State: Wisconsin

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

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

Health Home Services ☒

How are Health Home Services Provided to the Medically Needy? Choose an item.

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i. Geographic Limitations Choose an item. If Targeted Geographic Basis, Brown, Kenosha, Milwaukee and Dane Counties

ii. Population Criteria The State elects to offer Health Home Services to individuals with: Choose an item. from the list of conditions below:

☐ Mental health condition
☐ Substance abuse disorder
☐ Asthma
☐ Diabetes
☐ Heart Disease
☐ BMI over 25
☒ Other chronic condition covered? AIDS/HIV

The population includes Medicaid and BadgerCare Plus members with a diagnosis of AIDS/HIV and who have at least one other diagnosed chronic condition, or is at risk of developing another chronic condition. Individuals at "at-risk" for developing another chronic condition include:

- Individuals having a CD4 cell count of less than 200 cells/µL or CD4 cells accounting for fewer than 14 percent of all lymphocytes
- Individuals with a body mass index <18.5 kg/ m^2
- Individuals whose fasting plasma blood sugar is 100-125 mg/dL or A1C 5.7% - 6.4%
- Individuals with systolic pressure between 120 - 139 mm Hg; diastolic pressure between 80 – 89 mm Hg
- Individuals with hyperlipidemia:
  Total cholesterol >200 mg/dL
  HDL levels <40 mg/dL for men and <50mg/dL for women
  LDL levels >130 mg/dL

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For the purposes of this benefit, a chronic condition is defined as one that has lasted at least 6 months, can reasonably be expected to continue for six months, or is likely to recur. Members meeting the above criteria will be automatically enrolled in the health home. Health home providers will be responsible for educating members about the benefits of health home enrollment and inform them of the option to disenroll. Members agree to health home services by actively participating in the assessment and care plan process.

iii. Provider Infrastructure

Designated providers as described in Section 1945(h)(5) AIDS Service Organizations funded by the Wisconsin Department of Health Services under Wisconsin Statute ch 252.12(12)(a)8, for the purpose of providing life care services to persons diagnosed as having AIDS/HIV

Team of Health Care Professionals as described in Section 1945(h)(6) _____

Health Team as described in Section 1945(h)(7), via reference to Section 3502 _|_____

iv. Service Definitions	Service Name	Service Definition	Ways Health IT Will Link
	Comprehensive Care Management	Comprehensive care management involves the use of evidence-based guidelines to provide systematic, responsive and coordinated management of all aspects of primary and specialty care (physical and behavioral needs) for individuals with AIDS/HIV. Comprehensive care management includes early identification of individuals who meet the criteria for health home enrollment.	All contacts with health home members will be documented in the electronic health record. The patient's electronic health record will be accessible to all members of the patient's core team.
	Care Coordination	Care coordination is the ongoing management of the patient's medical, behavioral, pharmacological, dental care, and community care needs by a designated team lead. The team lead will ensure that the	The patient's treatment plan will be electronic and must be accessible to all members of the patient's core team.

		patient has a current, written, individualized, multidisciplinary care and treatment plan that addresses all aspects of the patient's care (including preventive care needs, all medical subspecialties, institutional care, home and community care).	
	Health Promotion	Health promotion services include all activities aimed at prevention, assisting the patient in better understanding their disease and, learning how to direct the care and treatment they receive. Enhanced patient education and active promotion of self-management and self care are part of health promotion.	The designated team lead will be responsible for ensuring that the patient's electronic treatment plan is updated to include all patient education, including medication management and self care regimen.
	Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)	Comprehensive transitional care involves the establishment of an automatic referral arrangement between institutional care providers and the health home provider to ensure that there is immediate communication and/or referrals of patients with AIDS/HIV who are admitted to the institution or are seen in the emergency room. Transitional care will include timely face-to-face or telephone contacts with the patient (or the patient's authorized representative) after an emergency room visit or a hospital or nursing home discharge.	The care coordinator will be responsible for ensuring that the patient's electronic treatment plan is updated to reflect all transitional care needs.
	Individual and Family Support Services (including authorized representatives)	Individual and family support services include activities related to advocating on the member's behalf and mobilizing services and support for the member. It	The care coordinator will update the patient's electronic health record to reflect all activities related to individual and family support services.

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		will include contacts with anyone identified as instrumental to the member's day-to-day support and care. Peer-to-peer information sharing and support are included in these support services.	
	Referral to Community and Social Support Services	Referral to community and social support services includes activities related to providing assistance to members to ensure they have access to support services identified in the care plan.	The care coordinator will document all referrals and the outcome of those referrals in the patient's electronic health record.

v. Provider Standards	Designated providers must: 1. Be located in a setting that integrates medical, behavioral, pharmacy, and oral health care 2. Be accredited by a nationally recognized accreditation program, as a patient-centered medical home or, meet the requirements detailed below: ▪ Have systems and infrastructure in place to provide comprehensive health home services to individuals with AIDS/HIV ▪ Provide written support, from the highest level of the provider organization, for coordinated care through the use of a health home model ▪ Meet all of the qualification standards outlined below: □ Adopt written standards for patient access and patient communication □ Use data to show that they meet standards for patient access and patient communication □ Use electronic charting tools to organize clinical information □ Use data to identify diagnoses and conditions among individual provider's patients that have a lasting detrimental effect on health □ Adopt and implement guidelines that are based on evidence for treating and managing AIDS and HIV-related conditions □ Actively support and promote patient self-management □ Systematically track patient test results and have a systematic way to identify abnormal patient test results □ Establish procedures to systematically accept referrals from hospitals (inpatient and outpatient) that treat

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	individuals with AIDS/HIV - Systematically track referrals using an electronic system - Measure the quality of the performance of individual providers and of individuals who perform services on behalf of these providers, including the provision of clinical services, patient outcomes, and patient safety - Report to employees and contractors of individual providers and to other persons on the quality of the performance of these providers and of individuals who perform services on behalf of the providers 3. Agree to the following practices in providing services: ▪ Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services; ▪ Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders; ▪ Coordinate and provide access to medication management, mental health and substance abuse services; ▪ 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; ▪ 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; ▪ 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.
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vi. Assurances	A. The State assures that hospitals participating under the State plan or a waiver of such plan will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to	The state will require that health home providers establish formal relationships with the hospitals in their service area to ensure coordination between the health home and hospital/emergency department. Clinics that currently provide services to individuals with AIDS/HIV currently have established working relationships

	designated providers.	with their local hospitals.
	B. The State has consulted and coordinated with the Substance Abuse and Mental Health Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.	The state will coordinate with SAMHSA in addressing issues related to the prevention and treatment of mental illness and substance abuse among eligible individuals with AIDS/HIV.
	C. The State will report to CMS information submitted by health home providers to inform the evaluation and Reports to Congress as described in section 2703(b) of the Affordable Care Act, and as described by CMS.	The state will provide CMS with all data described below on an agreed upon schedule.

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vii. Monitoring	A. Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications.	The state will rely on claims data and on data submitted by the health home provider. The exact measure is yet to be determined.
	B. Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications.	The state will use paid claims data to compare costs for providing health care services to members with AIDS/HIV prior to the implementation of the health home and annually thereafter to identify the areas of cost reduction. The state will also assess the costs of providing services to members with AIDS/HIV who are not enrolled in the health home and compare these costs and outcomes to those of members in the health home
	C. Describe the State's proposal for using health information technology in providing health home services under this program and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).	The state will require health home providers to adopt health information technology, including the use of electronic health records which interface with specialty and inpatient care providers, for the provision of services.

viii. Quality Measures

Comprehensive Care Management

	Measure	**Data Source**	**Measure Specification**	**How Health IT will be Utilized**
Clinical Outcomes	1. The percentage of health home patients, with a CD4 count of ≤350 cells per microliter (µL), who initiates antiretroviral therapy (ART). 2. The percentage of health home patients with an undetectable viral load within 6 months of ART initiation	Public health surveillance data MMIS – Pharmacy claims Medical record	1. Denominator: The number of health home patients with a CD4 count of ≤350 cells/µL Numerator: The number of health home patients with a CD4 count of ≤350 cells/µL who initiate ART 2. Denominator: The number of health home patients with	The patient's electronic health record

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			a CD4 count of ≤350 cells/µL who initiate ART Numerator: The number of eligible health home patients with an undetectable viral load after 6 months of ART.	
Experience of Care	N/A	N/A	N/A	N/A
Quality of Care	N/A	N/A	N/A	N/A

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Care Coordination

	Measure	**Data Source**	**Measure Specification**	**How Health IT will be Utilized**
Clinical Outcomes	N/A	N/A	N/A	N/A
Experience of Care	The percentage of patients who know the identity of their care coordinator	Satisfaction survey	Denominator: The number of patients enrolled for at least 6 months in the health home, who respond to the survey Numerator: The number of patients who report knowing the identity of their care coordinator	IT will not be used
Quality of Care	1. The percentage of patients with at least two preventive medicine visits during the measurement year, one visit for each six month period of enrollment 2. The percentage of patients who had at least one dental visit during the measurement year.	MMIS	Denominator: The number of patients enrolled for at least 6 months in the health home 1. Numerator: The number of health home patients with at least one preventive medicine visit for each six month period of enrollment 2. The number of patients with one or more visits with a dental care provider.	The patient's electronic health record

Health Promotion

	Measure	**Data Source**	**Measure Specification**	**How Health IT will be Utilized**
Clinical Outcomes	The percentage of health home enrollees with one or more avoidable hospitalizations during the report year	MMIS Medical record	Denominator: The number of health home patients with any hospitalization within the measurement year. Excludes patients who were	The patient's EHR

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			enrolled in the health home for less than 6 months. Numerator: The number of patients with one or more hospital stays due to an opportunistic infection, pneumonia, or other preventable condition.	
Experience of Care	The percentage of patients who report receiving health information related to self care	Patient satisfaction survey	Denominator: The number of patients enrolled for at least 6 months in the health home, who respond to the survey Numerator: The number of patients who report receiving information on self care	N/A
Quality of Care	The percentage of patients receiving counseling regarding their disease, separately or in conjunction with their medical appointment	MMIS Medical record	Denominator: The number of patients enrolled for at least 6 months in the health home. Numerator: The number of patients whose chart document they received counseling in self-care	The patient's EHR

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

	Measure	**Data Source**	**Measure Specification**	**How Health IT will be Utilized**
Clinical Outcomes	N/A	N/A	N/A	N/A
Experience of Care	The percentage of patients who report having one or more contact with their health home provider (physician or care coordinator) following an inpatient stay	Patient satisfaction survey	Denominator: The number of patients with a hospital admission within the reporting year, who respond to the survey Numerator: The number of patients who report having one or more contacts with their health home provider following discharge.	N/A
Quality of Care	The percentage of patients with a written transition plan from an inpatient setting back to the primary care/community care setting	Medical record	Denominator: The number of patients with a hospital or nursing home admission within the reporting year Numerator: The number of patients whose chart includes documentation of a post-discharge continuing care plan	The patient's EHR

Individual and Family Support Services (including authorized representatives)

	Measure	Data Source	Measure Specification	How Health IT will be Utilized
Clinical Outcomes	N/A	N/A	N/A	N/A
Experience of Care	The percentage of patients who report knowing who to call with questions related to their care	Patient satisfaction survey	Denominator: The number of patients who respond to the survey. Excludes patients enrolled for less than 6 months of the measurement year.	N/A

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			Numerator: The number of patients who report an understanding of how to navigate the health care system and how to get the support they need	
Quality of Care	The percentage of patients with a signed release of information	Medical record	Denominator: The number of patients enrolled for at least 6 months of the measurement year Numerator: The number of patients with documentation of a signed release of information in their record	The patient's EHR

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Referral to Community and Social Support Services

	Measure	**Data Source**	**Measure Specification**	**How Health IT will be Utilized**
Clinical Outcomes	N/A	N/A	N/A	N/A
Experience of Care	The percentage of patients who report little or no problem in accessing (removing barriers) to needed support services	Patient satisfaction survey	Denominator: The number of patients who respond to the survey. Excludes patients enrolled for less than 6 months of the measurement year. Numerator: The number of patients who report little or no problem accessing support services.	N/A
Quality of Care	The percentage of patients who receive a follow up contact from the health home within 2 weeks of a community or social support referral.	Medical record Provider report	Denominator: The number of patients who received a support referral (as reported by the health home). Numerator: The number of patients with documentation in their record of a follow up contact.	The patient's EHR

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ix. Evaluations

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

	Description	**Data Source**	**Frequency of Data Collection**
i. Hospital admissions	The number of hospital admissions and the length of stay for individuals enrolled in the health home(s)	Claims data	Quarterly
ii. Emergency room visits	The number of emergency room visits for individuals enrolled in the health home	Claims data	Quarterly
iii. Skilled Nursing Facility admissions	The number of nursing home stays for individuals enrolled in the health home	Claims data	Quarterly

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

i. Hospital admission rates	The state will use claims data for fee-for-service claims paid on behalf of members enrolled in the health home. The state will compare admission rates for the health home participants to the rates of members with AIDS/HIV who are not participating. Additionally, the state will use pre-implementation (baseline) data to compare to post-implementation rates.
ii. Chronic disease management	The state will use claims data (examples, office visits, lab testing, pharmacy, emergency room visits) to monitor chronic disease management. In addition, providers will be required to submit semi-annual reports responding to a series of identified indicators (for example, the number of face-to-face visits between the member and the care coordinator and the number of patients who received self-management counseling and support).
iii. Coordination of care for individuals with chronic conditions	The state will use claims data to determine the amount of care coordination provided. The state will monitor data reports and survey results from health home providers to further determine the level and frequency of coordination activities.
iv. Assessment of program implementation	The state Medicaid and Public Health (AIDS/HIV) Divisions will collaborate on the assessment of program implementation. Assessment activities are to be determined but could include joint health home visits and reviews of reports and data.
v. Processes and lessons learned	The state Medicaid and Public Health (AIDS/HIV) Divisions will collaborate on the review of the processes established by the health homes. The state will work in partnership with the health home providers to identify aspects of the health home implementation that works and those that need modification. A significant portion of this activity will be a reliance on the outcome of member surveys (both formal and informal).

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vi. Assessment of quality improvements and clinical outcomes	The state Medicaid and Public Health (AIDS/HIV) Divisions will use the clinical outcome measures described above to assess quality improvements and gains/set backs in clinical outcomes within the health homes.
vii. Estimates of cost savings	On an annual basis, the state will perform an analysis of the cost of providing care to members within and outside of the health home. The exact focus of the analysis is yet to be determined but will include an analysis of the level of utilization for routine care versus emergency care (inpatient hospital, emergency department and ambulance transportation).

Attachment 4.19-B Payment Methodology

Payment Type	Provider Type	Description	Tiered?
Monthly Case Rate	AIDS Service Organi-zations	Reimbursement will be limited to a monthly case rate. The reimbursement will be the same regardless of the frequency or intensity of care management activities provided within the month, except that health home providers will be required to provide at least one care management activity during the billable month. Health home providers must submit a claim to receive payment. Allowable care management activities include: ▪ Comprehensive care management ▪ Care coordination and monitoring ▪ Assessment and care plan updates ▪ Health promotion ▪ Comprehensive transitional care (including appropriate follow-up from inpatient to other settings) ▪ Individual and family support services (including authorized representatives) ▪ Referral to community and social support services ▪ Activities related to updating the care plan and documenting contacts Allowable activities will include face-to-face, telephone and other modes of communication among the care team, the member and collaterals. Direct health care or social services are not covered. This fee is reimbursable only for eligible members who have gone through the assessment and care plan development process and who have an assigned care coordinator. Reimbursement will be limited to the lesser of the amount billed or the established maximum fee. The state considered the following factors in developing the monthly rate: the development of a core health home team, associated Medicaid reimbursement rates (based on max fee schedule), claims data to determine appropriate levels of service across provider types, and the acuity and chronicity of members being served. Reimbursement will be the same for private and public providers.	No

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		Maximum allowable fees and reimbursement rates under the methods and standards set forth in this Attachment are published in the schedules posted online on the Wisconsin Medicaid website at: https://www.forwardhealth.wi.gov/WIPortal/Max%20Fee%20Home/tabid/77/Default.aspx Health home services rates, as of October 1, 2012, are effective for services provided on or after that date. If and when rate are updated, the update will be based on analysis of care management provided by those professionals and based on the acuity of and chronicity of the members receiving home health services. The State assures CMS that health home service payments will not result in any duplication of payment or services between Medicaid programs, services, or benefits, including management care, other delivery systems including waivers, any future health homes, and other state plan services.	
Alternate Payment Methodology	AIDS Service Organi-zations	Health home providers will receive a flat fee for the initial, comprehensive assessment of needs and the development of the integrated care plan. This initial fee is reimbursable only for members who meet the eligibility criteria and who agree to participate in the health home. The member's agreement to participate in the health home is determined by their active participation in the assessment and care plan development process. Health home providers will be allowed to bill a comprehensive assessment and care plan review once every 365 days if the member's health and support needs dictate the need. Reimbursement will be limited to the lesser of the amount billed or the established maximum fee. Payment of this service is limited to once every 365 days or less if the state approves a greater frequency. Providers must submit a claim to receive this fee. The state considered the following factors in developing the rate for the initial comprehensive assessment and care plan development: the development of a core health home team, associated Medicaid reimbursement rates (based on max fee schedule), claims data to determine appropriate levels of service across provider types, and the acuity and chronicity of members being served. Reimbursement will be the same for private and public providers. Maximum allowable fees and reimbursement rates under the methods and standards set forth in this Attachment are published in the schedules posted online on the Wisconsin Medicaid website at: https://www.forwardhealth.wi.gov/WIPortal/Max%20Fee%20Home/tabid/77/Default.aspx Health home services rates, as of October 1, 2012, are effective for services provided on or after that date. The State assures CMS that health home service payments will not result in any duplication of payment or services between Medicaid programs, services, or benefits, including management care, other delivery systems including waivers, any future health homes, and other state plan services.	No