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State/Territory Name: Alabama

State Plan Amendment (SPA) #: 14-0001

This file contains the following documents in the order listed:

1) Approval Letter
2) Companion letter
3) CMS 179 Form
4) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

March 4, 2015

Ms. Stephanie Azar, Acting Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
Post Office Box 5624
Montgomery, Alabama 36103-5624

Attention: Stephanie Lindsay

Re: Title XIX State Plan Amendment, AL-14-0001

Dear Ms. Azar:

The Centers for Medicare & Medicaid Services (CMS) Atlanta Regional Office has completed its review of Alabama State Plan Amendment (SPA) Transmittal Number 14-0001. This SPA expands the state's health homes program statewide and adds Hepatitis C as a covered chronic condition. The State plan pages for this SPA were submitted through the Medicaid Model Data Lab (MMDL) on September 17, 2014.

This SPA was approved on March 4, 2015, with an effective date of April 1, 2015. The approved plan pages and CMS 179 form are included with this letter. A companion letter is also being issued along with this approval to address concerns regarding the state's payment methodology.

In accordance with the statutory provisions at Section 1945(c)(1) of the Social Security Act, for payments made to health home providers in the new counties served under this amendment, during the first eight fiscal quarters that the SPA is in effect, April 1, 2015 through March 31, 2017, the federal medical assistance percentage (FMAP) rate applicable to such payments shall be equal to 90 percent. The FMAP rate for payments made to health home providers in all counties will return to the state's published FMAP rate on April 1, 2017.

This approval is based on the state's agreement to collect and report information required for the evaluation of the health home model. States are also encouraged to report on the CMS recommended core set of quality measures.

If you have any questions concerning this amendment or require further assistance, please contact Alice Hogan at (404) 562-7432 or Alice.Hogan@cms.hhs.gov.

Sincerely,

//s//

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

March 4, 2015

Ms. Stephanie McGee Azar
Acting Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
Post Office Box 5624
Montgomery, AL 36103-5624

RE: Alabama State Plan Amendment 14-0001

Dear Ms. Azar:

This letter is being sent as a companion to our approval of Alabama State Plan Amendment (SPA) 14-0001 submitted on September 17, 2014 by the Alabama Medicaid Agency and effective on April 1, 2015. This SPA amends Alabama's current Health Home program by expanding the program statewide and adding Hepatitis C as a covered chronic condition.

Section 1902(a)(30)(A) of the Social Security Act (the Act) requires that states have methods and procedures in place to assure that payments to providers are consistent with efficiency, economy, and quality of care.

Our review of AL SPA 14-0001 disclosed that under Alabama's current Health Home program and the expansion under this SPA, there are two per member per month payments and multiple fee for service payments, all made by the Alabama Medicaid Agency to a variety of providers. Our concern is that this maintains the silos of care rather than providing a coordinated system of care as was the intent of Health Home Section 2703 of the Affordable Care Act. In addition, we have concerns that these multiple payments are not economic and efficient as required by Section 1902(a)(30)(A) and Section 1945 of the Social Security Act.

Please respond within 90 days of the date of this letter with a state plan amendment that addresses the issues described or a corrective action plan describing how you will resolve these issues. During the 90-day period, we would be happy to provide any technical assistance that you need. State plans that are not in compliance with requirements referenced above are grounds for initiating a formal compliance process.

If you have any questions or need any further assistance, please contact Joyce Wilkerson at (404) 562-7426 or Alice Hogan at (404) 562-7432.

Sincerely,

//s//

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: AL-14-0001

2. STATE: Alabama

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

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

4. PROPOSED EFFECTIVE DATE
April 1, 2015

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 430 Subpart B ACA 2703

7. FEDERAL BUDGET IMPACT:
a. FFY 2015 $14,191,733
b. FFY 2016 $42,575,199

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-H

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

10. SUBJECT OF AMENDMENT:
The primary purpose for this amendment is to expand the current Health Home to the additional counties of the state. The enhanced match ended 6/30/2014. The amendment would add 46 new counties affective 4/1/2015. The amendment is also adding a chronic condition of Hepatitis C Virus.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Governor's designee on file via letter with CMS

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//s//

13. TYPED NAME:
Stephanie McGee Azar

14. TITLE:
Acting Commissioner

15. DATE SUBMITTED:

16. RETURN TO:
Stephanie McGee Azar
Acting Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
Post Office Box 5624
Montgomery, Alabama 36103-5624

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 09-17-14

18. DATE APPROVED: 03-04-15

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
04-01-15

20. SIGNATURE OF REGIONAL OFFICIAL:
//s//

21. TYPED NAME:
Jackie Glaze

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

23. REMARKS:

Transmittal Number: AL-14-0001 Supersedes Transmittal Number: AL-12-011 Proposed Effective Date: Apr 1, 2015 Approval Date: 03-04-15
Attachment 3.1-H Page Number: 5

Health Homes Population Criteria and Enrollment

Population Criteria

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

☑ **Two or more chronic conditions**

Specify the conditions included:

☑ **Mental Health Condition**
☑ **Substance Abuse Disorder**
☑ **Asthma**
☑ **Diabetes**
☑ **Heart Disease**
☑ **BMI over 25**

Other Chronic Conditions	
Cancer	
Cardiovascular Disease	
Chronic Obstructive Pulmonary Disease	
Hepatitis C Virus	
HIV	
Sickle Cell Anemia	
Transplants	

☑ **One chronic condition and the risk of developing another**

Specify the conditions included:

☑ **Mental Health Condition**
☑ **Substance Abuse Disorder**
☑ **Asthma**
☑ **Diabetes**
☑ **Heart Disease**
☑ **BMI over 25**

Other Chronic Conditions	

Specify the criteria for at risk of developing another chronic condition:
Alabama will identify individuals with a chronic condition on a monthly basis through analysis of Medicaid claims data for the previous 18 months. However, Transplants will be identified with a look back of Medicaid claims data for five years rather than 18 months. HIV will have a look back of Medicaid claims data of 18 months on the basis for identification medications. In addition, the PMP or local hospital may refer a patient for enrollment.

☑ **One or more serious and persistent mental health condition**

Specify the criteria for a serious and persistent mental health condition:
Individuals with a Serious and Persistent Mental Health Condition (SPMH) and Mental Health Condition include mental diseases or mental disorders, such as 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 reviewed monthly with a look back to the previous 18 months.

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

Geographic Limitations

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

Describe statewide geographical phase in/expansion. This should include dates and corresponding geographical areas that bring the program statewide.
July 1, 2012: Tuscaloosa, Fayette, Pickens, Greene, Hale, Sumter, Lamar, Bibb, Lee, Chambers, Tallapoosa, Coosa, Bullock, Russell, Macon, Limestone, Morgan, Cullman, Madison, Washington and Mobile Counties
April 1, 2015: Colbert, Franklin, Jackson, Lauderdale, Lawrence, Marshall, Blount, Calhoun, Cherokee, Chilton, Clay, Cleburne, Dekalb, Etowah, Jefferson, Randolph, St. Clair, Shelby, Talladega, Walker Choctaw, Marengo, Marion, Perry, Winston, Autauga, Barbour, Butler, Coffee, Covington, Crenshaw, Dale, Dallas, Elmore, Geneva, Henry, Houston, Lowndes, Montgomery, Pike, Wilcox, Baldwin, Clarke, Conecuh, Escambia, and Monroe Counties

If no, specify the geographic limitations:

○ **By county**
Specify which counties:

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

○ **By city/municipality**
Specify which cities/municipalities:

○ **Other geographic area**
Describe the area(s):

Enrollment of Participants

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

◉ **Opt-In to Health Homes provider**
Describe the process used:
Individuals eligible for health home services have the option to select amongst the Patient 1st Primary Medicaid Providers (PMPs), who are the state's designated PMPs and provide the comprehensive care management. Upon selection of the Patient 1st PMP, the eligible individual will be assigned to the Health Home 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.

In addition to the Health Homes, who can serve all individuals with chronic conditions, the local CMHC is the designated provider for individuals who are eligible for Health Homes services based on a mental health (MH) designation, while the SA provider is the designated Health Home provider based on an SA designation. Individuals with a MH condition will be assigned a care manager from the CMHC when appropriate, but may choose to change care managers within the CMHC. Individuals with an SA condition will be assigned a care manager from the SA Provider when appropriate, but may choose to change care managers within the SA Providers.
Health Homes must provide and maintain on file documentation that an enrollee has consented to participate in a Health Home.

○ **Automatic Assignment with Opt-Out of Health Homes provider**
Describe the process used:

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

○ **Other**
Describe:

☑ **The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**
☑ **The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**
☑ **The State provides assurance that hospitals participating under the State Plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.**
☑ **The State provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each Health Homes enrollee will be claimed. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.**
☑ **The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

Transmittal Number: AL-14-0001 Supersedes Transmittal Number: AL-12-011 Proposed Effective Date: Apr 1, 2015 Approval Date: 03-04-15

Transmittal Number: AL-14-0001 Supersedes Transmittal Number: AL-12-011 Proposed Effective Date: Apr 1, 2015 Approval Date: 03-04-15
Attachment 3.1-H Page Number: 6

Health Homes Providers

Types of Health Homes Providers

☐ **Designated Providers**

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

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards:

☐ **Rural Health Clinics**

Describe the Provider Qualifications and Standards:

☐ **Community Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Community Mental Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Home Health Agencies**

Describe the Provider Qualifications and Standards:

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

☐ **Case Management Agencies**

Describe the Provider Qualifications and Standards:

☐ **Community/Behavioral Health Agencies**

Describe the Provider Qualifications and Standards:

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

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☑ **Teams of Health Care Professionals**

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

☑ **Physicians**

Describe the Provider Qualifications and Standards:

• PMPs must have contracts with the Alabama Medicaid Agency (AMA) and sign agreements with Health Homes addressing core competencies;
• 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. 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 (HIT)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.

☑ **Nurse Care Coordinators**

Describe the Provider Qualifications and Standards:

Nurse Care Coordinators will be utilized in care coordination, transitional care and quality care. They must have a minimum of a BSN degree and maintain a current license.
• 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;

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☑ **Social Workers**

Describe the Provider Qualifications and Standards:

Social Workers are utilized in care coordination and quality care. They must have at a minimum a Bachelor's degree in Social Work from an accredited school of social work and maintain a current license.
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;

☑ **Behavioral Health Professionals**

Describe the Provider Qualifications and Standards:

Behavioral Health Nurses musthave a minimum of a BSN degree, maintain a current license, have experience in the behavioral health field and the following:
• 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;

☑ **Other (Specify)**

Provider
Name: Alabama Department of Public Health (ADPH) Provider Qualifications and Standards: • ADPH must meet all state qualifications; • Sign a contract with AMA and be assigned a Medicaid Provider ID. Staff are required to have documented work experience with the population, an administrative capacity to insure quality of services in accordance with state and federal requirements, a functional financial management system that provides documentation of services and costs, capacity to document and maintain individual case records in accordance with state and federal requirements, demonstrated ability to assure a referral process consistent with Section 1092a(23) of the Social Security Act, allow freedom 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 have a minimum of a BSN or Bachelor's Degree in Social Work and appropriate license.
Name: Community Mental Health Centers Provider Qualifications and Standards: • CMHCs must be certified by the Alabama Department of Mental Health (ADMH) • Meet all state qualifications; • Sign a contract with AMA and be assigned a Medicaid Provider ID. Staff are required to have documented work experience with the population, an administrative capacity to insure quality of services in accordance with state and federal requirements, a functional financial management system that provides documentation of services and costs, capacity to document and maintain individual case records in accordance with state and federal requirements, demonstrated ability to assure a referral process consistent with Section 1092a(23) of the Social Security Act, allow freedom 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;

Provider
• Individual care managers must have a minimum of a BSN or Bachelor's Degree in Social Work and appropriate license.
Name: Federal Qualified Health Centers (FQHCs) Provider Qualifications and Standards: • FQHCs must meet all state and federal qualifications • Sign agreements with the Health Homes that address core competencies. • Must ensure that care is person-centered, culturally competent and linguistically capable; • 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. 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.
Name: Pharmacists Provider Qualifications and Standards: A Clinical Pharmacist must have a minimum of a Pharm.D. Degree and formal residency training or equivalent clinical experience (minimum of three calendar years) to work in concert with the Health Home leadership. A Network Pharmacist must have a current Alabama Pharmacy license in good standing.
Name: Rural Health Clinics (RHCs) Provider Qualifications and Standards: • RHCs must meet all state and federal qualifications; • Sign agreements with the Health Homes that address core competencies; • Must ensure that care is person-centered, culturally competent and linguistically capable; • 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 • 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 HIT to link services, facilitate communication among

Provider
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.
Name: Substance Abuse (SA) Providers Provider Qualifications and Standards: • SA Providers must be certified by the Alabama Department of Mental Health (ADMH); • Meet all state qualifications; • Sign a contract with AMA and be assigned a Medicaid Provider ID; • Staff are required to have documented work experience with the population, an administrative capacity to insure quality of services in accordance with state and federal requirements, a functional financial management system that provides documentation of services and costs, capacity to document and maintain individual case records in accordance with state and federal requirements, demonstrated ability to assure a referral process consistent with Section 1092a(23) of the Social Security Act, allow freedom 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 have a minimum of a BSN or Bachelor's Degree in Social Work and appropriate license.

☐ **Health Teams**

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

☐ **Medical Specialists**

Describe the Provider Qualifications and Standards:

☐ **Nurses**

Describe the Provider Qualifications and Standards:

☐ **Pharmacists**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Dieticians**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Specialists**

Describe the Provider Qualifications and Standards:

☐ **Doctors of Chiropractic**

Describe the Provider Qualifications and Standards:

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Describe the Provider Qualifications and Standards:

☐ **Physicians' Assistants**

Describe the Provider Qualifications and Standards:

Supports for Health Homes Providers

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

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

Description:

Health Home Providers are required to have a documented work experience with the target population; an administrative capacity to insure quality of services in accordance with state and federal requirements; capacity to document and maintain individual case records in accordance with state and federal requirements; demonstrated ability to assure a referral process consistent with Section 1902a(23) of the Social Security Act; allow for free choice of provider; and demonstrated capacity to meet the care management service needs of the target population they are serving. Additionally, Health Homes are required to have an identified member of the team with behavioral health knowledge/expertise to work with the local CMHC and SA providers and include them in their management meetings.

Health Homes will continue the care coordination and transitional care program of qualified staff to meet the needs of patients with chronic conditions to improve medical management, transition from an inpatient or residential setting to the community, and integrate medical and behavioral health care. A person-centered, holistic care plan is developed and integrates all clinical and non-clinical health-care related needs and services.

Health Homes must use information technology systems and processes to integrate and share elements such as demographic data, enrollment data, assessment results, care plans, case notes, claims and pharmacy data. This system must be linked to other databases, systems and the centralized Health Home recipient record that the Health Home uses to maintain information about the recipient. The goal is to integrate the recipient's information in a meaningful way to facilitate care coordination.

In order to ensure the delivery of quality health home services, the Alabama Medicaid Agency (AMA) provides state learning activities for health home providers through regularly scheduled meetings.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.
Attachment: "Alabama Health Home Care Coordination Model" explains the process for recipients receiving health home services.

The Health Home Services in Alabama are provided by a team of health care professionals from different agencies and health care providers to assure that Health Home recipients are receiving the six core elements of Health Homes. The lead Health Home Entity, currently called Patient Care Network of Alabama coordinates these services to assure that patients are identified and services are provided without duplication. This organization contracts with PMPs as part of the team, and has developed a relationship with FQHCs, RHCs, ADPH, and CMHCs in order to fulfill these goals. The Health Home Entity receives a PMPM for their coordination of these services, leading the medical management/ quality improvement initiatives of the team of health care professionals, as well as care coordination and transitional care services. Staff hired by the lead Health Home Entity to provide services under this PMPM rate include social workers, nurses, pharmacists, and a medical director. The Health Home Entity does not pay a fee to any organization, agency, or PMP for services.

Eligible Team of Health Care Professionals include: Categories of physicians that are authorized under the Alabama Medicaid State Plan as PMP 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. "Eligible Team of Health Care Professionals" authorized to provide care coordination under SPA include Health Home Care Coordinators, ADPH, and ADMH contracted CMHCs and SA providers. Health Home staff include a medical director, pharmacist, and a nurse or social work care coordinator.

Health Homes are required to have an identified member of their team with behavioral health knowledge/expertise to work with the local CMHC and SA provider and include them in their management meetings. PMPs and Health homes are contractually required to partner with CMHCs.

Services provided by the Health Homes include:
• Comprehensive Care Management: PMPs, which include physicians, FQHCs, and RHCs will provide comprehensive care management by identifying high-risk individuals with chronic conditions and/or a mental health condition to refer for transitional care, care coordination, or other needed services to manage their conditions; outreach services to plan and communicate with other primary specialty care providers regarding patient's care; develop a comprehensive health plan informed by the patient, which integrates care across various systems (MH/SA/Primary Care); and clarify and communicate the patient's preferences to all involved providers while assuring timely delivery of services.
• Care Coordination: Care Coordination services are provided by Nurse or Social Work Care Coordinators and Behavioral Health Nurses employed by Health Homes, Community Mental Health Centers (CMHC), or Alabama Department of Public Health (ADPH). Health Home recipients identified with MH/SA diagnoses, or with public health needs receive care coordination from the appropriate agencies. The recipient may change care coordinators by choice at any time within the CMHC, ADPH, or Health Home to best serve their needs. Care coordination is an enrollee-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual's needs and preferences are assessed, a comprehensive care plan developed, and services managed, monitored and reassessed as needed by an identified care coordinator following evidence-based standards of care to the degree possible. In addition to the core elements of care coordination, 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.
• Health Promotion: Health promotion is considered a key component in managing chronic diseases and is provided by the team of Health Care Professionals including physicians, FQHCs, RHCs, Social Workers, Nurses, Behavioral Health, Pharmacists, and Public Health. Information is provided to the health home recipient and reinforced through care management, care coordination, and transitional care in order to prevent adverse outcomes.
• Comprehensive transitional care/ follow-up: Comprehensive transitional care is led by a transitional care nurse or behavioral health nurse, but may include a multidisciplinary team of physicians, social workers, and pharmacists to assist the recipient in safe transitioning of care to the next most appropriate level including movement from inpatient to a nursing facility or home setting. Health home recipients are identified through claims or inpatient facilities and screened for services. The transitional care nurse or team explains health home services to the recipient. If the patient chooses to receive transitional care services, an assessment of the patient's health and psychosocial needs is completed and a care plan developed in order to assist the patient in transitioning to a new level of care. Follow up services are provided in the home or new residential setting by the appropriate health care team member. Care Coordination services may begin simultaneously or following the transitional care services depending on the recipient's needs.
• Patient and family support: Services are provided by all health care team members to provide the patient and family with needed education, information, and resources in order to better manage their chronic conditions.

• Referral to community and social support services: The PMPs, social workers, and nurses identify needs of the patients through their assessments and refer to needed services based on those needs.

Provider Standards

The State's minimum requirements and expectations for Health Homes providers are as follows:

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":

1. Must be registered with the State, required to meet state qualifications, and have been provided a state assigned Medicaid Provider ID;
2. Must ensure that care is person-centered, culturally competent and linguistically capable;
3. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
4. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
5. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
6. 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;
7. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
8. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
9. Coordinate and provide access to long-term care supports and services;
10. 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;
11. 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
12. 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.

PMPs and Health Home: 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 the Patient 1st PMP and Health Home, and in the contract between the Health Home and their providers. PMPs and Health Homes must sign agreements with the State and each other. Alabama standards may be amended as necessary and appropriate. Standards include:

1. Capacity to provide access to care that includes an 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.
2. 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.
3. Ability to provide continuous personal clinician assignment and clinician care, organization of clinical information, clinical information exchange and specialized care settings.
4. Capability to coordinate and integrate that includes a capacity for population data management; to use health information technology (HIT); 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 Health Homes and provide comprehensive care management (PMPs), care management (Health Homes), and transitional care across settings (Health Homes and PMPs), and to coordinate and provide access to long-term care supports and services and end of life planning.
5. 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.

Contract Requirements:

1. PMPs must have contracts with AMA and the local Health Home. PMPs must sign agreements that address core competencies. Integration and coordination of services for individuals with MH and/or SA shall be addressed in all contracts (PMP and Health Home), including the requirement for ongoing processes with community providers and other community agencies to coordinate the planning and provision of care management. Alabama standards, which may be met onsite 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 the Health Home and in the contract between the Patient 1st, Health Home and their providers. PMPs and Health Homes must sign agreements with the state and each other. Alabama standards may be amended as necessary and appropriate.

2. Health Homes 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. In addition, the Health Home team must include a care coordinator with expertise and/or knowledge in behavioral health who will serve as a liaison between the PMP and the CMHC and or SA provider.

3. The CMHC will complete behavioral health screening (non-standardized) for Health Home recipients with substance use diagnoses and determines if individual is eligible for care management through the ADMH SA care management provider. If not eligible, the individual is referred back to the PMP. If the recipient is determined to be "unstable", the Health Home is notified and the individual becomes eligible for care management services through the Health Home.

4. The ADPH provider completes screening (non-standardized) and determines if the individual is eligible for care management through ADPH Care management provider. If not eligible, the individual is referred back to the PMP. If "unstable", the Health Home is notified and the individual becomes eligible for care management services through the Health Home.

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Health Homes Service Delivery Systems

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

☑ **Fee for Service**

☐ **PCCM**

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

○ **The PCCMs will be a designated provider or part of a team of health care professionals.**
The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:

☐ **Fee for Service**

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

☐ **Other**

Description:

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

If yes, describe how requirements will be different:

☐ **Risk Based Managed Care**

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

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

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

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

☐ **Other**

Describe:

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

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

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

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

○ **Yes**

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

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

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

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

○ **No**

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

☐ **Fee for Service**

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

☐ **Other**

Description:

☐ **Other Service Delivery System:**

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

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

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Health Homes Payment Methodologies

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

☑ **Fee for Service**

☑ **Fee for Service Rates based on:**

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

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

Some Health Home Recipients receive care coordination services through ADMH or ADPH based on their condition and needs, such as behavioral health, substance use disorders, or issues related to public health. Since this is only a portion of the Health Home population, these providers are paid on a Fee for Service basis through AMA.

The Payment System for services for the Health Homes in Alabama:

Health Homes (Lead Entity): PMPM of $9.50 monthly from AMA to coordinate services provided by the Team of Health Care Professionals to assure all six core services are provided, lead medical management meetings and Quality Initiatives, and provide care coordination and transitional care services.
Private PMPs: PMPM of $8.50 monthly from AMA to coordinate and through the regional health home entity provide access to comprehensive care management, care coordination services, transitional care, health promotion, individual and family support, and referrals to community and social support services. Care coordination services are provided by the Health Home Entity, ADPH, and the CMHCs.

FQHCs: No additional payment provided. The Providers at FQHCs coordinate and through the regional health home entity provide access to comprehensive care management, care coordination services, transitional care, health promotion, individual and family support, and referrals to community and social support services. The more intensive, health home level of care coordination services are provided by the Health Home Entity, ADPH, and the CMHCs.

RHCs: No payment provided at this time. The Providers at RHCs coordinate and through the regional health home entity provide access to comprehensive care management, care coordination services, transitional care, health promotion, individual and family support, and referrals to community and social support services. The more intensive, health home level of care coordination services are provided by the Health Home Entity, ADPH, and the CMHCs.

ADPH: AMA directly pays Fee for Service on a fee schedule to provide Care Coordination Services to Health Home recipients by nurses and social workers.

CMHCs: AMA directly pays Fee for Service on a fee schedule to provide Care Coordination Services to Health recipients by nurses and social workers.

All Health Home team members will be covered by the PMPM rate described in the Payment Methodology section with the exception of the 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 coordination provider.

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

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

☐ **Other: Describe below.**

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

☑ **Per Member, Per Month Rates**

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

Private PMPs are provided a monthly payment of $8.50 if the following requirements are met:
1. The person is identified as meeting Health Home eligibility criteria on the State's MMIS and in the Care Management Information System;
2. The person is enrolled as a Health Home member at the PMP; and
3. 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 Health Home on a monthly basis reports by individual that indicate potential gaps in service delivery. The Health Home 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).

The Payment System for services for the Health Homes in Alabama:

Health Homes (Lead Entity): PMPM of $9.50 monthly from AMA to coordinate services provided by the Team of Health Care Professionals to assure all six core services are provided, lead medical management meetings and Quality Initiatives, and provide care coordination and transitional care services.
Private PMPs: PMPM of $8.50 monthly from AMA to coordinate and through the regional health home entity provide access to comprehensive care management, care coordination services, transitional care, health promotion, individual and family support, and referrals to community and social support services. Care coordination services are provided by the Health Home Entity, ADPH, and the CMHCs.

FQHCs: No additional payment provided. The Providers at FQHCs coordinate and through the regional health home entity provide access to comprehensive care management, care coordination services, transitional care, health promotion, individual and family support, and referrals to community and social support services. The more intensive, health home level of care coordination services are provided by the Health Home Entity, ADPH, and the CMHCs.

RHCs: No payment provided at this time. The Providers at RHCs coordinate and through the regional health home entity provide access to comprehensive care management, care coordination services, transitional care, health promotion, individual and family support, and referrals to community and social support services. The more intensive, health home level of care coordination services are provided by the Health Home Entity, ADPH, and the CMHCs.

ADPH: AMA directly pays Fee for Service on a fee schedule to provide Care Coordination Services to Health Home recipients by nurses and social workers.

CMHCs: AMA directly pays Fee for Service on a fee schedule to provide Care Coordination Services to Health recipients by nurses and social workers.

☐ **Incentive payment reimbursement**

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

the incentive payment amounts, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

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

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

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

☐ **Tiered Rates based on:**

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

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

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

☐ **Rate only reimbursement**

Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.

Alabama has taken care to ensure the reimbursement model is designed to only fund Health Home Services that are not covered by any of the currently available Medicaid funding mechanisms.

Through the screening assessment process with the enrollees, Health Home staff determine if similar services are being provided under othe Medicaid authorities in order to prevent duplication of services.

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

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

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Submission - Categories of Individuals and Populations Provided Health Homes Services

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

☑ **Categorically Needy eligibility groups**

Health Homes Services (1 of 2)

Category of Individuals
CN individuals

Service Definitions

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

Comprehensive Care Management

Definition:
PMPs will provide comprehensive care management to all Health Home eligible by:
1. Identifying high-risk individuals (in addition to the efforts by the state directly to identify high-risk enrollees);
2. Outreach to, plan and communicate with other primary and specialty care providers regarding a patient's care;
3. Developing a comprehensive health plan informed by the patient, which integrates care across various systems (MH/SA/Primary Care); and
4. Clarifying and communicating the patient's preferences to all involved providers while assuring timely delivery of services.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
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. Health Homes will be required to use the CCD which is a component of an Electronic Health Record (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.

In the interim, the state approves web-based tools, such as 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 a care management tool to track and impact key health indicators of their patients with Congestive Heart Failure, Hypertension, and Diabetes.
Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**
☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☑ **Physicians**

Description

Physicians serve as the PMP in the Medical Home and coordinate the care of the patient by developing a person-centered treatment plan that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services, including access to care coordination and transitional care across settings.

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Care Coordination

Definition:
Care Coordination is 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.

The Health Home Care Coordinator, a member of the Health Home team, provides care management, serves as a liaison between the family, PMP, 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 Health Home, specialists and other ancillary providers involved in the participant's care.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
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. Health Homes will be required to use the CCD which is a component of an Electronic Health Record (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.

In the interim, the state approves web-based tools, such as 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 a care management tool to track and impact key health indicators of their patients with Congestive Heart Failure, Hypertension, and Diabetes.
Scope of benefit/service

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

☑ **Behavioral Health Professionals or Specialists**

Description
1. Screening for clinical depression.
2. Coordination and access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
3. Coordination and access to mental health and substance abuse services.
4. Facilitate 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 services.

☑ **Nurse Care Coordinators**

Description
1. Development of a comprehensive health plan (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, Health Home, specialists and other ancillary providers involved in the participant's care;
2. Coordination and access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
3. Coordination and access to mental health and substance abuse services;
4. Coordination and access to long-term care supports and services;
5. 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;
6. 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.;
7. Screening for clinical depression;

8. Disease management education, medication reconciliation, facilitation of sub-specialty referrals and transitional care interventions;
fragmentation in services;
9. Assistant to the individual in the safe transitioning of care to the next most appropriate level.

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description

1. Development of a comprehensive health plan (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, Health Home, specialists and other ancillary providers involved in the participant's care;
2. Coordination and access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
3. Coordination and access to mental health and substance abuse services;
4. Coordination and access to long-term care supports and services;
5. 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;
6. 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.;
7. Screening for clinical depression;

8. Disease management education, medication reconciliation, facilitation of sub-specialty referrals and transitional care interventions;
fragmentation in services;
9. Assistant to the individual in the safe transitioning of care to the next most appropriate level.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Health Promotion

Definition:
Health Home staff, through Care Coordinators, Behavioral Health Nurses, and Transitional Care Nurses provide disease management education, utilization of services, and the importance of a medical home.
Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
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. Health Homes will be required to use the CCD which is a component of an Electronic Health Record (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.

In the interim, the state approves web-based tools, such as 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.
Scope of benefit/service

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

☑ **Behavioral Health Professionals or Specialists**

Description

1. Coordination and access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
2. Disease management education.
3. Encouragement of the appropriate use of health care services to improve quality of care and maintain cost effectiveness.
4. Adhering to Early and Periodic Screening, Diagnosis, and treatment (EPSDT) requirements.
5. Providing health-promoting lifestyle interventions, such as substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity.
6. Support health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers.
7. Promoting evidence based wellness and prevention by linking Health Home recipients with resources for smoking cessation, diabetes, asthma and other services based on individual needs and preferences.

☑ **Nurse Care Coordinators**

Description

1. Coordination and access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
2. Disease management education.
3. Encouragement of the appropriate use of health care services to improve quality of care and maintain cost effectiveness.
4. Adhering to Early and Periodic Screening, Diagnosis, and treatment (EPSDT) requirements.
5. Providing health-promoting lifestyle interventions, such as substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity.
6. Support health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers.
7. Promoting evidence based wellness and prevention by linking Health Home recipients with resources for smoking cessation, diabetes, asthma and other services based on individual needs and preferences.

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description

1. Coordination and access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
2. Disease management education.

3. Encouragement of the appropriate use of health care services to improve quality of care and maintain cost effectiveness.
4. Adhering to Early and Periodic Screening, Diagnosis, and treatment (EPSDT) requirements.
5. Providing health-promoting lifestyle interventions, such as substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity.
6. Support health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers.
7. Promoting evidence based wellness and prevention by linking Health Home recipients with resources for smoking cessation, diabetes, asthma and other services based on individual needs and preferences.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Health Homes Services (2 of 2)

Category of Individuals
CN individuals

Service Definitions

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

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

Definition:
AMA requires that PMPs, and Health Home Care Coordinators, who are social workers or nurses, assist the enrollee in the safe transitioning of care to the next most appropriate level including movement from inpatient to a nursing facility or home setting. PMPs and Health Home Care Coordinators 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 Health Homes, 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 Health Home Care Coordinators 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 Health Home Care Coordinators have a working relationship with all hospitals in their geographic area. In addition, the Health Home 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 Health Home and in the contract between the Patient 1st Health Home and their providers. PMPs and the Health Home must sign agreements with the state and each other. Alabama standards may be amended as necessary and appropriate.

Provider Types Furnishing the Service: PMPs, Health Home Care Coordinators
Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
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. Health Homes will be required to use the CCD which is a component of an Electronic Health Record (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.

In the interim, the state approves web-based tools, such as 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 a care management tool to track and impact key health indicators of their patients with Congestive Heart Failure, Hypertension, and Diabetes.
Scope of benefit/service

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

☑ **Behavioral Health Professionals or Specialists**

Description
Health Home Care Coordinators with Behavioral Health experience to assist with transitioning of patients from residential or inpatient behavioral health facilities to the community.

☑ **Nurse Care Coordinators**

Description
Health Home Nurse Care Coordinators to assist patients with transitioning from an inpatient setting to the community. These Transitional Nurse Care Coordinators identify patients in an inpatient setting, screen for eligibility, explain services, assist with discharge planning, and complete home visits to patients as follow up for needs.

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☑ **Physicians**

Description
Physicians (PMPs) develop care plans for medical needs for the patient and refer to needed agencies and DME services to assist with patient's transition to the community.

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description

Social Work Care Coordinators are utilized to explain services in the inpatient setting, assess for psychosocial needs, and refer to community agencies and resources to assist patient with transition back to the community.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Individual and family support, which includes authorized representatives

Definition:

Activities within the 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 caregiver about treatment options, community resources, insurance benefits, psychosocial concerns, and care management, so that timely and informed decisions can be made.
- Alabama requires health home care management providers Health Home, CMHCs, SA providers and ADPH) to provide patient and family support as appropriate.
- Alabama specifically requires the PMPs and Health Home Care Coordinators 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.

Provider Type: PMPs, Health Home Care Coordinators, CMHCs, SA Providers, and ADPH

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

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. Health Homes will be required to use the CCD which is a component of an Electronic Health Record (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.

In the interim, the state approves web-based tools, such as 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.
Scope of benefit/service

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

☑ **Behavioral Health Professionals or Specialists**

Description
Behavioral Health Specialists from the CMHCs, SA and the Health Homes (Care Coordinators) assist patients and families through education to the enrollee and family about treatment options, community resources, and linking to behavioral health care needs.

☑ **Nurse Care Coordinators**

Description
Nurse Care Coordinators in the Health Home (Health Home Care Coordinators) assist patients and families through education of the treatment plan, medical regime, treatement options; and empower the patient and family to be proactive in their care in order to have positive outcomes.

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☑ **Physicians**

Description
Physicians (PMPs) provide patient and family support as needed through education and empowerment to the enrollee and family about treatment options, community resources, insurance benefits, psychosocial concerns, and care management so that timely and informed decisions can be made.

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description
Social Workers (Health Home Care Coordinators) provide patient and family support through addressing psychosocial concerns and education of community resources.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**
Description

☐ **Nutritionists**
Description

☐ **Other (specify):**
Name

Description

Referral to community and social support services, if relevant

Definition:
Activities within the scope for referral to community and social support services include:
• Where relevant and as appropriate, PMPs and Health Home Care Coordinators 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 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 and 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.
• Health Homes are required to have a member of their team with expertise/knowledge in MH/SA to assure integration with CMHCs, SA providers and community resources

Provider Types: PMPs, Health Home Care Coordinators, CMHCs, SAs, and ADPH
Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.
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. Health Homes will be required to use the CCD which is a component of an Electronic Health Record (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.

In the interim, the state approves web-based tools, such as 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.
Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**
☑ **Behavioral Health Professionals or Specialists**
Description

Behavioral Health Specialists from the Health Homes, SA and the CMHCs provide education as needed for community resources to enrollees and their families and link them to any needed behavioral health services.

☑ **Nurse Care Coordinators**

Description

Nurse Care Coordinators assist as needed with referrals to community resources.

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☑ **Physicians**

Description

Physicians assist as needed to refer to community resources for the enrollee.

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description

Social Work Care Coordinators assess for any psychosocial needs, educated the patient and family on community resources and agencies, and assist as needed for referrals.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Health Homes Patient Flow

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

Patients are referred to Health Homes through inpatient settings, RMEDE, PMPs, or community agencies. Home Health recipients identified in an inpatient setting received transitional care through the Health Homes to assist in returning to a community based setting. Transitional care services include discharge planning, medication reconciliation, referrals to community resources, and education on the recipient's chronic condition and medical care. After the transition to the community, the Transitional Care nurse from the Health Home refers the patient to a Care manager for further assessment. All other Health Home recipients are assessed by the Care Manager after patient accepts services. The objectives of the Health Home Care Management Program are to:

a) Develop and implement patient centered holistic plans of care;
b) Improve health literacy, health outcomes and self-management'
c) Improve utilization of Information Technology resources by participants and providers in Health Home as available;
d) Promote effective use of the healthcare system and community resources;
e) Reduce the potential for risks of catastrophic or severe illness;
f) Prevent disease exacerbations and complications;
g) Reduce inappropriate utilization and costs associated with Emergency Department, and hospital inpatient services;
h) Work to identify additional key resources and incorporate these into the strategies implemented such as partnerships with ADPH and ADMH;

If an eligible Health Home recipient elects not to participate in a Health Home, the Care Manager or Transitional Care Nurse refers the recipient to any needed resources.
Health Home recipients are discharged once they no longer choose to participate.
See Attachment 3 for a flow chart of the Health Home Process.

☐ **Medically Needy eligibility groups**

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

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Attachment 3.1-H Page Number: 1

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:
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 for each age, gender and total combination.

Measure Specification, including numerator and denominator: 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.
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.
Frequency: Annual
Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.
Data Source: Medicaid claims
Specification: Total cost per member per month (PMPM) will be tracked and calculated based on total cost all patients in the Health Home geographical 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.
Describe how the State will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).
The Alabama health information exchange (HIE) initiative, One Health Record®, uses a standardized Continuity of Care Document (CCD) to share a summary of patient data. One Health Record is the gateway for individual or group entities (primary providers, pharmacies, EMTs, hospitals, clinics, organized health systems, payers, consumers for Personal Health Records and government institutions), within the state to connect with other state HIEs and Medicaid agencies, federal agencies, and exchange at the federal level. One Health Record® is part of Alabama's MMIS and will connect to other HIEs throughout Alabama and neighboring states.
The state currently requires an integrated medical record but not an electronic continuity of care record. Patient 1st Providers and Health Homes connected to One Health Record® will have the ability to push and consume a CCD through secure routing and a statewide provider directory. The exchange will enable the providers to pull summaries from disparate sources and create a holistic view of the patient's status and care.

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 a care management tool to track and impact key health indicators of their patients with Congestive Heart Failure, Hypertension, and Diabetes.

Quality Measurement

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

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

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

Evaluations

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

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

Hospital Admissions

Measure:

For Health Home Target members 18 years of age and older

Measure Specification, including a description of the numerator and denominator.
The number of acute inpatient stays during the mesurement 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, gendar, 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 Sources:
Medicaid Claims for acute care hospital
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Emergency Room Visits

Measure:

Percentage of patients who have had a visit to an Emergency Department (ED)/ Urgent Care office fo

Measure Specification, including a description of the numerator and denominator.
Specifications: Patients with a diagnosis of Asthma.

Numerator: The number patients from the denominator who have had a visit to an ED/ Urgent Care office for sthma 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.
Data Sources:
Medicaid Claims
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**