State-by-State Health Home State Plan Amendment Matrix: Summary Overview

This matrix outlines key program design features from health home State Plan Amendments (SPAs) approved by the Centers for Medicare & Medicaid Services (CMS) as of May 2013. For more information about health homes (HH), visit http://www.Medicaid.gov.

Overview of Approved Health Home SPAs

State	Target Population	HH Providers	Enrollment	Payment	Geographic Area
Alabama **SPA APPROVED (4/9/13)** **SPA EFFECTIVE (7/1/12)**	Two chronic conditions; or one chronic condition and the risk of developing another, from the following list of conditions: Mental Health Condition, Substance Use Disorder, Asthma, Diabetes, Heart Disease; Transplants with a look back of Medicaid claims data for five years rather than 18 months, Cardiovascular Disease, Chronic Obstructive Pulmonary Disease, Cancer, HIV with an 18 month look back of Medicaid claims data for the identification of medications, and Sickle Cell Anemia.	Team of health care professionals: Primary Medicaid Providers, including FQHCs and Rural Health Clinics.	Voluntary	Per-member-per-month (PMPM) and fee-for-service (FFS)	Four geographic regions
Idaho **SPA APPROVED (11/21/12)** **SPA EFFECTIVE (1/1/13)**	A chronic condition of SPMI or SED; Diabetes and asthma; or Have either diabetes or asthma and be at risk for another chronic condition.	Current Healthy Connections providers that meet set standards, including physicians, clinical practices or clinical group practices, rural clinics, community health centers, community mental health centers, home health agencies, or any other current Healthy Connections providers.	Can self-refer or be referred by any service provider. Eligible beneficiaries will be automatically enrolled, with ability to opt-out.	Per-member-per-month (PMPM) payment for comprehensive care management services.	Statewide

State	Target Population	HH Providers	Enrollment	Payment	Geographic Area
Iowa **SPA APPROVED (06/08/12)** **SPA EFFECTIVE (07/01/12)**	Two chronic conditions or one and at risk for another. Conditions consistent with definition in statute plus Hypertension.	Primary care practices, CMHCs, FQHCs, rural health centers meeting State standards and shares policies/procedures and electronic systems if practice includes multiple sites.	Patient can opt-in when beneficiary presents at HH provider's office.	Patient management per-member-per-month (PMPM) Performance payment based on quality beginning in 2013.	Statewide
Maine **SPA APPROVED (1/22/13)** **SPA EFFECTIVE (01/01/13)**	Two chronic conditions or one chronic condition and at risk for another. Conditions include: Mental health condition (non-SMI), Substance use disorder, Asthma, Diabetes, Heart disease, BMI over 25, tobacco use, COPD, hypertension, hyperlipidemia, developmental disabilities or autism spectrum disorders, acquired brain injury, seizure disorders and cardiac and circulatory congenital abnormalities.	Community Care Teams (CCTs) partner with primary care health home practices to manage the care of eligible individuals.	Eligible individuals identified by the state and auto-assigned to practices. Patients receiving services from practice that becomes a HH can opt out if they choose.	Per-member-per-month (PMPM) payments for HH services.	Statewide
Missouri **CMHC SPA APPROVED (10/20/11)** **SPA EFFECTIVE (01/01/12)**	SPMI only Mental health (MH) or substance abuse (SA) disorder plus a chronic condition. MH or SA disorder plus tobacco use.	CMHC meeting State qualifications CMHCs well-positioned to be HH providers after ongoing investments in recent years (e.g., disease management, care management, electronic health records (EHR), etc.).	Eligible individuals identified, auto-assigned, and notified by State. Beneficiary has option to change HH providers or opt out.	Clinical care management per-member-per-month (PMPM) payment. Interested in shared savings strategy and performance incentive payment – both for HH providers and for Medicaid - and will revisit after initial approval.	Statewide
Missouri **PCP SPA APPROVED (12/22/11)** **SPA EFFECTIVE**	At least two of the following: asthma, cardiovascular disease, diabetes, developmental disabilities (DD), or overweight (BMI >25); *or* One of the previous chronic conditions and at risk of developing another. At risk criteria include: Tobacco use or diabetes.	Designated providers of HH services will be FQHCs, RHCs and primary care clinics operated by hospitals.	Eligible individuals identified, auto-assigned and notified by State. Beneficiary has option to either change HH providers	Same as CMHC	Statewide

State	Target Population	HH Providers	Enrollment	Payment	Geographic Area
(01/01/12)			or opt out of program.		
New York **SPA APPROVED** **(02/03/12)** **SPA EFFECTIVE** **(07/01/12)**	Individuals with SMI, chronic medical and behavioral health conditions	Any interested providers or groups of providers that meet State defined health home requirements that assure access to primary, specialty and behavioral health care and that support the integration and coordination of all care.	Auto-enrollment (with opt-out)	PMPM adjusted based on region, case mix (from Clinical Risk Group (CRG) method) and eventually by patient functional status.	Three-phase regional roll-out; phase one includes 10 counties
North Carolina **SPA APPROVED** **(5/24/12)** **SPA EFFECTIVE** **(10/01/11)**	Two chronic medical conditions or one and at risk of another condition. List of qualifying chronic medical conditions include 10 conditions based on analysis of prevalence in Medicaid population.	Medical Homes	Enrollment in HHs program is voluntary through Community Care of North Carolina (CCNC). Health home services will be delivered through the CCNC program.	Tiered PMPM reimbursement based on ABD or non-ABD status, plus add-on payments that support specialized care management for individuals with special health needs.	Statewide
Ohio **SPA APPROVED** **(9/17/12)** **SPA EFFECTIVE** **(10/01/12)**	Individuals with SPMI (children and adults)	Community Behavioral Health Centers (CBHCs)	Enrollment in HHs program is opt-out.	Site-specific monthly case rates (PMPM)	Targeted to 5 counties. Statewide by end of first year.
Oregon **SPA APPROVED** **(3/13/12)** **SPA EFFECTIVE** **(10/01/11)**	Consistent with definition in statute, with additional chronic conditions (hepatitis C, HIV/AIDS, chronic kidney disease, cancer)	Patient-Centered Primary Care Homes (PCPCHs). Oregon Health Authority will recognize practices as Tier 1, 2, or 3 PCPCHs. Primary care providers or	Patients assigned to PCPCH; can opt-out or change providers.	PMPM based on PCPCH Tier met by practice or provider group; reflecting foundational, intermediate and	Statewide

State	Target Population	HH Providers	Enrollment	Payment	Geographic Area
		practices that meet the State's qualifying criteria.		advanced functions.	
Rhode Island **CEDARR Family Centers SPA approved (11/23/11)** **SPA effective (10/01/11)**	Diagnosis of SMI or SED, two chronic conditions or one of the following and risk of developing another: Mental health condition, Asthma, Diabetes, DD, Down Syndrome, mental retardation, seizure disorders.	CEDARR Family Centers certified to meet HH criteria (CEDARR Family Centers provide services to Medicaid-eligible children who are identified as having 1 or more special health care needs).	Voluntary	Alternate payment methodology; rate developed based on level of effort required and market based hourly rate.	Statewide
Rhode Island **CMHO SPA approved (11/23/11)** **SPA effective (10/01/11)**	Individuals with SPMI who are eligible for State's community support program.	7 CMHOs and 2 smaller providers of specialty mental health services.	Auto-assignment (with opt-out). Potentially eligible individuals receiving services in the hospital ED or inpatient will be notified about health homes and referred.	Case rate	Statewide
Wisconsin **SPA approved (1/29/13)** **SPA effective (10/01/12)**	Diagnosis of HIV and at least one other diagnosed chronic condition, or at risk of developing another chronic condition.	AIDS Service Organizations (ASOs)	Auto-enrollment (with opt-out).	Per-Member-Per-Month: Monthly case rate	Targeted to four counties: Brown, Kenosha, Milwaukee and Dane.

State-by-State Health Home SPA Comparison Matrix: Detailed Approved State Programs

STATE: ALABAMA

Program Design Feature	Description

STATE: ALABAMA	
Target Population	Two chronic conditions; or one chronic condition and the risk of developing another, from the following list of conditions: Mental Health Condition, Substance Use Disorder, Asthma, Diabetes, Heart Disease; Transplants with a look back of Medicaid claims data for five years rather than 18 months, Cardiovascular Disease, Chronic Obstructive Pulmonary Disease, Cancer, HIV with an 18 month look back of Medicaid claims data for the identification of medications, and Sickle Cell Anemia.
Geographic Area	Includes four geographic areas: Tuscaloosa, Fayette, Pickens, Greene, Hale, Sumter, Lamar and Bibb; Lee, Chambers, Tallapoosa, Coosa, Bullock, Russell and Macon, Limestone, Morgan, Cullman and Madison, and Washington and Mobile.
Delivery Systems	PCCM
Enrollment	Alabama will identify individuals with a chronic condition on a monthly basis through analysis of Medicaid claims data for the previous 18 months. In addition, the PMP or local hospital may refer a patient for enrollment. Individuals eligible for HH services have the option to select amongst the Patient 1st Primary Medicaid Provider (PMP), who will be the state's designated Primary Medicaid Providers (PMPs) and provide the comprehensive care management. Upon selection of the Patient 1st Primary Medicaid Provider (PMP), the eligible individual will be assigned to the Patient Care Network (PCNA) to which the PMP has a contract. Individuals eligible for HH services have the option to select amongst the Patient 1st PMPs and may change providers at any time. Under the provisions of the SPA, enrollment into Patient 1st for purposes of the HH services is voluntary; however, the state has a 1915(b) waiver that the state will simultaneously amend which will continue the requirement for mandatory enrollment for non-HH services covered under the 1915(b) waiver. All eligible HH enrollees will receive a letter from the state and a booklet that describes Patient 1st rules and guidelines. (See SPA for further details)
Building Blocks	Patient Care Networks of Alabama
Designated Providers	Eligible Team of Health Care Professionals: Categories of physicians that are authorized under the Alabama Medicaid State Plan as Primary Medicaid Providers (PMPs) include physicians, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). PMPs have direct responsibility to provide comprehensive care management services in coordination with a team of health care professionals, who provide the care coordination under the SPA. Care coordination will be referred to throughout the SPA as care management using the state's terminology (SPA care coordination equals care management). "Eligible Team of Health Care Professionals" authorized to provide care management (care coordination under the SPA include Patient Care Networks of Alabama (PCNAs), the Alabama Department of Public Health (ADPH), and the Alabama Department of Mental Health (ADMH) contracted Community Mental Health Centers (CMHCs) and SA providers. PCNAs include a medical director, pharmacy director, nurse or social worker care coordinator and BSN chronic care champion team, who work with the Primary Medical Providers (PMPs) to support eligible chronic care enrollees. Starting in 2012 PCNAs are required to have an identified member of their team with behavioral health knowledge/expertise to work with the local CMCH and include the local CMCH In their management meetings. PMPs and PCNAs are already contractually required to partner with CMHCs. In addition in 2012, each PCNA will be contractually required to have a member of the local CMHC as a member of the team to facilitate communication and coordination between members of the health care team and involve the enrollee in the decision-making process in order to minimize fragmentation in the services. The member will assist the CMCH, PCNA and PMP in assuring the individual's physical as well as behavioral health needs are addressed by the appropriate entity.
Provider	Qualifications: These HH care management providers are required to have documented work experience with the target population; an

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Standards/Qualifications

administrative capacity to insure quality of services in accordance with state and federal requirements; a functional financial management system that provides documentation of services and costs; capacity to document and maintain individual case records in accordance with state and federal requirement; demonstrated ability to assure a referral process consistent with Section 1902a(23) of the Social Security Act; allow for free choice of provider, and demonstrated capacity to meet the care management service needs of the target population they are serving.

Provider Standards: The Alabama HH model of service delivery will operate under a "whole-person" approach to care within a culture of continuous quality improvement that looks at all the needs of the person and does not compartmentalize aspects of the person, his or her health, or his or her well-being.

- Members of the "Health Home Team of Health Care Professionals":
  - Must be is registered with the State, required to meet state qualifications, and have been provided a state assigned Medicaid Provider ID.
  - Must ensure that care is person-centered, culturally competent and linguistically capable.
  - 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 prevention of mental illness and substance use disorders;
  - 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;
  - 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; and
  - 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.
  - PMP and PCNA: The following Alabama standards, which may be met on-site or through coordination and/or offering of these services through partnerships with or in the surrounding community, are addressed through a contract between the state and Patient 1st PMP and PCNA and in the contract between the Patient 1st PCNA and their providers. PMPs and PCNAs must sign agreements with the state and each other. Alabama standards may be amended as necessary and appropriate.
  - Capacity to provide access to care that includes in-person, afterhours and telephone. The PMP must provide voice-to-voice access to medical advice and care for enrollees 24 hours a day 7 days a week.
  - Ability to provide comprehensive whole person care that includes a comprehensive health care assessment (including mental health

and substance use), coordination and access to preventive and health promotion services, including prevention of mental illness and substance use disorders, medical and health care services informed by evidence-based clinical practice guidelines, mental health, substance abuse, and developmental services, and chronic disease management, including self-management support to individuals and their families, and interventions.

- Ability to provide continuity of personal clinician assignment and clinician care, organization of clinical information, clinical information exchange and specialized care settings. . .
- Capability to coordinate and integrate that includes capacity for population data management; to use health information technology (healthIT); to develop a comprehensive health plan for each individual that coordinates and integrates clinical and non-clinical health-care related needs and services; for test and result tracking; to coordinate and provide access to (PCNAs) and provide comprehensive care management (PMPs), care management (PCNAs), and transitional care across settings (PCNAs and PMPs), and to coordinate and provide access to long-term care supports and services and end of life planning.
- Capacity to provide culturally appropriate, and person-and family-centered health home services, coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services, and provide a positive experience of care.
- ADPH, ADMH SA Providers and CMHC:
- Health home care management providers (SPA care coordination) are required to have documented work experience with the population, an administrative capacity to insure quality of services in accordance with state and federal requirements, a functional financial management system that provides documentation of services and costs, capacity to document and maintain individual case records in accordance with state and federal requirements, demonstrated ability to assure a referral process consistent with Section 1902a(23) of the Social Security Act, allow free of choice of provider within their organization, and have a demonstrated capacity to meet the care management service needs of the target population they are serving.
- Individual care managers must also have a minimum of a BA or BS or be a registered nurse and have training in a care management curriculum approved by the ASMA. SA and CMHC health home providers must also be certified by and contracted With the ADMH.

Care Management Infrastructure: Providers are required to have an integrated medical record. The PCNA in partnership with the PMP will be responsible for overall management and coordination of the enrollee's care plan which will include medical/behavioral health, long term care services and support, and social service needs and goals.

Contract Requirements:

- PMPs must have contracts with ASMA and the local PCNA. PMPs must sign agreements that address core competencies. Integration and coordination of services for individuals with MH and/or SA is addressed in all contracts (PMP and PCNA), including the requirement for ongoing processes with community providers and other community agencies to coordinate the planning and provision of care management. PMP contracts will be amended for 2012 to explicitly require a relationship with the local CHMC and SA health home providers. Alabama standards, which may be met on-site or through coordination and/or offering of these services through partnerships with or in the surrounding community, are addressed through a contract between the state and Patient 1st PMP and PCNA and in the contract between the Patient 1st PCNA and their providers. PMPs and PCNAs must sign agreements with the state and each other. Alabama standards may be amended as necessary and appropriate. (See SPA for further details).

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	Provider Education Assurance: In order to ensure the delivery of quality HH services, ASMA provides statewide learning activities for HH providers through regularly scheduled meetings. State activities are supplemented with the requirement that Patient 1st PCNAs sponsor regional meetings for the providers in their geographic area to feedback information and learning collaborative opportunities to foster shared learning, information sharing and problem solving. Learning activities and technical assistance will also support providers of HH services to address HH activities. (See SPA for further details).
Payment Methodology	PMPs are provided a monthly payment of $8.50 if the following requirements are met: • The person is identified as meeting HH eligibility criteria on the State's MMIS and in the Care Management Information System; • The person is enrolled as a HH member at the PMP; and • At a minimum each individual has received care management monitoring for treatment gaps or another HH service was provided that was documented in the Care Management Information System. The state will provide the PCNA on a monthly basis reports by individual that indicate potential gaps in service delivery. The PCNA on a monthly basis must review each individual's data and where there is a gap in service delivery, take appropriate action or request the PMP to take appropriate action or meet with the patient to assure the providers and/or patients are addressing the identified issue(s). PMPs receive the standard Medicaid FFS payment for other State Plan non-HH direct services. For their HH activities under this SPA, they will receive an overlaying per-member-per-month (PMPM) payment of $8.50. Network: The PMPM HH network payment will be $9.50 for each patient who meets the chronic conditions eligibility. The state will provide the PCNA on a monthly basis reports by individual that indicate potential gaps in service delivery. The PCNA on a monthly basis must review each individual's data and where there is a gap in service delivery, take appropriate action or request the PMP to take appropriate action or meet with the patient to assure the providers and/or patients are addressing the identified issue(s). Other governmental and private providers of case management and care coordination: Except as otherwise noted in the plan, payment for these services is based on state-developed fee schedule rates, which are the same for both governmental and private providers of case management and care coordination. The agency's rates were set as of January 20, 2012 and are effective for services provided on or after that date. The fee schedule is subject to annual/periodic adjustment. All rates, including current and prior rates, are published and maintained on the agency's website. Specifically, the fee schedule and any annual/periodic adjustments to the fee schedule are published at www.medicaid.alabama.gov (See SPA for further details).
Definition of Comprehensive Care Management	Activities within Scope: • Identify high-risk individuals (in addition to the efforts by the state directly to identify high-risk enrollees); • Outreach to, plan and communicate with other primary and specialty care providers regarding a patient's care; • Develop a comprehensive health plan informed by the patient, which integrates care across various systems (MH/SA/ Primary Care); • Clarify and communicate of the patient's preference to all involved providers while assuring timely delivery of services.

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Definition of Care Coordination	Care Management (Care Coordination): defined by Alabama as an enrollee-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual's needs and preferences are assessed, a comprehensive care plan developed, and services managed, monitored and reassessed as needed by an identified care coordinator following evidence-based standards of care to the degree possible. In addition to the core elements of care coordination/care management, the care coordinator provides disease management education, medication reconciliation, facilitation of sub-specialty referrals, transitional care interventions, works to ensure appropriate level of care is being provided and unnecessary emergency department visits are avoided, as well as providing education to patients about the importance of a medical home. Activities within scope of health home care management (care coordination) providers: • Staffing to support the PMP in care management. Patient care team must be accessible to individuals 24/7; • Screening for clinical depression; • Development of a comprehensive assessment of an individual's health and psychosocial needs and preferences, including health literacy status and deficits; • Planning with the individual, family or caregiver, the primary care physician/provider, other health care providers, the payer, and the community to maximize health care responses, quality, and cost-effective outcomes; • Development of a comprehensive health plan (SPA individualized care plan) that is person centered for each individual and coordinates and integrates all of the individual's clinical and non-clinical health-care related needs and services. Development of the comprehensive health plan is collaborative with the enrollee and family or caregiver and using a team approach. The comprehensive health plans must have the capacity to accommodate individuals with multiple diseases and co-morbidities. The comprehensive health plan identifies the individual, caregiver, PCNA, specialists and other ancillary providers involved in the participant's care; • Coordination and access to preventive and health promotion services, including prevention of mental illness and substance use disorders; • Coordination and access to mental health and substance abuse services; • Coordination and access to long-term care supports and services; • Establishment of a continuous quality improvement program, and collection and reporting 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; • Management, monitoring and reassessment of an individual as needed by an identified care coordinator following evidence-based standards of care and enrollee-centered, assessment-based interdisciplinary approach to integrating health care and social support services; • Traditional case management services through public health, including assistance with understanding program requirements, helping with transportation needs, and assessment of the home environment and factors that may prevent the patient from being compliant with medical care protocols. It also includes mental health, substance abuse and child health issues such as understanding the need for preventive care, i.e. immunizations, etc; • Disease management education, medication reconciliation, facilitation of sub-specialty referrals and transitional care interventions; • Facilitated communication and coordination between members of the health care team and involving the individual in the decision-making process in order to minimize fragmentation in the services; • Empowerment of the individual to problem-solve by exploring options of care, when available, and alternative plans, when necessary, to achieve desired outcomes.

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	• Encouragement of the appropriate use of health care services to improve quality of care and maintain cost effectiveness on a case-by-case basis; • Assistant to the individual in the safe transitioning of care to the next most appropriate level; • Promotion of individual self-advocacy and self-determination, and • Advocating for both the individual and the Medicaid Program to facilitate positive outcomes for the individual, the health care team, and the Medicaid Program.
Definition of Health Promotion	Activities within scope of health promotion: • Patient education to the individual, family or care-giver, and members of the health care delivery team about treatment options, community resources, insurance benefits, psychosocial concerns, care management, etc., so that timely and informed decisions can be made. Also, patient education about the importance of a medical home; • Adhering to EPSDT requirements; • Providing health education specific to an individual's chronic conditions; • Providing education regarding the importance of immunizations and screenings, child physical and emotional development; • Providing health-promoting lifestyle interventions, such as substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity; • Supporting health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers; and • Promoting evidence based wellness and prevention by linking health home enrollees with resources for smoking cessation, diabetes, asthma and other services based on individual needs and preferences.
Definition of Comprehensive Transitional Care	Activities within scope of Transitional Care: • Alabama requires that PMPs assist the enrollee in the safe transitioning of care to the next most appropriate level including movement from inpatient to a NF or home setting • Alabama requires that PCNAs assist the enrollee in the safe transitioning of care to the next most appropriate level PMPs and PCNAs must sign agreements that address core competencies and require the establishment of "an ongoing process with community providers and other community agencies to coordinate the planning and provision of care management and other support services for enrollees needing those services." Hospitals have had an ongoing voluntary working relationship with their local PCNAs, but have a bigger incentive to work with the PMPs and PCNAs to arrange appropriate follow-up in order to avoid hospital readmission penalties. Medicaid enrollees who meet the criteria will be identified through claims, thus the PCNA and PMP is not dependent on the hospital for identification. There are no formal MOUs, but the state requirements of HH providers are such that they are aware when someone goes into the hospital. The PCNAs have a working relationship with all hospitals in their geographic area. In addition, the PCNA team will include an individual with knowledge/expertise in MH/SA. Alabama standards, which may be met on-site or through coordination and/or offering of these services through partnerships with or in the surrounding community, are addressed through a contract between the state and Patient 1st PMP and PCNA and in the contract between the Patient 1st PCNA and their providers. PMPs and PCNAs must sign agreements with the state and each other.
Definition of Individual and Family Support Services	Activities within scope of patient and family support (including authorized representatives): • Alabama requires PMPs to provide patient and family support as appropriate. PMPs must educate and empower the enrollee and the family

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	or care-giver about treatment options, community resources, insurance benefits, psychosocial concerns, care management, etc. so that timely and informed decisions can be made. • Alabama requires health home care management providers (PCNAs, CMHCs, SA providers, and ADPH) to provide patient and family support as appropriate. • Alabama specifically requires the PMPs and PCNAs to advocate for both the state and the enrollee to facilitate positive outcomes for the enrollee and where a conflict arises to prioritize the needs of the enrollee.
Definition of Referral to Community and Social Support Services	Activities within scope for referral to community and social support services: • Where relevant and as appropriate, PMPs and PCNAs are specifically required to establish "an ongoing process with community providers and other community agencies to coordinate the planning and provision of care management and other support services for enrollees needing those services; however, all care management managers may engage in this activity for their specific population. Services include long term care services and support such as housing, home delivered meals, services for individuals with disabilities and adult day care. • For individuals with public health needs, the ADPH will take the lead to assure community and social support services relevant to public health and obtained through the public health infrastructure are available to health home services enrollees. Since much of the public health infrastructure in Alabama is through the State, the ADPH will coordinate these efforts as a participant in the team. • Starting 2012, the PCNAs will be required to have a member of their team with expertise/knowledge in MH/SA to assure integration with CMHCs, SA providers and community resources. In addition, the PCNA contracts will require a SA provider and the local CMHC on the PCNA board and the state is working with the PCNAs to create a consent document that will work in school (PCNAs have been trained on FERPA) as well as other state agencies.
Quality Measures	Goal based quality measures: • Care for adults with diabetes • Percent of patients with a diagnosis of diabetes mellitus having HbA1c testing performed during the past year. • Percentage of members 18 through 75 years of age with diabetes mellitus (type 1 and type 2) who had low-density lipoprotein cholesterol (LDL-C) test performed. • Percent of patients who have had a visit to an ED/Urgent Care office for asthma in the past six months. • Screening for Clinical Depression and Follow-Up • Adult BMI assessment • Ambulatory care-sensitive condition admission • Plan-All Cause Readmission • Improved rate of children receiving HH SPA services with an asthma diagnosis who receive an influenza immunization. • Care Transitions • Assess age 12 through ages 21 who had at least one comprehensive well-care visit with a MPM • Access to Dental care for children • Quality of Dental care for children Service-based quality measures: • Follow-up after hospitalization for mental illness • Percentage of adolescents and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: Initial and engagement of AOD treatment. • Transition record with specified elements received by discharged patients (inpatient discharges to home or any other care site) See SPA for further details and calculations.

STATE: IDAHO

PROGRAM DESIGN FEATURE	DESCRIPTION
Target Population	Beneficiaries with either a chronic condition of SPMI or SED; diabetes and asthma; or those that have either diabetes or asthma and are determined at risk for another chronic condition. At risk factors include: a body mass index greater than 25, dyslipidemia, tobacco use, hypertension, or diseases of the respiratory system.
Geographic Area	Statewide
Delivery Systems	HH PMPM payments will be made on top of the existing fee-for-service (FFS) payments within Idaho's primary care case management system.
Enrollment	Can self-refer or be referred by any service provider. Eligible beneficiaries will be automatically enrolled, with ability to opt-out. To avoid duplication of services, qualifying members currently receiving Targeted Case Management (TCM) as a service will shift the delivery of this care to their HH practice.
Building Blocks	Building off Idaho's Medicaid primary care case management program, Healthy Connections.
Designated Providers	Current Healthy Connections providers, including physicians, clinical practices or clinical group practices, rural clinics, community health centers, community mental health centers, home health agencies, or any other current Healthy Connections providers. Must have the systems and infrastructure in place to provide HH services. See section below on provider standards and qualifications for further details. Designated providers may operate in coordination with health care professionals inside and outside of their practice as they feel it is necessary to meet the needs of any particular patient. Other health care professionals could include, but are not limited to, a registered nurse, medical assistant, dietician, behavioral health provider, etc.
Provider Standards/Qualifications	Under Idaho State's approach, designated providers are the central point for directing patient-centered care. Designated providers are accountable for reducing avoidable health care costs (specifically preventable hospital admissions/readmissions and avoidable ER visits), providing timely post discharge follow-up, and improving patient outcomes by addressing primary medical, specialist and mental health care through direct provision with appropriate service providers, of comprehensive, integrated services. Designated providers will be held accountable by providing documentation of HH processes (transition to NCQA PCMH recognition) that ensures suitable HH service delivery. Documentation can include, but is not limited to, transformation assessments, clinical process and outcome measures, and care plans for each HH participant. Designated providers must be participating primary providers in Idaho's Primary Care Case Management program, Healthy Connections. The designated provider will: 1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Home 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 and management of mental illness; 4. Coordinate and provide access to mental health services; 5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care

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	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; and 12. Become at least level one NCQA recognized by the end of year two after initiation.
Payment Methodology	The payment methodology for HHs is in addition to the existing fee-for-service and is structured as follows: Idaho will center the PMPM around a team of healthcare professionals that consist of a primary care provider, registered nurse, behavioral health professional, clerical staff, and medical assistant. The healthcare team will provide comprehensive care management for each established chronic care patient that is empanelled to the team. This reimbursement model is designed to only fund HH functionalities that are not covered by any of the currently available Medicaid funding mechanisms. The coordination of care and Primary Care Provider Consultant duties often does not involve face-to-face interaction with HH patients. However, when these duties do involve such interaction, they are not traditional clinic treatment interactions that meet the requirements of currently available billing codes. Idaho's HH model includes significant support for the leadership and administrative functions that are required to transform a traditional primary care clinic service delivery system to the new data-driven, population focused, patient-centered HH requirements. Idaho anticipates the healthcare team will spend an additional 30 minutes per member per month on comprehensive care management for the services described in section 2703 of the ACA. The HH PMPM was derived using average salaries, to include benefits, for each staff member that will assist in the comprehensive care management within the HH team. Average pay/hour was taken from the Bureau of Labor Statistics as reported in the state of Idaho. Staff members were given a percentage that was focused on the additional comprehensive care Idaho anticipates each team member assisting towards the chronic care patient.
Definition of Comprehensive Care Management	A care plan will be developed based on the information obtained from a health risk assessment performed by the designated provider. The assessment will identify the enrollee's physical, behavioral, and social service needs. This will ensure the patient's needs are identified, documented and addressed. Idaho anticipates family members and other support involved in the patient's care to be identified and included in the plan and executed as requested by the patient. The care plan must also include outreach and activities which will support engaging the patient in their own care and promote continuity of care. The care plan will include periodic reassessment of the individual's needs, goals, and clearly identify the patient's

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	progress towards meeting their goals. Changes in the care plan will be made based on changes in patient needs. The designated provider's comprehensive assessment and care plan may include, but are not limited to family/social/cultural characteristics, medical history, advanced care planning, communication needs, and a depression screening for adults and children. Designated providers will identify patients/families that might benefit from additional care management support. The care coordinator in each practice will work closely with the designated provider to develop reminders for needed tests (e.g. HGAlCs), track medical services provided out of the primary care clinic office, and streamline communication and coordination of the comprehensive care needs of each patient. Comprehensive care management functions can include, but are not limited to: Conducts pre-visit preparations, collaborates with the patient/family to develop an individual care plan (including treatment goals that are reviewed and updated at each relevant visit), gives the patient/family a written care plan, assesses and addresses barriers when the patient has not met treatment goals, and gives the patient/family a clinical summary at each relevant visit. The care coordinator in each HH will track all referrals to ensure coordination of care between service providers. Designated providers will be responsible for obtaining and reviewing follow-up reports from medical and mental health specialists regarding services provided outside the HH.
Definition of Care Coordination	Patients will choose and be assigned to a designated provider to increase continuity, and to ensure individual responsibility for care coordination functions. A person-centered plan will be developed based on the needs and desires of the patient with at least the following elements: options for accessing care, information on care planning and care coordination, names of other primary care team members when applicable, and information on ways the patient participates in this care coordination, including home and community based services (HCBS). Care coordination functions can include, but are not limited to: tracking of ordered tests and result notification, tracking referrals ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and clinicians, demonstrating a process for consistently obtaining patient discharge summaries from the hospital and emergency departments, following up to obtain a specialist's reports, and direct collaboration or co-management of patients with mental health or substance abuse diagnoses. Under the direction of the designated provider, the care coordinator will help facilitate the patient's care needs. The coordinator should have knowledge and experience in the healthcare setting.
Definition of Health Promotion	A designated provider will be required to actively seek to engage patients in their care by phone, letter, HIT and community outreach. Each of these outreach and engagement functions will include all aspects of comprehensive care management, care coordination, and referrals to community and social support services. All of the activities are built around the notion of relationships to care that address all of the clinical and non-clinical care needs of an individual including health promotion. The designated provider will support continuity of care and health promotion through the development of a treatment relationship with the individual and the health care professionals. The designated provider will promote evidence based wellness and prevention by linking HH enrollees with resources for tobacco cessation, diabetes, asthma, hypertension, self- help recovery resources, and other services based on individual needs and preferences.
Definition of Comprehensive Transitional Care	Comprehensive transitional care will be provided to prevent enrollee avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing or treatment facility) and to ensure proper and timely follow up care. To accomplish this, Idaho Medicaid requires the designated provider to develop and utilize a process with hospitals and residential/rehabilitation facilities in their region to provide the HH care coordinator prompt notification of an enrollee's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting. The designated provider will be required to develop and have a systematic follow-up protocol in place to assure timely access to follow-up care post discharge that includes at a minimum receipt of a summary care record from the discharging entity, medication reconciliation, and a plan for timely scheduled appointments at recommended outpatient providers. The HH care coordinator will be an active participant in all phases of care transition.
Definition of Individual and	Peer supports, support groups, and self-care programs will be utilized by the designated provider to increase patients' and caregiver's knowledge

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Family Support Services	of the individual's disease(s), promote the enrollee's engagement and self-management capabilities, and help the enrollee improve adherence to their prescribed treatment. The designated provider will ensure that communication and information shared with the patient/patient's family is understandable.
Definition of Referral to Community and Social Support Services	The designated provider will identify available community-based resources and actively manage appropriate referrals, access to care, engagement with other community and social supports, coordinate services and follow-up post engagement with services. Designated providers will develop policies, procedures and accountabilities to support effective collaboration with community-based resources that clearly define the roles and responsibilities of the patients. They will also assist the participant in locating individual and family supports, including referral to community, social support, and recovery services.
Quality Measures	Goal based quality measures: • Improve care for diabetes among adults • Improve outcomes for individuals with mental illness • Increase preventive care for adults • Improve care for patients with heart disease • Improve care for asthma among adults and children • Increase preventive care for children See SPA for further details and calculations.

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PROGRAM DESIGN FEATURE	DESCRIPTION
Target Population	Two chronic conditions (mental health condition; substance use disorder; asthma; diabetes; heart disease; BMI over 25 or over 85 percentile for pediatric population; and hypertension); or one chronic condition and at risk for another. At risk criteria defined as: documented family history of a verifiable heritable condition included as eligible chronic condition; a diagnosed medical condition with an established co-morbidity to an eligible chronic condition; or a verifiable environmental exposure to an agent or condition known to be causative of an eligible chronic condition. To identify at risk conditions, providers can use guiding principles that use USPSTF guidelines (posted on Department's website). To avoid duplication of services, delivery of care will be shifted to HHs for members receiving targeted case management (TCM) and case management (CM) or service coordination from a DHS social worker.
Geographic Area	Statewide
Delivery Systems	Iowa is primarily fee-for-service with a mental health managed care carve out (Magellan) and a PCCM program called MediPASS with approximately 195,000 members. MediPASS members that qualify for a HH and agree to participate will be removed from MediPASS as they enroll in the HH.
Enrollment	Member enrollment will be an opt-in process when the members presents at a HH provider's office. The provider will assess the patients' conditions to determine if they qualify for HH services. The provider will discuss the benefits of HH services with the member and present the member with an agreement form. The provider will attest to the member's agreement to participate and send a patient assessment that tiers the severity of the chronic conditions for the provider's PMPM payment.
Building Blocks	Building off CMHC/FQHC/ACT partnership pilot project for "integrated health homes", to improve coordination and integration of behavioral and physical health services. Building off an 1115 waiver Medical Home pilot running in Iowa.
Designated Providers	A HH practice may include multiple sites when they are identified as a single organization or medical group that shares policies and procedures and electronic systems across all practice sites. HH practices must adhere to provider standards and may include but are not limited to primary care practices, Community Mental Health Centers (CMHC), Federally Qualified Health Centers (FQHC) and Rural Health Clinics. At a minimum, the practice must fill the following roles: • Designated Practitioner • Dedicated Care Coordinator • Health Coach • Clinic support staff
Provider Standards/Qualifications	Designated providers must sign an agreement attesting to the following standards: • Comply with the Iowa Dept. of Public Health rules, which are likely to require NCQA, or other national accreditation. • Until above rules are final, providers must complete a TransforMed self-assessment and submit for NCQA or other national accreditation within 1st year of operation.

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	• Ensure each patient has an ongoing relationship with a personal provider, trained to provide first contact, continuous and comprehensive care where both patient and the provider/care team recognize each other as partners in care. This relationship is initiated by the patient choosing the health home. • Update and maintain a Continuity of Care Document (CCD) for all patients. • Provide whole person care (includes care for all stages of life, acute care, chronic care, preventive services, long term care and end of life care). • Provide coordinated/integrated care - responsible for assisting members with medication adherence, appointments, referral scheduling, tracking follow-up results from referrals, understanding health insurance coverage, reminders, transition of care, wellness education, health support and/or lifestyle modifications, and behavior changes. • Communicate with patient and authorized family member/caregivers in a culturally appropriate manner. • Monitor, arrange and evaluate evidence-based and/or evidence-informed preventive services. • Coordinate/provide mental health/behavioral health services, oral health, long term care, chronic disease management, recovery services and social services available in the community, behavior modifications interventions aimed at supporting health management (including but not limited to obesity counseling, smoking cessation, and health coaching). • Comprehensive transitional care. • Assess social, educational, vocational, housing and transportation needs. • Maintain systems and written standards and protocols for tracking patient referrals. • Demonstrate use of clinical decision support with practice workflow. • Demonstrate use of population management tool (patient registry), and the ability to evaluate results and implement interventions that improve outcomes overtime. • Demonstrate evidence of acquisition, installations and adoption of EHR and establish a plan to meaningfully use Health information in accordance with Federal law. • When available, connect to and participate with the statewide health information network (IHIN). • Implement or support a formal diabetes disease management program, which includes: the goal to improve health outcomes using evidence based guidelines and protocols; and a measure for diabetes clinical outcomes. • Implement a formal screening tool to assess behavioral health treatment needs along with physical health care needs. • Provide the department with outcomes and process measures annually. • Provide enhanced, 24/7 access to the care team and monitor access outcomes such as the average 3rd next available appointment and same day scheduling availability. • Use of email, text messaging, patient portals and other technology as available to the practice to communicate with patients is encouraged.
Payment Methodology	Standard FFS or managed care plan reimbursement plus a patient management PMPM targeted only to eligible/qualified individuals who have chronic disease. Payments are tiered based on acuity/risk of the individual (determined by a state provided tier tool that looks at Expanded Diagnosis Clusters to score the number of conditions that are chronic, severe and requires a care team); health home will attest by a monthly claim submission that the minimum service required to merit PMPM payment is met. The patient medical record will document health home service activity (covered service or care management for treatment gaps) and the documentation will include either a specific entry, at least monthly or an ongoing plan of activity updated in real time and current at the time of claim submission. Performance payments available starting July 1, 2013 and tied to quality outcomes measures in five categories: preventive measures; diabetes measures; hypertension measure; mental

	health measure; and total cost of care. Maximum a health home can attain is 20% of the total PMPM payment.
Definition of Comprehensive Care Management	Managing comprehensive care for each member enrolled includes at a minimum: • Providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services and end of life care. • Developing and maintaining a Continuity of Care Document (CCD) for all patients, detailing all important aspects of the patient's medical needs, treatment plan, and medication list. • Implementing a formal screening tool to assess behavioral health (mental health and substance abuse) treatment needs along with physical health care needs. Comprehensive care management services are the responsibility of the designated practitioner role within the health home.
Definition of Care Coordination	Care coordination includes assisting members with medication adherence, appointments, referral scheduling, understanding health insurance coverage, reminders, transition of care, wellness education, health support and/or lifestyle modification, and behavior changes. The designated provider coordinates, directs, and ensure results are relayed back to the health home. The use of HIT is the recommended means of facilitating these processes that include the following components of care: Mental health/ behavioral health; Oral health; Long term care; Chronic disease management; Recovery services and social health services available in the community; Behavior modification interventions aimed at supporting health management (e.g., obesity counseling and tobacco cessation, health coaching); and Comprehensive transitional care from inpatient to other settings, including appropriate follow-up. The care coordinator role is responsible for ensuring these services are performed with the assistance of the entire HH team.
Definition of Health Promotion	Includes coordinating or providing behavior modification interventions aimed at supporting health management, improving disease outcomes, disease prevention, safety and an overall healthy lifestyle. Use of Clinical Decision Support within the practice workflow. Implement a formal Diabetes Disease Management Program. Health promotion services are the responsibility of the Health Coach role and Designated Practitioner role within the HH.
Definition of Comprehensive Transitional Care	Comprehensive transitional care from inpatient to other settings includes the services required for ongoing care coordination. For all patient transitions, a HH shall ensure the following: • Receipt of updated information through a CCD. • Receipt of information needed to update the patients care plan (could be included in the CCD) that includes short-term transitional care coordination needs and long term care coordination needs resulting from the transition. The designated provider shall establish personal contact with the patient regarding all needed follow up after the transition. Comprehensive transitional care services are the responsibility of the Designated Care Coordinator role and the Designated Practitioner role within the HH.
Definition of Individual and Family Support Services	Communicate with patient, family and caregivers in a culturally appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives. Activities could include but are not limited to: • Advocating for individuals and families • Assisting with obtaining and adhering to medications and other prescribed treatments

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	• Increasing health literacy and self management skills • Assessing the member's physical and social environment so that the plan of care incorporates areas of needs, strengths, preferences, and risk factors Individual and family support services are the responsibility of the Health Coach role within the HH.
Definition of Referral to Community and Social Support Services	Referral to community and social support services includes coordinating or providing recovery services and social health services available in the community, such as understanding eligibility for various health care programs, disability benefits, and identifying housing programs. Referral to community and social support services are the responsibility of the Dedicated Care Coordinator role within the HH.
Quality Measures	• Increase use of preventive services • Follow up care for children prescribed ADD medication • Well child visits • Pap tests for cervical cancer • Influenza vaccinations • Annual dental visits • Breast cancer screening • Improved diabetes management, including annual dilated eye exams, annual micro albumin, annual foot exams, HbA1c and LDL testing

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PROGRAM DESIGN FEATURE	**DESCRIPTION**
Target Population	Two chronic conditions or one chronic condition and at risk for another. Conditions include: mental health condition, substance use disorder, asthma, diabetes, heart disease, BMI over 25, tobacco use, COPD, hypertension, hyperlipidemia, developmental disabilities or autism spectrum disorders, acquired brain injury, seizure disorders and cardiac and circulatory congenital abnormalities.
Geographic Area	Statewide
Delivery Systems	Primary care case management program.
Enrollment	Individuals will be enrolled in a HH as follows: 1) HH eligible members who currently are either enrolled with or who have a plurality of PCP visits with a Primary Care Case management (PCCM) practice that applies for and meets HH eligibility criteria will receive written notification that their current practice is becoming a HH for MaineCare members with chronic conditions. The Member will receive information about the benefits of participating in a HH and be notified of their ability to opt out of the initiative. If the Member does not opt out of HH services within 28 days, they will automatically be enrolled into HHs on either the 1st or the 15th of the month. They will receive a confirmation letter once they are officially assigned a HH; 2) HH eligible MaineCare members who are not enrolled with or who do not have a plurality of PCP visits with PCCM practices that apply for and meet HH eligibility criteria will receive written notification on the benefits of participating in a MaineCare HH as well as a list of HHs in their area that they can choose from. These members will be encouraged to respond within 28 days of receiving the letter, though they will also be able to enroll at a later date if they so choose and remain eligible; 3) HH eligible members currently receiving TCM services will receive written notification of their choice to either continue receiving TCM or to receive care management through a HH. There will be no duplication of services and payments for similar services provided under other Medicaid authorities.
Building Blocks	Maine built its HHs program off its existing primary care case management program and all-payer primary care medical home initiative.
Designated Providers	The HH team of health care professionals centers on the primary care HH practice. Each HH enrollee is linked to a PCP to serve as a medical home that provides acute and preventive care, manages chronic illnesses, coordinates specialty care and referrals to social, community, and long-term care supports, provides comprehensive care management, and provides access to 24/7 coverage. Maine's current PCCM providers ensure access to preventive care for enrolled MaineCare members (see SPA for further details). To qualify as a HH, PCCM provider practices must significantly exceed the baseline PCCM requirements by offering a more patient-centered, proactive, and highly coordinated set of HH services. HH practices are required to have NCQA PCMH recognition, have a fully implemented EHR, and fully implement the following ten "Core Expectations' that align with Maine's multi-payer Patient Centered Medical Home Pilot: • Demonstrated leadership • Team-based approach to care • Population risk stratification and management • Practice-integrated care management • Enhanced access to care • Behavioral-physical health integration • Inclusion of patients & families in implementation of PCMH model

- Connection to community
- Commitment to reducing unnecessary healthcare spending, reducing waste, and improving cost-effective use of healthcare services
- Integration of health information technology (HIT)

The HH Team of Health Care Professionals must certify that it will provide each of the services delineated under the CMS HH definition. The HH contracts with each participating practice will further define service and staffing expectations. Maine's HHs Initiative incorporates a component of wraparound clinical services provided by a Community Care Team (CCT). The HH Practices are required to contract with CCTs in order to deliver services as a HH Team. These contracts may vary given the particular arrangements, but all member of the HH Team will be subject to the core expectations. The CCT complements the care management provided directly by PCPs and their care teams. The CCT care managers work in concert with the HH practice to identify and manage care for high-cost, high-risk patients (e.g. typically, the top 5% of high utilizing/high cost patients), as required in an agreement between the CCT and the Office of MaineCare Services. CCTs are locally-based and serve multiple roles. CCT care managers visit patient homes, when appropriate, to perform medication reconciliation and assessments. They work with the HH practice to plan and coordinate referrals for community and social supports and assist with referrals, as needed.

The role of the CCT a complementary to and coordinated with existing services, so as not to duplicate or offer redundant services within the HH team. The HH team member that takes the lead on providing each service, the HH practice or the CCT, depends on whether the beneficiary is experiencing a period of high needs. All beneficiaries will receive care and HH services from their HH practice team, while a smaller number (approximately 5% of beneficiaries) will be offered additional, more intensive care coordination services from the partnering CCT.

Provider Standards/Qualifications

Under Maine's approach to HH implementation, the HH (i.e., the qualified practice and CCT) is the central point for directing patient-centered care, and is accountable for reducing avoidable health care costs and improving patient outcomes by addressing primary medical, specialist and behavioral health care (by direct provision, or contractual arrangements with appropriate service providers) in a comprehensive, integrated service model. The HH Team of Health Care Professionals need to meet the following criteria:

- Enrollment in the MaineCare program, (i.e. must sign or be a party to a MaineCare Provider/Supplier Agreement if appropriate to that MaineCare practice or managed care Primary Care Provider (PCP) practice);
- Commitment to meeting the ten core expectations that align with Maine's multi-payer PCMH Pilot as outlined in the SPA; and
- Must perform each of the eleven CMS HH core functional components as outlined in the SPA.

The HH must also have the capability to share information with other providers and for collecting reporting and reporting quality measures and it must have a system in place with hospitals and residential facilities to provide HH prompt notification of individual's admission and/or discharge and systematic follow-up protocols to assure timely access to follow-up care. The Team of Health Care Professionals must participate in Maine multi-payer PCMH Learning Collaborative activities. Participating HHs are expected to designate a leadership team to attend day-long "learning sessions" (3/year). The Collaborative also includes support between Learning Sessions through coaching and regular outreach. (See SPA for further details).

Additional criteria for the HH practice component are:

- HH practices must sign or be party to a MaineCare PCMH Rider to the MaineCare Provider/Supplier Agreement. Please see Maine’s

	SPA for details on participation in the PCCM. • HH practices must have achieved PCMH recognition by the NCQA by June 30, 2013; • HH practices must have a fully implemented electronic health record (EHR); and • Each HH practice must partner with a HH-eligible Community Care Team in order to qualify together as a HH. Additional Criteria for the Community Care Team component are: • A CCT must have a CCT Manager, Director or Coordinator that provides leadership and oversight to ensure the CCT meets goals; • A CCT must have a Medical Director (at least 4 hours/month/ that works with all providers in partnering Health Home practice practices to select and rollout evidenced-based clinical initiatives, lead quality improvement efforts, evaluate progress, and convene provider clinical quality improvement meetings; • A clinical leader that directs care management activities across the CCT, but does not duplicate care management that is already in place in the partnering Health Home practices; and • A CCT must partner with a Health Home practice.
Payment Methodology	The HH per member per month (PMPM) is distributed to the member of the Team of Healthcare Professionals using the methodologies described below. • The HH practice payment component is determined by calculating care management and care coordination costs that are incurred in the individual practice. The Community Care Team payment is an add-on payment supporting care management services for individuals with special health needs. The state will provide add-on payments for no more than 5% of the total number of HH enrollees associated with HH practices. • All payments are contingent on the Team of Health Care Professionals meeting the requirements set forth in this SPA and the resulting MaineCare rule, as determined by the State of Maine. Failure to meet such requirements is grounds for revocation of Health Home status and termination of payments. • Maine will pay for reimbursement of the cost of staff associated with the delivery of HH services to HH-eligible members not covered by other reimbursement under MaineCare. CCT PMPM add-on payment: Maine will pay for reimbursement of the cost of staff associated with the delivery of care management supports for individuals with special health needs served by the HH practices, not covered by other reimbursement under MaineCare. The state will provide add-on payments for no more than 5% of the total number of HH enrollees associated with HH practices. The state will review rates annually to ensure that rates are economic and efficient based on analysis of care management costs conducted by the Team of Health Care Professionals and its components. Payments based on the costs of staff to provide the care management services. (See SPA for further details).
Definition of Comprehensive Care Management	Levels of care management change according to member needs over time. As in the multi-payer PCMH Pilot model, the CCT will provide wraparound services for those with the highest needs; otherwise, care management will be provided by the HH practice. Outlined below are the HH practice and CCT relationships to members (1) with baseline needs (receives all care from HH practice), and (2) during periods of high need (receives highly coordinated care between HH practice and CCT until high need is resolved).

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	HH Practice Care for HH Members with Baseline Needs: The HH practice team, provides care management services for specific individuals within the practice who have one or more chronic conditions and are at risk for experiencing adverse outcomes. These services include: (1) Prospective identification of at-risk patients; (2) Conducting clinical assessments, monitoring & follow up of clinical and social service needs; (3) Conducting medication review & reconciliation; (4) Communicating and coordinating care with treating providers. HH practice Care for HH Members During Period(s) of Very High Needs: When a patient is identified as having a particularly intense or complex set of needs (e.g. multiple hospitalizations, ED visits, multiple/complicated service needs), HH practice identifies the patient for CCT care management during the period of time for which the patient experiences a high level of need. CCT Care for HH Members During Period(s) of Very High Needs: The CCT, working closely with the PCP practice, provides care management services for very high-needs individuals within the practice who have been identified for more intensive services when they have particularly intense or complex set of needs (e.g. multiple hospitalizations, ED Visits, multiple/complicated service needs). Please refer to the SPA for the services to be provided by the CCT during this period of high needs. The Care Plan: The PCP within the HH practice team (i.e. physician or nurse practitioner will develop a patient centered care plan that will identify the patient's health goals, identified in partnership with the patient, and identify all services necessary to meet the health goals of care management for the enrollee. The care plan will be recorded in the EHR. Other members of the practice team may contribute as appropriate (e.g. may cite patient-established goals, record pertinent clinical data, note medication changes, etc.). The CCT will stay informed about the beneficiary's care from the HH practice care provider through regular communications with the HH practice team. The HH practice and CCT, where appropriate, will work together to ensure that the patient (and/or their guardian) plays a central and active part in the development and execution of the care plan and that they are in agreement with the care plans goals, interventions, and timeframes. Family members and other supports involved in the patient's care should be identified and included in the plan, as requested by the patient.
Definition of Care Coordination	A comprehensive set of services provided by the HH practice team to assure patients receive timely, quality care. The HH will: (1) Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines; (2) Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders; (3) Coordinate and provide access to mental health and substance abuse services; (4) Develop a care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services as appropriate. HH Practice Care for all HH Members: The HH practice team provides all patients with a comprehensive set of high quality health care services informed by evidence-based guidelines, and coordinates care across providers to assure that patients receive timely, safe, and high-quality care. (Please see SPA for list of services and further details). The HH practice will be required to develop and have policies, procedures and accountabilities (contractual agreements) in place with their CCT to support and define roles and responsibilities for effective collaboration among the practice, CCT; primary care, specialist, long term care, behavioral health providers; and community-based organizations. For patients receiving home-based long-term care services and supports the HH team will communicate with and conduct outreach to providers of these services, and will work actively to incorporate

	these services into the patient's care plan. To support care management/coordination activities, the HH practice and the CCT will have the option of utilizing technology conferencing tools. (See SPA for further details). The HH practice, in collaboration with the CCT will develop and utilize a system to track and share patient information and care needs across providers, monitor patient outcomes, and initiate changes in care as necessary to address patient need.
Definition of Health Promotion	For eligible HH enrollees, health promotion will begin with patient engagement and outreach by the HH team. The HH practice will then promote patient education and chronic illness self-management for eligible patients in the HH beginning with practice-based screening for tobacco and alcohol use, as primary causes of chronic illness, and proceeding to the CCT for the highest need members for follow-up education with the patient and family, and patient/family referrals to community-based prevention programs and resources. Maine's HH plan for outreach and engagement will require HH practices to confirm eligible HH patients' involvement with the practice; actively seek to engage patients in care by phone, letter, HIT and/or community outreach. Community Care Teams' outreach and engagement activities will seek to engage the highest five percent of HH-eligible patients who have been referred to the CCT and/or have been identified as high needs patients based on their history of ED use admissions, etc. Outreach and engagement functions will include aspects of comprehensive care management, care coordination, and linkages to care that address all of a patient's clinical and non-clinical care needs, including health promotion. The HH practice will support continuity of care through coordination with the interdisciplinary CCT, and will promote evidence-based care for tobacco cessation, diabetes, asthma, hypertension, chronic obstructive pulmonary disease (COPD), hyperlipidemia, developmental and intellectual disorders, acquired brain injury, seizure disorders, and cardiac and circulatory congenital abnormalities, self-help recovery resources, and other services based on individual needs and preferences.
Definition of Comprehensive Transitional Care	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. HH Practice Care for HH Members with Baseline Needs: The HH practice team supports the coordination of care for all patients transitioning between care settings (See SPA for further details): • Acute Inpatient Hospital, Skilled Nursing, and Long-Term Care Facilities; and • Pediatric patients. HH Practice Care for HH Members During Period(s) of Very High Needs: For HH members who have been referred to CCT for higher-level care management, the HH practice team supports the coordination of care during transitions of care by ensuring that the member is seen in the practice for a timely follow up visit. CCT care for HH Members During Period(s) of Very High Needs: The CCT provides "wrap-around" care management support to address the complex needs of CCT patients and/or to help CCT patients overcome barriers to care, while coordinating care with the HH practice team. The CCT will establish processes with the major acute care hospital(s), SN-LTC, and residential facilities in their community to ensure that they are notified in a timely manner when CCT patients are discharged. The CCT conducts a follow up call to discharged patients and ensures that medication reconciliation and timely post-discharge follow up are completed, and may conduct a home visit if indicated. The CCT will also ensure that a timely follow-up visit with the HH practice is scheduled, and will help to address barriers such as transportation needs to ensure that the visit occurs. (See SPA for further details).

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Definition of Individual and Family Support Services	HH Practice Care for HH Members with Baseline Needs: The HH practice team provides self-management support to patients (See SPA for further details). HH Practice Care for HH Members During Period(s) of Very High Needs: For HH members who have been referred to CCT for higher-level care management, the HH practice team supports the coordination of care during transitions of care by ensuring that the member is seen in the practice for a timely follow up visit. CCT care for HH Members During Period(s) of Very High Needs: The CCT provides "wrap-around" care management support to address the complex needs of CCT patients and/or to help CCT patients overcome barriers to care, while coordinating care with the HH practice team. The CCT will establish processes with the major acute care hospital(s), SNFs, LTC and residential facilities in their community to ensure that they are notified in a timely manner when CCT patients discharged. The CCT conducts follow up calls to discharged patients and ensures that medication reconciliation and timely post-discharge follow up are completed, and may conduct a home visit. The HH will use peer supports, support groups, and self-care programs to increase patient and caregiver knowledge about an individual's chronic illness(es), promote the enrollee's engagement and self-management capabilities, and help the enrollee improve adherence to their prescribed treatment. The HH will also discuss and provide information on advance directives, in order to allow the enrollee, the enrollee's family and care givers to make informed end-of-life decisions ahead of time. The HH will ensure that all communication and information shared with the patient, the patient's family and care givers meets health literacy standards and is culturally appropriate, and the plan of care will reflect and incorporate member and/or family preferences, education and support for self -management, self -recovery and other resources as appropriate.
Definition of Referral to Community and Social Support Services	HH Practice Care for HH Members with Baseline Needs: The HH practice team provides referrals to community and social support services as relevant to patient needs, i.e. (1) Actively connects patients to community organizations that offer supports for self-management and healthy living, and routine social service needs HH Practice Care for HH Members During Period(s) of Very High Needs: The HH practice team provides clinical guidance and oversight to the CCT. CCT Care for HH Members During Period(s) of Very High Needs: The CCT provides referrals to community, social support and recovery services to high-needs patients while they are in a high-needs period, i.e. (1) Actively connects patients to community and social service support organizations that offer supports for self-management and healthy living, as well as social service needs such as transportation assistance, housing, literacy, economic and other assistance to meet basic needs. The plan of care will include community-based and other social support services, and appropriate and ancillary healthcare services that address and respond to the patient's needs and preferences, and contribute to achieving the patient's goals.
Quality Measures	• Ambulatory Care-Sensitive Condition Admission • Diabetic Care HbA1c • Plan- All Cause Readmission • ED Utilization • Non-Emergent ED visits • Initiation and engagement of alcohol and other drug dependence treatment • Use of Imaging Studies for low back pain • Adolescent well-care visit (12-20) • Developmental screenings in the first 3 years of life • Percent of Members with fragmented primary care • Diabetic Eye Care Exams • Diabetic LDL measured within previous 12 months • Diabetic Nephropathy Screening • Use of Spirometry Testing in Assessment and Diagnosis of COPD • Cholesterol Management for Patients with CVD conditions • Well Child Visits in first 15 months of life • Follow-up after hospitalization for Mental illness HEDIS Claims • Well-child visits between 15 months and 3 years of age • Well-child visits ages 3-6 and 7-11

STATE: MAINE

	• Use of appropriate medications for people with asthma/pediatric measures	• Non evidence-based antipsychotic prescribing • Use of high-risk medications in the elderly(DAE)

STATE: MISSOURI: Community Mental Health Center SPA

PROGRAM DESIGN FEATURE	DESCRIPTION
Target Population	SPMI only; mental health condition plus chronic condition (e.g., asthma, cardiovascular disease, diabetes, DD, overweight); substance use disorder plus chronic condition; or mental health or substance use disorder plus tobacco use
Geographic Area	Statewide by catchment area
Delivery Systems	Beneficiaries in managed care or fee-for-service (FFS) will be enrolled in HHs; State making HH payments directly to HH providers
Enrollment	Auto-assignment of eligible beneficiary to CMHC with possibility to opt-out; potential eligible individuals receiving services in ER notified and referred to a health home
Building Blocks	Building off of recent investments in CMHCs (e.g., wrap-around services including disease management, care management, EHRs)
Designated Providers	CMHCs are the State's designated providers. CMHCs are physician-led with teams minimally comprised of a: HH Director, HH primary care physician consultant, nurse care manager(s) and HH administrative support staff. Optional staff include: an individual's treating physician and psychiatrist, mental health case manager, nutritionist/dietician, pharmacist, peer recovery specialist, or grade school personnel.
Provider Standards/ Qualifications	In addition to being a CMHC, each HH provider must meet state qualifications that minimally require: significant number of Medicaid patients; strong engaged leadership; meet state requirements for patient empanelment; meet minimum access requirements. Prior to implementation of HH service coverage, provide assurance of enhanced patient access to the health team, including the development of alternatives to face-to-face visits, such as telephone or email, 24 hours per day 7 days per week; must actively use EHRs; utilize interoperable patient registry to input annual metabolic screening results, track and measure care, automate care reminders and produce exception reports for care planning; use a behavioral pharmacy management system to determine problematic prescribing patterns; conduct wellness interventions based on level of risk; complete status reports to document client's housing, legal, employment status education, custody, etc.; must convene regular internal HH team meetings. Ongoing qualification include: must develop contract or MOU with regional hospitals or systems for transitional care planning (within 3 months of implementation); develop quality improvement plans; demonstrate fundamental health home functionality at 6 and 12 months; demonstrate significant improvement on clinical indicators; demonstrate cost effectiveness; meet NCQA Level 1 PCMH requirements (or submit application for NCQA recognition by 18 months by date at which supplemental payments start); participate in statewide learning activities.
Payment Methodology	Clinical care PMPM payment in addition to existing FFS or managed care organization (MCO) payments for direct services. Administrative payment is included in the rate to support transforming traditional CMHCs into HHs. Minimum HH service required for PMPM payment is documentation by a health home director or nurse care manager on a monthly HH activity report that the enrolled individual has received care management monitoring for treatment gaps or another HH service.

STATE: MISSOURI: Community Mental Health Center SPA

Definition of Comprehensive Care Management	Comprehensive care management services, conducted by the nurse care manager, primary care physician consultant, and HH director with the participation of other team members, include: • Identification of high-risk individuals and use of client information to determine level of participation in care management services; • Assessment of preliminary service needs; treatment plan development, which will include client goals, preferences and optimal clinical outcomes; • Assignment of health team roles and responsibilities; • Development of treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions; • Monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines and; • Development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.
Definition of Care Coordination	Care coordination is the implementation of the individualized treatment plan (with active client involvement) through appropriate linkages, referrals, coordination, and follow-up to needed services and supports, including referral and linkages to long-term services and supports. Specific activities include, but are not limited to: appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes, and communicating with other providers and clients/family members. Nurse care managers with assistance from health home administrative support staff will be responsible for conducting care coordination activities across the health team. The primary responsibility of the nurse care manager is to ensure implementation of the treatment plan for achievement of clinical outcomes consistent with the needs and preferences of the client.
Definition of Health Promotion	Health promotion services shall minimally consist of providing health education specific to an individual's chronic conditions, development of self-management plans with the individual, education regarding the importance of immunizations and screenings, child physical and emotional development, providing support for improving social networks and providing health- promoting lifestyle interventions, including but not limited to, substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity. Health promotion services also assist clients to participate in the implementation of the treatment plan and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions. The HH director, primary care physician consultant, and nurse care manager will provide health promotion activities.
Definition of Comprehensive Transitional Care	In conducting comprehensive transitional care, a member of the health team provides care coordination services designed to streamline plans of care, reduce hospital admissions, ease the transition to long-term services and supports, and interrupt patterns of frequent hospital emergency department use. The health team member collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing clients' and family members' ability to manage care and live safely in the community, and shift the use of reactive care and treatment to proactive health promotion and self management. The HH director, primary care physician consultant, and nurse case manager will all provide comprehensive transitional care activities, including, as possible, participating in discharge planning.

Definition of Individual and Family Support Services	Individual and family support services activities include, but are not limited to: advocating for individuals and families, assisting with obtaining and adhering to medications and other prescribed treatments. In addition, health team members are responsible for identifying resources to help support individuals in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services. A primary focus will be increasing health literacy, self management, and participation in ongoing revisions of care/treatment plans. For individuals with DD, the health team will refer to and coordinate with the approved DD case management entity for habilitation-related services and coordinate with the approved DD case management entity for care-related services. Nurse care managers will provide this service.
Definition of Referral to Community and Social Support Services	Referral to community and social support services, including long-term services and supports, involves providing assistance for clients to obtain and maintain eligibility for health care, disability benefits, housing, personal need and legal services, and additional support services as needed. For individuals with DD, the health team will refer to and coordinate with the approved DD case management entity for these services. The nurse care manager and administrative support staff will provide this service.
Quality Measures	• Prevent/reduce hospital admission rate • Care coordination/contact with care manager post discharge • Use of CyberAccess • Appropriate medication prescribed for members with pediatric/adult asthma • Adherence to CVD/anti-hypertensive medication • Readmissions within 30 days • Metabolic screening • Adherence to antipsychotics, antidepressants and mood stabilizers • Adult diabetes under control • ED visits • Reduce illicit drug use and excessive drinking • BMI control • Adherence to asthma/COPD medication • Use of statin for history of CAD • Use of personal EHR • Hypertension under control • Satisfaction with services • Lipid levels under control

STATE: MISSOURI: Primary Care Provider SPA

PROGRAM DESIGN FEATURE	DESCRIPTION
Target Population	At least two of the following: asthma, cardiovascular disease, diabetes, developmental disabilities (DD), or overweight (BMI >25); One of the previous chronic conditions and at risk of developing another. At risk criteria includes: tobacco use and diabetes.
Geographic Area	Statewide for Federally Qualified Health Centers, Rural Health Clinics and primary care clinics operated by hospitals.
Delivery Systems	Beneficiaries in managed care or fee-for-service (FFS) will be enrolled in HHs; State making HH payments directly to HH providers
Enrollment	Auto-assignment of eligible beneficiary to PCHH with possibility to opt-out; potential eligible individuals receiving services in ER notified and referred to a health home
Building Blocks	Building off of established infrastructure of FQHCs, RHCs and primary care clinics operated by hospitals
Designated Providers	Federally Qualified Health Centers, Rural Health Clinics and primary care clinics operated by hospitals. Practice sites will be physician-led and shall form a health team comprised of a primary care physician (i.e., family practice, internal medicine, or pediatrician) or nurse practitioner, a licensed nurse or medical assistant, behavioral health consultant, a nurse care manager and the practice administrator or office manager. The team is supported as needed by the care coordinator and HH Director. In addition, other optional team members may include a nutritionist, diabetes educator, public school personnel and others as appropriate and available.
Provider Standards/ Qualifications	In addition to being a FQHC, Rural Health Clinic or primary care clinic operated by a hospital, each HH provider must meet state qualifications, that minimally require that each HH: have a substantial percentage of its patients enrolled in Medicaid; have strong, engaged leadership; meet state requirements for patient empanelment; and meet the state's minimum access requirements. Prior to implementation of HH service coverage, HH's must provide assurance of enhanced patient access to the health team, including the development of alternatives to face-to-face visits, such as telephone or email, 24 hours per day 7 days per week; have a formal and regular process for patient input into services provided, quality assurance, access and other practice aspects; have completed EMR implementation and been using the EMR as its primary medical record solution, to e-prescribe, and to generate, or support the generation of through a third party such as a data repository, clinical quality measures relevant to improving chronic illness care and prevention for at least six months prior to the beginning of HH services; actively utilize MO HealthNet's comprehensive electronic health record for care coordination and prescription monitoring for Medicaid participants; utilize an interoperable patient registry; within three months of PCHH service implementation, have a contract or MOU with regional hospital(s) or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions of primary care health home participants, maintain a mutual awareness and collaboration to identify individuals seeking ED services that might benefit from connection with a primary care health home site, and motivate hospital staff to notify the primary care health home's designated staff of such opportunities; the state will assist in obtaining hospital/primary care health home MOU if needed; convene regular internal PCHH team meetings; meet ongoing certification requirements such as develop quality improvement plans; demonstrate fundamental medical home functionality at 6 and 12 months; demonstrate improvement on clinical outcome and process indicators; submit application for NCQA recognition by 18 months.
Payment Methodology	Clinical care PMPM payment in addition to FFS or managed care organization (MCO) payment for direct services. Administrative payment included in the rate to support transformation to meet person-centered Primary care health home requirements. Minimum health home service

	required for PMPM payment is documentation by a health home director or nurse care manager on a monthly health home activity report that the enrolled individual has received care management monitoring for treatment gaps or another health home service.
Definition of Comprehensive Care Management	Comprehensive care management services are conducted by the nurse care manager and involve identification of high-risk individuals and use of client information to determine level of participation in care management services; assessment of preliminary service needs; treatment plan development, which will include client goals, preferences and optimal clinical outcomes; assignment by the care manager of health team roles and responsibilities; development of treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions; monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines and; development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.
Definition of Care Coordination	Care coordination is the implementation of the individualized treatment plan (with active client involvement) through appropriate linkages, referrals, coordination and follow-up to needed services and supports. Specific activities include, but are not limited to: appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes and communicating with other providers and clients/family members. Nurse Care Managers with the assistance of the Care Coordinator will be responsible for conducting care coordination services across the health team. The primary responsibility of the Nurse Care Manager is to ensure implementation of the treatment plan for achievement of clinical outcomes consistent with the needs and preferences of the client.
Definition of Health Promotion	Health promotion services shall minimally consist of providing health education specific to an individual's chronic conditions, development of self-management plans with the individual, education regarding the importance of immunizations and screenings, child physical and emotional development, providing support for improving social networks and providing health promoting lifestyle interventions, including but not limited to, substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity. Health promotion services also assist patients to participate in the implementation of the treatment plan and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions. The Primary Care Health Home Director, Nurse Care Manager, Behavioral Health Consultant and appropriate primary care health home Administrative Support staff will provide health promotion services.
Definition of Comprehensive Transitional Care	In conducting comprehensive transitional care, a member of the health team provides care coordination services designed to streamline plans of care, reduce hospital admissions, ease the transition to long term services and supports and interrupt patterns of frequent hospital emergency department use. The health team member collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing clients' and family members' ability to manage care and live safely in the community, and shift the use of reactive care and treatment to proactive health promotion and self management. The HH director and nurse care manager will provide comprehensive transitional care activities, including, as possible, participating in discharge planning.
Definition of Individual and Family Support Services	Individual and family support services activities include, but are not limited to: advocating for individuals and families, assisting with obtaining and adhering to medications and other prescribed treatments. In addition, health team members are responsible for identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in the community, including

	transportation to medically necessary services. A primary focus will be increasing health literacy, ability to self manage their care and facilitate participation in the ongoing revision of their care/treatment plan. For individuals with DD the health team will refer to and coordinate with the approved DD case management entity for services more directly related to Habilitation and coordinate with the approved DD case management entity for services more directly related to a particular healthcare condition. Nurse Care Managers, Behavioral Health Consultant and Care Coordinator will provide individual and family support services.
Definition of Referral to Community and Social Support Services	Referral to community and social support services involves providing assistance for clients to obtain and maintain eligibility for health care, including long term services and supports, disability benefits, housing, personal need and legal services, and additional support services as needed. For individuals with DD, the health team will refer to and coordinate with the approved DD case management entity for these services. The nurse care manager and care coordinator will provide this service.
Quality Measures	• Prevent/reduce hospital admission rate • Readmissions within 30 days • Reduced illicit drug use and excessive drinking • MH screening through EPSDT • Use of personal HER • Use of CyberAccess • Weight assessment and counseling for youth • Adult and child diabetes under control • Adherence to diabetes medication • Adherence to asthma/COPD medication • Lipid levels under control • ED visits • Care coordination/contact with care manager post discharge • Depression screening • Substance abuse screening • Satisfaction with services • BMI control • Child vaccinations • Blood pressure and lipid levels under control for members with diabetes • Appropriate medication prescribed for members with pediatric/adult asthma • Hypertension under control • Adherence to CVD/anti-hypertensive medication

STATE: NEW YORK: Chronic Behavioral and Medical Conditions SPA

PROGRAM DESIGN FEATURE	DESCRIPTION
Target Population	SMI only; Two or more chronic conditions; HIV/AIDS and at risk for another chronic condition. Conditions include: mental health condition; substance use disorder; asthma; diabetes; heart disease; BMI over 25; HIV/AIDS; hypertension and other conditions associated with 3M™ Clinical Risk Group categories of chronic behavioral and medical conditions.
Geographic Area	Three phase regional roll-out; beginning in 10 counties (Bronx, Brooklyn, Nassau, Warren, Washington, Essex, Hamilton, Clinton, Franklin, Schenectady)
Delivery Systems	Managed care and Fee-for-service (FFS)
Enrollment	Auto-enrollment (with option to choose another or opt-out)
Building Blocks	Chronic Illness Demonstration Projects; Managed Addiction Treatment Services (MATS); Targeted Case Management; Medical home initiative
Designated Providers	NYS plans to certify HHs that build on current provider partnerships. Eligible providers include managed care plans, hospitals, medical mental and chemical dependency treatment clinics, primary care practices, PCMHs, FQHCs, TCM and certified home health care agencies that meet provider standards. It is expected that HH providers will develop HH networks with primary, medical, specialty and mental health providers, substance abuse service providers, community based organizations, managed care plans and others to provide enrollees access to needed services. HHs will use multidisciplinary teams, led by one dedicated care manager. Optional team members may include nutritionists/dieticians, pharmacists, outreach workers including peer specialists and other representatives as appropriate to meet the enrollee needs (housing representatives, entitlement, employment).
Provider Standards/Qualifications	Under New York State's approach to HH implementation, a HH provider is the central point for directing patient-centered care and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual arrangements with appropriate service providers, of comprehensive, integrated services. General qualifications are as follows: • HH providers/plans must be enrolled (or be eligible for enrollment) in the NYS Medicaid program and agree to comply with all Medicaid program requirements. • HH providers can either directly provide, or subcontract for the provision of, HH services. HH provider remains responsible for all program requirements, including services performed by subcontractor. • Care coordination and integration of heath care services will be provided to all HH enrollees by an interdisciplinary team of providers, where each individual's care is under the direction of a dedicated care manager who is accountable for assuring access to medical and behavioral health care services and community social supports as defined in the enrollee care plan. • Hospitals that are part of a HH network 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 DOH designated health home provider. • HH providers must demonstrate their ability to perform each of the eleven CMS health home core functional components and must provide written documentation that demonstrates how the core health home service requirements are being met.

	• HH provider must meet: core health home requirements for the core health home services, requirements for use of HIT to link services and quality measurement and reporting requirements, and must provide written documentation that demonstrate how requirements are being met.
Payment Methodology	HHs will be paid a per member per month (PMPM) care management fee that is adjusted based on 1) region, 2) case mix (using the Clinical Risk Group method), and 3) patient functional status (after the data is available). This risk-adjusted payment will allow providers to receive a diverse population of patients and assign patients to various levels of care management intensity without having to meet preset standards for contact counts. Providers will be able to respond to and adjust the intensity and frequency of intervention based on a patient's current condition and needs. The care management fee will be paid in two increments, based on whether a patient is 1) in the finding group or 2) intervention group. A reduced PMPM (80%) will be paid for the case finding group for outreach and engagement and is only available for the first three months after a patient has been assigned to a HH. Following this interval, case finding can be billed for another three months while outreach and engagement is attempted again. Once a member has been assigned to a care manager and enrolled in a HH, the active care management PMPM (full PMPM amount) may be billed. A unit of service will be defined as a billable unit per service quarter that will be distributed monthly. To be reimbursed for a billable unit of service per quarter, HH providers must, at a minimum, provide one of the core HH services. The monthly distribution will be paid via the case finding and active care management PMPM.
Definition of Comprehensive Care Management	A comprehensive individualized patient centered care plan will be required for all HH enrollees. The care plan will be developed based on the information obtained from a comprehensive health risk assessment used to identify the enrollee's physical, mental health, chemical dependency and social service needs. The individualized care plan will be required to include and integrate the individual's medical and behavioral health services, rehabilitative, long term care, social service needs, as applicable. The care plan will be required to clearly identify: 1) the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager and other providers directly involved in the individual's care; 2) community networks and supports that will be utilized to address their needs; 3) Goals and timeframes for improving the patient's health, their overall health care status and the interventions. The care manager will be required to ensure the individual/guardian plays a central and active role in development and execution of their care plan, and that they are in agreement with the goals, interventions and timeframes. Family and other supports involved in the patient's care should be identified and included in execution of the plan as requested by the individual. The care plan must also include outreach and engagement activities which will support engaging the patient in their own care and promote continuity of care. In addition, the plan of care will include periodic reassessment of the individual's needs and goals and clearly identify the patient's progress in meeting goals. Changes in the plan of care will be made based on changes in patient need.

Definition of Care Coordination	The health home provider will be accountable for engaging and retaining health home enrollees in care, as well as coordinating and arranging for the provision of services, supporting adherence to treatment recommendations, and monitoring and evaluating the enrollee's needs. The plan of care will identify all services necessary to meet goals needed for care management of the enrollee such as prevention, wellness, medical treatment by specialists and behavioral health providers, transition of care from provider to provider, and social and community services where appropriate. In order to fulfill the care coordination requirements, the HH provider will assign each individual enrollee one dedicated care manager who is responsible for overall management of the enrollee's plan of care. The enrollee's HH care manager will be clearly identified in the patient record and will have overall responsibility and accountability for coordinating all aspects of the individual's care. The HH provider will be responsible to assure that communication will be fostered between the dedicated care manager and treating clinicians to discuss, as needed, enrollee's care needs, conflicting treatments, change in condition, etc., which may necessitate treatment change (i.e., written orders and/or prescriptions). The HH provider will be required to develop and have policies, procedures and accountabilities (contractual agreements) in place, to support and define the roles and responsibilities for effective collaboration between primary care, specialists, behavioral health providers and community based organizations. The health home providers policies and procedures will direct and incorporate successful collaboration through use of evidence-based referrals, follow-up consultations, and regular, scheduled case review meetings with all members of the interdisciplinary team. The health home provider will have the option of utilizing technology conferencing tools including audio, video and /or web deployed solutions when security protocols and precautions are in place to protect PHI to support care management/coordination activities.
Definition of Health Promotion	Health promotion begins with outreach and engagement activities. NYS' health home plan for outreach and engagement will require a health home provider to actively seek to engage patients in care by phone, letter, HIT and community "in reach" and outreach. Each of these outreach and engagement functions will all include aspects of comprehensive care management, care coordination, and referral to community and social support services. All of the activities are built around the notion of linkages to care that address all of the clinical and non-clinical care needs of an individual and health promotion. The HH provider will support continuity of care and health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers. The HH provider will promote evidence based wellness and prevention by linking HH enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self- help recovery resources, and other services based on individual needs and preferences. Health promotion activities will be utilized to promote patient education and self management of their chronic condition.
Definition of Comprehensive Transitional Care	Comprehensive transitional care will be provided to prevent enrollee avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing or treatment facility) and to ensure proper and timely follow up care. To accomplish this, the health home provider will be required to develop and have a system in place with hospitals and residential/rehabilitation facilities in their network to provide the health home care manager prompt notification of an enrollee's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting. The HH provider will also have policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals and residential/rehabilitation settings, providers and community based services to ensure coordinated, and safe transition in care for its patients who require transfers to/from sites of care. The health home provider will be required to develop and have a systematic follow-up protocol in place to assure timely access to follow-up care post discharge that includes at a minimum receipt of a summary care record from the discharging entity, medication reconciliation, and a plan for

	timely scheduled appointments at recommended outpatient providers. The HH care manager will be an active participant in all phases of care transition, including: discharge planning and follow-up to assure that enrollees received follow up care and services and re-engagement of patients who have become lost to care.
Definition of Individual and Family Support Services	The patient's individualized plan of care will reflect and incorporate the patient and family or caregiver preferences, education and support for self-management; self help recovery, and other resources as appropriate. The provider will share and make assessable to the enrollee, their families or other caregivers (based on the individual's preferences), the individualized plan of care by presenting options for accessing the enrollee's clinical information. Peer supports, support groups, and self-care programs will be utilized by the health home provider to increase patients' and caregivers knowledge about the individual's disease(s), promote the enrollee's engagement and self management capabilities, and help the enrollee improve adherence to their prescribed treatment. The provider will discuss and provide the enrollee, the enrollee's family and care givers, information on advance directives in order to allow them to make informed end-of-life decisions ahead of time. The HH provider will ensure that all communication and information shared with the enrollee, the enrollee's family and caregiver is language, literacy and culturally appropriate so it can be understood.
Definition of Referral to Community and Social Support Services	The HH provider will identify available community-based resources and actively manage appropriate referrals, access to care, engagement with other community and social supports, coordinate services and follow-up post engagement with services. To accomplish this, the HH provider will develop policies, procedures and accountabilities (through contractual agreements) to support effective collaboration with community-based resources, that clearly define the roles and responsibilities of the participants. The plan of care will include community-based and other social support services, appropriate and ancillary health care services that address and respond to the patient's needs and preferences, and contribute to achieving the patient's goals.
Quality Measures	• Inpatient utilization • ED visits • Mental health utilization • Follow up after MH hospitalization • Follow up after hospitalization for alcohol and chemical dependency detoxification • Adherence to antipsychotics, antidepressants and mood stabilizers • Follow up care for children prescribed ADHD medication • Use of appropriate medication for members with asthma • Asthma medication management • HbA1c and LDL-c testing • Beta-blocker treatment after heart attack • Lipid testing for cardiovascular conditions • Comprehensive care for members living with HIV/AIDS • Chlamydia screening • Colorectal cancer screening

STATE: NORTH CAROLINA	
PROGRAM DESIGN FEATURE	**DESCRIPTION**
Target Population	Two chronic conditions (asthma, diabetes, heart disease, BMI over 25, blindness, chronic cardiovascular disease, chronic pulmonary disease, congenital anomalies, chronic disease of the alimentary system, chronic endocrine and metabolic disease, chronic infectious disease, chronic mental and cognitive conditions not including mental illness or developmental disabilities, chronic musculoskeletal conditions and chronic neurological disorders), or one medical condition and at risk for another (presumed with presence of some diagnosis, i.e. diabetes, hypertension, BMI over 25, etc.). Conditions specific to pregnancy (i.e. gestational diabetes, gestational hypertension, etc.) are not considered qualifying conditions; however, will be monitored as presenting a risk of developing a chronic condition. Individuals with a single HH qualifying condition and a condition specific to pregnancy (i.e. gestational diabetes) will be eligible for HHs.
Geographic Area	Statewide
Delivery Systems	PCCM
Enrollment	Enrollment in HHs is voluntary through Community Care of North Carolina (CCNC).
Building Blocks	HH services will be delivered through the CCNC program. CCNC program building blocks include: medical homes or pregnancy medical homes as designated HH providers; regional, provider-run non-profit community networks; care management infrastructure (statewide, regional network, and provider level); and non-profit statewide coordinating agency to work with Medicaid.
Designated Providers	The Team of Health Care Professionals centers on the PCP. Each Community Care enrollee is linked to a primary care provider to serve as a medical home (24/7 assistance) that provides acute and preventive care, manages chronic illnesses, coordinates specialty care and referrals to social, community and long term care supports. HHs will provide three elements of wraparound services that work with PCMHs. These are as follows: 1. Provider run non-profit community networks for managing care, comprised of physicians, hospitals, social service agencies, and county health departments; 2. Care management infrastructure; 3. Non-profit statewide coordinating agency - works with Medicaid, regional networks, primary care providers and case managers.
Provider Standards/Qualifications	Each CCNC Network executes agreements with local PCPs to work collaboratively with the Network to provide HH services. In addition to meeting basic requirements of Medicaid primary care providers (e.g., 24 hours per day/7 days per week coverage, admitting privileges, etc.), Network providers must do the following as part of their participation in the Network: • Cooperate with the CCNC Network in the development and utilization of care management systems and tools for managing the care of Medicaid enrollees. • Comply with the policies and procedures developed by the Network's Medical Management Committee and / or Steering Committee that aim to effectively manage the quality, utilization, and cost of services, including but not limited to inpatient admissions; emergency room visits; specialty and ancillary referrals; early detection and health promotion; Health Check (EPSDT); chronic and high cost diseases, at risk patients; and pharmacy prescribing patterns. • Cooperate with the Network's patient risk assessment process to identify and track those Medicaid recipients that would most benefit from

STATE: NORTH CAROLINA	
	targeted care management and disease management activities. • Participate, as required by the network, in interdisciplinary teams to help manage and optimize patient care of those enrollees at highest risk and cost. • Authorize and coordinate with the Network care managers in carrying out the enhanced care management activities targeting Medicaid recipients enrolled with the practice. • Participate in the implementation of network approved care management plans for at-risk and/or high-cost enrollees. • Work in concert with the network to develop strategies to address special needs of the Medicaid population; develop local referral processes and communication with specialists; promote self-management; develop plans to meet CCNC utilization and budget targets; evaluate and implement appropriate changes in service utilization; and develop and refine CCNC measures, utilization reports, management reports, quality improvement goals and care management initiatives.
Payment Methodology	PMPM payment plus add-on rate to support specialized care management supports for special health needs. Payment amounts tied to staff and related costs of delivering chronic illness management responsibilities at the practice and network levels. Minimum HH service required to merit PMPM is that person received care management monitoring for treatment gaps, or another HH service was provided, and the HH will report activity on a monthly HH activity report. PMPM tiered based on ABD or non-ABD status.
Definition of Comprehensive Care Management	Comprehensive care management involves active participation from PCPs, care managers, and patient and family/caregivers and includes: patient identification and comprehensive assessment through direct referrals, by mining administrative claims data (e.g. risk stratification tools, frequent hospital and emergency room admissions), through screenings and assessments and chart reviews that identify gaps in care; developing an individualized care plan involving the health care team including the care manager, primary care provider, patient and family/caregiver. They all must agree on goals in the care plan; care coordination where the care manager ensures the care plan is implemented, communicated and coordinated across providers and delivery settings. Care manager interventions are identified and documented; reassessment and monitoring – the health care team monitors the patient's progress toward goal achievement on an ongoing basis, adjusting care plan as needed; and outcomes and evaluation – the care team uses quality metrics, assessment survey results and utilization of services to monitor and evaluate the impact of interventions. An average aid to Families with Dependent children caseload ranges from 5,000-7,500 enrollees per care manager and an average ABD caseload ranges from 1,500-3,500 enrollees per care manager. Case loads are assigned with the assumption that only 5-10% of the population will require care management at any given time and care managers provide interventions at varying levels of intensity (some face to face, others telephonic).
Definition of Care Coordination	Care Coordination, a core component of Care Management, is the implementation of the individualized care plan (developed by the health care team with active PCP, care manager, and patient and family/caregiver involvement) through appropriate linkages, referrals, coordination and follow-up to needed services and supports. Specific activities include, but are not limited to: appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes and communicating with other providers and clients/family members. Care managers or PCP team members are responsible for conducting care coordination activities across providers and settings, with their primary responsibility being to ensure implementation of the care plan for achievement of clinical outcomes consistent with the needs and preferences of the client. CCNC care manager care coordination interventions are identified and documented in CMIS. The Mental Health Integration Program aims to improve the screening and treatment of mental health conditions in the primary care setting and enhance the medical care of individuals with behavioral health problems. CCNC is working to implement the four quadrant clinical integration

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	model as the foundation for communication, collaboration, assessment, referral and clinical management of care. After an initial pilot period, the model is being implemented statewide, with primary care practices having incorporated behavioral health treatment in the primary care provider office setting while also supporting enhanced referral processes for more complex patients to specialty mental health services and behavioral health care coordination. The CCNC central office and networks use psychiatrists to coordinate implementation of the four quadrant model and to identify patients with behavioral and physical health care needs for the PCPs.
Definition of Health Promotion	Health Promotion services assist patients to participate in the implementation of their care plan and place a strong emphasis on skills development for management and monitoring chronic health conditions. Health promotion is an integral service provided by PCPs and their care teams or CCNC care managers. Most of the quality improvement initiatives conducted by the networks include a health promotion component, which educates PCPs and their care teams about ways to promote health with their patients and also gives PCPs easily accessible tools to use with their patients. Health promotion services include CCNC care managers and PCPs or their care teams providing health education and coaching specific to an individual's chronic conditions, development of self-management plans with the individual, education regarding the importance of immunizations and screenings, promoting lifestyle interventions, including but not limited to, substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity.
Definition of Comprehensive Transitional Care	A transition occurs any time a patient moves from one care setting to another or when s/he moves from one area to another within the same care setting. Every CCNC hospital admission is assessed for transitional care need using real-time data from multiple sources. Transitional care is initiated, in some cases on the first admission, for patients with chronic conditions at high risk of readmission and for conditions in which the admission is ambulatory-care sensitive. Networks provide transitional care management to all hospitals in their region. Networks are mandated to maintain active referring relationships with all hospitals to facilitate access to primary care following hospital discharge or emergency department services. Onsite embedded care management is provided through 55 CCNC transitional care nurses who work full time in hospitals with large volumes of admissions from the ABD population. Hospitals with embedded transitional care managers account for 80% of Medicaid ABD inpatient admissions. The primary role of the care manager in the transitional care process is to: facilitate interdisciplinary collaboration among providers during transitions; encourage the PCPs, patients and family/caregivers to play a central and active role in the formation and execution of the care plan; promote self-management skills and direct communication among the patient and caregiver, the PCP and other care providers; achieve medication reconciliation by consulting with the network pharmacist, hospital, PCP, specialists, and the patient and his/her caregiver. The Community Care networks connect the PCP/medical home to the community. To support more effective transitions, networks have forged links with all North Carolina hospitals to obtain timely information about their hospitalized patients.## # CCNC care managers also schedule visits with patients in the hospital and follow up with home visits within three days of discharge. One of the key functions is to perform medication reconciliation on hospitalized patients that seek to make sense of all the different medication the patient may take (from the medicine cabinet, the PCPs list, hospital discharge instructions, specialist and behavioral health providers, over-the-counter medication, etc.). Post discharge home visits not only support medication reconciliation efforts but also provide care managers with valuable knowledge about the patients' home environments and support issues. The PCP is informed about an admission by CCNC care manager provision copy of the hospital discharge summary, either electronically or by

	mail, depending on what format is available. CCNC transitional care staff update the patient's medical homes about hospitalizations, other prescribed medications, social and environmental concerns and other agencies providing services such as personal care, home health care and behavioral health support, and make sure the PCP receives discharge summaries. Network pharmacists review medication lists and alert the PCP of discrepancies and other findings. Transitional care staff shares information among a variety of local agencies, including behavioral health providers and long term care support providers.
Definition of Individual and Family Support Services	Individual and family support services activities are provided by PCPs and their care teams or CCNC care managers and include, but are not limited to: advocating for individuals and families, assisting with obtaining and adhering to medications and other prescribed treatments. In addition, health team members are responsible for identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services and access to long-term care and support services. PCPs have a key role in CCNC initiatives to support appropriate referrals. Many network activities are geared toward supporting and educating PCPs on how to promote access to community services and resources in their role as health home provider. In different practice areas this guidance takes different forms. For patients in need of long term care and aging services, Regional networks have each formed a LTC steering committee to connect CCNC network primary care practices to local Aging and Disability Resources Centers and Area Agencies on Aging. CCNC network clinical directors lead the steering committees. CCNC networks also produce resource manuals for network practices tied to local and regional continuum of medical, social and long term care services. Every CCNC resource manual incorporates detailed information regarding local resources. North Carolina received the CMS "state demonstration to integrate care for dual eligible individuals" grant, which is enabling further improvements in this area. CCNC networks provide detailed protocols regarding effective approaches to supporting recipients with chronic illnesses with regard to self-management of chronic illnesses and access to community and medical resources to support improved health and well-being. Care managers develop relationships with recipients and when possible, their family and social supports through face to face and telephonic interactions.
Definition of Referral to Community and Social Support Services	Community Care works holistically. We require network providers, with care management support, to attend not only to the delivery of physical health care services but to address social, mental and community issues that may impact health and medical care. Care management recognizes the social and environmental factors that affect population health. As part of our care management approach, Community Care works to increase access to appropriate community and social support services, and to utilize and organize community resources. Local agency and resource knowledge is a key advantage of our use of locally-based care managers, and they share this knowledge with network providers by providing Resource Manuals containing relevant contact information for an array of community and social support services.
Quality Measures	Goal based measures include: • ED visits • Getting needed care • Inpatient admissions • Heart failure admissions • Practices with co-located behavioral health providers • Access to care • Getting care quickly • Asthma hospitalizations • CAHPS – chronic conditions supplemental questions Service based measures include: • Members meeting CCNC priority criteria who receive • CAHPS – coordination of care, behavioral health, HEDIS measure

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	comprehensive health assessment or an intervention • Mammography • Colorectal cancer screening • Adolescent well-care visits • Preventable readmissions • Medication reconciliation after non-mental health hospital discharge	set, chronic conditions supplemental questions • Pap smear • Well-child visits • Blood pressure control for diabetes and hypertension • Heart failure 30-day readmissions

STATE: OHIO	
Program Design Feature	**DESCRIPTION**
Target Population	Serious and Persistent Mental Illness (SPMI), including both adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED).
Geographic Area	Targeted to 5 counties: Adams, Butler, Lawrence, Lucas and Scioto Counties. Statewide by end of first year.
Delivery Systems	Managed Care and Fee-for-service.
Enrollment	Enrollment in Health Homes program is opt-out.
Building Blocks	Four mental health provider institutions in Ohio received grant funding through SAMHSA's Primary Behavioral Health Care Integration initiative that served as a foundation for Health Homes.
Designated Providers	Community Behavioral Health Centers (CBHCs) will be the only provider type recognized by the state as eligible to provide Health Home services for persons with SPMI.
Provider Standards/Qualifications	A CBHC must meet state defined core requirements in order to qualify as a provider of health home services for individuals with SPMI. The State will contract with approved CBHC Health Homes for the provision of, and payment for, Health Home services. Unless otherwise indicated, CBHCs must meet the following minimum requirements prior to providing Health Home services: a. Be certified by the Ohio Department of Mental Health as eligible to provide the following Medicaid covered community mental health services: pharmacological management, mental health assessment, behavioral health counseling and therapy, and community psychiatric support treatment. (See SPA for further detail). b. Provide all of the following health home services as necessary and appropriate for beneficiaries: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family supports, referral to community and social support services, and the use of health information technology to support the delivery of health home services. c. Demonstrate integration of physical and behavioral health by defined criteria: i) Achieving one of the following accreditations at the agency's next accreditation survey (See SPA); ii) Ensuring that specific medical screening and treatment services, consistent with current professional standards of care, are provided to the Health Home consumer by directly providing the service on-site or assuring the service is provided through a written agreement with a primary care provider; iii) Identifying a single point of contact for each MCP who shall work with the MCP on activities (See SPA); iv) Establishing policies and written agreements with primary care providers for communication and integration between behavioral health and primary care if the CBHC does not have an ownership interest in a primary care organization or does not have embedded primary care services; and v) Establishing effective partnerships and referral/coordination processes with specialty providers, inpatient facilities, and managed care plans that support the delivery of health home services.

d. The CBHC must establish a partnership and a referral/coordination process with specialty providers and inpatient facilities. At a minimum, the referral/coordination process must address the roles of the CBHC and the partnering provider in coordinating and managing care for the consumer, including any necessary follow up with the consumer. The process shall include how and what type(s) of information will be exchanged in a HIPAA compliant manner between the CBHC and the partnering specialty provider or inpatient facility.
e. The CBHC must establish partnerships with managed care plans in the service area and develop written policies and procedures that include the following: (See SPA).
f. Provide a list of primary care providers and specialists/inpatient facilities to the MCP, for which the CBHC has integrated care agreements and referral/coordination processes, respectively. The CBHC shall refer to the plan's panel of providers when assisting the enrollee in obtaining necessary health care.
g. Collaborate with the MCP to ensure that the enrollee's selected/assigned PCP has a current, collaborative care agreement with the CBHC. If the enrollee requests a change to the selected PCP, the CBHC shall inform the MCP so that the plan's existing process to change the PCP is promptly initiated.
h. Support the delivery of person-centered care by providing: (See SPA).
i. Have the capacity to receive electronic data from a variety of sources to facilitate care management, care coordination, and comprehensive transitional care. At a minimum, this may include clinical patient summaries, medication profiles, and real-time notifications of a patient's admission to, or discharge from, an emergency department or inpatient facility.
j. Maintain a comprehensive and continuous quality improvement program capable of collecting and reporting data on utilization and health outcomes, and the ability to report to the state or its designee.
k. Participate in the Medicaid HHs Learning Community.
l. Serve as a current eligible provider in the Ohio Medicaid Program.
m. Have the capacity to serve Medicaid individuals who are eligible to receive health home services in the designated service area.

The CBHC will be required to maintain documentation in the care plan in order to demonstrate that HH services are being delivered in accordance with program rules and requirements. The CBHC must be compliant with the provider standards in order to maintain a designation as a Health Home provider.

While CBHCs will be the single provider type designated by the state to provide Health Home services for persons with SPMI, many consumers who are eligible to receive Health Home services will be enrolled in a Medicaid managed care plan. Therefore, the state recognizes that Medicaid managed care plans (MCPs) will play a critical role in supporting the CBHC HHs for their members. The contract between the state and the Medicaid MCPs will require that each MCP performs the following activities to support the CBHC HH:
a. Establishes a partnership with the CBHC Health Home and develops written policies and procedures that address the following components: (See SPA).
b. Develops a transition plan timely and in collaboration with the CBHC Health Home for each plan member that will receive HH services. The transition plan should confirm the start date for Health Home services and identify the member's primary care provider, the data/information that will be transferred to the CBHC Health Home, and the single point of contact designated for the CBHC HH.
c. Performs ongoing identification of the plan's members who have a diagnosis of SPMI and could benefit from receiving HH services. The MCP will contact these eligible members, educate the members about the benefits of receiving HH services, assist them in selecting a HH, and facilitate the referral to the selected Health Home.

	d. Establishes and maintains a mechanism to track the plan's members who are receiving HH services. e. Integrates all information/data transmitted by the CBHC HH or the State related to a member's receipt of HH services into the MCP's systems, such as member services, utilization management, etc. f. Participates in comprehensive transitional care activities with the CBHC Health Home for members who are discharged from, or transferred between, care settings and which may include the following, discharge planning, primary care provider follow up, medication reconciliation and timely provision of post discharge services (e.g., durable medical equipment). g. Integrates the results from the HHs quality measures into the plan's quality improvement program. h. Participates in the Medicaid HHs Learning Community. The State will routinely monitor the MCPs to ensure there is active and ongoing participation to support the CBHC Health Homes.
Payment Methodology	HH services will be reimbursed using a monthly case rate based on the following information submitted by the HH: i) Medicaid HH Enrollee Caseload; ii) Medicaid Dedicated HH Staffing Costs; and iii) Indirect Costs Related to the Provision of HH Services of Medicaid Enrollees.
Definition of Comprehensive Care Management	Comprehensive care management begins with the identification of individuals who are potentially eligible to receive health home services. The CBHC HH will be responsible for identifying individuals with severe and persistent mental illness who are currently affiliated with the health home site. SPMI individuals without a CBHC affiliation or a routine source of health care may be identified through referral from another provider or an administrative data review and connected to a CBHC HH to begin the comprehensive care management process. The next step is for the CBHC to engage the eligible individual and his/her family by explaining the benefits of participation and receiving health home services, and the right to opt-out of HH services. The CBHC HH will complete a comprehensive assessment of the individual's physical health, behavioral health (i.e., mental health, substance abuse disorders), long-term care and social needs. The assessment must account for the cultural and linguistic needs of the individual and use relevant comprehensive data from a variety of sources, including the individual/family, caregivers, medical records, team of health professional, etc. At a minimum, the CBHC HH will reassess the individual at least once every ninety days. Based on the health assessment, the CBHC health home will assemble a team of health professionals, and establish and negotiate roles and responsibilities for each member of the team, including the accountable point of contact. The CBHC HH will develop and continuously update a single, integrated, person-centered care plan that will include prioritized goals and actions with anticipated timeframes for completion and will reflect the individual's preferences. Prior to implementation of the care plan, a communication plan must be developed to ensure that routine information exchange (clinical patient summaries, medication profiles, updates on patient progress toward meeting goals), collaboration, and communication occurs between the team members, providers, and the individual/family. The CBHC HH will frequently and routinely monitor the care plan to determine adherence to treatment guidelines and medication regimes, barriers to care, or any clinical and non-clinical issues that may impact the individual's health status or progress in achieving the goals and outcomes outlined in the care plan. As part of the monitoring, the CBHC and team of health professionals are expected to adhere to the communication plan when providing updates and progress reports on the individual.
Definition of Care Coordination	Care coordination is the implementation of the single, integrated care plan. With a person-centered focus, the CBHC will facilitate and direct the coordination, communication, and collaboration which is necessary for the individual to demonstrate progress on the goals/actions of the care plan and achieve optimal health outcomes. This will include, but not be limited to, the following: providing assistance to the consumer in obtaining health care (i.e., primary and specialty medical care, mental health, substance abuse services and developmental disabilities services, long-term services and supports, and ancillary services and supports); performing medication management and reconciliation; tracking tests and

	referrals with the necessary follow up; sharing the crisis plan, assisting with and coordinating prevention, management and stabilization of crises and ensuring post-crisis follow-up care is arranged and received; participating in discharge planning; and making referrals to community, social and recovery supports. The CBHC HH will be required to assist the individual with making appointments and validating that the services were received by the individuals.
Definition of Health Promotion	Health promotion services are intended to equip the individual/family with relevant knowledge and skills which will: increase his/her understanding of diseases/conditions identified in the assessment, promote self-management, and improve quality of life and daily functioning. This may be accomplished through the following examples: education about wellness and healthy lifestyle choices; provision of or referrals to evidence based wellness programs, such as tobacco cessation, weight management, chronic disease management programs, wellness management and recovery, etc.; and connections to peer supports. A focus of health promotion will be to support and engage the individual and the family in the development, implementation and monitoring of the care plan. By empowering the individual and promoting self-advocacy, there will be an increased ability to be proactive in the self-management of existing conditions, increase the utilization of preventative services, and accessing care in appropriate settings.
Definition of Comprehensive Transitional Care	Comprehensive transitional care services are designed to ensure continuity of care and prevent unnecessary inpatient readmissions, emergency department visits and/or other adverse outcomes, such as homelessness. The CBHC HH will develop arrangements with inpatient facilities, emergency departments and residential facilities for prompt notification of an individual's admission and/or discharge to/from a hospital emergency department, inpatient unit or residential facility. The CBHC HH will coordinate and collaborate with inpatient facilities, hospital emergency departments, residential facilities and community partners to ensure that a comprehensive discharge plan and/or transition plan, and timely and appropriate follow up is completed for an individual who is transitioning to/from different levels and settings of care. The CBHC HH will conduct and/or facilitate effective clinical hand offs that include timely access to follow-up post discharge care in the appropriate setting, timely receipt and transmission of a transition/discharge plan from the discharging entity, and medication reconciliation.
Definition of Individual and Family Support Services	Individual and family support services include, but are not limited to, the following: providing expanded access and availability of services along with continuity in relationships between the individual/family, provider(s), and the care manager; supporting the delivery of person centered care; assisting with accessing natural support systems in the community; performing outreach and advocacy for the individual/family to identify and obtain needed resources (e.g., transportation); educating and teaching the individual on self-management techniques; facilitating further development of daily living skills; assisting with obtaining and adhering to medication and other prescribed treatments; providing interventions that address symptoms, and behaviors and assist the HH enrollee in eliminating barriers to seeking or maintaining education, employment or other meaningful activities related to his or her recovery-oriented goal; providing opportunities for the individual/family to participate in the assessment and care plan development/implementation, including providing access to electronic health records or other clinical information; and making referrals to community/social/recovery supports. HH services will also be delivered in a manner that takes into account the individual's and family's preferences and is culturally and linguistically appropriate. Individuals and their families will be integral to the quality improvement process by providing feedback on experience/satisfaction of care through surveys or by participating in patient/family advisory councils.

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Definition of Referral to Community and Social Support Services	The CBHC HH will offer and/or arrange for onsite and offsite community and social support services through effective collaborations with social service agencies and community partners. The CBHC HH will identify and provide referrals to community, social, or recovery support services such as maintaining eligibility for benefits, obtaining legal assistance, and housing. The CBHC HH will assist the consumer in making appointments; validate the service was received; and complete any follow up as necessary.
Quality Measures	• Cholesterol Management for Patients with Cardiovascular Conditions • SAMHSA National Outcome Measures (NOMS) (General satisfaction with care; access to care; quality and appropriateness of care; participation in treatment; and cultural competence) • Reconciled Medicated List Received by Health Home • Comprehensive Diabetes Care: LDL-C Screening, LDL-C < 100mg/dL • Proportion of Days Covered of Medication • Annual Assessment of Body Mass Index, Glycemic Control, and Lipids for People with Schizophrenia Who Were Prescribed Antipsychotic Medications • Annual Assessment of Body Mass Index, Glycemic Control, and Lipids for People with Bipolar Disorder Who Were Prescribed Mood Stabilizer Medications • Prenatal and Postpartum Care • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents • Adults' Access to Preventive/Ambulatory Health Services • Annual Dental Visit (age 2-21) • Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment • Ambulatory Care Sensitive Condition Hospitalization Rate • All-Cause Readmission • Controlling High Blood Pressure • Timely Transmission of Transition Record • Comprehensive Diabetes Care: HbA1c level < 7.0% • Use of Appropriate Medications for People with Asthma • Follow Up After Hospitalization for Mental Illness • Screening for Clinical Depression and Follow-up Plan • Percent of Live Births Weighing Less than 2,500 grams • Adult BMI Assessment • Adolescent Well-Care Visits • Appropriate Treatment for Children with Upper Respiratory Infections • Annual Dental Visit (age 22 and older) • Smoking & Tobacco Use Cessation • Inpatient and Emergency Department (ED) Utilization Rate

STATE: OREGON	
PROGRAM DESIGN FEATURE	**DESCRIPTION**
Target Population	Two chronic conditions (asthma, cardiovascular disease, diabetes, substance use disorder, a BMI >25 or 85 percentile if under 20, Hepatitis C, HIV/AIDS, Chronic Kidney Disease, Chronic Respiratory Disease, Cancer); One chronic condition and at risk for another; SMI. Providers will use information identified by the US Preventive Services Task Force, HRSA Women's Preventive Services or Bright Futures when making decisions about at risk factors. Individuals that meet the requirements of these criteria are termed "ACA Qualified" members.
Geographic Area	Statewide
Delivery Systems	Managed care and Fee-for-service (FFS)
Enrollment	Providers submit a list of Medicaid FFS patients to the Oregon Health Authority (OHA), Division of Medical Assistance Programs (DMAP). Patients are entered into MMIS and assigned to a PCPCH provider. Managed care organizations (MCO) work with providers to obtain the same information and submit the information to the OHA for people enrolled in managed care. Providers and MCOs specify whether enrollees are "ACA Qualified" or "non-ACA Qualified". Assigned enrollees are send a notice by the OHA of their assignment, brief information about what a PCPCH is, and the voluntary nature of the program. Members may opt-out or request to change provider assignment.
Building Blocks	Patient-Centered Primary Care Homes (PCPCH): Primary care providers or practices that meet the State's qualifying criteria.
Designated Providers	Designated providers include physicians (family practice, general practice, pediatric provider, gynecologists, obstetricians, internal medicine, certified nurse practitioners and physician assistants), clinical or group practices, FQHCs, RHCs, Tribal clinics, Community Health Centers, Community Mental Health Programs or Drug and Alcohol Treatment Programs with integrated PCPs. Health homes can also be made up of a team of health care professionals. The team is interdisciplinary and includes non-physician health care professionals, e.g. nurse care coordinator, nutritionists, social worker behavioral health professional, Community Health Workers, Personal Health Navigators or Peer Wellness Workers. Providers must submit information to OHA and are screened to determine if they meet the PCPCH standards as described under the Provider Standards section. Care management is included in the PCPCH standards and is provided through the PCPCH. Managed care organizations (MCOs) may assist providers to communicate and coordinate care, but are required to provide reports on the number of PCPCH recognized providers in their network, number of members assigned to PCPCHs and number of members meeting health home eligibility criteria assigned to a PCPCH.
Provider Standards/Qualifications	The Oregon Health Authority has invested significant time working with stakeholders to develop a set of standards that define a Patient-Centered Primary Care Home (PCPCH). The standards include six core attributes (Access to Care, Accountability, Comprehensive Whole Person Care, Continuity, Coordination and Integration and Person and Family Centered Care) each having a number of corresponding standards and measures. These measures have been divided into "Tiers" to reflect the level of complexity of service described by the measure. Practices will provide information, corresponding to each of the measures, to the Oregon Health Authority (OHA) allowing the OHA to recognize practices as Tier 1, 2, or 3 PCPCHs. The PCPCH measures are divided into "Must-Pass Measures" and levels or "Tiers" that reflect basic to more advanced PCPCH/Health Home functions. Must-Pass and Tier 1 measures focus on foundational primary care home elements that should be achievable by most primary care clinics in Oregon with significant effort, but without significant financial outlay. Tier 2 and Tier 3 measures reflect intermediate and advanced

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	functions. Only those practices that apply, and meet the state PCPCH standards will be recognized by the OHA as PCPCHs.
Payment Methodology	PCPCH recognized providers receive per member per month payments for assigned members based upon the "Tier" met by the individual practice or provider group. In order to be eligible for payment, PCPCH providers must also: 1) Document PCPCH/Health home services and related activities (consistent with the core service definitions) in patient medical records at least quarterly; 2) Submit a beneficiary roster of PCPCH ACA Qualified members under their assigned care; a MCO may also do this on behalf of the practice. The roster must be refreshed each quarter and services as an attestation that the provider has met the service delivery and documentation requirements; and 3) Log into a portal/panel management system and review data regarding services rendered to effectively manage and identify gaps in services. The PMPM payment will be made monthly, and is in addition to the FFS payments made for direct services under state plan authority. DMAP will make a payment to MCOs for managed care enrollees assigned to a PCPCH and eligible for health homes and directly to PCPCH providers for members not enrolled in managed care. If the MCO retains any portion of the PCPCH payment and does not pass it to the provider, that portion will be used to carry out PCPCH functions and is subject to approval by DMAP.
Definition of Comprehensive Care Management	The Patient Centered Primary Care Home (PCPCH) will be able to identify patients with high risk environmental or medical factors, including patients with special health care needs, who will benefit from additional care planning. Care management activities may include but are not limited to population panel management, defining and following self-management goals, developing goals for preventive and chronic illness care, developing action plans for exacerbations of chronic illnesses and developing end-of-life care plans when appropriate. PCPCH services will occur under the direction of a licensed health professional, physician, physician assistant, nurse practitioner, nurse, social worker or professional counselor.
Definition of Care Coordination	Care coordination will be an integral part of the HH. Patients will choose and be assigned to that provider/clinic or team to increase continuity with the chosen provider or team, and to ensure individual responsibility for care coordination functions. A person-centered plan will be developed based on the needs and desires of the patient with at least the following elements: options for accessing care, information on care planning and care coordination, names of other primary care team members when applicable and information on ways the patient participates in this care coordination. Care coordination functions can include but are not limited to: tracking of ordered tests and result notification, tracking referrals ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and clinicians, and direct collaboration or co-management of patients with specialty mental health, substance abuse, and providers of services and supports to people with developmental disabilities and people receiving long term care services and supports. Co-location of behavioral health and primary care is strongly encouraged. PCPCH/Health home services will occur under the direction of a licensed health professional, physician, physician assistant, nurse practitioner, nurse, social worker or professional counselor.
Definition of Health Promotion	The PCPCH/HH provider will support continuity of care and health promotion through the development of a treatment relationship with the individual, other primary care team members and community providers. The HH provider will promote the use of evidence based, culturally sensitive wellness and prevention by linking the enrollee with resources for smoking cessation, diabetes, asthma, self-help resources and other services based on individual needs and preferences. Health promotion activities will be utilized to promote patient/family education and self-management of the chronic conditions. Health home services will occur under the direction of a licensed health professional, physician, physician assistant, nurse practitioner, nurse, social worker or professional counselor, community health worker, personal health navigators or peer wellness specialist. Community health workers, personal health navigators and peer wellness specialists must meet criteria established by OHA, pass criminal history background checks. Licensed health professionals approving the patient-centered plan must have the knowledge, skills and

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	abilities to safely and adequately provide the services authorized.
Definition of Comprehensive Transitional Care	The PCPCH/HH will emphasize transitional care by demonstrating either a written agreement and/or procedures in place with its usual hospital providers, local practitioners, health facilities and community based services to ensure notification and coordinated, safe transitions, as well as improving the percentage of patients seen or contacted within 1 week of facility discharges. Health home services will occur under the direction of a licensed health professional, physician, physician assistant, nurse practitioner, nurse, social worker or professional counselor, community health worker, personal health navigators or peer wellness specialist. Community health workers, personal health navigators and peer wellness specialists must meet criteria established by OHA, pass criminal history background checks. Licensed health professionals approving the patient-centered plan must have the knowledge, skills and abilities to safely and adequately provide the services authorized.
Definition of Individual and Family Support Services	The PCPCH/HH will have processes for patient and family education, health promotion and prevention, self management supports, and information and assistance obtaining available non-health care community resources, services and supports. The person centered plan will reflect the client and family/caregiver preferences for education, recovery and self management. Peer supports, support groups and self care programs will be utilized to increase the client and caregivers knowledge about the client's individual disease. Health home services will occur under the direction of a licensed health professional, physician, physician assistant, nurse practitioner, nurse, social worker or professional counselor, community health worker, personal health navigators or peer wellness specialist. Community health workers, personal health navigators and peer wellness specialists must meet criteria established by OHA, pass criminal history background checks. Licensed health professionals approving the patient-centered plan must have the knowledge, skills and abilities to safely and adequately provide the services authorized.
Definition of Referral to Community and Social Support Services	The PCPCH/HH will demonstrate processes and capacity for referral to community and social support services, such as patient and family education, health promotion and prevention, and self management support efforts, including available community resources. Care coordination functions will include the use of the person centered plan to manage such referrals and monitor follow up as necessary. Health home services will occur under the direction of a licensed health professional, physician, physician assistant, nurse practitioner, nurse, social worker or professional counselor, community health worker, personal health navigators or peer wellness specialist. Community health workers, personal health navigators and peer wellness specialists must meet criteria established by OHA, pass criminal history background checks. Licensed health professionals approving the patient-centered plan must have the knowledge, skills and abilities to safely and adequately provide the services authorized.
Quality Measures	Goal based measures: • Readmission rate following pneumonia hospitalization • Transition record at time of ED discharge to ambulatory care/home health care • Ambulatory care utilization • BMI documentation • Prevention education • Follow up post MH hospitalization • Information sharing among providers Service based measures: • Comprehensive care management measures • BMI assessment • Transition record at time of ED discharge to ambulatory care/home health care

STATE: RHODE ISLAND – CEDARR Family Center	
PROGRAM DESIGN FEATURE	**DESCRIPTION**
Target Population	SMI or SED, two chronic conditions (Mental Health, Asthma, Diabetes, DD, Down Syndrome, Mental Retardation or Seizure Disorder) or one chronic condition and at risk of another
Geographic Area	Statewide
Delivery Systems	Managed care and Fee-for-service (FFS)
Enrollment	Eligible individuals can choose from any CEDARR Family Center to receive services
Building Blocks	CEDARR Family Centers certified to meet HH criteria (CEDARR Family Centers provide services to Medicaid-eligible children who are identified as having 1 or more special health care needs).
Designated Providers	The CEDARR Family Center will operate as a designated provider of health home services. CEDARR Family Centers are comprised of teams of licensed health care professionals such as psychologists, licensed clinical social workers, Masters level RNs and licensed marriage and family therapists, as well as staff to provide care coordination, individual and family support and other health home services. The health home team minimally comprises of a licensed clinician and a family service coordinator. The team will consult, coordinate, and collaborate on a regular basis with the child's primary care physician/medical home and with other providers providing treatment services to that child. Medical specialists and other medical professionals will be included on the team depending on the unique needs of the enrolled child.
Provider Standards/Qualifications	The current standards under which CEDARR Family Centers operate are utilized as the provider standards for HHs. Existing certification standards mandate that CEDARR Family Centers: 1) Be legally incorporated with defined governance structure; 2) Function as integrated system; 3) Use principles of family centeredness; 4) Have statewide capacity, geographically accessible; and 5) Work closely with direct service providers and community agencies. (See: http://www.dhs.ri.gov/Portals/0/Uploads/Documents/Public/Children%20w%20Spec%20Needs/CEDARR_cert_stds.pdf). In addition, HHs must agree to: provide quality driven, cost effective, person-centered services; coordinate and provide access to high quality services informed by evidence based practices; coordinate and provide access to preventive and health promotion services; coordinate and provide mental health and substance abuse services; provide the six health home services; coordinate and provide access to chronic disease management services, including self-management support; coordinate and provide access to long term supports and services; develop a person-centered plan for each individual that coordinates and integrates all clinical and non-clinical services; demonstrate a capacity to use HIT to link services, facilitate communication among team members, between the health team and individual and family care givers and provide feedback to practices; establish a continuous quality improvement program and establish a protocol to collect and transmit data to the state; conduct yearly (documented) outreach to PCPs and Medicaid managed care plan (if applicable); conduct yearly (documented) BMI screening for all children six and up; conduct yearly (documented) depression screening using the CESDC scale for all children 12 and up; conduct yearly review of immunizations, screenings and other clinical information contained in the KIDSNET Health Information System.

STATE: RHODE ISLAND – CEDARR Family Center

Payment Methodology	Alternate payment methodology; payment based on average and relative level of effort required by CEDARR Family Center service team to perform services, development of market based hourly rate, considering factors such as: prevailing wages, adjustments to direct wages, fringe benefits, etc. Each of the three different CEDARR services have been assigned a payment based the assumptions of time, level of effort and staff involvement required in order to successfully complete each service per DHS service definition.
Definition of Comprehensive Care Management	Comprehensive Care Management is provided by CEDARR Family Centers by working with the child and family to: assess current circumstances and presenting issues, identify continuing needs, and identify resources and/or services to assist the child and family to address their needs through the provision of an Initial Family Intake and Needs Determination; develop a Family Care (or Treatment) Plan which will include child specific goals, treatment interventions and meaningful functional outcomes; and regular review and revision of the Family Care Plan to determine efficacy of interventions and emerging needs. Integral to this service is ongoing communication and collaboration between the CEDARR Team and the clients Primary Care Physician/Medical Home Managed Care Organization, Behavioral Health and Institutional/Long Term Care Providers. This service will be performed by the Licensed Clinician with support from the Family Service Coordinator.
Definition of Care Coordination	Care Coordination is designed to be delivered in a flexible manner best suited to the family's preferences and to support goals that have been identified by developing linkages and skills in order for families to reach their full potential and increase their independence in obtaining and accessing services. This includes: Follow up with families, Primary Care provider, service providers and others involved in the child's care to ensure the efficient provision of services; Information about specific disorders, treatment and provider options, systems of support, services, assistance and legal rights available to Children with Special Health Care Needs and their families, resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, funding options, school-based services, faith based organizations, etc.; service delivery oversight and coordination to ensure that services are being delivered in the manner that satisfies the requirements of the individual program(s) and meet the needs of the child and family; Assistance in locating and arranging specialty evaluations as needed, in coordination with the child's Primary Care Provider. This also includes follow-up and ongoing consultation with the evaluator as needed. Care Coordination will be performed by the Licensed Clinician or the Family Service Coordinator depending on the exact nature of the activity.
Definition of Health Promotion	Health Promotion assists children and families in implementing the Family Care Plan and in developing the skills and confidence to independently identify, seek out and access resources that will assist in managing and mitigating their conditions and in preventing the development of secondary or other chronic conditions, addressing family and child engagement, promoting optimal physical health and behavioral health and addressing and encouraging activities related to health and wellness. This service will include the provision of health education, information, and resources with an emphasis on resources easily available in the families' community and peer group(s). This service will be performed by the Licensed Clinician.
Definition of Comprehensive Transitional Care	Transitional Care will be provided by the CEDARR Team to both existing clients who have been hospitalized or placed in other non-community settings as well as newly identified clients who are entering the community. The CEDARR Team will collaborate with all parties involved including the facility, primary care physician, Health Plan (if enrolled) and community providers to ensure a smooth discharge into the community and prevent subsequent re-admission(s). Transitional Care is not limited to Institutional Transitions but applies to all transitions that will occur throughout the development of the child and includes transition from Early Intervention into School based services and pediatric services to adult services. This service will be provided by the Licensed Clinician with support from the Family Service Coordinator.

STATE: RHODE ISLAND – CEDARR Family Center	
Definition of Individual and Family Support Services	The CEDARR Team is responsible for providing assistance to the family in accessing and coordinating services. These services include the full range of services that impact on Children with Special Health Care Needs and include, but are not limited to, health, behavioral health, education, substance abuse, juvenile justice and social and family support services. The CEDARR Team will actively integrate the full range of services into a comprehensive program of care. At the family's request, the CEDARR Team can play the principal role as organizer, information source, guide, advocate, and facilitator for the family by helping the family to assess strengths and needs, identify treatment goals and services, and navigate agency and system boundaries. This service will be performed by the Licensed Clinician or the Family Service Coordinator depending on the exact nature of the activity.
Definition of Referral to Community and Social Support Services	Referral to Community and Social Support Services will be provided by members of the CEDARR Team and will include information about formal and informal resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, funding options, school-based services, faith based organizations, etc. Whenever possible**,** families will be informed of opportunities and supports that are closest to home, that are the least restrictive and that promote integration in the home and community. Members of the CEDARR Team will emphasize the use of informal, natural community supports as a primary strategy to assist children and families. This service will be provided by the Licensed Clinician or the Family Service Coordinator depending on the exact nature of the activity.
Quality Measures	• Collaboration during care plan development • Use of electronic medical record • Coordination with MCOs • Satisfaction with services • Accessibility/availability of services • Timely appointments for initial assessment • Timely completion of care plans • Timely review of care plans • Health education • Stress • Community based referrals • Ability to take part in age appropriate social activities • BMI calculation and intervention • Reduction in BMI • Depression screening • Follow up treatment/evaluation if positive for depression • ED visits • Prevention of acute care admissions • Medical follow up within 7 days of ACS admission/ACS ED visit • Active participation by health home staff for admissions > 7 days • Contact by HH staff post discharge for admissions > 7 days • Readmission/ED visits within 30 days of discharge • Psychiatric and non-psychiatric admissions within 30 days of discharge

STATE: RHODE ISLAND – Community Mental Health Organization (CMHO)

PROGRAM DESIGN FEATURE	DESCRIPTION
Target Population	Individuals eligible for the State's community support program with serious and persistent mental health condition
Geographic Area	Statewide
Delivery Systems	Managed care and Fee-for-service (FFS)
Enrollment	Individuals will be auto-assigned to a HH provider. Patients will retain ability to opt-out and choose another HH.
Building Blocks	Rhode Island has seven CMHOs, which along with two other smaller providers of specialty mental health services form a statewide, fully integrated, mental health delivery system, providing a comprehensive range of services to clients. The seven CMHO's and the two smaller specialty providers are all licensed by the state. The two specialty providers will be expected to meet the same requirements as the seven CMHOs. Each CMHO is responsible for establishing an integrated service network within its own catchment area, and for coordinating service provision with other catchment areas.
Designated Providers	The State's seven CMHOs, Fellowship Health Resources, Inc. and Riverwood Mental Health Services, will serve as designated providers of CMHO health home services. The seven CMHOS, Fellowship Health Resources, Inc and Riverwood Mental Health Services, represent the only entities that would meet eligibility requirements as a CMHO health home and all will be required to meet identical CMHO health home certification requirements, described under the Provider Standards section of this State plan amendment. Each CMHO health home is responsible for establishing an integrated service network within its own geographic area and for coordinating service provision with other geographic areas. The team will vary according to unique needs of individuals but will minimally consists of a Master's team coordinator who will serve as the central coordinator of health home services, psychiatrist, registered nurse MA level clinician, CPST Specialist/hospital liaison and CPST Specialist and Peer Specialist. Other team members may include: primary care physicians, pharmacists, substance abuse specialists, vocational and community integration specialists. CMHOs will participate in statewide learning activities to promote practice transformation.
Provider Standards/Qualifications	In addition to meeting state licensure requirements, BHDDH will also require CMHOs to: report on designated Core Quality Measures; have a psychiatrist(s)/advanced practice psychiatric registered nurse specialist assigned to each individual receiving CMHO health home services, available 24/7 for individuals in need of referral, mental health crisis intervention or stabilization, etc.; conduct wellness interventions; participate in any statewide learning sessions; within three months of implementation have developed a contract or MOU with regional hospitals or systems to ensure formal structure for transitional care planning, to include communication of inpatient admissions and maintain mutual awareness and collaboration to identify individuals seeking ED services that might benefit from CMHO health homes; convene ongoing and documented internal health home team meetings; participate in CMS and state-required evaluation activities; develop required reports; maintain compliance with the terms and conditions as a CMHO health home provider; and, present a proposed health home delivery model (including description of the health team and members roles/functions, how the six services will be carried out, processes for integrating physical health and behavioral health, hospitals the CMHO will establish transitional care agreements with, a list of primary care practices the CMHO will develop referral arrangements with and use of EHRs) that the state determines to have a reasonable likelihood of being cost-effective. Community support professionals will undergo a 17-week certification training program.

STATE: RHODE ISLAND – Community Mental Health Organization (CMHO)	
Payment Methodology	Case rate methodology
Definition of Comprehensive Care Management	Comprehensive care management services are conducted with high need individuals, their families and supporters to develop and implement a whole-person oriented treatment plan and monitor the individual's success in engaging in treatment and supports. Comprehensive care management services are carried out through use of a biopsychosociall assessment. A biopsychosocial assessment of each individual's physical and psychological status and social functioning is conducted for each person evaluated for admission to the CMHO. Assessments may be conducted by a psychiatrist, registered nurse or a licensed and/or master's prepared mental health professional. The assessment determines an individual's treatment needs and expectations of the individual served; the type and level of treatment to be provided, the need for specialized medical or psychological evaluations; the need for the participation of the family or other support persons; and identification of the staff person(s) and/or program to provide the treatment. Based on the biopsychosocial assessment, a goal-oriented, person centered care plan is developed, implemented and monitored by a multi-disciplinary team in conjunction with the individual served. Comprehensive care management services may be provided by any member of the CMHO health home team; however, Master's Level HH Team Coordinators will be the primary practitioners providing comprehensive care management services.
Definition of Care Coordination	Care coordination is the implementation of the individualized treatment plan (with active involvement of the individual served) for attainment of the individuals' goals and improvement of chronic conditions. Care managers are responsible for conducting care coordination activities across providers and settings. Care coordination involves case management necessary for individuals to access medical, social, vocational, educational, as well as other individualized supportive services, including, but not limited to: • Assessing support and service needs to ensure the continuing availability of required services; • Assistance in accessing necessary health care; and follow up care and planning for any recommendations; • Assessment of housing status and providing assistance in accessing and maintaining safe and affordable housing; • Conducting outreach to family members and significant others in order to maintain individuals' connection to services; and expand social network • Assisting in locating and effectively utilizing all necessary community services in the medical, social, legal and behavioral health care areas and ensuring that all services are coordinated; and • Coordinating with other providers to monitor individuals' health status, medical conditions, medications and side effects. Care coordination services may be provided by any member of the CMHO health home team; however, CPST Specialists will be the primary practitioners providing care coordination services.
Definition of Health Promotion	Health promotion services encourage and support healthy ideas and concepts to motivate individuals to adopt healthy behaviors. The services also enable individuals to self-manage their health. Health promotion services may be provided by any member of the CMHO health home team. Health promotion activities place strong emphasis on self-direction and skills development for monitoring and management of chronic health conditions. Health promotion assists individuals to take a self-directed approach to health through the provision of health education. Specific health promotion services may include, but are not limited to, providing or coordinating assistance with: promoting individuals' health and ensuring that all personal health goals are included in person centered care plans; promotion of substance abuse prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and increased physical activity; providing health education to individuals and family members about chronic conditions; providing prevention education to individuals and family members about health screening and immunizations; providing self-management support and development of self-management

STATE: RHODE ISLAND – Community Mental Health Organization (CMHO)	
	plans and/or relapse prevention plans so that individuals can attain personal health goals; and promoting self direction and skill development in the area of independent administering of medication. Health promotion services may be provided by any member of the CMHO health home team; however, Psychiatrists and Nurses will be the primary practitioners providing these services.
Definition of Comprehensive Transitional Care	Comprehensive transitional care services focus on the transition of individuals from any medical, psychiatric, long-term care or other out-of-home setting into a community setting. Designated members of the health team work closely with the individual to transition the individual smoothly back into the community and share information with the discharging organization in order to prevent any gaps in treatment that could result in a re-admission. To facilitate timely and effective transitions from inpatient and long-term settings to the community, all health home providers will maintain collaborative relationships with hospital emergency departments, psychiatric units of local hospitals, long-term care and other applicable settings. In addition, all health home providers will utilize hospital liaisons to assist in the discharge planning of individuals, existing CMHO clients and new referrals, from inpatient settings to CMHOs. Care coordination may also occur when transitioning an individual from a jail/prison setting into the community. Hospital liaisons, community support professionals and other designated members of the team may provide transitional care services. The team member collaborates with physicians, nurses, social workers, discharge planners and pharmacists within the hospital setting to ensure that a treatment plan has been developed and works with family members and community providers to ensure that the treatment plan is communicated, adhered to and modified as appropriate. Comprehensive transitional care services may be provided by any member of the CMHO health home team; however, Hospital Liaisons will be the primary practitioners providing these services.
Definition of Individual and Family Support Services	Individual and family support services are provided by community support professionals and other members of the health team to reduce barriers to individuals' care coordination, increase skills and engagement and improve health outcomes. Individual and family support services may include, but are not limited to: providing assistance in accessing needed self-help and peer support services; advocacy for individuals and families; assisting individuals identify and develop social support networks; assistance with medication and treatment management and adherence; identifying resources that will help individuals and their families reduce barriers to their highest level of health and success; and connection to peer advocacy groups, wellness centers, NAMI and Family Psychoeducational programs. Individual and family support services may be provided by any member of the CMHO health home team; however, CPST specialists will be the primary practitioners providing these services.
Definition of Referral to Community and Social Support Services	Referrals to community and social support services provide individuals with referrals to a wide array of support services that will help individuals overcome access or service barriers, increase self-management skills and improve overall health. Referrals to community and social support services involves facilitating access to support and assistance for individuals to address medical, behavioral, educational, and social and community issues that may impact overall health. The types of community and social support services to which individuals will be referred may include, but are not limited to: primary care providers and specialists; wellness programs, including smoking cessation, fitness, weight loss programs, yoga; specialized support groups (i.e. cancer, diabetes support groups); substance treatment links in addition to treatment – supporting recovery with links to support groups, recovery coaches, 12-step; housing (Sober Housing); social integration (NAMI support groups, MHCA OASIS, alive program (this program and MHCA are Advocacy and Social Centers) and/or Recovery Center;; assistance with the identification and attainment of other benefits; SNAP; connection with the Office of programs/jobs; social integration and social skill building; faith based organizations; employment and educational program or training. Referral to community and social support services may be provided by any member of the CMHO health home team; however, CPST specialists will be the primary

	practitioners providing these services.	
Quality Measures	• Documentation of physical and behavioral health needs • Follow up visit post discharge • Regular source of health care • Annual physical • Contact by hospital liaison post discharge • ED visits • ED visits for a mental health condition • Satisfaction with services • Accessibility of care • Percent who smoke • Percent who report illicit drug use • BMI documentation • Pap test • Mammogram • Colonoscopy	• Depression screening and follow up • Initiation of AOD treatment and encouragement of AOD treatment for adults with new episode of alcohol or other drug dependence Smoking cessation/counseling • Drug/alcohol abusers counseled/referred to treatment • Diabetes under control • Appropriately prescribed asthma medication • Hypertension under control • Lipid levels under control • Adherence to asthma/COPD medication • Adherence to CVD/anti-hypertension medication • Use of statin medication for history of CAD • Follow up post MH hospitalization • Transition record transmitted to PCP/facility within 24 hours • Appropriate ambulatory care prevents/reduces admissions • Readmissions

STATE: WISCONSIN

Program Design Feature	Description
Target Population	Diagnosis of HIV and at least one other diagnosed chronic condition, or at risk of developing another chronic condition. Individuals "at-risk" for developing another chronic condition include: Individuals having a CD4 cell count of less than 200 cells/uL or CD4 cells accounting for fewer than 14 percent of all lymphocytes; Individuals with a body mass index <18.5 kg/m2; 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 <40mg/dL for men and <50mg/dL for women, LDL levels >130 mg/dL.
Geographic Limitations	Targeted to four counties: Brown, Kenosha, Milwaukee and Dane.
Delivery Systems	The delivery system is fee-for-service only.
Enrollment	Auto-enrollment with opt-out.
Building Blocks	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.
Designated Providers	AIDS Service Organizations
Provider Standards/Qualifications	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: o 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 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; and 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.
Payment Methodology	Per-Member-Per-Month. Monthly case rate. Reimbursement will be the same regardless of the frequency or intensity of care management activities provided within the month, except the HH providers will be required to provide at least one care management activity during the billable month. 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.
Definition of 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.
Definition of 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 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).
Definition of 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.
Definition of Comprehensive Transitional Care	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.
Definition of Individual and Family Support Services	Individual and family support services include activities related to advocating on the member's behalf and mobilizing services and support for the member. It will include contacts with anyone identified as instrumental to the member's day-to-day support and care. Peer-to-peer

STATE: WISCONSIN	
	information sharing and support are included in these support services.
Definition of 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.
Quality Measures	• Percentage of HH patients with a CD4 count of less than or equal to 350 cells per microliter, who initiates antiretroviral therapy • Percentage of patients who had at least one dental and medical health history (initial or updated), at least once during the measurement year • Adult BMI Assessment • Ambulatory Care-Sensitive Condition Admission • Care Transition – Transition Record Transmitted to Health Care Professional • Follow – Up After Hospitalization for Mental Illness • Plan – All Cause Readmission • Screening for Clinical Depression and Follow-Up Plan • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment