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: 10-06

2. STATE: Minnesota

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
July 1, 2010

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR §447.201(b0

7. FEDERAL BUDGET IMPACT: (in thousands)
a. FFY '10: $ 282,295
b. FFY '11: $910,960

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 3.1-A, pages 19b, 19c, 19d
Att. 3.1-B, pages 18b, 18c, 18d
Att. 4.19-B, page 4e, 4f, 5e, 5f, 10h, 10i

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: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

10. SUBJECT OF AMENDMENT:
Health care homes service

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Brian Osberg

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
April 7, 2010

16. RETURN TO:

Lisa Knazan
Minnesota Department of Human Services
Federal Relations Unit
PO Box 64983
St. Paul, MN 55164-0983

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
April 7, 2010

18. DATE APPROVED:
JUL 06 2010

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2010

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Verlon Johnson

22. TITLE:
Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

5.a. Physicians' services (continued):

- **~~Provider-directed care coordination~~ Health care home** services: Health care home ~~**pro**vider-directed care coordination~~ services are physicians' services provided in a clinical setting to recipients with complex and chronic medical conditions. All aspects of care are coordinated by the clinical staff team, which must be managed by a physician, nurse practitioner, or a physician assistant under the supervision of a physician. The team must include a dedicated care coordinator. Payment for this service ~~must be in conjunction with payment for an evaluation and management visit and is made no more frequently than once every six months~~ cannot be made more than once per patient per month.

  The service is comprised of the following components:

  A. Identifying recipients appropriate for health care home services ~~provider-directed care coordination~~ and matching intervention with need.

     1. This service is medically necessary for people with ~~five~~ one or more major chronic ~~diagnoses~~ conditions that are recurrent or persist for at least ~~one year~~ six months. Based on established methodologies, recipients with ~~chronic diagnoses~~ major chronic conditions are grouped as follows:
        - Group 1: those with ~~5-6 chronic diagnoses~~ 1-3 major chronic conditions;
        - Group 2: those with ~~7-9 chronic diagnoses~~ 4-6 major chronic conditions;
        - Group 3: those with 7-9 ~~chronic diagnoses~~ major chronic conditions:
        - Group 4: those with 10 or more ~~chronic diagnoses~~ major chronic conditions.

  B. Assessing an identified recipient's health status, risk factors, self-management skills, adherence to a treatment plan, and knowledge of and adherence to a prescribed medication regimen;

  C. Partnering with the recipient and/or family in decision-making through care team meetings with the recipient and/or family;

  D. Developing a comprehensive, individualized care plan where warranted due to patient complexity, detailing the recipient's specific medical needs and specific plans for all aspects of medical care, including preventive care, chronic care, acute care, and when appropriate, end-of-life-care and advanced

5.a. Physicians' services (continued):

directives, while incorporating social service needs and cultural preferences;

E. Documenting all levels of care provided;

F. Coordinating care with other medical providers who are responsible for pertinent aspects of care as defined in the individual care plan;

G. Conducting periodic monitoring and evaluating a recipient's response to care provided including face-to-face contact with the primary care provider occurring at least once every six months;

H. Providing an annual comprehensive review to identify, resolve and prevent problems in utilization of care;

I. Providing available access to medical professionals with knowledge of the recipient's medical history 24 hours per day and seven days per week;

J. Assisting recipients in improving health outcomes using evidence-based guidelines and protocols;

K. Promoting behavior modification aimed at encouraging lifestyle changes to support health self-management;

Providers of health care home services ~~provider-directed care coordination~~ must be certified by the Department as having the capacity to provide the components described in items A through K, above and as qualified to engage in the following:

1. Quality improvement activities, including:

a. Participating in a quality improvement training program including ongoing training on care coordination, evidence based medicine and best practices;

b. Creating and following clinic-level, team-based internal quality improvement processes;

c. Analyzing clinic processes and patient outcome measures.

5.a. Physicians' services (continued):

d. Participating in quality improvement processes with other providers in order to develop and share best practices.

2. Create and maintain patient information in a searchable, internal clinical registry for the following purposes:

a. Provide reminders and follow-up for comprehensive preventive care according to nationally accepted guidelines;

b. Manage chronic illness, organize patient care and track interventions;

c. Track patient information including diagnoses, primary language and cultural preferences and needs.

3. Designate a dedicated care coordinator to:

a. Provide information, support and resources to ensure that the recipient adheres to therapeutic regimens;

b. Provide information about available community and social service providers necessary for improvement and maintenance of optimal health outcomes;

c. Provide education and training to enhance recipient understanding of and appropriate management of the recipient's condition(s). This includes education about self-management, appropriate use of resources, how to navigate the health care system, and how the primary care provider will work with the recipient to develop a plan of care where warranted due to patient complexity, in coordination with the recipient and the recipient's family and caregivers.

5.a. Physicians' services (continued):

- **~~Provider-directed care coordination~~ Health care home** services: Health care home **~~pro~~**~~vider-directed care coordination~~ services are physicians' services provided in a clinical setting to recipients with complex and chronic medical conditions. All aspects of care are coordinated by the clinical staff team, which must be managed by a physician, nurse practitioner, or a physician assistant under the supervision of a physician. The team must include a dedicated care coordinator. Payment for this service ~~must be in conjunction with payment for an evaluation and management visit and is made no more frequently than once every six months~~ cannot be made more than once per patient per month.

  The service is comprised of the following components:

  L. Identifying recipients appropriate for health care home services ~~provider-directed care coordination~~ and matching intervention with need.

     1. This service is medically necessary for people with ~~five~~ one or more major chronic ~~diagnoses~~ conditions that are recurrent or persist for at least ~~one year~~ six months. Based on established methodologies, recipients with ~~chronic diagnoses~~ major chronic conditions are grouped as follows:

        - Group 1: those with ~~5-6 chronic diagnoses~~ 1-3 major chronic conditions;
        - Group 2: those with ~~7-9 chronic diagnoses~~ 4-6 major chronic conditions;
        - Group 3: those with 7-9 ~~chronic diagnoses~~ major chronic conditions:
        - Group 4: those with 10 or more ~~chronic diagnoses~~ major chronic conditions.

  M. Assessing an identified recipient's health status, risk factors, self-management skills, adherence to a treatment plan, and knowledge of and adherence to a prescribed medication regimen;

  N. Partnering with the recipient and/or family in decision-making through care team meetings with the recipient and/or family;

  O. Developing a comprehensive, individualized care plan where warranted due to patient complexity, detailing the recipient's specific medical needs and specific plans for all aspects of medical care, including preventive care, chronic care, acute care, and when appropriate, end-of-life-care and advanced

5.a. Physicians' services (continued):

directives, while incorporating social service needs and cultural preferences;

P. Documenting all levels of care provided;

Q. Coordinating care with other medical providers who are responsible for pertinent aspects of care as defined in the individual care plan;

R. Conducting periodic monitoring and evaluating a recipient's response to care provided including face-to-face contact with the primary care provider occurring at least once every six months;

S. Providing an annual comprehensive review to identify, resolve and prevent problems in utilization of care;

T. Providing available access to medical professionals with knowledge of the recipient's medical history 24 hours per day and seven days per week;

U. Assisting recipients in improving health outcomes using evidence-based guidelines and protocols;

V. Promoting behavior modification aimed at encouraging lifestyle changes to support health self-management;

Providers of health care home services ~~provider-directed care coordination~~ must be certified by the Department as having the capacity to provide the components described in items A through K, above and as qualified to engage in the following:

4. Quality improvement activities, including:

a. Participating in a quality improvement training program including ongoing training on care coordination, evidence based medicine and best practices;

b. Creating and following clinic-level, team-based internal quality improvement processes;

c. Analyzing clinic processes and patient outcome measures.

5.a. Physicians' services (continued):

d. Participating in quality improvement processes with other providers in order to develop and share best practices.

5. Create and maintain patient information in a searchable, internal clinical registry for the following purposes:

a. Provide reminders and follow-up for comprehensive preventive care according to nationally accepted guidelines;

b. Manage chronic illness, organize patient care and track interventions;

c. Track patient information including diagnoses, primary language and cultural preferences and needs.

6. Designate a dedicated care coordinator to:

a. Provide information, support and resources to ensure that the recipient adheres to therapeutic regimens;

b. Provide information about available community and social service providers necessary for improvement and maintenance of optimal health outcomes;

c. Provide education and training to enhance recipient understanding of and appropriate management of the recipient's condition(s). This includes education about self-management, appropriate use of resources, how to navigate the health care system, and how the primary care provider will work with the recipient to develop a plan of care where warranted due to patient complexity, in coordination with the recipient and the recipient's family and caregivers.

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic.

cardiovascular care for each recipient. To qualify for the rate adjustment, the clinic must submit documentation of the provision of specific services and complete clinical results per recipient that meet the above criteria for optimal diabetic and/or cardiovascular care. Effective July 1, 2009, the rate adjustment is $250 plus 2% every six months when all of the above criteria are met.

C. Effective ~~July 1, 2009~~July 1, 2010, for clinics certified as meeting the ~~provider-directed care coordination~~ health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one ~~six-month~~ one-month payment per recipient with ~~5-6~~ 1-3 major chronic ~~diagnoses~~ conditions receiving Group 1 ~~provider-directed care coordination~~ health care home services~~, associated with an evaluation and management visit~~, is the lower of:

- Submitted charge; or
- ~~$243.24~~ $10.14, plus 2 percent.

Effective ~~July 1, 2009~~July 1, 2010, for clinics certified as meeting the ~~provider-directed care coordination~~ health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one ~~six-month~~ one-month payment per recipient with ~~7-8~~ 4-6 major chronic ~~diagnoses~~ conditions receiving Group 2 ~~provider-directed coordination~~ health care home services~~, associated with an evaluation and management visit,~~ is the lower of:

- Submitted charge; or
- ~~$316.20~~ $20.27, plus 2 percent.

Effective ~~July 1, 2009~~July 1, 2010, for clinics certified as meeting the ~~provider-directed care coordination~~ health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one ~~six-month~~ one-month payment per recipient with ~~10 or more~~ 7-9 major chronic ~~diagnoses~~ conditions receiving Group 3 ~~provider-directed care coordination~~ health care home services~~, associated with an evaluation and management visit,~~ is the lower of:

- Submitted charge; or
- ~~$458.52~~ $40.54, plus 2 percent.

2.b. Rural health clinic services and other ambulatory services that are covered under the plan and furnished by a rural health clinic.

Effective July 1, 2010, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 10 or more major chronic conditions receiving Group 4 health care home services is the lower of:

- Submitted charge; or
- $60.81, plus 2 percent.

For each of the Groups 1-4 above, the payment rates listed will be increased by 15% if either of the following apply:

- The recipient (or caregiver of a dependent recipient) uses a primary language other than English to communicate about their health care; or
- The recipient (or caregiver of a dependent recipient) has a serious and persistent mental illness.

~~For provider-directed care coordination payment based on services less than six months in duration, the payment rate listed above may be allocated to the time period served. Allocation can only occur in the case of a recipient's death, loss of eligibility or change of payer. Payment must be associated with the last evaluation and management visit occurring during the preceding six months.~~

A rural health clinic providing services under a contract with a Medicaid MCE will receive quarterly state supplemental payments for the cost of providing such services. The supplemental payments are an estimate of the difference between the payments the clinic receives from the MCE and the payments the clinic would have received in accordance with the alternative payment methodology of §1902(bb)(6) of the Act.

At the end of the clinic's fiscal year, the total amount of supplemental and MCE entity payments received will be reviewed against the amount that the actual number of visits provided under the clinic's contract with the MCE would have yielded under the alternative payment methodology. The clinic will be paid the difference between the amount calculated using the alternative payment methodology and actual number of visits, and the total amount of supplemental and MCE payments received, if the alternative amount exceeds the total amount of supplemental and MCE payments. The clinic will refund the difference between the alternative amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received, if the alternative amount is less than the total amount of supplemental and MCE payments.

For rural health clinic payments, "visit" means a face-to-face encounter between a clinic patient and any health professional whose services are paid under the State plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (continued)

provision of specific services and complete clinical results per recipient that meet the criteria for optimal diabetic and/or cardiovascular care. Effective July 1, 2009, the rate adjustment is $250 plus 2% every six months when all of the above criteria are met.

C. Effective July 1, ~~2009~~ 2010, for FQHCs certified as meeting the ~~provider-directed care coordination~~ health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one ~~six-month~~ one-month payment per recipient with ~~5-6~~ 1-3 major chronic ~~diagnoses~~ conditions receiving Group 1 ~~provider-directed care coordination~~ health care home services~~, associated with an evaluation and management visit,~~ is the lower of:

- Submitted charge; or
- ~~$243.24~~ $10.14, plus 2 percent.

Effective July 1, ~~2009~~ 2010, for FQHCs certified as meeting the ~~provider-directed care coordination~~ health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one ~~six-month~~ one-month payment per recipient with ~~7-8~~ 4-6 major chronic ~~diagnoses~~ conditions receiving ~~provider-directed coordination~~ Group 2 health care home services~~, associated with an evaluation and management visit,~~ is the lower of:

- Submitted charge; or
- ~~$316.20~~ $20.27, plus 2 percent.

Effective July 1, ~~2009~~ 2010, for FQHCs certified as meeting the ~~provider-directed care coordination~~ health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one ~~six-month~~ one-month payment per recipient with ~~10 or more~~ 7-9 major chronic ~~diagnoses~~ conditions receiving ~~provider-directed care coordination~~ Group 3 health care home services~~, associated with an evaluation and management visit,~~ is the lower of:

- Submitted charge; or
- ~~$458.52~~ $40.54, plus 2 percent.

~~For provider-directed care coordination payment based on services less than six months in duration, the payment rate listed above may be allocated to the time period served. Allocation can only occur in the case of a recipient's death, loss of eligibility or change of payer. Payment must be associated with the last evaluation and management visit occurring during the preceding six months.~~

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC. (continued)

Effective July 1, 2010, for clinics certified as meeting the health care home criteria described in Attachments 3.1-A and 3.1-B, item 5.a, Physicians' services, one one-month payment per recipient with 10 or more major chronic conditions receiving Group 4 health care home services is the lower of:

- Submitted charge; or
- $60.81, plus 2 percent.

For each of the Groups 1-4 above, the payment rates listed will be increased by 15% if either of the following apply:

- The recipient (or caregiver of a dependent recipient) uses a primary language other than English to communicate about their health care; or
- The recipient (or caregiver of a dependent recipient) has a serious and persistent mental illness.

A FQHC providing services under a contract with a Medicaid MCE will receive quarterly state supplemental payments for the cost of providing such services. The supplemental payments are an estimate of the difference between the payments the FQHC receives from the MCE and the payments the FQHC would have received in accordance with the alternative payment methodology of §1902(bb)(6) of the Act.

At the end of the FQHC's fiscal year, the total amount of supplemental and MCE entity payments received will be reviewed against the amount that the actual number of visits provided under the FQHC's contract with the MCE would have yielded under the alternative payment methodology. The FQHC will be paid the difference between the amount calculated using the alternative payment methodology and actual number of visits, and the total amount of supplemental and MCE payments received, if the alternative amount exceeds the total amount of supplemental and MCE payments. The FQHC will refund the difference between the alternative amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received, if the alternative amount is less than the total amount of supplemental and MCE payments.

For FQHC payments, "visit" means a face-to-face encounter between a FQHC patient and any health professional whose services are paid under the State plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

The State uses the FQHC's audited Independent Rural Health

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere. (continued)

(b) Primary care component provided by a physician assistant, nurse practitioner, or clinical nurse specialist plus the psychiatrist component:

CPT code 99499 HE $78.79
CPT code 99499 HE TF $155.07
CPT code 99499 NE TG $194.50

(c) Primary care component provided by a physician extender plus the psychiatrist component:

CPT code 99499 HE U7 $ 73.64
CPT code 99499 HE TF U7 $143.54
CPT code 99499 HE TG U7 $178.02

The rate reductions affecting services rendered on or after July 1, 2009, do **not** apply to the ~~provider directed care coordination~~ health care home rates that follow.

Effective ~~January 1, 2009~~ July 1, 2010, one ~~six-month~~ one-month payment per recipient with ~~5-6~~ 1-3 major chronic ~~diagnoses~~ conditions receiving Group 1 ~~provider-directed care coordination~~ health care home services~~, associated with an evaluation and management visit~~, is the lower of:

- Submitted charge; or
- ~~$243.24~~ 10.14.

Effective ~~January 1, 2009~~ July 1, 2010, one ~~six-month~~ one-month payment per recipient with ~~7-8~~ 4-6 major chronic ~~diagnoses~~ conditions receiving Group 2 ~~provider-directed coordination~~ health care home services~~, associated with an evaluation and management visit,~~ is the lower of:

- Submitted charge; or
- ~~$316.20~~ 20.27.

Effective ~~January 1, 2009~~ July 1, 2010, one ~~six-month~~ one-month payment per recipient with ~~10 or more~~ 7-9 major chronic ~~diagnoses~~ conditions receiving Group 3 ~~provider-directed care coordination~~ health care home services~~, associated with an evaluation and management visit,~~ is the lower of:

- Submitted charge; or
- ~~$458.52~~ 40.54

Effective July 1, 2010, one one-month payment per recipient with 10 or more major chronic conditions receiving Group 4 health care home services is the lower of:

- Submitted charge; or
- $60.81.

For each of the Groups 1-4 above, the payment rates listed will be increased by 15% if either of the following apply to the recipient:

- The recipient (or caregiver of a dependent recipient) uses a primary language other than English to communicate about their health care; or
- The recipient (or caregiver of a dependent recipient) has a serious and persistent mental illness.

~~For provider-directed care coordination payment based on services less than six months in duration, the payment rate listed above may be allocated to the time period served. Allocation can only occur in the case of a recipient's death, loss of eligibility or change of payer. Payment must be associated with the last evaluation and management visit occurring during the preceding six months.~~