MEDICAID MODEL DATA LAB

Id: ALABAMA
State: Alabama
Health Home Services Forms (ACA 2703)
Page: 1-10

TN#: AL-12-0011 | Superseeds TN#: AL-00-0000 | Effective Date: 07/01/2012 | Approved Date: 04/09/2013

Transmital Numbers (TN) and Effective Date

Please enter the numerical part of the Transmital Numbers (TN) in the format YY-0000 where YY = the last two digits of the year for which the document relates to, and 0000 = a four digit number with leading zeros. The dashes must also be entered. State abbreviation will be added automatically.

Supersedes Transmital Number (TN)

00-0000

Transmital Number (TN)

12-0011

Please enter the Effective Date with the format MM/dd/yyyy where MM = two digit month number, dd = the two digit day of the month, and yyyy = the four digit year. Please also include the slashes (/).

Effective Date

07/01/2012

3.1 - A: Categorically Needy View

Attachment 3.1-H

Page 1

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

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

Health Home Services

How are Health Home Services Provided to the Medically Needy?

Not provided to Medically Needy

i. Geographic Limitations

Targeted Geographic Basis

If Targeted Geographic Basis,

- Less than statewide
- Effective upon approval of the State Plan Amendment, Alabama will include four geographic areas: Tuscaloosa, Fayette, Pickens, Greene, Hale, Sumter, Lamar and Bibb; Lee, Chambers, Tallapoosa, Coosa, Bullock, Russell and Macon, Limestone, Morgan, Cullman and Madison, and Washington and Mobile. The eight quarters of increased Federal Medical Assistance Payment (FMAP) will begin upon the effective date of the State Plan. No enrollee will be reimbursed for enhanced funding for more than eight (8) quarters.

ii. Population Criteria

The State elects to offer Health Home 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 Use Disorder

Asthma

Diabetes

Heart Disease

BMI Over 25

Other Chronic Conditions Covered?

Description of Other Chronic Conditions Covered.

- Transplants with a look back of Medicaid claims data for five (5) years rather than 18 months.
- Cardiovascular Disease (CVD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Cancer
- HIV with a look back of Medicaid claims data 18 months but the basis for identification medications
- Sickle Cell Anemia

Population Selection Criteria:

Individuals who have at Least Two Chronic Conditions and Individuals who have One Chronic Condition and are at Risk for Another: Based on data from the population enrolled in Patient 1st as of December 2011 using the state criteria for the chronic conditions eligible for health home services under the Alabama State Plan Amendment (SPA), the preponderance and risk of a second chronic condition is extremely high. Per Table For Patient 1st Recipients (HH_SPA_TABLE1_MultipleChroni), teenagers with one chronic who also have a second are 25%, that more than doubles by age 22, and almost triples by age 40. Therefore, Alabama children with one chronic condition have a high risk for a second chronic condition as they grow older and adults already have a significant risk of a second chronic disease with a percentage of near 80%. Thus, Alabamians who have one chronic condition either have or are at risk for a second chronic condition.

Alabama is 45th in the nation in its population's health assessment. Alabama is the second overweight state in the US (70% overweight and obese vs. 63% national average). Alabama's diabetes rate is 50% higher than the national average, and Alabama is ranked 7th in heart disease . Depression is three times more common in patients after an acute myocardial infarction (AMI) than in the general community. 12 Previous hospital-based assessments indicate that 15% to 20% of patients with myocardial infarction (MI) meet Diagnostic and Statistical Manual of Mental Disorders. 13 criteria for major depression (duration since admission, no assessment of functional impairment), and an even greater proportion show an elevated level of depressive symptoms.14–16
Sixteen percent of patients treated in Seattle for cardiac arrest survived, compared to 3% in Alabama. In a sample of Alabama women with suspected myocardial ischemia, somatic but not cognitive/affective depressive symptoms were associated with an increased risk of cardiovascular-related mortality and events. These are just a sampling of studies that validate that an Alabamian with one chronic diseases based on the criteria established above has either met the requirement for having at least two chronic conditions, or the requirement to have one chronic condition and at risk for another without further identification prior to approval.
Substance disorder covers substance use disorders (substance dependence and substance abuse) and substance-induced disorders (substance intoxication, substance withdrawal, substance-induced delirium, substance-induced persisting dementia, substance-induced persisting amnestic disorder, substance-induced psychotic disorder, substance-induced mood disorder, substance-induced anxiety disorder, substance-induced sexual dysfunction and substance-induced sleep disorder). Alabama refers to Individuals with substance disorders as individuals with substance abuse (SA) through this State Plan Amendment (SPA). COPD includes chronic obstructive pulmonary disease and allied conditions, including bronchitis, emphysema, asthma, bronchiectasis, extrinisic allergic alveolitis and COPD not otherwise specified. Cancer includes malignant neoplasm and carcinoma but does not include benign neoplasms, or neoplasms of unspecified or uncertain nature. Sickle cell disease includes sickle-cell anemia but excludes sickle-cell thalassemia.

Alabama will identify individuals with a chronic condition on a monthly basis through analysis of Medicaid claims data for the previous 18 months.

Individuals with a Serious and Persistent Mental Health Condition (SPMH) and Mental Health Condition: mental diseases or mental disorders, which include various psychiatric conditions, usually characterized by impairment of an individual's normal cognitive, emotional, or behavioral functioning, and caused by physiological or psychosocial factors. Diagnoses include schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, Attention Deficit Disorders (ADD/ADHD) and other disorders of childhood or adolescents. Analysis of the Medicaid claims data will be monthly with a look-back to the previous 18 months.

Limitations: No limitations.

Identification: Alabama will identify individuals with a chronic condition on a monthly basis through analysis of Medicaid claims data for the previous 18 months. In addition, the PMP or local hospital may refer a patient for enrollment.

Individuals with SPMH, a mental health condition or substance abuse disorder (SA) will be identified based claims/payment data from Medicaid and/or the Alabama Department of Mental Health (ADMH). Analysis of the Medicaid claims/ADMH payment data will be monthly with a look-back to the previous 18 months. The Executive Director or his/her Chronic Care Champion for the Patient 1st Patient Care Networks of Alabama (PCNA) currently review lists with Community Mental Health Centers (CMHCs) and will begin to review the lists with SA providers in 2012 to identify individuals who could benefit from care management and support. State contracts with PMPs and PCNAs for the Patient 1st Program will be amended to require PMPs and PCNAs in 2012 to integrate bi-directional access and referrals between CMHCs and SA Providers and the PMPs and PCNAs.

Enrollment: Individuals eligible for health home services have the option to select amongst the Patient 1st Primary Medicaid Provider (PMP), who will be the state's designated Primary Medicaid Providers (PMPs) and provide the comprehensive care management. Upon selection of the Patient 1st Primary Medicaid Provider (PMP), the eligible individual will be assigned to the Patient Care Network (PCNA) to which the PMP has a contract. Individuals eligible for health home services have the option to select amongst the Patient 1st PMPs and may change providers at any time. Under the provisions of the SPA, enrollment into Patient 1st for purposes of the health home services is voluntary; however, the state has a 1915(b) waiver that the state will simultaneously amend which will continue the requirement for mandatory enrollment for non-health home services covered under the 1915(b) waiver. All eligible health home enrollees will receive a letter from the state and a booklet that describes Patient 1st rules and guidelines. A copy of the letter is provided as Attachment HH_SPA_Letter1_Enrollment.

In addition to the PCNA, who can serve all individuals with a chronic condition, the local CMHC is the designated provider for individuals who are eligible for health homes services based on a MH designation, while the SA provider is the designated health home provider based on SA designation. Individuals with MH will be assigned a care manager from the CMHC when appropriate, but may choose to change care managers within the CMHC. Individuals with SA will be assigned a care manager from the SA Provider when appropriate, but may choose to change care managers within the SA Provider.

iii. Provider Infrastructure

Designated Providers as described in Section 1945(h)(5)

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

The HH SPA Diagram1 Team Circle attachment presents the providers that are eligible as the team of health care professional as described in section 1915(h)(6), including the PMPs, PCNAs, CMCHs, SA Providers, and ADPH.

Eligible Team of Health Care Professionals: Categories of physicians that are authorized under the Alabama Medicaid State Plan as Primary Medicaid Providers (PMPs) include physicians, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). PMPs have direct responsibility to provide comprehensive care management services in coordination with a team of health care professionals, who provide the care coordination under the SPA. Care coordination will be referred to throughout the SPA as care management using the state's terminology (SPA care coordination equals care management). "Eligible Team of Health Care Professionals" authorized to provide care management (care coordination under the SPAinclude Patient Care Networks of Alabama (PCNAs), the Alabama Department of Public Health (ADPH), and the Alabama Department of Mental Health (ADMH) contracted Community Mental Health Centers (CMHCs) and SA providers. PCNAs include a medical director, pharmacy director, nurse or social worker care coordinator and BSN chronic care champion team, who work with the Primary Medical Providers (PMPs) to support eligible chronic care enrollees. All Health Home PCNA team members' time will be covered by the PMPM rate described in the Payment Methodology section with the exception of FQHCs and RHCs. Their current reimbursement under the prospective payment system includes compensation for management of those populations who meet the definition of a chronic health condition. ADPH and ADMH will be reimbursed for health homes services when one of them serves as a care management provider.

Starting in 2012 PCNAs are required to have an identified member of their team with behavioral health knowledge/expertise to work with the local CMCH and include the local CMCH in their management meetings. PMPs and PCNAs are already contractually required to partner with CMHCs. In addition in 2012, each PCNA will be contractually required to have a member of the local CMHC as a member of the team to facilitate communication and coordination between members of the health care team and involve the enrollee in the decision-making process in order to minimize fragmentation in the services. The member will assist the CMCH, PCNA and PMP in assuring the individual's physical as well as behavioral health needs are addressed by the appropriate entity. HH_SPA_Diagram2_UseCaseExample is provided in the attachments and illustrates how the PMP relates to the other "Eligible Team of Health Care Professionals" and how "Eligible Team of Health Care Professionals" relate to each other using MH/SA as an example.

Qualifications: These health home care management providers are required to have documented work experience with the target population; an administrative capacity to insure quality of services in accordance with state and federal requirements; a functional financial management system that provides documenta¬tion of services and costs; capacity to document and maintain individual case records in accordance with state and federal requirement; demonstrated ability to assure a referral process consistent with Section 1902a(23) of the Social Security Act; allow for free choice of provider, and demonstrated capacity to meet the care management service needs of the target population they are serving. Individual care managers must also have a BA or BS or be a registered nurse and have training in a care management curriculum approved by the ASMA. SA and CMCH health home providers must also be certified by the ADMH.

Each member of the team of health care professionals is registered with the State, is required to meet state qualifications and has been provided a state assigned Medicaid Provider ID. All members "Eligible Team of Health Care Professionals" will be responsible for ensuring that care is person-centered, culturally competent and linguistically capable.

Provider Standards: The Alabama health home model of service delivery will operate under a "whole-person" approach to care within a culture of continuous quality improvement that looks at all the needs of the person and does not compartmentalize aspects of the person, his or her health, or his or her well-being. Providers of health home services will use a person-centered planning approach to identifying needed services and supports, providing care and linkages to care that address all of the clinical and non-clinical care needs of an individual.

- Members of the "Health Home Team of Health Care Professionals":
- Must be is registered with the State, required to meet state qualifications, and have been provided a state assigned Medicaid Provider ID.
- Must ensure that care is person-centered, culturally competent and linguistically capable.
- Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
- Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
- Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
- Coordinate and provide access to long-term care supports and services;
- Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;
- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
- Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.
- PMP and PCNA: The following Alabama standards, which may be met on-site or through coordination and/or offering of these services through partnerships with or in the surrounding community, are addressed through a contract between the state and Patient 1st PMP and PCNA and in the contract between the Patient 1st PCNA and their providers. PMPs and PCNAs must sign agreements with the state and each other. Alabama standards may be amended as necessary and appropriate.
- Capacity to provide access to care that includes in-person, afterhours and telephone. The PMP must provide voice-to-voice access to medical advice and care for enrollees 24 hours a day 7 days a week.
- Ability to provide comprehensive whole person care that includes a comprehensive health care assessment (including mental health and substance use), coordination and access to preventive and health promotion services, including prevention of mental illness and substance use disorders, medical and health care services informed by evidence-based clinical practice guidelines, mental health, substance abuse, and developmental services, and chronic disease management, including self-management support to individuals and their families, and interventions.
- Ability to provide continuity of personal clinician assignment and clinician care, organization of clinical information, clinical information exchange and specialized care settings.
- Capability to coordinate and integrate that includes capacity for population data management; to use health information technology (health-IT); to develop a comprehensive health plan for each individual that coordinates and integrates clinical and non-clinical health-care related needs and services; for test and result tracking; to coordinate and provide access to (PCNAs) and provide comprehensive care management (PMPs), care management (PCNAs), and transitional care across settings (PCNAs and PMPs), and to coordinate and provide access to long-term care supports and services and end of life planning.
- Capacity to provide culturally appropriate, and person- and family-centered health home services, coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services, and provide a positive experience of care.
- ADPH, ADMH SA Providers and CMHC:
- Health home care management providers (SPA care coordination) are required to have documented work experience with the population, an administrative capacity to insure quality of services in accordance with state and federal requirements, a functional financial management system that provides documenta-tion of services and costs, capacity to document and maintain individual case records in accordance with state and federal require¬ments, demonstrated ability to assure a referral process consistent with Section 1902a(23) of the Social Security Act, allow free of choice of provider within their organization, and have a demonstrated capacity to meet the care management service needs of the target population they are serving.
- Individual care managers must also have a minimum of a BA or BS or be a registered nurse and have training in a care management curriculum approved by the ASMA. SA and CMHC health home providers must also be certified by and contracted with the ADMH.

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

Contract Requirement:

- PMPs must have contracts with ASMA and the local PCNA. PMPs must sign agreements that address core competencies. Integration and coordination of services for individuals with MH and/or SA is addressed in all contracts (PMP and PCNA), including the requirement for ongoing processes with community providers and other community agencies to coordinate the planning and provision of care management. PMP contracts will be amended for 2012 to explicitly require a relationship with the local CHMC and SA health home providers. Alabama standards,

which may be met on-site or through coordination and/or offering of these services through partnerships with or in the surrounding community, are addressed through a contract between the state and Patient 1st PMP and PCNA and in the contract between the Patient 1st PCNA and their providers. PMPs and PCNAs must sign agreements with the state and each other. Alabama standards may be amended as necessary and appropriate.
• PCNAs must sign agreements that address core competencies. Integration and coordination of services for individuals with MH and/or SA is addressed in all contracts, including the requirement for ongoing processes with CMHCs and other community agencies to coordinate the planning and provision of care management. The PCNA contracts with ASMA will be amended for 2012 to add as a required member of PCNA board someone from the local CMHC and a SA provider. In addition, the PCNA team must include a care coordinator with expertise and/or knowledge in BH who will serve as a liaison between the PMP and the CMHC and/or SA provider.
• CMHC completes MH screening (non-standardized) and determines if individual is eligible for care management through CMHC. If not eligible, individual referred back to PMP. If "unstable", PCNA notified and individual becomes eligible for care management services through PCNA.
• ADMH SA Provider completes screening (standardized) and determines if individual is eligible for care management through ADMH SA care management provider. If not eligible, individual referred back to PMP. If "unstable", PCNA notified and individual becomes eligible for care management services through PCNA.
• ADPH provider completes screening (non-standardized) and determines if individual is eligible for care management through ADPH care management provider. If not eligible, individual referred back to PMP. If "unstable", PCNA notified and individual becomes eligible for care management services through PCNA.

Provider Education Assurance: In order to ensure the delivery of quality health home services, ASMA provides statewide learning activities for health home providers through regularly scheduled meetings. ASMA held face to face meetings with the PCNAs and PMPs regarding the Health Home State Plan Amendment several times, including a meeting on January 10, 2012. State activities are supplemented with the requirement that Patient 1st PCNAs sponsor regional meetings for the providers in their geographic area to feedback information and learning collaborative opportunities to foster shared learning, information sharing and problem solving. Learning activities and technical assistance will also support providers of health home services to address health home activities.

State Oversight Assurance: ASMA will monitor health home providers to ensure that health home services are being provided that meet the state's health home provider standards and CMS' health home core functional requirements. Oversight activities will include, but are not limited to contract management, clinical and claims data review and analysis, and other activities defined by the state for Medicaid program integrity and ongoing management. Examples include: ASMA surveys enrollees on the performance of the PMP; ASMA randomly calls the 24/7 phone number of PMPs to assure access to care 24/7 is provided; ASMA conducts quarterly site reviews of PCNAs to assure compliance with state standards, and weekly conference calls to address issues. The ASMA assures that the population meeting the health home definition will not receive non-Health Home Targeted Case Management and Health Home Services simultaneously.

Health Team as described in §ection 1945(h)(7), via reference to §ection 3502

iv. Service Definitions

Comprehensive Care Management

Service Definition

Population: Provided to all Health Home Eligible Population

Provider: PMPs

Contract Requirement: PMPs must have contracts with ASMA and the local PCNA. PMPs must sign agreements that address core competencies. Integration and coordination of services for individuals with MH and/or SA is addressed in all contracts (PMP and PCNA), including the requirement for ongoing processes with community providers and other community agencies to coordinate the planning and provision of care management. PMP contracts will be amended for 2012 to explicitly require a relationship with the local CHMC and SA health home providers.

Payment: PMPM

Activities within Scope:
• Identify high-risk individuals (in addition to the efforts by the state directly to identify high-risk enrollees);
• Outreach to, plan and communicate with other primary and specialty care providers regarding a patient's care;
• Develop a comprehensive health plan informed by the patient, which integrates care across various systems (MH/SA/ Primary Care);
• Clarify and communicate of the patient's preference to all involved providers while assuring timely delivery of services.

Limitations: Alabama has not identified any health home services exclusions or limitations. Prior authorization will continue to be required for some medical equipment and some services (MRI) authorized by the PMP but there will be no requirement for prior authorization for any of the health home services.

Ways Health IT Will Link

The state currently requires an integrated medical record but not an electronic continuity of care record. When national standards are finalized, One Health Record™ will use a standardized CCD. Patient 1st Providers and PCNAs will be required to use the CCD which is a component of an EHR for transport of information through the One Health Record™. In addition, in order to receive EHR Incentive Payments for meaningful use, providers will need to connect to One Health Record™. Thus, One Health Record™ will become the "norm" for the exchange of health information in Alabama. The state will determine at a later date if they need to amend the contracts to mandate the use if voluntary incentives do not produce the results desired.

In the interim, the state approves web-based tools, such as a web-based application, that facilitates the efficient exchange of medical information between physician offices and healthcare facilities. The use of the process is not required, but can take the place of the written referral. The state currently contracts with the University of South Alabama (USA) Center for Strategic Health Innovations (CSHI) to support Patient 1st through a web-based secure management system called Real Time Medical Electronic Data Exchange (RMEDE). Based on Medicaid's paid claims information, the care management system provides a foundation for practice improvement by providing timely reports on select clinical measures that can be addressed with patients through targeted interventions. An Interactive Voice Response (IVR) system allows Patient 1st Health Home patients with chronic diseases to transmit home monitoring information into care management system. PMPs are able to use data generated by the care management clinical management tool to track – and impact – key health indicators of their patients with asthma and diabetes.

Currently, the Medicaid Covered Services Handbook provides information on data sharing for the delivery of health care. Once the One Health Record™ system is operational, the state will also consider the viability of requirements related to share consent forms, etc. One Health Record™ system as integrated the QSOA agreement into their policies and procedures. The QSOA is a required document for participation in the state One Health Record™ system, which will facilitate compliance. In addition, the state is working with the PCNAs to create a consent document that will work in school (PCNAs have been trained on FERPA) as well as other state agencies. State will follow the requirements of the various federal and state agency consent education and licensure and requirements for consent.

Care Coordination

Service Definition

Ways Health IT Will Link

Care Management: Alabama terminology for Health Home Service Care Coordination

Eligible Providers of Care Management: dependent on the population served
• PCNAs: Provide services to all eligible for health homes service populations whose health care status is "unstable". "Unstable" is identified through referral by physician, ER or hospital and from informatics (identified through data on ER, hospital and costs reports). Anyone who goes into an ER or acute hospital is screened. PCNAs receive a list daily on individuals seen in ER. Based on results of screening an individual is eligible to receive care management health home services.
• Contract Requirement: PCNAs must sign agreements that address core competencies. Integration and coordination of services for individuals with MH and/or SA is addressed in all contracts, including the requirement for ongoing processes with CMHCs and other community agencies to coordinate the planning and provision of care management. The PCNA contracts with ASMA will be amended for 2012 to add as a required member of PCNA board someone from the local CMHC and a SA provider. In addition, the PCNA team must include a care coordinator with expertise and/or knowledge in BH who will serve as a liaison between the PMP and the CMHC and/or SA provider.
• Payment: PMPM
• Provider Level of Screener: nurse care manager, provider care manager, coordinator or supervisor.
• PCNA Specific Activities: The network care coordinator, who does care management (care coordination), serves as a liaison between the family, PMP, who provides comprehensive care management, other care managers, and Medicaid. Care coordination is assured through care plans that are developed using a team approach. The care plans must have the capacity to accommodate participants with multiple diseases and co-morbidities. The individualized care plan identifies the enrollee, enrollee's caregiver, enrollee's PCNA, specialists and other ancillary providers involved in the participant's care.

PCNAs are notified when an enrollee is care managed by another entity. They are required to work with CMCHs, SA Providers, ADPH and ADHR. PCNAs are required to provide the staffing to support the PMP in care management through care management services. In addition, the PCNA is responsible for assuring a screening for depression is completed on the population managed.

• CMHCs: provide care management services (State Plan Care Coordination) to individuals eligible for health homes services based on a dominant issue of MH
• Contract Requirement: CMHC completes MH screening (non-standardized) and determines if individual is eligible for care management through CMHC. If not eligible, individual referred back to PMP. If "unstable", PCNA notified and individual becomes eligible for care management services through PCNA.
• CMHC Payment: FFS
• Provider Level of Screener: CMHC screeners are trained staff of the CMHC. Masters level provider for all assessments (therapists). Not all individuals screened by therapists will get care management through CMHC.

• ADMH SA Providers: provide care management services to individuals eligible for health homes services based on a dominant issue of SA
• Contract Requirement: ADMH SA Provider completes screening (standardized) and determines if individual is eligible for care management through ADMH SA care management provider. If not eligible, individual referred back to PMP. If "unstable", PCNA notified and individual becomes eligible for care management services through PCNA.
• ADMH SA Payment: FFS
• Provider Level of Screener: SA provider screeners are trained staff of the SA provider. Masters level provider for all assessments (therapists). Not all individuals screened by therapists will get care management services through ADMH SA Provider.

• ADPH: provides care management services to individuals who are eligible with for health home services and also have public health focused needs
• Contract Requirement: ADPH provider completes screening (non-standardized) and determines if individual is eligible for care management through ADPH care management provider. If not eligible, individual referred back to PMP. If "unstable", PCNA notified and individual becomes eligible for care management services through PCNA.
• ADPH Payment: FFS

Activities within scope of health home care management (care coordination) providers:
• Staffing to support the PMP in care management. Patient care team must be accessible to individuals 24/7;
• Screening for clinical depression;
• Development of a comprehensive assessment of an individual's health and psychosocial needs and preferences, including health literacy status and deficits;
• Planning with the individual, family or caregiver, the primary care physician/provider, other health care providers, the payer, and the community to maximize health care responses, quality, and cost-effective outcomes;
• Development of a comprehensive health plan (SPA individualized care plan) that is person centered for each individual and coordinates and integrates all of the individual's clinical and non-clinical health-care related needs and services. Development of the comprehensive health plan is collaborative with the enrollee and family or caregiver and using a team approach. The comprehensive health plans must have the capacity to accommodate individuals with multiple diseases and co-morbidities. The comprehensive health plan identifies the individual, caregiver, PCNA, specialists and other ancillary providers involved in the participant's care;
• Coordination and access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
• Coordination and access to mental health and substance abuse services;
• Coordination and access to long-term care supports and services;
• Establishment of a continuous quality improvement program, and collection and reporting on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level;
• Management, monitoring and reassessment of an individual as needed by an identified care coordinator following evidence-based standards of care and enrollee-centered, assessment-based interdisciplinary approach to integrating health care and social support services;
• Traditional case management services through public health, including assistance with understanding program requirements, helping with transportation needs, and assessment of the home environment and factors that may prevent the patient from being compliant with medical care protocols. It also includes mental health, substance abuse and child health issues such as understanding the need for preventive care, i.e. immunizations, etc;
• Disease management education, medication reconciliation, facilitation of sub-specialty referrals and transitional care interventions;
• Facilitated communication and coordination between members of the health care team and involving the individual in the decision-making process in order to minimize fragmentation in the services;
• Empowerment of the individual to problem-solve by exploring options of care, when available, and alternative plans, when necessary, to achieve desired outcomes.
• Encouragement of the appropriate use of health care services to improve quality of care and maintain cost effectiveness on a case- by- case basis;
• Assistant to the individual in the safe transitioning of care to the next most appropriate level;
• Promotion of individual self-advocacy and self-determination, and
• Advocating for both the individual and the Medicaid Program to facilitate positive outcomes for the individual, the health care team, and the Medicaid Program

Care Management (Care Coordination): defined by Alabama as a enrollee-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual's needs and preferences are assessed, a comprehensive care plan developed, and services managed, monitored and reassessed as needed by an identified care coordinator following evidence-based standards of care to the degree possible. In addition to the core elements of care coordination/care management, the care coordinator provides disease management education, medication reconciliation, facilitation of sub-specialty referrals, transitional care interventions, works to ensure appropriate level of care is being provided and unnecessary emergency department visits are avoided, as well as providing education to patients about the importance of a medical home.

Building off the work of Q-Tool, the infrastructure for One Health Record™ and the infrastructure for Meaningful Use will be utilized for the Patient 1st Program, including a HIPAA-client portal that enables providers to view paid claims data submitted for an enrollee by any provider. The portal will provide access to hospital emergency department services claims data, specific preferred drug lists (PDL), prescription information for an individual enrollee, information regarding whether a prescription meets requirement for Medicaid payment. Providers will be able to transmit a prescription electronically to the enrollee's pharmacy of choice, review laboratory data and determine medication adherence information. Enhancements under consideration specifically address the opportunity for a unified web-based assessment tool,

particularly related to mental health and substance use.

Alabama currently requires an integrated medical record but not an electronic continuity of care record. When national standards are finalized, One Health Record™ will use a standardized CCD. Patient 1st Providers and PCNAs will be required to use the CCD which is a component of an EHR for transport of information through the One Health Record™. In addition, in order to receive EHR Incentive Payments for meaningful use, providers will need to connect to One Health Record™. One Health Record™ system will provide secure messaging, a provider registry and DIRECT and CONNECT capability for Patient 1st Providers. Thus, One Health Record™ will become the "norm" for the exchange of health information in Alabama. The state will determine at a later date if they need to amend the contracts to mandate the use if voluntary incentives do not produce the results desired.

In the interim, the state approves web-based tools, such as a web-based application, that facilitates the efficient exchange of medical information between physician offices and healthcare facilities. The use of the process is not required, but can take the place of the written referral. The state currently contracts with the University of South Alabama (USA) Center for Strategic Health Innovations (CSHI) to support Patient 1st through a web-based secure management system called Real Time Medical Electronic Data Exchange (RMEDE). Based on Medicaid's paid claims information, the care management system provides a foundation for practice improvement by providing timely reports on select clinical measures that can be addressed with patients through targeted interventions. An Interactive Voice Response (IVR) system allows Patient 1st Health Home patients with chronic diseases to transmit home monitoring information into care management system.

The state through the University of South Alabama (USA) provides a data warehouse with Medicaid claims data and analytic capabilities for the state and providers to manage the Patient 1st Program and the state is in the process of developing a state government enterprise wide data repository to link to One Health Record™ so PMPs and PCNAs can access clinical and administrative data and report quality measures.

Currently, the Medicaid Covered Services Handbook provides information on data sharing for the delivery of health care. Once the One Health Record™ system is operational, the state will also consider the viability of requirements related shared consent forms, etc. One Health Record™ system as integrated the Qualified Service Organization Agreement (QSOA) agreement into their policies and procedures. The QSOA is a required document for participation in the state One Health Record™ system, which will facilitate compliance. In addition, the state is working with the PCNAs to create a consent document that will work in school (PCNAs have been trained on FERPA) as well as other state agencies. State will follow the requirements of the various federal and state agency consent education and licensure and requirements for consent.

Health Promotion

Service Definition

Eligible Providers of Health Promotion: PMPs and all Care Management (care coordination) managers (CMHCs, SA Providers, ADPH)

Activities within scope of health promotion:
- Patient education to the individual, family or care-giver, and members of the health care delivery team about treatment options, community resources, insurance benefits, psychosocial concerns, care management, etc., so that timely and informed decisions can be made. Also, patient education about the importance of a medical home;
- Adhering to EPSDT requirements;
- Providing health education specific to an individual's chronic conditions;
- Providing education regarding the importance of immunizations and screenings, child physical and emotional development;
- Providing health- promoting lifestyle interventions, such as substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity;
- Supporting health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers; and
- Promoting evidence based wellness and prevention by linking health home enrollees with resources for smoking cessation, diabetes, asthma and other services based on individual needs and preferences.

Ways Health IT Will Link

The PMPs and all Care Management (care coordination) managers (CMHCs, SA Providers, and ADPH) will be encouraged to utilize current health-IT systems and connect to One Health Record when it becomes available to link to, promote, manage and follow health promotion activities such as the use of public health and patient registries.

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

Service Definition

Eligible Providers of Transitional Care: PMPs and all Care Management (care coordination) managers (CMHCs, SA Providers and ADPH)

Activities within scope of Transitional Care:
- Alabama requires that PMPs assist the enrollee in the safe transitioning of care to the next most appropriate level including movement from inpatient to a NF or home setting
- Alabama requires that PCNAs assist the enrollee in the safe transitioning of care to the next most appropriate level

PMPs and PCNAs must sign agreements that address core competencies and require the establishment of "an ongoing process with community providers and other community agencies to coordinate the planning and provision of care management and other support services for enrollees needing those services." Hospitals have had an ongoing voluntary working relationship with their local PCNAs, but have a bigger incentive to work with the PMPs and PCNAs to arrange appropriate follow-up in order to avoid hospital readmission penalties.

Medicaid enrollees who meet the criteria will be identified through claims, thus the PCNA and PMP is not dependent on the hospital for identification. There are no formal MOUs, but the state requirements of health home providers are such that they are aware when someone goes into the hospital. The PCNAs have a working relationship with all hospitals in their geographic area. In addition, the PCNA team will include an individual with knowledge/expertise in MH/SA.

Alabama standards, which may be met on-site or through coordination and/or offering of these services through partnerships with or in the surrounding community, are addressed through a contract between the state and Patient 1st PMP and PCNA and in the contract between the Patient 1st PCNA and their providers. PMPs and PCNAs must sign agreements with the state and each other. Alabama standards may be amended as necessary and appropriate.

Ways Health IT Will Link

The PMPs and all Care Management (care coordination) managers (CMHCs, SA Providers, and ADPH) will be encouraged to utilize current health-IT systems and connect to One Health Record when it becomes available to facilitate interdisciplinary collaboration among all members of the team including the client, family and local supports.

Currently the process for addressing transitions of care to another setting is manual and informal. The PMPs and PCNAs will be encouraged to utilize current health-IT systems and connect to One Health Record™ when it becomes available to communicate with health facilities and to facilitate interdisciplinary collaboration among all members of the team including the individual, family and local supports. Upon finalization of the ONC Continuity of Care record specifications, it is the intent of One Health Record™ to utilize the CCD.

Individual and Family Support Services (including authorized representatives)

Service Definition

Eligible Provider's Individual and Family Support: PMPs and all Care Management (care coordination) managers (CMHCs, SA Providers, and ADPH)

Activities within scope of patient and family support (including authorized representatives):
• Alabama requires PMPs to provide patient and family support as appropriate. PMPs must educate and empower the enrollee and the family or care-giver about treatment options, community resources, insurance benefits, psychosocial concerns, care management, etc., so that timely and informed decisions can be made.
• Alabama requires health home care management providers (PCNAs, CMHCs, SA providers, and ADPH) to provide patient and family support as appropriate.
• Alabama specifically requires the PMPs and PCNAs to advocate for both the state and the enrollee to facilitate positive outcomes for the enrollee and where a conflict arises to prioritize the needs of the enrollee.

Ways Health IT Will Link

OneHealthRecord consumer portal is already operational and provides information to consumers on Alabama state programs. One Health Record™ will provide the infrastructure for PMPs and PCNAs to also connect with state agencies, including Medicaid, ADPH, and ADMH as a state "gateway" will be available in 2012. PMPs and PCNAs will be encouraged to utilize current health-IT systems and connect to One Health Record™ when it becomes available to communicate with patients, family and caregivers in a culturally appropriate manner.

Referral to Community and Social Support Services

Service Definition

Eligible Providers for Referral to Community and Social Support Services: PMPs and all Care Management (care coordination) managers (CMHCs, SA Providers, and ADPH)

Activities within scope for referral to community and social support services:
• Where relevant and as appropriate, PMPs and PCNAs are specifically required to establish "an ongoing process with community providers and other community agencies to coordinate the planning and provision of care management and other support services for enrollees needing those services; however, all care management managers may engage in this activity for their specific population. Services include long term care services and support such as housing, home delivered meals, services for individuals with disabilities and adult day care.
• For individuals with public health needs, the ADPH will take the lead to assure community and social support services relevant to public health and obtained through the public health infrastructure are available to health home services enrollees. Since much of the public health infrastructure in Alabama is through the State, the ADPH will coordinate these efforts as a participant in the team.
• Starting 2012, the PCNAs will be required to have a member of their team with expertise/knowledge in MH/SA to assure integration with CMHCs, SA providers and community resources. In addition, the PCNA contracts will require a SA provider and the local CMHC on the PCNA board and the state is working with the PCNAs to create a consent document that will work in school (PCNAs have been trained on FERPA) as well as other state agencies.

Ways Health IT Will Link

The PMPs and Care Management Providers, including PCNAs, will be encouraged to utilize current health-IT systems and connect to One Health Record™ when it becomes available to initiate, manage and follow up on community based and other social services referrals as developed. PMPs and all care management providers will have access to Medicaid and CHIP eligibility and clinical data through One Health Record™.

v.Provider Standards

Initial Provider Qualifications

PMP and PCNA: The following Alabama standards, which may be met on-site or through coordination and/or offering of these services through partnerships with or in the surrounding community, are addressed through a contract between the state and Patient 1st PMP and PCNA and in the contract between the Patient 1st PCNA and their providers. PMPs and PCNAs must sign agreements with the state and each other. Alabama standards may be amended as necessary and appropriate.
• Capacity to provide access to care that includes in-person, afterhours and telephone. The PMP must provide voice-to-voice access to medical advice and care for enrollees 24 hours a day 7 days a week.
• Ability to provide comprehensive whole person care that includes a comprehensive health care assessment (including mental health and substance use), coordination and access to preventive and health promotion services, including prevention of mental illness and substance use disorders, medical and health care services informed by evidence-based clinical practice guidelines, mental health, substance abuse, and developmental services, and chronic disease management, including self-management support to individuals and their families, and interventions.
• Ability to provide continuity of personal clinician assignment and clinician care, organization of clinical information, clinical information exchange and specialized care settings.
• Capability to coordinate and integrate that includes capacity for population data management; to use health information technology (health-IT); to develop a comprehensive health plan for each individual that coordinates and integrates clinical and non-clinical health-care related needs and services; for test and result tracking; to coordinate and provide access to (PCNAs) and provide comprehensive care management (PMPs), care management (PCNAs), and transitional care across settings (PCNAs and PMPs), and to coordinate and provide access to long-term care supports and services and end of life planning.
• Capacity to provide culturally appropriate, and person- and family-centered health home services, coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services, and provide a positive experience of care.

ADPH, ADMH SA Providers and CMHC:
• Health home care management providers (SPA care coordination) are required to have documented work experience with the target population, an administrative capacity to insure quality of services in accordance with state and federal requirements, a functional financial management system that provides documenta¬tion of services and costs, capacity to document and maintain individual case records in accordance with state and federal require¬ments, demonstrated ability to assure a referral process consis¬tent with Section 1902a(23) of the Social Security Act, allow free of choice of provid¬er within their organization, and have a demonstrated capacity to meet the care management ser¬vice needs of the target population they are serving.
• Individual care managers must also have a minimum of a BA or BS or be a registered nurse and have training in a care management curriculum approved by the ASMA. SA and CMHC health home providers must also be certified by and contracted with the ADMH.
• Each health home providers who are part of the "team of health care professionals" is registered with the State, is required to meet state qualifications, and has been provided a state assigned Medicaid Provider ID. All members of the team will be responsible for ensuring that care is person-centered, culturally competent and linguistically capable.

Ongoing Provider Qualifications

Health Home SPA Service providers must meet the standards that have been established by the state and that comply with federal requirements. Alabama standards may be amended as necessary and appropriate.
• Required Contractual Relationships: PMP with the state, PCNA with the state and PMP with their PCNA. Patient 1st physicians' contractual agreements, which are Medicaid Provider Enrollment agreements, are updated every two years. Each PCNA will be contractually required as of 2012 to have an identified member of their team to work with the local CMHC and SA providers, include the local CMHC/SA providers in their management meetings, and have a member of their team that has behavioral health knowledge/expertise that will coordinate care between the PMPs, CMHCs and SA provider. In addition, the CMHC and/or SA provider (as appropriate) will become a member of the patient specific

team, assuring the individual's physical as well as behavioral health needs are addressed by the appropriate entity.

State Oversight: The state of Alabama will aggregate claims data for the providers on a monthly, quarterly and yearly basis and feed it back to the providers. ASMA will produce reports based initially on Medicaid claims data with the intention to expand and include ADMH data and clinical data once it is available through One Health Record™.

vi. Assurances

A. The State assures that hospitals participating under the State plan or a waiver of such plan will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to 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 and substance abuse among eligible individuals with chronic conditions.

C. The State will report to CMS information submitted by health home providers to inform the evaluation and Reports to Congress as described in section 2703(b) of the Affordable Care Act, and as described by CMS.

vii. Monitoring

A. Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications.

Alabama has historically tracked two separate hospital readmission performance measures. The data source is the Medicaid claims data.
• 14 and 30 day avoidable readmission rate per provider, per network and per hospital vs. non-network statewide average using the Medicaid Medical Director Learning Network specifications, which are used nationally for Medicaid re-admissions but are not nationally recognized measures. Readmission rate is defined as the percentage of patients who have at least one readmission with 14 or 30 days after being discharged alive from their initial hospital stay. The measures will be reported quarterly per age (<1, 1-5, 6-18, >19), and by medium PMPM for providers in region.
• Top 10 readmission diagnoses per provider, per network and per hospital vs. non-network statewide average reported quarterly per age (<1, 1-5, 6-18, >19).

Alabama will transition effective 2012 to the national standard for reporting that is identified in the quality measurement section to assure standardization in collection and reporting of measures. The state will analyze state Medicaid claims on a quarterly basis for management purposes; however, will report the data to CMS annually. For purposes of management, the state will segment the data by SPA health home population category to differentiate individuals readmitted due to primary diagnosis of cardiac versus cancer versus diabetes. The state is focusing on overcoming common process breakdowns contributing to readmits.

Description
For Health Home target members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission

Numerator: The number of Index Hospital Stays with a readmission within 30 days for each age, gender and total combination

Denominator: The number of Index Hospital Stays for each age, gender and total combination

Specifications: Age as of 12/31 of the measurement year by ages 18, 19, 20 ....up to age 85 and group everyone 85 and above together.

Data Source: Medicaid Claims for acute care hospital

Frequency: Annual

B. Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications.

Total cost per member per month (PMPM) will be tracked and calculated based on total cost for all patients in the Health Home Patient 1st Region divided by Total Number Eligible. This is a state specific measure as there is no national measure to use and will be reported monthly per age (<1, 1-5, 6-18, >19) and by median PMPM for providers in region.

Pharmacy cost compared to inpatient and ER cost for targeted medications and diagnosis will also be calculated. The numerator is the total cost of preventative medication and the denominator is the total cost of ER and Inpatient Claims for targeted diagnosis based on Medicaid claims data. A second measure will compare the Patient 1st population with asthma diagnosis costs of all asthma medications to the cost of ER/hospital visits attributed to asthma-related I-CD9 code. The state will move to ICD-10 codes at the appropriate time.

The State will annually perform an assessment of overall cost savings using a pre/post-period comparison. The growth in costs for the new regions will be compared at pre and post to the geographic areas in the state that are not covered by this SPA. The data source will be Medicaid claims and the measure will be PMPM Medicaid expenditure.

C. Describe the State's proposal for using health information technology in providing health home services under this program and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

Alabama will use health-IT to improve service delivery and coordination across the care continuum, including the use of wireless patient technology in improving coordination, management of care, and patient adherence to recommendations made by their providers. The state will seek to move to more electronic information sharing so information can be available, accessible and integrated in the care team's work flow and available at the point of care. The intent is to allow care team members and patients to communicate clearly, consistently and accurately about a patient's health status and service delivery needs through the use of tools and resources that facilitate data exchange that synthesizes, reconciles, interprets and informs the healthcare provider.

It is the longer term goal of Patient 1st to provide timely and complete clinical information to health care providers at the point of care, including PMPs, PCNAs and all Eligible Team of Health Care Professionals; specialty physicians; emergency physicians; hospitalists and other providers within acute care facilities; health care providers at skilled nursing facilities and rehabilitation centers. Through the use of One Health Record™ capacity, PMPs and PCNAs will be able to access radiology reports, laboratory results and medications.

The state's Medicaid systems that support Patient 1st and all proposed enhancements will support accurate and timely processing of claims, adjudications, and effective communications with providers, enrollees and the public. The state has reporting solutions that produce transaction data, reports and performance information that will contribute to program evaluation, continuous improvement in business operations, and transparency and accountability. Patient 1st payments and reporting will continue to be made through the Alabama MMIS claims system and no significant changes are anticipated.

Patient 1st's secure web-based care management system, Realtime Medical Electronic Data Exchange (RMEDETM), includes home monitoring of patients with chronic disease and an interventional informatics reporting system. Patient 1st enrollees suffering from chronic illnesses such as diabetes, congestive heart failure, and hypertension are monitored for significant changes by using an innovative Interactive Voice Response (IVR) system. Patients are instructed to dial-in their key physiological parameters, and an ADPH Life Care Nurse is assigned to

monitor the results and submit reports to the patient's provider. The state's care management system is used to develop a data collection system with reporting capabilities utilizing recipient information gathered from enrollment activities to evaluate compliance with accepted national standards of practice. The care management system provides Medicaid and their contractors the ability to enter and view the data online. Data is utilized by Medicaid to determine benchmarks for compliance and comparisons.

The state intends to leverage One Health Record™, the Alabama Health Information Exchange (A-HIE), which is scheduled to go live in 2012; the Alabama Health Insurance Exchange (HIX), which is scheduled to go live in 2014, and the enhancements to the Medicaid eligibility system. One Health Record™ will provide the infrastructure to exchange information and provide medication alerts and lab information in order to avoid unnecessary duplication of services. Alabama is currently updating its landscape and gap analysis for its ONC grant and will specifically look to address Patient 1st PCNA and PMP capacity. Alabama submitted its State Medicaid HIT Plan (SMHP) in November and incorporated the Health Home SPA initiative in the SMHP. In addition, when the Medicaid I-APD is submitted in the first quarter of 2012, any appropriate system needs related to this SPA initiative, particularly looking to the expansion areas, will be incorporated.

The state will use MITA approaches to address care management; member management, provider management, program management, operation management, program integrity, business relationship management and contract management to the degree which changes to contracts are required.

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions

Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

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

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:

Improved Health Outcomes for Adults with Diabetes. BENCHMARK GOAL: Increase the compliance of care for Patient 1st diabetic Patients receiving Health Home Services by 2% from the baseline for year one and another 2% by year two.

Clinical Outcomes

Measure

Care for adults with diabetes.

Percent of patients with a diagnosis of diabetes mellitus having HbA1c testing performed during the past year.

Percentage of members 18 through 75 years of age with diabetes mellitus (type 1 and type 2) who had low-density lipoprotein cholesterol (LDL-C) test performed.

Data Source

Medicaid Claims

Measure Specification

Numerator:
Patients with a diagnosis of diabetes mellitus who had hemoglobin A1c (HbA1c) test in the past year

Denominator: Eligible patients 18–75 years of age with diabetes

Numerator: A low-density lipoprotein cholesterol (LDL-C) test performed during the measurement year, as identified by claim/encounter or automated laboratory data.

Denominator: Members with diabetes (Type 1 and Type 2) 18 through 75 years of age as of December 31 of the measurement year

Numerator: A low-density lipoprotein cholesterol (LDL-C) test performed during the measurement year, as identified by claim/encounter or automated laboratory data.

Denominator: Members with diabetes (Type 1 and Type 2) 18 through 75 years of age as of December 31 of the measurement year

How Health IT will be Utilized

MMIS claims data will be analyzed using the current and future enterprise wide state data repository/warehouse system with other systems as they become available through OneHealthRecord and Medicaid system enhancements

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

Goal 2:

Improved health through the reduction of Adult BMI. The initial measurement will be of the assessment of BMI by providers. The "identification" measure provided below will be reported collected for the remainder of 2012 and 2013 (full year) in order to create an accurate baseline. In 2014, identification will be re-measured to determine the increase in identification of BMI by providers. For measurement years starting in 2014, the state will establish a baseline for quality improvement of BMI to address "overweight" (BMI>25). The state will move to the appropriate national weight measure in 2014 and may or may not retain the identification measure as the state transitions from identification to quality improvement. BENCHWORK GOAL: 2012 baseline and increase identification by 2% in year one.

Clinical Outcomes

Measure

Adult BMI Assessment

Data Source

Denominator is Medicaid Claims

Numerator: look back 2 years-check on claims but this would be new

EHR is future data source

Measure Specification

Numerator: Body mass index documented during the measurement year or the year prior to the measurement year

Denominator: Patient 1st enrollees receiving health home services who are 18-74 of age who had an outpatient visit

How Health IT will be Utilized

Incentivize checking over 25

Issue: not currently documenting on claims

CCD will be data source

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

Goal 3:

Improve Health Outcomes of Individuals with Chronic Illnesses through Reduction in Hospital Re-admission Rates and Ambulatory Care Sensitive Condition Admissions. BENCHMARK GOAL: Reduce the ambulatory care sensitive conditions admissions rate for Patient 1st Patients receiving Health Home Services by 2.5% from the baseline for year one and another 2.5% by year two. BENCHMARK GOAL: Reduce the 30 day re-admission rate for Patient 1st Patients receiving Health Home Services by 2.5% from the baseline for year one and another 2.5% by year two.

Clinical Outcomes

Measure

Ambulatory Care-Sensitive Condition Admission

Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care

prevents or reduces the need for admission to the hospital, per 100,000 populations under age 75 years. http://www.guideline.gov/content.aspx?id=15067

Data Source

Medicaid Claims

Specifications: website definition of ambulatory care sensitive conditions

Measure Specification

Numerator: Total number of acute care hospitalizations for ambulatory care sensitive conditions for Patient 1st enrollees receiving health home services and are under age 75 years

Denominator: Total mid-year population under age 75

How Health IT will be Utilized

New measure:

DSS and will move to data warehouse when it is available

Available for first run April 2012

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Plan-All Cause Readmission: For Health Home target members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Specifications: age as of 12/31 of the measurement year by ages 18, 19, 20 ....up to age 85 and group everyone 85 and above together

Data Source

Medicaid Claims

Measure Specification

Numerator: The number of Index Hospital Stays with a readmission within 30 days for each age, gender and total combination

Denominator: The number of Index Hospital Stays for each age, gender and total combination.

How Health IT will be Utilized

MMIS claims data will be analyzed using current and new data warehouse and distributed via e-mail or disc distribution.

Goal 4:

Improve coordination of care for individuals with asthma BENCHMARK GOAL: Percentage of Patient 1st children receiving Health Home SPA services with an asthma diagnosis who receive an influenza immunization during the 12 month review period increases by 1% from the baseline for year one and another 1% by year two. Reduction in ER visit rate for asthmatic Patient 1st enrollees receiving Health Home Services decreases by 5% from the baseline for year one and another 2.5% by year two.

Clinical Outcomes

Measure

Improved rate of children receiving Health Home SPA services with an asthma diagnosis who receive an influenza immunization.

Data Source

Medicaid Claims and eligibility data

Measure Specification

Numerator: The number of patients from the denominator who have a record of influenza immunization in the past 12 months

Denominator: all Patient 1st children (ages 0-21) with an asthma diagnosis receiving health home SPA services who were eligible for Medicaid in the previous year and in the reporting year

How Health IT will be Utilized

Current and future data repository/warehouse system will be used to analyze data from claims for reports to be issued from the state to the PCNAs for management and CMS for federal reporting. Claims data collected from MMIS

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Percent of patients who have had a visit to an Emergency Department (ED)/Urgent Care office for asthma in the past six months. http://www.qualitymeasures.ahrq.gov/content.aspx?id=6914&search=asthma

Data Source

Medicaid Claims

Measure Specification

Numerator: The number of patients from the denominator who have had a visit to an Emergency Department (ED)/Urgent Care office for asthma in the past six months

Denominator: Total number of patients with asthma who were eligible for Medicaid in the measurement year and in the reporting year.

How Health IT will be Utilized

Claims data collected from MMIS. Current and future state enterprise wide data repository/warehouse system will be used to analyze data from claims for reports to be issued from the state to the PCNAs for management and CMS for federal reporting.

Goal 5:

Improved care coordination through timely transmission of transition records. BENCHMARK GOAL: Increase the timely transmission of transition record (inpatient discharges to home/self care or any other site of care for Patient 1st Patients receiving Health Home Services by 5% from the baseline for year one and another 2.5% by year two.

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

Care Transition—Transition Record Transmitted to Health care

Care transitions: percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.

http://qualitymeasures.ahrq.gov/content.aspx?id=15178

Data Source

Denominator:
Medicaid Claims

Numerator: One Health Record™ audit trail

Current chart review until One Health Record

State specific report

Measure Specification

Numerator: Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge

Denominator: All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care

How Health IT will be Utilized

Intent to utilize One Health Record health information exchange connectivity once it goes live in 2012 – CCD at that point in time

Goal 6:

Improved preventive care for children receiving health home services. BENCHMARK GOALS: Evaluate initial measure year's performance to gather baseline. Once baselines are determined, the goal will be established by QI/S in collaboration with the appropriate program staff. For Patient 1st children receiving Health Home Services by 2% from the baseline for year one and maintained.

Clinical Outcomes

Measure

Assess age 12 through ages 21 who had at least one comprehensive well-care visit with a primary medical provider (PMP)

Data Source

Medicaid Claims

Measure Specification

Numerator: Of those in denominator, the number who had at least one comprehensive well-care with a PMP during the measure year.

Denominator: Medicaid Patient 1st Enrollees receiving Health Home Services in the measurement and reporting year who were age 12 through age 21

How Health IT will be Utilized

Current and future enterprise state enterprise wide data repository/
warehouse
system

Experience of Care

Measure

Access to Dental Care for Children

Data Source

CAHPS

Measure Specification

CAHPS 1.0 Clinician and Group Adult and Child Recipient Satisfaction Survey specification. Baseline 2012.

How Health IT will be Utilized

Current and future enterprise state enterprise wide data repository/
warehouse
system

Quality of Care

Measure

Dental Care for Children.

Data Source

Medicaid Claims

Measure Specification

HEDIS Measure: Percentage of Medicaid Health Home eligible children (under 21 years of age) who had at least one dental visit during the measure year.

How Health IT will be Utilized

DSS Query and ASMA Dental Statistics Report.

Goal 7:

Improved treatment of individuals identified as having clinical depression using a standardized tool. BENCHMARK GOALS: Baseline in 2013 after the initiation of standardized tool. Benchmark goal to be determined based on information from baseline.

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

Screening for Clinical Depression and Follow-up

Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documentation

Data Source

Web-based standardized assessment that needs to be created.

Measure Specification

Numerator : Total number of Patient 1st patients who are receiving health home services from the denominator who have follow-up documentation

Denominator: All Patient 1st patients who are receiving health home services patients 18 years and older screened for clinical depression using a standardized tool

How Health IT will be Utilized

New to be developed – need to phase in over one year –

Alternative in the meantime: none as no standardized form

Goal 8:

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

Goal 9:

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

Goal 10:

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

3.1 - A: Categorically Needy View

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

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

viii. Quality Measures: Service Based Measures

Service

Comprehensive Care Management

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

Follow-Up After Hospitalization for Mental Illness

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 7 days of discharge.

http://qualitymeasures.ahrq.gov/content.aspx?id=14965

Data Source

Medicaid Claims and Mental Health Data

Measure Specification

Numerator: An outpatient visit, intensive outpatient encounter, or partial hospitalization (refer to Table FUH-C in the original measure documentation for codes to identify visits) with a mental health practitioner within 7 days after discharge of a Patient 1st member receiving health home services. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

Denominator: Members 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December of the measurement year

How Health IT will be Utilized

Current and future enterprise state enterprise wide data repository/warehouse system

Service

Care Coordination

Clinical Outcomes

Measure

Percentage of adolescents and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: Initiation and engagement of AOD treatment.

Data Source

Medicaid Claims, Mental Health Data &
Eventually EHRs through One Health Record™

Assessment : Data from the assessment data based at the ADMH

Measure Specification

Numerator Initiation of AOD treatment: Health Home Targeted Members with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalizations within 14 days of diagnosis.

Denominator Initiation of AOD treatment: Patient 1st Members receiving health home services who are 13 years of age and older as of 12/31 of the measurement year with a new episode of AOD during the intake period, reported in two age stratifications (13-17 years, 18+ years) and a total rate (the sum of 2 numerators divided by the sum of 2 denominators).

Engagement of AOD Treatment Numerator: Initiation of AOD treatment & 2 or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after date of initiation encounter (inclusive). Multiple engagement visits on the same day must be with different providers to be counted.

Engagement of AOD Treatment Denominator: Patient 1st members receiving health home services and 13 years of age and older as of 12/31 of the measurement year with a new episode of AOD during the intake period, reported in 2 age stratifications (13-17 years, 18+ years) and a total rate (the sum of the 2 numerators divided by the sum of the 2 denominators).

How Health IT will be Utilized

Data warehouse to be automated – in the interim DMH will run a report annual and provide to DMA, who will run a special report annual)

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

Service

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

Service

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

Transition record with specified elements received by discharged patients (inpatient discharges to home or any other care site)

Data Source

State Specific Report based on the One Health Record™ audit report

Measure Specification

Timely transmission of transition record (inpatient discharges to home/self care or any other site of care).

Numerator: Patient 1st patients who are receiving health home services or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the following elements: Inpatient Care, Post-Discharge/Patient Self- Management, and Advance Care Plan.

Denominator: All Patient 1st patients receiving health home services , regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, SNF, or rehabilitation facility) to home/ self care or any other site of care.

How Health IT will be Utilized

Use of One Health Record™ will be considered after it is operational for a year.

Current and future state enterprise wide data repository/ warehouse.

Service

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

Service

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

3.1 - A: Categorically Needy View

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

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

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

For Health Home target members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission

Numerator: The number of Index Hospital Stays with a readmission within 30 days for each age, gender and total combination

Denominator: The number of Index Hospital Stays for each age, gender and total combination

Specifications: Age as of 12/31 of the measurement year by ages 18, 19, 20 ....up to age 85 and group everyone 85 and above together.

Data Source

Medicaid Claims for acute care hospital

Frequency of Data Collection

Annual

ii. Emergency room visits

Description

Preventable/ambulatory care-sensitive emergency room visits [algorithm, not formally a measure] http://wagner.nyu.edu//chpsr/index.html?p=61

Data Source

Medicaid Claims

Frequency of Data Collection

Annual

iii. Skilled Nursing Facility admissions

Description

Skilled nursing admissions for Patient 1st Health Home enrollees compared to total non-Patient 1st Health Home Medicaid enrollees.

Data Source

Medicaid Claims and eligibility data

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

Assess hospital admission rates, by service (medical, surgical. Maternity, mental health and chemical dependency), for acute care hospitals (non-psychiatric hospitals) in the participating health home geographic sites and remainder of state for the chronic conditions identified as eligible for health home services using Medicaid Claims (annual). MMIS claims data will be analyzed using current and new data warehouse and distributed via e-mail or disc distribution. Eligible population will be those 18 years of age and older age as of 12/31 of the measurement year and the focus of the collection is the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

The State will utilize the quality process and outcome measures described in the SPA to assess quality improvements and clinical outcomes. For registry-based, claims-based and audit-based measures, assessment will occur both at the individual practice level, the PCNA level, at the aggregate level for each geographic area, and for all participating health homes. For claims-based measures, the State will track change over time to assess whether statistically significant improvement has been achieved. One year after OneHealthRecord™ is operational, the state will move to national measures where national measures exist.

ii. Chronic disease management

The state will assess the provision of chronic disease management by the PMPs and Networks for individuals with the chronic conditions specified within this State Plan Amendment based on the measurements presented earlier in this State Plan. Medical Claims/Charts. The state has determined that it will start with national standardized methodologies, including the use of NQF and/or CHIPRA measure specifications until further clarification is provided, for pre- and post-comparisons.

The Alabama Medicaid care management system has data on referrals sent. The care management system tracks referrals to social services and community and social support. One Health Record™ consumer portal is already operational and provides information to consumers on

Alabama state programs. One Health Record™ will provide the infrastructure for PMPs and PCNAs to also connect with state agencies, including Medicaid, ADPH, and ADMH and other health home providers who choose to connect to One Health Record™ through a state "gateway" that will be available in 2012. PMPs and PCNAs will be encouraged to utilize current health-IT systems and connect to One Health Record™ when it becomes available to communicate with patients, family and caregivers in a culturally appropriate manner.

The state has also already put into place quality measure reporting requirements for health homes that apply to both the PMPs and the PCNAs, including the collection and reporting of data on patient outcomes and the collection of data on patient experience of care. The state is planning a CAHPS survey for CY 2013. Barriers to implementation identified by the state include the remaining uncertainty of the final set of measures, as adult measures are anticipated the first quarter of CY 2012. The state will not be able to address all of the core set of measures on the effective date of the SPA, but has a plan to address barriers to implementation, including but not limited to health information capacity statewide.

The state is developing a timeline by which to phase in the implementation, to be completed within one year. The state has identified proxy measures that will be reported to CMS in the interim. Alabama will establish business and technical operational structures to comply with the evaluation reporting requirements, including: nature, extent, and use of the health home model of service delivery, assessment of program implementation processes and lessons, assessment of quality improvements and clinical outcomes and estimates of cost savings.

MMIS claims data can be shared across the systems. It will be analyzed using the current and future state enterprise wide data repository/warehouse system along with other systems as they become available through One Health Record™ and Medicaid eligibility system enhancements. Chart review replacement will be considered once One Health Record™ is operational for a year to give all providers the opportunity to fully utilize their EHR systems.

The Alabama care management system is used for data analysis and will continue to be used until and if it is replaced by a future state enterprise wide data repository/warehouse that includes analytical capabilities. The PMPs and PCNAs will be encouraged to utilize current health-IT systems and connect to One Health Record™ when it becomes available to link to, promote, manage and follow health promotion activities such as the use of public health and patient registries.

iii. Coordination of care for individuals with chronic conditions

The state will also assess the provision of care coordination services for individuals with the chronic conditions specified within this State Plan Amendment based on the measurements presented earlier in this State Plan. Medical Claims/Charts. The state has already put into place quality measure reporting requirements for health homes that apply to both the PMPs and the PCNAs, including the collection and reporting of data on patient outcomes and the collection of data on patient experience of care. The state is planning a CAHPS survey for CY 2013. MMIS claims data can be shared across the systems. It will be analyzed using the current and future state enterprise wide data repository/warehouse system along with other systems as they become available through One Health Record™ and Medicaid eligibility system enhancements. Chart review replacement will be considered once One Health Record™ is operational for a year to give all providers the opportunity to fully utilize their EHR systems.

The Alabama care management system is used for data analysis and will continue to be used until and if it is replaced by a future state enterprise wide data repository/warehouse that includes analytical capabilities. The PMPs and PCNAs will be encouraged to utilize current health-IT systems and connect to One Health Record™ when it becomes available to link to, promote, manage and follow health promotion activities such as the use of public health and patient registries.

The state will not be able to address all of the core set of measures on the effective date of the SPA, but has a plan to address barriers to implementation, including but not limited to health information capacity statewide. The state is developing a timeline by which to phase in the implementation, to be completed within one year. The state has identified proxy measures that will be reported to CMS in the interim. Alabama will setup business and technical operational structures to comply with the evaluation reporting requirements, including: nature, extent, and use of the health home model of service delivery, assessment of program implementation processes and lessons learned, assessment of quality improvements and clinical outcomes, and estimates of cost savings.

iv. Assessment of program implementation

The State will monitor implementation through the evaluation process addressed in this State Plan. The Medicaid Agency is also working directly with the ADPH, ADMH, etc. and meeting regularly to goals established in this State Plan and performance indicators provided elsewhere in this State Plan Amendment. The state has already put into place quality measure reporting requirements for health homes that apply to both the PMPs and the PCNAs, including the collection and reporting of data on patient outcomes and the collection of data on patient experience of care. The state is planning a CAHPS survey for CY 2013.

The state will not be able to address all of the core set of measures on the effective date of the SPA, but has a plan to address barriers to implementation, including but not limited to health information capacity statewide. The state is developing a timeline by which to phase in the implementation, to be completed within one year. The state has identified proxy measures that will be reported to CMS in the interim. Alabama will setup business and technical operational structures to comply with the evaluation reporting requirements, including: nature, extent, and use of the health home model of service delivery, assessment of program implementation processes and lessons learned, assessment of quality improvements and clinical outcomes, and estimates of cost savings.

The State will monitor health home providers to ensure that health home services are being provided that meet the state's health home provider standards and CMS' health home core functional requirements. Oversight activities will include, but not be limited to contract management, clinical and claims data review and analysis, and other activities defined by the state for Medicaid program integrity and ongoing management.

v. Processes and lessons learned

The State will monitor implementation through the evaluation process addressed in this State Plan. The Medicaid Agency is also working directly with the ADHR, ADMH, ADPH and meeting regularly to goals established in this State Plan and performance indicators provided elsewhere in this State Plan Amendment. Federal requirement are provided for in contracts between the State and the PCNAs and the State and the PMPs.

vi. Assessment of quality improvements and clinical outcomes

The State will utilize the quality process and outcome measures described in the prior section to assess quality improvements and clinical outcomes. For registry-based, claims-based and audit-based measures, assessment will occur both at the individual practice level, the Network level, at the aggregate level for each geographic area, and all participating health homes. For claims-based measures, the State will track change over time to assess whether statistically significant improvement has been achieved. One year after OneHealthRecord is operational, the state will move to national measures where national measures exist.

The state has already put into place quality measure reporting requirements for health homes that apply to both the PMPs and the PCNAs, including the collection and reporting of data on patient outcomes and the collection of data on patient experience of care. The state is planning a CAHPS survey for CY 2013. The state will not be able to address all of the core set of measures on the effective date of the SPA, but has a plan to address barriers to implementation, including but not limited to health information capacity statewide.

The state is developing a timeline by which to phase in the implementation, to be completed within one year. The state has identified proxy measures that will be reported to CMS in the interim. Alabama will setup business and technical operational structures to comply with the evaluation reporting requirements, including: nature, extent, and use of the health home model of service delivery, assessment of program implementation processes and lessons learned, assessment of quality improvements and clinical outcomes, and estimates of cost savings.

vii. Estimates of cost savings

The State will determine total Cost All Patients in the Region divided by Total Number Eligible reported monthly, Per Age (<1, 1-5, 6-18, >19) and also report median PMPM for providers in region as no national measurement is available to match. PMPM amounts for the geographic regions will be compared with projected PMPM to determine cost savings. Through the use of the proposed CHIPRA measures, the adult Medicaid measures and the Meaningful Use measures, the state seeks to align with some of the information, including cost savings, which will be collected for the Report to Congress.

Page

3.1 - B: Medically Needy View

Attachment 3.1-H

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy

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

Health Home Services

i. Geographic Limitations

If Targeted Geographic Basis,

ii. Population Criteria

The State elects to offer Health Home 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 Use Disorder
Asthma
Diabetes
Heart Disease
BMI Over 25
Other Chronic Conditions Covered?

Description of Other Chronic Conditions Covered.

iii. Provider Infrastructure

Designated Providers as described in §ection 1945(h)(5)

Team of Health Care Professionals as described in §ection 1945(h)(6)

Health Team as described in §ection 1945(h)(7), via reference to §ection 3502

iv. Service Definitions

Comprehensive Care Management

Service Definition

Ways Health IT Will Link

Care Coordination

Service Definition

Ways Health IT Will Link

Health Promotion

Service Definition

Ways Health IT Will Link

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

Service Definition

Ways Health IT Will Link

Individual and Family Support Services (including authorized representatives)

Service Definition

Ways Health IT Will Link

Referral to Community and Social Support Services

Service Definition

Ways Health IT Will Link

v.Provider Standards

vi. Assurances

A. The State assures that hospitals participating under the State plan or a waiver of such plan will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to 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 and substance abuse among eligible individuals with chronic conditions.

C. The State will report to CMS information submitted by health home providers to inform the evaluation and Reports to Congress as described in section 2703(b) of the Affordable Care Act, and as described by CMS.

vii. Monitoring

A. Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications.

B. Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications.

C. Describe the State's proposal for using health information technology in providing health home services under this program and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy

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

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:

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

Goal 2:

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

Goal 3:

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

Goal 4:

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

Goal 5:

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

Goal 6:

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

Goal 7:

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

Goal 8:

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

Goal 9:

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

Goal 10:

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

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy

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

viii. Quality Measures: Service Based Measures

Service

Comprehensive Care Management

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

Service

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

Service

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

Service

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

Service

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

Service

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

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy

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

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

Data Source

Frequency of Data Collection

ii. Emergency room visits

Description

Data Source

Frequency of Data Collection

iii. Skilled Nursing Facility admissions

Description

Data Source

Frequency of Data Collection

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

ii. Chronic disease management

iii. Coordination of care for individuals with chronic conditions

iv. Assessment of program implementation

v. Processes and lessons learned

vi. Assessment of quality improvements and clinical outcomes

vii. Estimates of cost savings

4.19 - B: Payment Methodology View

Attachment 4.19-B

Page 1

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

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

Payment Methodology

Payment Type: Per Member Per Month

Provider Type

Eligible Designated Provider: PMP; Network; Other governmental and private providers of case management and care coordination

Description

PMPs are provided a monthly payment of $8.50 if the following requirements are met:
• The person is identified as meeting health home eligibility criteria on the State's MMIS and in the Care Management Information System;
• The person is enrolled as a health home member at the PMP; and
• At a minimum each individual has received care management monitoring for treatment gaps or another health home service was provided that was documented in the Care Management Information System. The state will provide the PCNA on a monthly basis reports by individual that indicate potential gaps in service delivery. The PCNA on a monthly basis must review each individual's data and where there is a gap in service delivery, take appropriate action or request the PMP to take appropriate action or meet with the patient to assure the providers and/or patients are addressing the identified issue(s).

PMPs receive the standard Medicaid FFS payment for other State Plan non-health home direct services. For their health home activities under this SPA, they will receive an overlaying per-member-per-month (PMPM) payment of $8.50.

Network: The PMPM health home network payment will be $9.50 for each patient who meets the chronic conditions eligibility. The state will provide the PCNA on a monthly basis reports by individual that indicate potential gaps in service delivery. The PCNA on a monthly basis must review each individual's data and where there is a gap in service delivery, take appropriate action or request the PMP to take appropriate action or meet with the patient to assure the providers and/or patients are addressing the identified issue(s)

Other governmental and private providers of case management and care coordination: Except as otherwise noted in the plan, payment for these services is based on state-developed fee schedule rates, which are the same for both governmental and private providers of case management and care coordination. The agency's rates were set as of January 20, 2012 and are effective for services provided on or after that date. The fee schedule is subject to annual/periodic adjustment. All rates, including current and prior rates, are published and maintained on the agency's website. Specifically, the fee schedule and any annual/periodic adjustments to the fee schedule are published at www.medicaid.alabama.gov

Strategy to not duplicate services/payments:

Eligible Designated Providers are The "Eligible Team of Health Care Professionals": Primary Medicaid Providers (PMPs), including physicians, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) who have direct responsibility to provide comprehensive care management services in coordination with a other members of the team of health care professionals; Patient Care Networks of Alabama (PCNAs); the Alabama Department of Public Health (ADPH);and the Alabama Department of Mental Health (ADMH) contracted Community Mental Health Centers (CMHCs) and SA providers who are authorized to provide care management (care coordination under the SPA). PCNAs include a medical director, pharmacy director, nurse or social worker care coordinator, BSN chronic care champion and someone with expertise/knowledge in MH/SA who work with the Primary Medical Providers (PMPs) to support eligible chronic care enrollees. All mandatory Health Home PCNA team members' time will be covered by the PMPM rate described in the Payment Methodology section. ADPH and ADMH will be reimbursed for health homes services when one of them serves as a care management provider. The current reimbursement for FQHC's and RHC's under the prospective payment system includes compensation for management of those populations who meet the definition of a chronic health condition. The AMA assures that the population meeting the health home definition will not receive Targeted Case Management and Health Home Services simultaneously. Attachment HH_SPA_Diagram3.TrangleModel illustrates how the "PMP relates to the other members of the "Eligible Team of Health Care Professionals" and how the other "Eligible Team of Health Care Professionals" relate to each other.

PMPs receive a payment of $.50 PMPM to participate in the 1915(b) waiver, which is for care management services. Since the Patient 1st case management fee for Health Home eligible recipients pays for Health Home care management services, the PMP will receive an additional $8.00 in Health Home care management PMPM to avoid duplication of payment.

Tiered?

Payment Type: Alternate Payment Methodology

Provider Type

N/A

Description

N/A

Tiered?