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State/Territory Name: Oklahoma

State Plan Amendment (SPA) #: 14-12 HH

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved SPA Pages (New Pages)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, Texas 75202
DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

February 10, 2015

Dr. Garth Splinter
State Medicaid Director
2401 NW 23rd Street, Suite 1A
Oklahoma City, Oklahoma 73107

Our Reference: SPA-OK-14-0012

Dear Dr. Splinter:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Oklahoma State Plan Amendment (SPA) Transmittal Number 14-0012. This SPA implements Health Homes as authorized under Section 2703 of the Patient Protection and Affordable Care Act. To qualify for enrollment in this health home program an individual must have one or more serious and persistent mental illness (SMI) conditions.

This SPA is approved with an effective date of January 1, 2015. Enclosed is a copy of the CMS 179 form, as well as, the approved pages for incorporation into the Oklahoma State plan.

In accordance with the statutory provisions at Section 1945(c)(1) of the Social Security Act, for payments made to health home providers under this amendment, during the first eight fiscal quarters that the SPA is in effect, January 1, 2015 through December 31, 2016, the federal medical assistance percentage (FMAP) rate applicable to such payments shall be equal to 90 percent. The FMAP rate for payments made to health home providers will return to the state's published FMAP rate on July 1, 2016. The Form CMS-64 has a designated category of service Line 43 for States to report health home services expenditures for enrollees with chronic conditions.

If you have any questions, please contact Tamara Sampson at (214) 767-6431.

Sincerely,

[redacted]

Bill Brooks
Associate Regional Administrator
Division of Medicaid and Children's Health

Enclosures

Health Home State Plan Amendment

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

Transmittal Number: OK-14-0012 Supersedes Transmittal Number: Proposed Effective Date: Jan 1, 2015 Approval Date: Attachment 3.1-H Page Number:

Submission Summary

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

OK-14-0012

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

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

Name of Health Homes Program:

OK HH - adults

State: Oklahoma
Date Received: 10-13-14
Date Approved: 2-10-15
Date Effective: 1-1-15
Transmittal Number OK 14-12 HHA

State Information

State/Territory name: **Oklahoma**

Medicaid agency: Oklahoma Health Care Authority

Authorized Submitter and Key Contacts

The authorized submitter contact for this submission package.

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Title: Health Policy Unit Director

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Email: tywanda.cox@okhca.org

The primary contact for this submission package.

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Transmittal Number: OK 14-12 HHA Date Approved: 2-10-15 Date Effective: 1-1-15

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The secondary contact for this submission package.

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The tertiary contact for this submission package.

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Email:	joseph.fairbanks@okhca.org

Proposed Effective Date

01/01/2015 (mm/dd/yyyy)

State: Oklahoma
Date Received: 10-13-14
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Executive Summary

Summary description including goals and objectives:
The State is collaborating with the Oklahoma Department of Mental Health Substance Abuse Services (ODMHSAS) to provide coordinated care through a health home for individuals with chronic conditions. Health Homes service delivery model will enhance integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons across the lifespan with chronic illness. This particular proposal will provide services for adults with serious mental illness.

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2015	$ 4740528.00
Second Year	2016	$ 7719797.00

Federal Statute/Regulation Citation

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Section 2703 of the Affordable Care Act (Public Law 111-148); Section 1945 of Social Security Act

Date Received: 13-13-14
Date Approved: 2-10-15 /s/

Governor's Office Review Signature of Approving Official
Printed Name & Title: BILL BROOKS, Associate Regional Administrator
Division of Medicaid & Children's Health

- **No comment.**
- **Comments received.**
  Describe:
- **No response within 45 days.**
- **Other.**
  Describe:
  The Governor does not review State Plan material.

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Submission - Public Notice

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

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

Indicate how public notice was solicited:

- ☐ **Newspaper Announcement**
- ☐ **Publication in State's administrative record, in accordance with the administrative procedures requirements.**
  Date of Publication: (mm/dd/yyyy)
- ☐ **Email to Electronic Mailing List or Similar Mechanism.**
  Date of Email or other electronic notification: (mm/dd/yyyy)
  Description:

State: Oklahoma
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☑ **Website Notice**

Select the type of website:

☑ Website of the State Medicaid Agency or Responsible Agency

Date of Posting:

07/09/2014 (mm/dd/yyyy)

Website URL:

www.okhca.org

☐ Website for State Regulations

Date of Posting:

(mm/dd/yyyy)

Website URL:

☐ Other

☐ **Public Hearing or Meeting**

☐ **Other method**

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

☑ **Access**

Summarize Comments

Two comments were received in which the constituents were worried that if Health Homes was implemented in the state, members would not be able to keep their services with their current service provider.

One commenter expressed worry that small agencies would have to close because they would be put out of service by the Health Homes.

Summarize Response

It was explained that members would have the option to keep their current behavioral health provider or switch to a health home.

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

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Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☑ **Service Delivery**

Summarize Comments
A comment was submitted that suggested the term physician-led team be switched to provider-led team.
Summarize Response
Changes to the Health Home rules were made to reflect suggestion.

☑ **Other Issue**

Issue
Issue Name:
Support for Health Homes
Summarize Comments One comment was submitted expressing support for the Health Home initiative. **Summarize Response**

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Submission - Tribal Input

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

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

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

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

Tribal consultation was conducted in the following manner:

☑ **Indian Tribes**

Indian Tribes	
Name of Indian Tribe: Absentee Shawnee Date of consultation: 03/04/2014 (mm/dd/yyyy) Method/Location of consultation: Oklahoma Health Care Authority 4345 N. Lincoln Blvd. Oklahoma City, OK 73105	State: Oklahoma Date Received: 10-13-14 Date Approved: 2-10-15 Date Effective: 1-1-15 Transmittal Number OK 14-12 HHA
Name of Indian Tribe: Cherokee Nation Date of consultation: 03/04/2014 (mm/dd/yyyy) Method/Location of consultation:	

Indian Tribes	
Oklahoma Health Care Authority 4345 N. Lincoln Blvd. Oklahoma City, OK 73105	
Name of Indian Tribe: Chickasaw Nation Date of consultation: 03/04/2014 (mm/dd/yyyy) Method/Location of consultation: Oklahoma Health Care Authority 4345 N. Lincoln Blvd. Oklahoma City, OK 73105	
Name of Indian Tribe: Choctaw Nation Date of consultation: 03/04/2014 (mm/dd/yyyy) Method/Location of consultation: Oklahoma Health Care Authority 4345 N. Lincoln Blvd. Oklahoma City, OK 73105	

☐ **Indian Health Programs**

☑ **Urban Indian Organization**

Urban Indian Organizations	
Name of Urban Indian Organization: Indian Health Service Date of consultation: 03/04/2014 (mm/dd/yyyy) Method/Location of consultation: Oklahoma Health Care Authority 4345 N. Lincoln Blvd. Oklahoma City, OK 73105	

Indicate the key issues raised in Indian consultative activities:

☐ **Access**

Summarize Comments

Summarize Response

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☐ **Quality**

Summarize Comments

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Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☑ **Eligibility**

Summarize Comments

Tribal consultation members asked the OHCA if tribal facilities could participate in the Health Home initiative

Summarize Response

OHCA informed tribal consultation members that tribal facilities could participate in the Health Home initiative.

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

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Submission - SAMHSA Consultation

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

Date of Consultation	
Date of consultation: 10/23/2013 (mm/dd/yyyy)	

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Health Homes Population Criteria and Enrollment

Population Criteria

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

☐ **Two or more chronic conditions**

Specify the conditions included:

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

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Other Chronic Conditions	

- [ ] **One chronic condition and the risk of developing another**

Specify the conditions included:

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

Other Chronic Conditions	

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

- [x] **One or more serious and persistent mental health condition**

Specify the criteria for a serious and persistent mental health condition:
Adults living with serious mental illness (SMI) will qualify. Serious Mental Illness means a condition experienced by persons age 18 and over in which:
• The disability must have persisted for six months and be expected to persist for a year or longer.
• A condition or serious mental illness as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious mental illness.

The adult must exhibit either:
• Psychotic symptoms of a serious mental illness (e.g. Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or
• Experience difficulties that substantially interfere with or limit an adult from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills.

There is functional impairment in at least two of the following capacities (compared with expected developmental level):
• Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.
• Impairment in community function manifested by a consistent lack of appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement the criminal justice system.
• Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers.
• Impairment in family function manifested by a pattern of disruptive (e.g., fire setting, serious and chronic

destructiveness, inability to conform to reasonable limitations and expectations.
• Impairment in functioning at school or work manifested by the inability to pursue educational or career goals.

Geographic Limitations

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

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

If no, specify the geographic limitations:

○ **By county**

Specify which counties:

○ **By region**

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

○ **By city/municipality**

Specify which cities/municipalities:

○ **Other geographic area**

Describe the area(s):

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Enrollment of Participants

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

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○ **Opt-In to Health Homes provider**

Describe the process used:

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

Describe the process used:

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

◉ **Other**

Describe:
(1)If claims data shows that HH eligible member has an established relationship with an approved HH provider, the member will be attributed to that HH; members will be notified about their attribution. All notices will include a description of HH services, information of the member's options to choose another HH, and a process to opt-out of enrollment in a HH. (2) If claims data shows that the HH eligible member does not have an established relationship with a designated HH provider, the member will receive written notification on the benefits of participating in a HH and a list of HHs in their area. (3) The State has several care coordination/CM services under Medicaid. To avoid duplication, if HH eligible members are receiving Targeted Case Management (TCM) or SoonerCare Health Management Program (SHMP) services, the member will receive written notification of their eligibility to either continue receiving SHMP or appropriate TCM services or to receive care through a HH. The notification will explain the benefits of participating in a HH and a list of HHs in their area. (4) Potential members with insufficient claims history may be referred to the program by contacting ODMHSAS or OHCA.

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

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

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

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

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

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Health Homes Providers

Types of Health Homes Providers

☑ **Designated Providers**

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

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards:

☐ **Rural Health Clinics**

Describe the Provider Qualifications and Standards:

☐ **Community Health Centers**

Describe the Provider Qualifications and Standards:

☑ **Community Mental Health Centers**

Describe the Provider Qualifications and Standards:

Oklahoma will require each HH provider that is a Community Mental Health Center to be licensed by the State as a Certified Community Mental Health Center (CMHC) in accordance with Oklahoma Administrative Code (OAC 450: 1; OAC 450:15; OAC 450:17. Each CMHC provider must also be contractually designated by the ODMHSAS as responsible for the provision of core publically funded

mental health services, including emergency services, in one or more of the state's 21 geographic catchment areas.

☐ **Home Health Agencies**

Describe the Provider Qualifications and Standards:

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

☐ **Case Management Agencies**

Describe the Provider Qualifications and Standards:

☑ **Community/Behavioral Health Agencies**

Describe the Provider Qualifications and Standards:

Outpatient Behavioral Health Providers that meet qualifications may be certified by the Department of Mental Health and Substance Abuse Services as Health Home providers.

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

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Teams of Health Care Professionals**

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

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Nurse Care Coordinators**

Describe the Provider Qualifications and Standards:

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☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Professionals**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Health Teams**

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

☐ **Medical Specialists**

Describe the Provider Qualifications and Standards:

☐ **Nurses**

Describe the Provider Qualifications and Standards:

☐ **Pharmacists**

Describe the Provider Qualifications and Standards:

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☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

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☐ **Dieticians**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Specialists**

Describe the Provider Qualifications and Standards:

☐ **Doctors of Chiropractic**

Describe the Provider Qualifications and Standards:

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Describe the Provider Qualifications and Standards:

☐ **Physicians' Assistants**

Describe the Provider Qualifications and Standards:

Supports for Health Homes Providers

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

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

Description:
Working together in partnership to develop the Health Homes proposal, DMHSAS and OHCA have hosted a number of Learning Collaboratives to ensure that the provider community is well informed about the holistic care philosophy that is the foundation of the Health Homes opportunity. These collaboratives will continue into the foreseeable future as a means of continuing to educate providers through the early steps of beginning to offer Health Home services and initial and ongoing data collection efforts. A resource web page has been established at http://www.ok.gov/odmhsas/Mental_Health_/Oklahoma_Health_Homes_Learning_Collaborative/index.html

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.
The Health Home Team for adults with SMI (Medium to Low) will be comprised of a team including, a Health Home director, nurse care manager, consulting PCP, psychiatric consultant, certified behavioral health case manager, wellness coach and administrative support (medical assistant).

The Health Home Team for adults with SMI (High) will be comprised of a team including, a team lead LBHP, nurse care manager, consulting PCP, psychiatric consultant, certified behavioral health case manager, other licensed behavioral health professional, substance abuse treatment specialist, employment specialist, wellness coach and administrative support (medical assistant).

Provider Standards

The State's minimum requirements and expectations for Health Homes providers are as follows:
The Health Home must make assurances that it will comply with all Health Home contractual and regulatory requirements.

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Health Homes Service Delivery Systems

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

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☑ **Fee for Service**
☐ **PCCM**

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

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

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

☐ **Fee for Service**

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

☐ **Other**

Description:

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

If yes, describe how requirements will be different:

☐ **Risk Based Managed Care**

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

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

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

Provide a summary of the contract language for the additional requirements:

☐ **Other**

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Describe:

○ **The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.**

Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Homes services.

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

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

○ **Yes**

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

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

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

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

No

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

Fee for Service

Alternative Model of Payment (describe in Payment Methodology section)

Other

Description:

Other Service Delivery System:

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

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

Health Homes Payment Methodologies

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

Fee for Service

Fee for Service Rates based on:

Severity of each individual's chronic conditions

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

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

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

☐ **Other: Describe below.**

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

☑ **Per Member, Per Month Rates**

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

Health home providers will receive a PMPM payment for adults based on a reimbursable unit of service based on member tier assignment that defines the level of care coordination services provided upon documented evidence of the provider meeting the minimum required HH activity (ies):

Tier one: Outreach and engagement. This code can be billed once per month for up to three months
Tier two: Medium to low intensity
Tier three: High Intensity; PACT

The rates for tiers two and three are also geographically adjusted based on urban and rural location. Locations are based on Metropolitan Statistical Areas.

These HH rates were derived from an analysis of caseloads and staffing configurations, productivity,

staffing costs and fee- for- service utilization. Staffing costs include salaries and wages, fringe benefits and operating and support costs. Salaries and wages were based on either actual provider surveys or data from the Bureau of Labor Statistics.

The State provides assurance that all costs used to establish the health home rates are limited to the costs for providing the health home services of comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow up, patient and family support, and referral to community and social support services.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of health homes. The agency's fee schedule rate was set as of August 13, 2014, and is effective for services provided on or after January 1, 2015. All rates are published on the agency's website at www.okhca.org.

☐ **Incentive payment reimbursement**

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

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

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

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

☐ **Tiered Rates based on:**

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

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

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

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☐ **Rate only reimbursement**

Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any

limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.
The State will ensure non-duplication of payment for similar services using the edits and audits of the CMS-approved Medicaid Management Information System. Codes will be converted in the system and will not be reimbursed individually for Health Home members. These include: T1016 and T1017, targeted case management; H0032 treatment plan review; H0034, medication training; H0025, behavioral health prevention education; H0039,PACT med management & support coordination linkage; S5185, medication reminder; T1502, medication administration; and T0123, outreach and engagement.

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

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

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Attachment 3.1-H Page Number:

Submission - Categories of Individuals and Populations Provided Health Homes Services

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

☑ **Categorically Needy eligibility groups**

Health Homes Services (1 of 2)

Category of Individuals
CN individuals

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Service Definitions

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

Comprehensive Care Management

Definition:
Comprehensive care management services involve the development of the comprehensive care plan for the member and involves the active participation of the adult and youth consumer, families and caregivers. Care management involves:
• identification of individuals for care planning and use of member information to determine level of participation in care management services;

• assessment of preliminary service needs utilizing a standardized tool;
• comprehensive, person-centered care plan development, including member physical and behavioral health goals, preferences and optimal clinical and functional outcomes;
• development of treatment guidelines that establish clinical pathways for HH 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 best practice guidelines; and
• development and dissemination of reports that indicate progress toward meeting outcomes for member satisfaction, health status, service delivery and costs.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
To facilitate the use of health information technology by Health Homes to improve service delivery and coordination across the care continuum, Oklahoma has developed initial and final HIT standards. Providers must meet the initial HIT standard to implement a HH, as feasible. The feasibility of exchanging electronic health information depends largely on the capacity of the external care providers, such as hospitals and physicians, to exchange information in an electronic, structured format. Currently, there is not an infrastructure within the State for electronic interchange, except for certified health information organizations (HIOs). Work is underway to create a network or networks but will not be completed for at least 12 months. All CMHCs utilize an electronic medical record (EMR) and are in the process of upgrading to an Office of the National Coordinator (ONC) certified electronic health record (EHR). Providers will be required to work with one of these HIOs. Through funding from a SAMHSA -HRSA award, CMHCs are being given vouchers to fund the development of an interface with an HIO and 12-month connection fees for clinicians. Similar voucher programs are being provided to rural hospitals and primary care professionals; however, until statewide adoption has occurred, many external physicians working with the HH will not be able to electronically accept or receive health information. Using secure messaging, HH can exchange health information with external care providers who are not capable of exchanging information through an HIO.

Applicant Health Homes must provide a plan in order to achieve the final HIT standards within 18 months of program initiation in order to be approved as a HH provider.

Scope of benefit/service

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

☑ **Behavioral Health Professionals or Specialists**

Description
• Coordinates and monitors the activities of the individual treatment team;
• Has primary responsibility to write the treatment plan;
• Participates in comprehensive care planning;
• Completes behavioral health assessment;
• Provides individual supportive therapy, illness management education,
• Ensures immediate revisions to the treatment plan as the consumer's needs change; and advocates for the consumer's rights and preferences
• Engage and work with community partners;
• Plan wellness and prevention events and activities;
• Supervise health home staff.

☑ **Nurse Care Coordinators**

Description
• Processes referrals;
• Gathers all pertinent health and mental health information;
• Conducts initial appointments - does initial health screenings;
• Completes healthcare goals and contributes to comprehensive care plan in partnership with team;
• Develops member registries;

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• Supervises Wellness Coach(es); conducts face to face interviews with clients to discuss wellness goals;
• Coordinate care with external providers (e.g. FQHCs, pharmacies, PCP);
• Inputs all pertinent health information into electronic health record.

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☑ **Physicians**

Description
The PCP consultant is a physician, PA or APRN that is embedded, or may be a partnership with multiple PCMHs, an FQHC or I/T/U facility.

• Participates in treatment planning;
• Consults with team psychiatrist;
• Consults regarding specific consumer health issues
• Assists with external medical providers;
• Serves as core team lead for health care ;
• Serves as primary liaison to health part of core team;
• Coordinates between all members of team as necessary;
• Coordinates input from all team members into the comprehensive treatment plan.

Psychiatric Consultant
• Consults with team PCP;
• Consults regarding specific behavioral health issues;
• Consults with team members as necessary;
• Contributes input into the comprehensive care plan.

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

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☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

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Care Coordination

Definition:
Care Coordination is the implementation of the comprehensive care plan with active member involvement through appropriate linkages, referrals, coordination, and follow-up to needed services and supports.

Care coordination is designed to be delivered in a flexible manner best suited to the individual and family's preferences and to support goals that have been identified by developing linkages and skills in order to allow children and families to reach their full potential and increase their independence in obtaining and accessing services.

Care coordination duties include, but are not limited to:
▪ coordinating with all team members to ensure all objectives of the comprehensive, person-centered service plan are progressing;
▪ scheduling and communicating appointment times, including arranging transportation and support if necessary;
▪ conducting referrals, facilitating linkages, and following up;
▪ monitoring; and
▪ participating in hospital discharge processes and communicating with other providers and members/family enrollees.

• Care coordination is designed to be delivered in a flexible manner best suited to the individual and family's preferences and to support goals that have been identified by developing linkages and skills in order to allow children and families to reach their full potential and increase their independence in obtaining and accessing services. Both behavioral health and physical health goals, and overall wellness goals are included in the comprehensive care plan and tracked to successful completion.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
HH providers will work with HIOs or through secure messaging to access patient data and to develop partnerships that maximize the use of HIT across providers. The Health Home provider will utilize HIT to communicate with health facilities and other systems and to facilitate interdisciplinary collaboration among all providers, the member, family, care givers and local supports when external partners have the capability to send and receive electronic, structured records. As part of the meaningful use compliance, HHs will work with their EHR vendors to provide patient portals. These portals will allow for ease in communicating with the members, encourage preventative care and empower members to play an active role in their recovery.

Scope of benefit/service

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

☑ **Behavioral Health Professionals or Specialists**

Description
The certified Behavioral Health (BH) Case Manager can be redeployed to the primary coordination role to ensure integration and compatibility of behavioral and physical health activities. The primary responsibility of the certified BH Case Manager is to ensure implementation of the comprehensive care plan, which will include mental health goals, physical health goals, and other life domain goals for achievement of clinical outcomes

consistent with the needs and preferences of the member. As part of the HH team, a BH Case Manager or a Nurse Care Manager, or may provide ongoing service coordination and link members to resources following appropriate training.

• Serves as primary liaison to health part of core team;
• Coordinates between all members of team as necessary;
• Coordinates input from all team members into the comprehensive treatment plan;
• Coordinates behavioral health referrals, follows up to ensure linkages
• Ensures that each member is aligned with a PCP.

☑ **Nurse Care Coordinators**

Description
The Nurse Care Manager is the main coordinator for primary healthcare, specialty healthcare, and transitional care from emergency departments and hospitals. As part of the HH team, a Nurse Care Manager, or BH Case Manager may provide ongoing service coordination and link members to resources following appropriate training.
• Processes referrals;
• Gathers all pertinent health and mental health information;
• Conducts initial appointment - Does initial health screenings;
• Completes healthcare goals and inserts into comprehensive treatment plan in partnership with behavioral health case manager
• Supervises Wellness coach(es); conducts face to face interviews with clients to discuss wellness goals;
• Coordinate care with external providers (e.g. FQHCs, pharmacies, PCP)
• Inputs all pertinent health information into electronic health record.

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

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☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

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☑ **Other (specify):**

Name

Coordinators

Description

Health Home Director
• Engages and works with community partners;
• Plans community wellness and prevention events and activities;
• Supervises health home;
• Tracks enrollment, declines, discharges and transfers;
• Coordinates management of HIT tools;
• Develops MOUs with hospitals and coordinates hospital admissions and discharges with nurse care manager.

Hospital Liaison/HH Specialist
• Serves as primary contact with hospitals;
• Helps to ensure smooth transitions to and from hospital

Administrative Support (Medical Assistant)
• Serves as first point of contact;
• Assists with electronic health record entry;
• Assists with scheduling appointments;
• Supports core team;
• Assists with wellness and community connections.

Health Promotion

Definition:
• Health promotion services assist members to participate in the implementation of their comprehensive care plan. providing health education specific to a member's chronic conditions;
• developing self-management plans with the individual;
• 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 increasing physical activity; and
• assisting members to participate in the implementation of the comprehensive care plan and placing a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
HH providers will work with HIOs or through secure messaging to access patient data and to develop partnerships that maximize the use of HIT across providers. The Health Home provider will utilize HIT to communicate with health facilities and other systems and to facilitate interdisciplinary collaboration among all providers, the member, family, care givers and local supports when external partners have the capability to send and receive electronic, structured records. As part of the meaningful use compliance, HHs will work with their EHR vendors to provide patient portals. These portals will allow for ease in communicating with the members, encourage preventative care and empower members to play an active role in their recovery.

Scope of benefit/service

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

☐ **Behavioral Health Professionals or Specialists**

Description

☑ **Nurse Care Coordinators**

Description
• Supervises Wellness coach(es); conducts face to face interviews with clients to discuss wellness goals;
• Coordinate care with external providers (e.g. FQHCs, pharmacies, PCP)
• Inputs all pertinent health information into electronic health record.

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☑ **Physicians**

Description
• Provides input into care planning;
• Consults with team psychiatrist;
• Consults regarding specific consumer health issues;
• Assists with external medical providers;
• Consults with members of team as necessary;
• Contributes input into the comprehensive care plan.

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☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

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☑ **Other (specify):**

Name

Welness Coach/Health Home Specialist

Transmittal Number: OK 14-12 HHA Date Approved: 2-10-15 Date Effective: 1-1-15

Description
- Engages person in wellness process;
- Reminds person receiving services of appointments;
- Contributes input into comprehensive care plan;
- Provides various wellness programs;
- Conducts a variety of wellness activities and groups;
- Coaches on wellness goals in comprehensive care plan;
- Interacts with team members.

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Health Homes Services (2 of 2)

Category of Individuals
CN individuals

Service Definitions

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

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

Definition:
Comprehensive transitional care is designed to streamline transition between the hospital or PRTF discharge plan and the comprehensive care plan, reduce hospital and PRTF admissions and interrupt patterns of frequent hospital emergency department use.
- Transitional Care is not limited to institutional transitions but applies to all transitions that will occur throughout the life cycle of the member and includes transition, for example, from and to school-based health services and pediatric services to adult services.
- Comprehensive transitional care services focus on the movement of individuals from any medical/psychiatric inpatient or other out-of-home setting into a community setting, and between different service delivery models.
- The HH will develop contracts or MOAs with regional hospital(s), or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of HH participants. The HH and its partners will maintain a mutual awareness and collaboration to identify individuals seeking emergency department services that might benefit from connection with a HH.

At a minimum, the HH will:
- utilize hospitalization episodes to locate and engage members in need of HH services;
- perform the required continuity of care coordination between inpatient and outpatient care, including establishment or reestablishment of community resources and necessary follow-up visits; and
- coordinate with the hospital or PRTF upon discharge as soon as possible and avoid readmission.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Details of the member health record are in the late planning stages and will be updated, as additional information is available. The goal will be to develop a module to facilitate self-management and monitoring necessary for an enrollee to attain the highest levels of health and functioning.

Scope of benefit/service

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

☑ **Behavioral Health Professionals or Specialists**

Description
Certified Behavioral Health Case Manager II:
• Serves as primary liaison for all team members;
• Coordinates between all members of team as necessary;
• Coordinates input from all team members into the comprehensive care plan;
• Coordinates behavioral health referrals, follows up to ensure linkages;
• Ensures transportation to appointments;
• Provides interventions to assist consumers to identify substance use, effects and patterns;
• Helps consumer develop motivation for decreasing substance use;
• Helps consumer develop alternatives to minimize substance use and achieve periods of abstinence and stability;
• Provides work-related services as needed to help consumers find and maintain employment in community-based job sites.

☑ **Nurse Care Coordinators**

Description
• Arranges and coordinates the consumer's medical care with community medical providers;
• May carry out some physical assessments and treatment;
• Processes referrals;
• Sets initial appointments;
• Gathers all pertinent health and mental health information ;
• Conducts initial appointment - does initial health screenings;
• Completes healthcare goals for the comprehensive care plan;
• Develops member registries;
• Supervises Wellness Coach(es);
• Inputs all pertinent health information into electronic health record.

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

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☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

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☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Individual and family support, which includes authorized representatives

Definition:
Individual and family support services assist individuals in accessing services that will reduce barriers and improve health outcomes, with a primary focus on increasing health literacy, the ability of the member to self-manage their care and facilitate participation in the ongoing revision of their comprehensive care plan. These services include, but are not limited to:
• teaching individuals and families self-advocacy skills;
• attending appointments with individuals and families when necessary to offer support and coaching;
• providing wellness and family support groups;
• responding to requests for peer support in a variety of settings;
• modeling and teaching how to access various community resources;
• assisting with obtaining and adhering to medications and other prescribed treatments; and
• 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.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
HH providers will work with HIOs or through secure messaging to access member data and to develop partnerships that maximize the use of HIT across providers. The HH provider will utilize HIT as feasible to provide the member access to care plans and options for accessing clinical information.

Scope of benefit/service

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

☑ **Behavioral Health Professionals or Specialists**

Description
Certified Behavioral Health Case Manager II:
• Serves as primary liaison for all team members;
• Coordinates between all members of team as necessary;
• Coordinates input from all team members into the comprehensive care plan;
• Coordinates behavioral health referrals, follows up to ensure linkages;
• Ensures transportation to appointments;
• Provides interventions to assist consumers to identify substance use, effects and patterns;
• Helps consumer develop motivation for decreasing substance use;
• Helps consumer develop alternatives to minimize substance use and achieve periods of abstinence and stability;
• Provides work-related services as needed to help consumers find and maintain employment in community-based job sites.

☑ **Nurse Care Coordinators**

Description
• Arranges and coordinates the consumer's medical care with community medical providers;
• May carry out some physical assessments and treatment;
• Processes referrals;
• Sets initial appointments;
• Gathers all pertinent health and mental health information ;
• Conducts initial appointment - does initial health screenings;
• Completes healthcare goals for the comprehensive care plan;
• Develops member registries;
• Supervises Wellness Coach(es);
• Inputs all pertinent health information into electronic health record.

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

State: Oklahoma
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☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

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☑ **Other (specify):**

Name

Wellness Coaches

Description

• Engages person in recovery process;
• Reminds person receiving services of appointments;
• Sometimes attends appointments with person receiving services;
• Coaches on wellness goals in comprehensive treatment plan;
• Interacts with BH specialist, case manager, and PCP as needed.

Referral to community and social support services, if relevant

Definition:
Involves providing assistance for:
• obtaining and maintaining eligibility for healthcare benefits;
• obtaining and maintaining eligibility for disability benefits;
• obtaining and maintaining affordable housing in a community of their choice;
• arranging reliable transportation;
• locating and enrolling in needed educational or vocational programs;
• finding and keeping a job;
• locating needed services, such as legal; and
• building an informal support system in the neighborhood of their choice.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.
HH providers will work with HIOs or through secure messaging to electronically communicate referrals to community and social support services and to follow-up on referrals and access to needed services as determined by the partnering agency's ability to communicate electronically.

Scope of benefit/service

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

☑ **Behavioral Health Professionals or Specialists**

Description
Certified Behavioral Health Case Manager II:
• Serves as primary liaison for all team members;
• Coordinates between all members of team as necessary;
• Coordinates input from all team members into the comprehensive care plan;
• Coordinates behavioral health referrals, follows up to ensure linkages;
• Ensures transportation to appointments;
• Provides interventions to assist consumers to identify substance use, effects and patterns;
• Helps consumer develop motivation for decreasing substance use;
• Helps consumer develop alternatives to minimize substance use and achieve periods of abstinence and stability;
• Provides work-related services as needed to help consumers find and maintain employment in community-based job sites.

☑ **Nurse Care Coordinators**

Description

• Arranges and coordinates the consumer's medical care with community medical providers;
• May carry out some physical assessments and treatment;
• Processes referrals;
• Sets initial appointments;
• Gathers all pertinent health and mental health information ;
• Conducts initial appointment - does initial health screenings;
• Completes healthcare goals for the comprehensive care plan;
• Develops member registries;
• Supervises Wellness Coach(es);
• Inputs all pertinent health information into electronic health record.

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

State: Oklahoma
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State: Oklahoma
Date Received: 10-13-14
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Transmittal Number OK 14-12 HHA

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

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Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:
See attached flow charts and narratives.

☐ **Medically Needy eligibility groups**

- ○ **All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.**
- ○ **Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.**
  - ○ **All Medically Needy receive the same services.**
  - ○ **There is more than one benefit structure for Medically Needy eligibility groups.**

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:
Using claims data, the State will track avoidable hospital readmissions by calculating Ambulatory Care Sensitive Conditions readmissions/1000: (# of readmissions with a primary diagnosis consisting of an AHRQ ICD-10 code for ambulatory care sensitive conditions/member months) x 12,000.

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.
Oklahoma will initially perform an estimate of cost savings using the Center for Health Care Strategies (CHCS) ROI Forecasting Calculator for Health Homes and Medical Homes. The State will use a 3-year average (2009-2011) of costs from the State's MMIS for the target population, which are SoonerCare members who had a status of SMI.

The baseline cost and utilization data will be trended and compared to an estimate of the savings that result from improved care coordination and management achieved through this program for HH enrollees, based on the assumptions described within the Forecasting model. These assumptions include reductions in avoidable hospitalizations, PRTF and emergency department utilization. The baseline data excludes both Medicare and SoonerCare cost of dual eligibles.

Describe how the State will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

Providers must meet the initial HIT standards to implement a Health Home. In addition, provider applicant must provide a plan to achieve the final standards within 18 months of program initiation in order to maintain HH status.

Initial Standards:

1. Have structured information systems, policies, procedures & practices to create, document, execute, and update a plan of care for every member;
2. Have a systematic process to follow up on tests, treatments, services and referrals;
3. Have a health record system which allows the member's health information and comprehensive, person-centered service plan to be accessible to the interdisciplinary team of providers and allow for population management and identification of gaps in care, including preventive services; and
4. Is required to make use of available HIT and access members' data through the health information exchange or Direct to conduct all processes, as feasible.

Final Standards: The final standards require HH providers to use HIT for the following:

1. Have structured interoperable health information technology systems, policies, procedures and practices
2. Utilize an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act. If the provider does not currently have such a system, they will have to provide a plan for when and how they will implement it.
3. Join a certified health information exchange for data exchange and make a commitment to share information with all providers.
4. Support the use of evidence based clinical decision making tools, consensus guidelines, and best practices.

Oklahoma HH providers will be encouraged to use wireless technology as available to improve coordination and management of care and member adherence to recommendations made by their provider. This may include the use of telemedicine, cell phones, peripheral monitoring devices, and access member care management records, as feasible.

Quality Measurement

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

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

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

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Evaluations

☑ **The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.**

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

Hospital Admissions

Measure:	

Use of HEDIS 2011 codes for inpatient general hospital/acute care, inpatient alcohol and other
Measure Specification, including a description of the numerator and denominator.
admissions per 1000 members 21 years and older for any diagnosis.
Data Sources:
Claims
Frequency of Data Collection:

- (○) **Monthly**
- (○) **Quarterly**
- (◉) **Annualy**
- (○) **Continuously**
- (○) **Other**

Emergency Room Visits

Measure:
Use of HEDIS 2011 codes for ED visits (part of ambulatory care (AMB) measure)
Measure Specification, including a description of the numerator and denominator.
ER visits per 1000 members 21 years and older for any diagnosis.
Data Sources:
Claims
Frequency of Data Collection:

- (○) **Monthly**
- (○) **Quarterly**
- (◉) **Annualy**
- (○) **Continuously**
- (○) **Other**

Skilled Nursing Facility Admissions

Measure:
Use of HEDIS 2011 codes for discharges for skilled nursing facility services (part of inpatient
Measure Specification, including a description of the numerator and denominator.
SNF admissions per 1000 members 21 years and older.
Data Sources:
Claims
Frequency of Data Collection:

- (○) **Monthly**
- (○) **Quarterly**
- (◉) **Annualy**
- (○) **Continuously**
- (○) **Other**

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

Hospital Admission Rates
The OHCA will consolidate data from its fee-for-service MMIS-based claims system for the participating HH sites to assess hospital admission rates, by service (medical, surgical, maternity, mental health and chemical dependency), for the participating Health Home sites and for a control group of non-participating sites.
The analysis will consider:
a. The experience of members with the clinical conditions of focus during the learning collaborative year (expected to

grow from year 1 to year 2), and
b. All members with SMI drawn from a list of chronic conditions defined by the State.

Chronic Disease Management
The OHCA will monitor chronic disease management through the measures listed within the State Plan Amendment. These include:
• Adult and adolescent BMI assessment;
• Appropriate use of lipid lowering therapy for coronary artery disease;
• Appropriate use of antihypertension multi-drug therapy where the regimen includes a thiazide diuretic.

Further, the State will document that there is a Licensed Nurse Care Manager in place; and that the Licensed Nurse Care Manager is operating consistently with the requirements set forth for the practices by the State.

Coordination of Care for Individuals with Chronic Conditions
The State will assess and measure provision of care coordination services for individuals with the chronic conditions specified within this State Plan Amendment as follows:
• Transition of records transmitted to the HH from inpatient facilities;
• Follow-up after inpatient hospitalization for mental illness;
• Initiation and engagement of alcohol and other drug dependence treatment.

Assessment of Program Implementation
A HH Workgroup comprised of the OHCA and ODMHSAS personnel and HH provider representatives will meet regularly to track implementation against a) a work plan and b) against performance indicators to assess implementation status. The workgroup will review provider documentation monthly, and then transition to monthly face–to-face meetings six months into implementation.

Processes and Lessons Learned
The workgroup will periodically compile information about how the Health Home operations are going and any Lessons Learned that can be identified.

Assessment of Quality Improvements and Clinical Outcomes
The State will use the quality process and outcome measures described in the prior section to assess quality improvements and clinical outcomes. For claims-based and other measures, assessment will occur both at the individual practice level, and at the aggregate level for all participating HHs. The State will track changes over time to assess whether statistically significant improvement has been achieved. For measures for which national Medicaid benchmark data are available, comparisons will be made to regional and national benchmarks, even though such benchmarks are not specific to persons with chronic conditions.

The aforementioned work group will approach the HH transformation process for the participating practices as an ongoing quality improvement exercise. Using a combination of evaluation data, information from the learning collaborative, feedback from any practice coaches, and feedback provided to the HH Workgroup by practice representatives, the State will assess what elements of its practice transformation strategy are working – and which are not. Critical attention will be paid to a) critical success factors, some of which have already been identified in the literature, and b) barriers to practice transformation.

Estimates of Cost Savings

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

If no, describe how cost-savings will be estimated.
Oklahoma will initially perform an estimate of cost savings using the Center for Health Care Strategies (CHCS) ROI Forecasting Calculator for Health Homes and Medical Homes. Using the ROI Forecasting Calculator, Oklahoma identified the baseline costs and utilization (most recent three-year average) for the target population (see tables below) and trended these costs forward using historical growth rates, thereby estimating future healthcare costs in the absence of intervention(The baseline cost analysis excludes the costs of dual eligibles; however it also includes the costs of other non-Medicaid eligibles).
Table 1: Target Population - SMI
Total Membership in Population Base 23,000
Outreach Goal 60%
Ramp-up Period 18 months
Total Enrollees 13,800

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The State assumed that 60% of the SMI population would be successfully enrolled in HHs. Changes to the trended utilization patterns that are expected to result from the HH intervention were indicated. The ROI Calculator compares the trended utilization costs under the status quo to the expected utilization costs following the HH intervention, to estimate the associated savings or cost increases.
The State will annually perform an assessment of cost savings using a pre/post-period comparison with a control group of SoonerCare CMHCs or other behavioral health organizations serving clinically similar populations but not participating as HHs. Control group clinics will be similar to participating HHs to the extent that it is feasible to do so. They will be identified by clinic type (e.g., private behavioral health organization), geographic region, and number of SoonerCare members with SMI. Savings calculations will net out the value of supplemental payments made to the participating sites during the eight-quarter period.
Dual eligibles will be included in the intervention groups; however, the analysis will not include the Medicare costs.

PRA Disclosure Statement

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