DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region 10
2201 Sixth Avenue, MS/RX 43
Seattle, Washington 98121

MAR 1 3 2012

Bruce Goldberg, MD, Director
Oregon Health Authority
500 Summer Street Northeast, E-15
Salem, Oregon 97301-1097

Re: Oregon State Plan Amendment (SPA) Transmittal Number 11-011

Dear Dr. Goldberg:

We are pleased to enclose a copy of the approved Oregon State Plan Amendment (SPA) Transmittal Number 11-011, to add a health home benefit under Section 1945 of the Social Security Act, which the State refers to as their Patient-Centered Primary Care Homes (PCPCH) for individuals with chronic conditions. The chronic conditions covered include: mental health condition; substance use disorder; asthma; diabetes; heart disease; body mass index (BMI) over 25; or other chronic conditions (Hepatitis C, HIV/AIDS, Chronic Kidney Disease or Cancer). The SPA designates the following as health home providers: physicians (including pediatricians, gynecologists, obstetricians, Certified Nurse Practitioners and Physician Assistants); clinical practices or clinical group practices; Federally Qualified Health Centers; Rural Health Clinics; Tribal clinics; community health centers; community mental health programs; and drug and alcohol treatment programs with integrated primary care providers. Health home providers may serve Medicaid enrollees through a fee-for-service or managed care delivery system. The effective date of OR 11-011 is October 1, 2011.

The federal medical assistance percentage applicable shall be equal to 90 percent for payments made to PCPCH providers under OR 11-011 during the first eight fiscal quarters that the SPA is in effect. This federal financial participation is in accordance with Section 1945(c)(1) of the Social Security Act.

In addition, this approval is based on the State's agreement to implement and comply with CMS' health home core set of quality measures.

If you have any questions or comments regarding this action, please contact me, or have your staff contact Wendy Hill Petras at either (206) 615-3814 or wendy.hillpetras@cms.hhs.gov.

Sincerely,

Carol J.C. Peverly
Associate Regional Administrator
Division of Medicaid and Children's Health
Operations

Enclosure

cc: Judy Mohr Peterson, Administrator, Division of Medical Assistance Programs

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **11-11**

2. STATE: Oregon

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Medical Assistance

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: October 1, 2011

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1945 of the Act

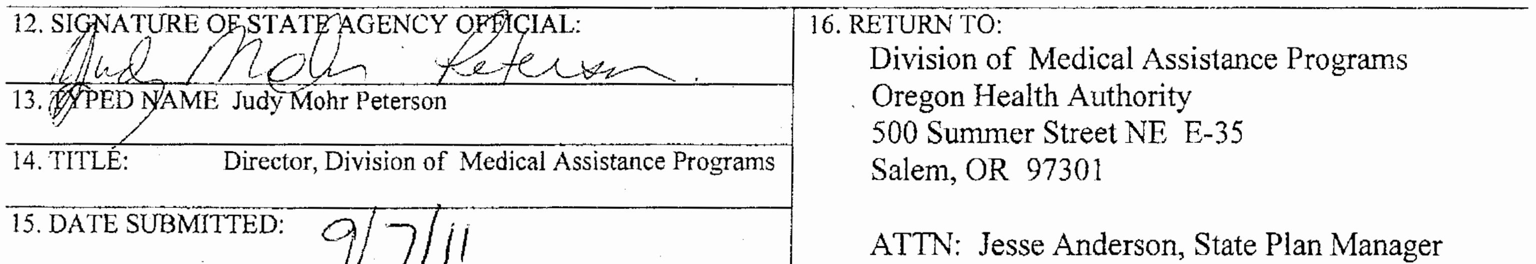
7. FEDERAL BUDGET IMPACT:
a. 2012 $ (672,753)
b. 2013 $ (583,663)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-H, Page x-x and Attachment 4.19-B, page x-x

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT: This transmittal is being submitted to add Health Homes for chronic conditions.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:



12. SIGNATURE OF STATE AGENCY OFFICIAL: Judy Mohr Peterson

13. TYPED NAME: Judy Mohr Peterson

14. TITLE: Director, Division of Medical Assistance Programs

15. DATE SUBMITTED: 9/7/11

16. RETURN TO:
Division of Medical Assistance Programs
Oregon Health Authority
500 Summer Street NE E-35
Salem, OR 97301

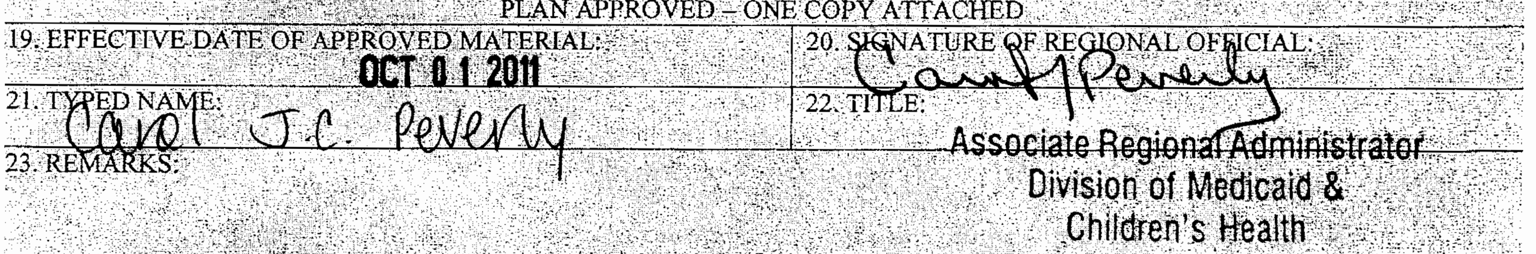
ATTN: Jesse Anderson, State Plan Manager

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **September 7, 2011**

18. DATE APPROVED: **MAR 1 3 2012**

PLAN APPROVED – ONE COPY ATTACHED



19. EFFECTIVE DATE OF APPROVED MATERIAL: **OCT 0 1 2011**

20. SIGNATURE OF REGIONAL OFFICIAL: Carol Peverly

21. TYPED NAME: Carol J.C. Peverly

22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

HEALTH HOMES FOR INDIVIDUALS WITH CHRONIC CONDITIONS
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES: CATEGORICALLY NEEDY

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i. Geographic limitation: ☒ Statewide basis

ii. Population Criteria: The state elects to offer health homes services to individuals with:
☒ Two chronic conditions
☒ One chronic condition and the risk of developing another
☒ One serious mental illness

From the list of conditions below:
☒ Mental Health Condition
☒ Substance abuse disorder
☒ Asthma
☒ Diabetes
☒ Heart Disease
☒ BMI over 25
☒ Other chronic conditions covered

BMI for under age 20 is at or above the 85th percentile, Hepatitis C, HIV/AIDS, Chronic Kidney Disease, Chronic Respiratory Disease, Cancer.

Oregon will direct PCPCH providers and Medicaid managed care plans to utilize information published by the US Preventive Services Task Force when making decisions about the particular risk factors for an additional Chronic Condition that may lead a Medicaid member with one Chronic Condition to meet the criteria of one chronic condition and at risk of another, that will lead to a determination of an individual meeting the ACA Qualifying Criteria. Oregon will also direct PCPCH providers to document the risk factor(s) in the patient's medical record.

The US Preventive Services Task Force conducts scientific evidence reviews of a broad range of clinical preventive health care services (such as screening, counseling, and preventive medications) and develops recommendations for primary care clinicians and health systems. These recommendations are published in the form of "Recommendation Statements." As part of their assessment, the Task Force includes an examination of risk factors. They may modify the recommendations based on those risk factors.

These risk factors will not necessarily be in administrative date, they would be present in a chart
Ovarian cancer is the fifth leading cause of cancer death among women in the U.S., accounting for an estimated 25,400 new cases and 14,300 deaths in 2003.3 Several risk factors are associated with ovarian cancer.

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Family history increases the risk for ovarian cancer: having 1 first- or second-degree relative with ovarian cancer increases risk by about threefold.4
(http://www.uspreventiveservicestaskforce.org/3rduspstf/ovariancan/ovcanrs.htm, accessed 11/30/2011)
A complete medical examination includes taking a medical history, which would include a family history of the disease. Signs and symptoms, as well as a complete medical examination will detail evidence of risk and assessments.
The objective is to be consistent with the policy objectives of the Affordable Care Act which identifies the USPTF Services with an evidence base of A or B rates, as well as Health Resources and Services Administration comprehensive guidelines for women and children, as being important evidence based practices that should be promoted to reduce the risk of developing or mitigating the effects of chronic conditions. Because these guidelines are designed for clinical use, consistency in their use, even beyond Medicaid, should be seamless and clear

iii. Provider Infrastructure:

☒ Designated providers as described in section 1945(h)(5)

These include physicians (family practice, general practice, pediatricians, gynecologists, obstetricians, Internal Medicine, Certified Nurse Practitioners and Physician Assistants), clinical practices or clinical group practices, Federally Qualified Health Centers, Rural Health Clinics, Tribal clinics, Community health centers, Community Mental Health Programs and Drug and Alcohol Treatment Programs with integrated Primary Care Providers.
Assignment to a Health Home will be voluntary and patients have the ability to opt out, by informing their provider or the state directly. The State will develop written materials for Providers (for FFS members) and plans (for Managed Care members) to use for their members. Providers will be required to document patient engagement and agreement to participate.

The process to assign beneficiaries to a PCPCH is:

Step 1) Provider submits information to OHA via a web portal, provider is screened based upon set criteria and Oregon PCPCH standards. This screening will determine if the provider meets the standards and determines the Tier of PCPCH (1, 2, or 3).

Step 2) Provider completes a PCPCH addendum to their Oregon Medicaid provider enrollment agreement and submits that to OHA, DMAP Provider Enrollment. Once processing complete the information is entered into the MMIS.

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iii. Provider Infrastructure (Cont):

Designated providers as described in section 1945(h)(5) (Cont)

Step 3) Provider submits the name or a list of their Medicaid FFS patients to OHA, DMAP Delivery Systems Unit. After appropriate screening, patients are entered into MMIS and assigned to PCPCH provider. Plans will obtain this same information from their participating providers and the Plan will submit this information to DMAP Delivery Systems Unit for Plan enrolled members.
Step 4) A monthly payment is generated to provider (or to plan for MCO members) based upon this assignment.
Step 5) Provider must document member engagement and agreement in members' medical record.

Member may request to opt out at any time either by notifying the provider or to state directly. Members may request a change their provider assignment at any time.

All PCPCH recognized providers wishing to participate in Medicaid will complete an addendum to their Medicaid provider enrollment agreement. This is true for providers serving both FFS and managed care enrolled members. PCPCH providers serving managed care enrolled members will also have a contract with the Medicaid managed care plan, and the payment responsibilities will be between the plan and provider.

Non Duplication:
Prior to the implementation of medical homes/health homes and Patient Centered Primary Care Homes, Oregon's Medicaid managed care organizations provided considerable care management functions on behalf of their members. With the implementation of Patient Centered Primary Care Homes, care management is provided through the PCPCH. Medicaid managed care organizations are required to assist providers within their delivery system to establish PCPCH's and expand the availability of PCPCH's to their members. In addition managed care organizations are required to promote and assist other providers to communicate and coordinate care with the PCPCH in a timely manner using electronic health information technology to the maximum extent feasible.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES: CATEGORICALLY NEEDY

iii. Provider Infrastructure (Cont):

Designated providers as described in section 1945(h)(5) (Cont)

Managed care organizations are required to provide reports to DMAP on the number of PCPCH recognized providers in their network, number of members assigned to PCPCH, and number of members meeting CMS approved SPA criteria for ACA sec. 2703 who are assigned to a PCPCH.

PCPCH Payment to Managed Care Organizations

DMAP will make payment to Medicaid managed care organizations for managed care enrollees assigned to a PCPCH who meet CMS approved SPA criteria outlined in ACA Sec. 2703 and detailed in Oregon's State Plan Amendment. The payments to managed care plans are the same amount and methodology as would be paid directly to PCPCH providers for members not enrolled in managed care. If Contractor retains any portion of the PCPCH payment and does not pass the entire payment to the provider, that portion shall be used to carry out functions related to PCPCH and is subject to approval by DMAP. DMAP will monitor the use of retained PCPCH payment by the managed care organization.

☒ Team of Health Care Professionals as described in section 1945(h)(6)

The team is interdisciplinary and inter-professional and includes non-physician health care professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or other traditional or non-traditional health care workers authorized through state plan or waiver authorities.. These professionals may operate in a variety of ways, such as free standing, virtual, or based at any of the clinics/facilities expressed above.

☐ Health Team as described in section 1945(h)(7), via reference to section 3502

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CARE AND SERVICES: CATEGORICALLY NEEDY

iv. Service Definitions:

Comprehensive Care Management

Service Definition

The Patient Centered Primary Care Home (PCPCH)/Health Home 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 professionals, physicians, physician assistants, nurse practitioners, nurses, social workers, or professional counselors.

Ways Health IT will link

The PCPCH/Health Home Provider will be encouraged to utilize current, contracted or Implemented Health IT systems to create the ability to gather and report data by PCPCH, team and/or clinic; to group data by subset: and to create and maintain a health record with at least the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record. Mature health IT systems will allow reporting of practice clinical quality measures to external entities.

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Care Coordination

Service Definition

Care coordination will be an integral part of the health home. 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 professionals, physicians, physician assistants, nurse practitioners, nurses, social workers, or professional counselors.

Ways Health IT will link

The Health Home Provider will be encouraged to utilize current, contracted or Implemented Health IT systems to allow the health home to share clinical information electronically in real time with the client, other providers and care entities, in concert with other developing health IT infrastructure.

Health Promotion

Service Definition

The PCPCH/Health Home 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 health home 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.

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Health Promotion (Cont)

Service Definition (Cont)

Health home services will occur under the direction of licensed health professionals, physicians, physician assistants, nurse practitioners, nurses, social workers, or professional counselors, community health workers, personal health navigators, or peer wellness specialists.

*Community health workers, personal health navigators and peer wellness specialists are individuals who meet criteria established by the Oregon Health Authority, have passed criminal history background check, and in the judgment of the Authority, hiring agency, and licensed health professional approving the patient centered plan, have the knowledge, skills, and abilities to safely and adequately provide the services authorized.

Ways Health IT will link

The PCPCH/Health Home Provider will be encouraged to utilize current, contracted or implemented Health IT systems to link to, promote, manage and follow health promotion activities such as the use of registries, nurse/provider advice lines and connectivity to programs that enhance awareness of needed preventive treatments, appropriate client level education materials and community resources.

Comprehensive Transitional Care

Service Definition

The PCPCH/Health Home 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 licensed health professionals, physicians, physician assistants, nurse practitioners, nurses, social workers, or professional counselors, community health workers, personal health navigators, or peer wellness specialists.

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Comprehensive Transitional Care (Cont)

Service Definition (Cont)

*Community health workers, personal health navigators and peer wellness specialists are individuals who meet criteria established by the Oregon Health Authority, have passed criminal history background check, and in the judgment of the Authority, hiring agency, and licensed health professional approving the patient centered plan, have the knowledge, skills, and abilities to safely and adequately provide the services authorized.

Ways Health IT will link

The health home provider will be encouraged to develop partnerships that maximize the use of HIT across provider groups and locations. The provider will utilize HIT when available to communicate with health facilities and to facilitate interdisciplinary collaboration among all members of the team including the client, family and local supports.

Individual and Family Support Services

Service Definition

The PCPCH/Health Home 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 licensed health professionals, physicians, physician assistants, nurse practitioners, nurses, social workers, or professional counselors, community health workers, personal health navigators, or peer wellness specialists.

*Community health workers, personal health navigators and peer wellness specialists are individuals who meet criteria established by the Oregon Health Authority, have passed criminal history background check, and in the judgment of the Authority, hiring agency, and licensed health professional approving the patient centered plan, have the knowledge, skills, and abilities to safely and adequately provide the services authorized.

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Individual and Family Support Services (Cont)

Ways Health IT will link

The PCPCH/Health Home will collect patient experience of care data via a validated standardized survey. The PCPCH/Health Home will utilize the results of this survey to improve care and to allow comparison of patient experience across sites.

Referral to Community and Social Support Services

Service Definition

The PCPCH/Health Home 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 licensed health professionals, physicians, physician assistants, nurse practitioners, nurses, social workers, or professional counselors, community health workers, personal health navigators, or peer wellness specialists.

*Community health workers, personal health navigators and peer wellness specialists are individuals who meet criteria established by the Oregon Health Authority, have passed criminal history background check, and in the judgment of the Authority, hiring agency, and licensed health professional approving the patient centered plan, have the knowledge, skills, and abilities to safely and adequately provide the services authorized.

Ways Health IT will link

The PCPCH/Health Home provider will be encouraged to utilize HIT as feasible to initiate, manage and follow up on community based and other social services referrals as developed.

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v.Provider Standards:

The Division will use a Patient-Centered Primary Care Home (PCPCH) Health Home model which is defined by the following six core Attributes. Each have a number of corresponding standards and measures. The 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/Health Homes. Only those practices providing services described by the PCPCH model will be recognized by the OHA as PCPCHs/Health Homes. The following list crosswalks each of the health home expectations, as defined by CMS, to the Oregon PCPCH model Attribute that addresses that expectation:

Access to Care

- All providers must have after hours telephone availability
- Other access hours vary depending upon the tier the provider meets

Accountability

- 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.

Comprehensive Whole Person Care

- 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 mental health and substance abuse services.
- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families.

Continuity

- N/A (Health home expectation not identified)

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v.Provider Standards (Cont):

Coordination and Integration

- 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 long-term care supports and services.
- Develop a person-centered 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.

Person- and Family-Centered Care

- Provide quality-driven, cost-effective, 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.

In addition to the Health home expectation articulated by CMS, the OHA addresses the concepts of adequate access to care and provider continuity within its definition of PCPCH/Health Home, two aspects critical to ensuring appropriate, high-quality care is delivered to Medicaid beneficiaries.

Following the model described above, each practice and/or provider must be recognized by the OHA as a PCPCH/Health Home by submitting data elements required for recognition.

The OHA will support providers with the transition to the PCPCH Health Home Model, and addressing the components of Oregon's standards through distribution of written materials, conducting learning collaborative and joint technical meetings with Medicaid Manage Care Plans Quality Assurance and Process Improvement representatives.

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vi. Assurances:

☒ A. The state assures that hospitals participating under the state plan or a waiver will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

☒ B. The state 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 ands substance abuse among eligible individuals with chronic conditions.

☒ C. The state will report to CMS information submitted by heaslth home providers to inform the evaluation and reports to congress as described in section 2703(b) of the Affordable Care Act, and as described by CMS.

vii. Monitoring:

A. Describe methodology for tracking avoidable hospital readmissions, to include data sources and measure specifics.

Administrative data will be the source. Re-admission measurement specifications are included in section viii. Quality Measures: Goal Based Quality measures.

B. Describe methodology for calculating costs savings resulting from improved chronic care coordination and management achieved through this program, include data sources and measure specifications.

Through the use of the MMIS claims data base Oregon Medicaid will monitor cost savings from health homes through measures of potentially avoidable ER and hospital admission and associated decreases in costs. The state provided a data set of Medicaid members with chronic conditions using the list of conditions that were planed to be included in the ACA Sec. 2703 SPA. This data was able to be displayed by type and number of chronic conditions and by individual member enrollment in a Medicaid Managed Care plan at a point in time. The result of this data set was approx 118,000 individuals with qualifying conditions. Each Medicaid Managed Care Organization was provided this data, as well as the raw data for the members in their plan. The MCO's were also provided the Oregon Standards for Patient Centered Primary Care Homes. The plans were asked to assess the providers in their networks that would meet the standards and at which tier, for the purpose of making some initial projections. The MCO's were asked to project the PCPCH member months they expected to have each quarter by Tier beginning in October of 2011, for eight quarters (only for members meeting the proposed ACA qualifying criteria).

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vii. Monitoring (Cont):

Number of Members meeting multiple Chronic Condition Criteria in Aug. 118,000
Total projected PCPCH member months for ACA Qualifying members,
FY 2012, 712,000 (average nearly 60,000 members each month for 12 mo.)
FY 2013, 861000 (average nearly 72,000 members each month for 12 mo.)
These estimates include members dually eligible for Medicaid and Medicare

The detail by tier in the projections was needed to estimate the PCPCH expenditures. Data about total Medicaid expenditures (excluding long term care) for all individuals with multiple chronic conditions was evaluated as was the inpatient and outpatient expenditures for ambulatory sensitive conditions. When making estimates of savings due to patient participation in PCPCH, the findings of studies of Group Health in Seattle, was ultimately used. Their study found a return on investment of 1.5 to 1, due primarily to decreased hospital and ER utilization. This information was used to develop projected savings for fiscal year 2012 and 2013. Projected expenditures for the PCPCH payments was subtracted from the projected savings to yield a projected net savings. The savings projections were then modified from state fiscal year to calendar year, and displayed here in terms of the federal share.

Net Savings FFY 2012 ($672,753) FF
Net Savings 2013 ($583,663) FF

C. Describe the state proposal for using health information technology in providing health home services and improving service delivery and coordination across the continuum.

Oregon has an office dedicated to the ongoing development of Health Information Technology that is working closely with Oregon Medicaid, the Office for Oregon Health Policy and Research and the Oregon Health Exchange Corporation and provider community as we move forward with the Primary Care Home Programs.

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viii. Quality Measures: Goal Based Quality Measures

Please describe a measureable goal of the health home model that will be operationalized utilizing measures within the domains listed below. The measures may or may not be tied to the services depending on the goal. If the measure is tied to a service, please complete the service-based quality measure section. If the measure is tied to a goal, please complete the goal-based measure section.

Goal 1:

Reduce the rate of potentially avoidable hospital readmissions.

Clinical Outcomes

Measure

Pneumonia (PN): hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following pneumonia hospitalization.

Data Source

Administrative Data

Measure Specification

Admissions for Medicare fee-for-service beneficiaries with a principal discharge diagnosis of pneumonia and with a complete claims history for 12 months prior to admission.

How Health IT will be Utilized

PCPCH/Health Homes will have written agreements with their usual hospital providers and be encouraged to identify, track and proactively manage the care needs of its patients. This will be accomplished via electronic communication, patient registries, MMIS, and/or EHRs.

Experience of Care

Measure

n/a

Data Source

n/a

Measure Specification

n/a

How Health IT will be Utilized

n/a

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Quality of Care

Measure

n/a

Data Source

n/a

Measure Specification

n/a

How Health IT will be Utilized

n/a

Goal 2:

Decrease potentially avoidable hospitalizations and increase the ratio of ambulatory care to emergency room visits.

Clinical Outcomes

Measure

n/a

Data Source

n/a

Measure Specification

n/a

How Health IT will be Utilized

n/a

Experience of Care

Measure

Provider's discuss illness prevention.

Data Source

Survey: CAHPS, Health Plans and Systems, Clinic and Groups or PCMH version

Measure Specification

Health plan members' experiences: percentage of adult health plan members who reported how often their doctor and other health provider talked about specific things they could do to prevent illness.

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CARE AND SERVICES: CATEGORICALLY NEEDY

Experience of Care (Cont)

How Health IT will be Utilized

Health homes will have screening strategies for mental health, substance use, and developmental disorders and will be asked to directly collaborate or co-manage patients with mental health providers. Health homes will be asked to have comprehensive health assessments and interventions for at least three health risk or developmental promotion behaviors. This information will be contained in a patient's health record. This will be accomplished via patient registries, MMIS, and/or EHRs.

Quality of Care

Measure

Ambulatory care: summary of utilization of ambulatory care in the following categories: outpatient visits, emergency department visits, ambulatory surgery/procedures, and observation room stays.

Data Source

Administrative/claims data

Measure Specification

All member months for the measurement year, stratified by age nd PCPCH enrollment.
Number of outpatient visits, emergency department (ED) visits, ambulatory surgery/procedures, observation room stays.

How Health IT will be Utilized

PCPCH/Health Homes will have written agreements with their usual hospital providers and will track and proactively manage the care needs of its patients. This will be accomplished via electronic communication, patient registries, MMIS, and/or EHRs.

Goal 3:

Improve transitions of care between primary care providers and inpatient facilities.

Clinical Outcomes

Measure

n/a

Data Source

n/a

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Goal 3(Cont):

Measure Specification

n/a

How Health IT will be Utilized

n/a

Experience of Care

Measure

Provider's aware of care that patients received from other health providers.

Data Source

Survey: CAHPS – health plans and systems, clinic and groups or PCMH version.

Measure Specification

Members' experiences: percentage of members who reported how often their personal doctor seemed informed and up-to-date about care they got from other doctors or other health provider.

How Health IT will be Utilized

PCPCH/Health Homes will have written agreements with their usual hospital providers, will be asked to manage hospital or skilled nursing facility care for its patients or demonstrate active involvement and coordination of care when their patients receive care in specialized settings, and be asked to coordinate care where appropriate for community settings outside the Health home. This will be accomplished via electronic communication, patient registries, MMIS, and/or EHRs.

Quality of Care

Measure

Care transitions: Emergency department (ED) to ambulatory care.

Data Source

Administrative data Medical record Sample

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Quality of Care (Cont)

Measure Specification

Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of specified elements.

How Health IT will be Utilized

PCPCH/Health Homes will have written agreements with their usual hospital providers, will be asked to manage hospital or skilled nursing facility care for its patients or demonstrate active involvement and coordination of care when their patients receive care in specialized settings, and be asked to coordinate care where appropriate for community settings outside the Health home. This will be accomplished via electronic communications, MMIS and/or EMR's.

Goal 4:

Improve care transitions for people with mental health conditions.

Clinical Outcomes

Measure

n/a

Data Source

n/a

Measure Specification

n/a

How Health IT will be Utilized

n/a

Experience of Care

Measure

n/a

Data Source

n/a

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Goal 4 (Cont):

Experience of Care (Cont)

Measure Specification

n/a

How Health IT will be Utilized

n/a

Quality of Care

Measure

Mental health: percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge.

Data Source

Administrative Data

Measure Specification

Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of specified elements.

How Health IT will be Utilized

PCPCH/Health Homes will have written agreements with their usual hospital providers and will track and proactively manage the care needs of its patients. This will be accomplished via electronic communication, MMIS, and/or EHRs.

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Goal 5:

Improve documentations, tracking, and reporting of health risks and use of preventive services.

Clinical Outcomes

Measure

n/a

Data Source

n/a

Measure Specification

n/a

How Health IT will be Utilized

n/a

Experience of Care

Measure

n/a

Data Source

n/a

Measure Specification

n/a

How Health IT will be Utilized

n/a

Quality of Care

Measure

Body mass index (BMI) assessment: percentage of members 18 to 74 years of age who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to the measurement year.

Data Source

Administrative Data, MMIS and/or EMRs

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CARE AND SERVICES: CATEGORICALLY NEEDY

Goal 5 (Cont):

Quality of Care (Cont)

Measure Specification

Body mass index (BMI) assessment: percentage of members 18 to 74 years of age who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to the measurement year.

How Health IT will be Utilized

PCPCH/Health Homes will maintain health records for each patient containing BMI percentiles and growth charts as well as have processes for identifying patients who would benefit from additional care planning. This will be accomplished via patient registries, MMIS, and/or EHRs

viii. Quality Measures: Service Based Measures

☒ **Comprehensive Care Management**

Clinical Outcomes

Measure

Mental health care.

Data Source

Administrative

Measure Specification

Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all specified elements.

How Health IT will be Utilized

PCPCH/Health Homes will maintain health records for each patient and have processes for identifying patients who would benefit from additional care planning. This will be accomplished via patient registries, MMIS, and/or EHRs

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☒ **Comprehensive Care Management (Cont)**

Experience of Care

Measure

n/a

Data Source

n/a

Measure Specification

n/a

How Health IT will be Utilized

n/a

Quality of Care

Measure

Body mass index (BMI) assessment:

Data Source

Administrative Data, MMIS and/or EMRs

Measure Specification

Percentage of patients who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to the measurement year.

How Health IT will be Utilized

PCPCH/Health Homes will maintain health records for each patient containing BMI percentiles and growth charts as well as have processes for identifying patients who would benefit from additional care planning. This will be accomplished via patient registries, MMIS, and/or EHRs

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☐ **Care Coordination**

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

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☐ **Health Promotion**

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

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

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

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☐ **Individual and Family Support Services** (including authorized representatives)

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

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☐ **Referral to Community and Social Support Services**

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

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ix. Evaluations

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

i. Hospital admissions

Description

The primary information source will be MMIS. Risk adjusted Prevention Quality Indicators, will be compared to non-PCPCH/Health Home enrollees. Assessments will be strafied by risk, medical home tier, length of enrollment on a medical home. Propensity scores and Differences will be used to assess rate, volume, length of stay, and billed charges for PQI, These will not be clinic (PCPCH) level assessment but PCPCHs in aggregate ,
Separation by type of hospital (critical access, rural) will also be made.

Data Source

MMIS

Frequency of Data Collection

Baseline, year two, and three. If data are not specific or sensitive enough to changes then adjustment in volume or frequency may be needed.

ii. Emergency room visits

Description

A comparison between ER use that did not result in an admission for non injury and illness DX for clients in a Medical Home for at least one year vs clients not in a Medical Home

Data Source

MMIS

Frequency of Data Collection

Annual

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iii. Skilled Nursing Facility admission

Description

A comparison between skilled nursing admissions for clients in a PCPCH/Health Home for at least one year vs clients not in a PCPCH/Health Home

Data Source

MMIS

Frequency of Data Collection

Annual

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

i. Hospital admission rates

Administrative Data, MMIS

ii. Chronic disease management

Through administrative data, MMIS and submitted quality measures required for PCPCH recognition, a series of national chronic disease specific quality measures will be monitored and compared to clients in a PCPCH/Health Home to clients not in a PCPCH/Health Home.

iii. Coordination of care for individuals with chronic conditions

Patient Experience of Care, such as CAHPS surveys, administered by the state annually beginning 2012

iv. Assessment of program implementation

Oregon has contracted to use Learning Collaborative Models throughout the implementation of the Health home initiative. Select group of practices, pediatric, mental health and family practice and select sets with individuals who have been identified as being the highest risk will meet to discuss the challenges and opportunities to provide medical homes in a variety of settings.

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v. Processes and Lessons learned

Oregon has contracted to use Learning Collaborative Models in a two stage process. A select group of practices, pediatric and family practice and a select set with individuals who have been identified as being the highest risk will meet to discuss the challenges and opportunities to provide medical homes in a variety of settings. These collaborative meeting are public and the results become a public record so that subsequent dissemination is both transparent and made easier.

vi. Assessment of quality improvements and clinical outcomes

Administrative Data, MMIS, additional quality measures submitted by PCPCH providers and Contracted Health Plans

vii. Estimates of cost savings

Administrative Data, MMIS, comparison of members enrolled and not enrolled in PCPCH providers for their primary care. Analysis of utilization, cost, and cost avoidance of Inpatient Admissions, Emergency Department visits, diagnostic, specialty care, pharmacy, DME and Emergent and non-emergent transportation.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment Methodology for Health Homes for Individuals with chronic Conditions

Payment Type: Per Member Per Month

Provider Type

These include physicians (family practice, general practice, pediatricians, gynecologists, obstetricians, Internal Medicine, Certified Nurse Practitioners and Physician Assistants), clinical practices or clinical group practices, Federally Qualified Health Centers, Rural Health Clinics, Tribal clinics, Community health centers, Community Mental Health Programs and Drug and Alcohol Treatment Programs with integrated Primary Care Providers.

Description

PCPCH/Health Home receive am amount per member per month based upon the standard met by the individual practice or provider group. The PCPCH/Health Home 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 functions.

Tier 1, $10 PMPM
Tier 2, $15 PMPM
Tier 3, $24 PMPM

The PMPM management fee will be made monthly, is in addition to the FFS payments made for direct services under state plan authority for those provider types listed above. In order to be considered an authorized payment, PCPCH/Health Home services and related activities are documented in the patients' medical record at a minimum, each quarter, for ACA qualifying members. The payment is made on a monthly basis to recognized PCPCH providers, but unit of service is quarterly. Providers must render and document a core service, or activity consistent with the definition of a core service, at a frequency not less than quarterly. In order to document the provision of a core service, PCPCH providers, or a managed care plan on behalf of and working with a PCPCH provider, will submit a beneficiary roster of PCPCH/Health Home eligible beneficiaries under their assigned care within the quarter.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

The Oregon Health Authority will only make payment for ACA qualified beneficiaries that are reported no less than quarterly. Provision of a core service will be documented by a PCPCH provider in each beneficiaries' medical record. In order to supplement documentation of the provision of a core service and/or activity, PCPH providers will also log into a provider portal/panel management system currently maintained by the Quality Corporation, a subcontractor of the OHA, or an alternative system approved by the OHA. In order to use an alternative provider portal/panel management system, providers would need to demonstrate to the OHA that the proposed system has similar capability as the Quality Corporation system. Providers will review data regarding the services rendered to Medicaid beneficiaries, allowing the provider to more effectively manage and identify gaps in services provided to their patient panels. The log generated from the provider portal and/or the list of approved alternative provider portals will be reconciled to the PCPCH provider roster on a quarterly basis to ensure that these providers are conducting "comprehensive care management," one of the core services. In the event that an activity is not documented within the quarter, FFP will be returned to CMS. Provider (s) receiving payments are subject to audit or other post payment review procedures for any payments applicable to items or services furnished or supplied by the provider to Medicaid clients. The lack of required documentation will be considered an overpayment and subject to recoupment consistent with Oregon's audit and recovery procedures.

Prior to the implementation of PCPCH/health homes, Oregon's Medicaid managed care organizations provided considerable care management functions on behalf of their members. With the implementation of Patient Centered Primary Care Homes, care management is provided through the PCPCH. Medicaid managed care organizations are required to assist providers within their delivery system to establish PCPCH's and expand the availability of PCPCH's to their members. In addition managed care organizations are required to promote and assist other providers to communicate and coordinate care with the PCPCH in a timely manner using electronic health information technology to the maximum extent feasible.

☒ Tierd

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Managed care organizations are required to provide reports to DMAP on the the number of PCPCH recognized provders in their network, number of members assigned to PCPCH, and number of members meeting CMS approved SPA criteria for ACA sec. 2703 who are assigned to a PCPCH.

The fee schedule is the same for both governmental and private providers. Payment for case management or targeted case management services under the plan does not duplicate payments with Home and Community Based Services.