervision of the primary care physician or advanced nurse practitioner, the nurse care coordinator supervises and facilitates the coordination of health care to the

member. Initial assessment and care plan development will be conducted in a face to face encounter. Follow up services may be conducted via telephone or telehealth modalities.

Medical Specialists

Description

Physicians

Description
Initial assessment and care plan development will be conducted in a face to face encounter.
Follow up services may be conducted via telephone or telehealth modalities.

Physicians' Assistants

Description

Pharmacists

Description

Social Workers

Description
Eligible as behavioral health specialist.
Initial assessment and care plan development will be conducted in a face to face encounter.
Follow up services may be conducted via telephone or telehealth modalities.

Doctors of Chiropractic

Description

Licensed Complementary and Alternative Medicine Practitioners

Description

Dieticians

Description

Nutritionists

Description

Other (specify):

Name

Description

Care Coordination

Definition:
Care Coordination is the delivery of comprehensive, multidisciplinary care to a member that links all involved resources by maintaining and disseminating current, relevant health and care plan data.
Care coordination manages resource linkages, referrals, coordination and follow-up to plan-identified resources. Activities include, but are not limited to: appointment scheduling, conducting referrals and follow-up monitoring, participating in facility discharge processes and communicating with other providers and members/family members.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Each Health Home provider will be encouraged to use the HIT resources they have available through their internal EHRs to track referrals and generate reminders for follow up. Where there are available electronic linkages with partner hospitals and their EHRs, the Health Home providers will be encouraged to maximize the use of these linkages to share bi-directional information. West Virginia is just starting its gradual roll-out of a state-wide HIE. As the state HIE is implemented, all Health Home providers will be encouraged to fully participate, as is feasible, to utilize the HIE to share information with members of their referral network. Health Home providers will also be encouraged to implement a patient portal to communicate with patients/ family members.
Health Home providers will be encouraged to utilize their EHRs and/ or patient portals to link to health

information and resources applicable to the member's condition. Member educational materials will be generated electronically to allow for customization and appropriateness to the member's condition, literacy level, and cultural preferences, where feasible.

Scope of benefit/service

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

Behavioral Health Professionals or Specialists

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Nurse Care Coordinators

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Nurses

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Medical Specialists

Description

Physicians

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Physicians' Assistants

Description

Pharmacists

Description

Social Workers

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

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 the provision of: health education specific to a member's health and behavioral health; development of self-management plans effectively emphasizing the importance of immunizations and preventive screenings; understanding and management of prescribed medications; supporting improvement of social networks; and providing healthy lifestyle interventions. Areas of focus include but are not limited to, substance use and smoking prevention and cessation, nutritional counseling, weight management, and increasing physical activity.
Health promotion services assist members to participate in the development and implementation of their care plan and emphasize person-centered empowerment to facilitate self-management of chronic health conditions through informed awareness.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Each Health Home provider will be encouraged to use the HIT resources they have available through their internal EHRs to track referrals and generate reminders for follow up. Where there are available electronic linkages with partner hospitals and their EHRs, the Health Home providers will be encouraged to maximize the use of these linkages to share bi-directional information. West Virginia is just starting its gradual roll-out of a state-wide HIE. As the state HIE is implemented, all Health Home providers will be encouraged to fully participate, as is feasible, to utilize the HIE to share information with members of their referral network. Health Home providers will also be encouraged to implement a patient portal to communicate with patients/ family members.
Health Home providers will be encouraged to utilize their EHRs and/ or patient portals to link to health information and resources applicable to the member's condition. Member educational materials will be generated electronically to allow for customization and appropriateness to the member's condition, literacy level, and cultural preferences, where feasible.

Scope of benefit/service

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

Behavioral Health Professionals or Specialists

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Nurse Care Coordinators

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Nurses

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Medical Specialists

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Physicians

Description

Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Physicians' Assistants

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Pharmacists

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Social Workers

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Doctors of Chiropractic

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Licensed Complementary and Alternative Medicine Practitioners

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Dieticians

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Nutritionists

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Other (specify):

Name
Care Coordinator; Others

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

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 is care coordination services designed to prevent avoidable emergency department visits, admissions, and readmission after discharge from an inpatient facility. For each enrollee transferred from one caregiver or site of care to another, the health home team ensures proper and timely follow-up care and safe, coordinated transitions, including reconciliation of medications. The transition could include any inpatient care to home and community based services and supports. This is accomplished through formal relationships and communication systems with health facilities including emergency departments, hospitals, long-term care facilities, residential/rehabilitation settings, as well as with other providers and community-based services.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Health Home providers will be encouraged to develop partnerships that maximize the use of HIT across various caregivers and care settings. The provider will be encouraged to use HIT when available to communicate with health facilities and to facilitate interdisciplinary collaboration among all care team members. Providers will be encouraged to share information through the statewide HIE once that capability becomes available. Providers will also be encouraged to provide enrollees with web-based access to their records that can follow the enrollees as they transition to different care settings.
To facilitate post-hospital follow-up, BMS will be exploring a means of communication to health homes about enrollees who have been admitted to a hospital.
APS Healthcare will provide via its web-based system a notification to the assigned Health Home when a non-MCO member has had a request for medical or psychiatric hospitalization made/authorized. The MCOs will be encouraged to provide like information to the Health Homes for their members served by a Health Home.

Scope of benefit/service

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

Behavioral Health Professionals or Specialists

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Nurse Care Coordinators

Description

Nurses

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Medical Specialists

Description

Physicians

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

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 service provision and resource identification that assist members to attain their highest level of health and functioning. Peer supports, support groups, and self-care programs can be utilized by providers to increase members' and support members' knowledge about the member's diseases, promote member's engagement and self-management capabilities, while assisting the member to adhere to their care plan.
A primary focus of individual and family supports will be strengthened through increased health literacy. This effort will include communicated information that is language, literacy, and culturally appropriate, and designed to improve the member's ability to self-manage their health and participate in the ongoing care planning.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Health Home providers will be encouraged to utilize their EHRs and/or patient portals to link to health information and resources applicable to the member's condition. The use of a patient portal or PHR is encouraged to provide for patient/ family interaction with the care team and for development and monitoring of shared care plans.
Member educational materials will be generated electronically to allow for customization and appropriateness to the member's condition, literacy level, and cultural preferences, where feasible.

Scope of benefit/service

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

Behavioral Health Professionals or Specialists

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Nurse Care Coordinators

Description

Nurses

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Medical Specialists

Description

Physicians

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

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

Referral to community and social support services, if relevant

Definition:
Referral to Community and Social Support Services includes the identification of available community resources, active management of referrals, access to care, including long term services and supports, engagement with other community and social supports, coordination of services and follow-up. This may include but not limited to, Alcoholics Anonymous and/or Narcotics Anonymous.
The Community and Social Support Services network includes development of policies, procedures and accountabilities (through contractual agreements, where applicable) which clearly define the roles and responsibilities of the participants in order to support effective collaboration between the health home and community-based resources, and the member.
The member's care plan will include community-based and other social support services that address and respond to the member's needs and preferences, and contribute to achieving the care plan goals.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.
Health Home providers will be encouraged to utilize HIT as feasible to initiate, manage and follow up on community based and other social services referrals.

Scope of benefit/service

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

☐ **Behavioral Health Professionals or Specialists**

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

☐ **Nurse Care Coordinators**

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

☐ **Nurses**

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

☐ **Medical Specialists**

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

☐ **Physicians**

Description

Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Physicians' Assistants

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Pharmacists

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Social Workers

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Doctors of Chiropractic

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Licensed Complementary and Alternative Medicine Practitioners

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Dieticians

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Nutritionists

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

Other (specify):

Name
Care Coordinator; Others

Description
Services may be provided in either a face to face encounter, telephonically, or via telehealth modalities.

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:

The admission continuing stay criteria for Tier 1 will be: Medicaid Eligibility and documented diagnosis of a Bipolar Disorder that are determined to be at risk for becoming infected with or currently have Hepatitis B and/or C.

The criteria for Tier 2 will be: at least one of the core health home services has been provided during the previous quarter and documented in the member's medical record. There has been marked deterioration in behavioral stability demonstrated via an appropriate screening tool and or marked deterioration of medical stability or a change in the complexity of the medical issues identified requiring daily co-ordination.

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:
Data Source: MMIS
Measurement Specifications: Total readmissions in the past month for health home enrollees that occurred within 30 days of discharge following an index admission.

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.
Data Source: MMIS
Measurement Specifications: Compare total cost of care for health home members to costs of care for similar cohorts not enrolled with a HH. Calculations will exclude claims for high cost outliers more than three standard deviations from the mean annual cost and will include incremental HH reimbursement.
HH member costs will also be compared pre- and post- HH implementation.

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).
West Virginia currently has several HIT initiatives in place and underway that will support the provision of health home services and improvement of care coordination across the care continuum.
• The state is in the process of implementing a statewide health information exchange that will facilitate the sharing of information across various care delivery settings. All health home providers will be expected to

participate in the HIE as it is implemented across the state. The HIE will be used to capture meaningful use measures and several of these are incorporated into the information that will be used to monitor and evaluate health home services. Until the HIE is fully in place in the state, each health home provider will also be expected to use their EHR to generate a Continuity of Care Document (CCD) that can be shared with other providers in order to facilitate transitions in care and care coordination across care settings.
• A pharmacy data warehouse is in place that will provide for monitoring of patient adherence to prescribed drug regimens as well as appropriate use of pharmaceutical agents.
• A data warehouse/ decision support system is being implemented to capture MMIS claims data as well clinical data that will flow through the HIE. This data warehouse will be a primary source of evaluation information for the health homes initiative.
• A web-based vendor system will be used for documentation of medically necessary services and authorization information.
• Information on hepatitis will be shared with Public Health. Epidemiology maintains a data base of information regarding incidence of hepatitis in the State.

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 admission rate for HH enrollees

Measure Specification, including a description of the numerator and denominator.
Rate of acute care hospital admissions for the Health Home members
Numerator: number of hospital admissions for the HH enrollees
Denominator: number of HH enrollees
Compare this rate pre- and post- implementation of HH initiative. Compare rate to similar cohort cared for by practices not recognized as HH.
Data Sources:
BMS MMIS claims data
Frequency of Data Collection:

Monthly

Quarterly

Annually

Continuously

Other
Monthly, aggregated annually

Emergency Room Visits

Measure:
Health Home enrollee ER visit rate
Measure Specification, including a description of the numerator and denominator.
Rate of ER visits for HH enrollees
Numerator: Number of ER visits by Health Home enrollees with a discharge disposition of home
Denominator: Number of HH enrollees
Compare this rate pre- and post- implementation of HH initiative. Compare rate to similar cohort cared for by practices not recognized as HH.
Data Sources:
BMS MMIS
Frequency of Data Collection:

Monthly
Quarterly
Annually
Continuously
Other
monthly, aggregated annually

Skilled Nursing Facility Admissions

Measure:
Health Home enrollee SNF admission rate
Measure Specification, including a description of the numerator and denominator.
Rate of SNF admissions for HH enrollees
Numerator: Number of SNF admits for Health Home enrollees
Denominator: Number of HH enrollees
Compare this rate pre- and post- implementation of HH initiative. Compare rate to similar cohort cared for by practices not recognized as HH.
Data Sources:
BMS MMIS
Frequency of Data Collection:

Monthly
Quarterly
Annually
Continuously
Other
monthly, aggregated annually

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
Consolidate BMS MMIS claims data to assess hospital admission rates by service (medical, surgical, maternity, mental health & chemical dependency) for participating Health Homes compared to a non-participating control group.
1. The experience of members' with clinical conditions of focus during the first year, and
2. All members with 2 or more chronic conditions, or 1 chronic condition and at risk for a second, obtained from a list of state-defined chronic conditions.

Chronic Disease Management

MMIS will be used to calculate process measures related to evidence-based guidelines for the targeted chronic conditions. Using the enrollee-specific clinical, medical, and social data, reported on a periodic basis by each Health Home through the APS Healthcare web-based system, additional clinical outcomes will be measurable.

Coordination of Care for Individuals with Chronic Conditions
Coordination of care is one of the elements assessed in the Care Connection (APS) survey and data collected through this source will be used to monitor care coordination from the member perspective

Assessment of Program Implementation
A learning community of health home participants will be set up to allow for regular sharing of experiences among health home providers and teams. Qualitative information about program implementation will be collected through this community.

Processes and Lessons Learned
Lessons learned will be harvested through the health home learning community.

Assessment of Quality Improvements and Clinical Outcomes
MMIS will be used to calculate process measures related to evidence-based guidelines for the targeted chronic conditions. Using the enrollee-specific clinical, medical, and social data, reported on a periodic basis by each Health Home through the APS Healthcare web-based system, additional clinical outcomes will be measurable.

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.
MMIS data will be used to compare costs of health home members to members with similar diagnoses and age. Analysis of utilization and cost will be made. Utilization parameters will include inpatient admissions by facility type as well as emergency department (ED) use. Cost parameters will include total cost as well as component cost, including inpatient, primary care services, specialty care, emergency care, and pharmacy.

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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.