

Health Home State Plan Amendment

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Transmittal Number: OK-14-0011 Supersedes Transmittal Number: Proposed Effective Date: Jan 1, 2015 Approval Date:
Attachment 3.1-H Page Number:

Submission Summary

Transmittal Number:

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

OK-14-0011

Supersedes Transmittal Number:

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

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

Name of Health Homes Program:

OK HH - children

State Information

State/Territory name:

Oklahoma

Medicaid agency:

Oklahoma Health Care Authority

Authorized Submitter and Key Contacts

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Proposed Effective Date

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

Executive Summary

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

Federal Budget Impact

Federal Fiscal Year		Amount
First Year	2015	\$ 2359986.00
Second Year	2016	\$ 4287203.00

Federal Statute/Regulation Citation

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

Governor's Office Review

No comment.

Comments received.

Describe:

.....

No response within 45 days.

Other.

Describe:

The Governor does not review State Plan material.

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Submission - Public Notice

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

Public notice was not required and comment was not solicited

Public notice was not required, but comment was solicited

Public notice was required, and comment was solicited

Indicate how public notice was solicited:

Newspaper Announcement

Publication in State's administrative record, in accordance with the administrative procedures requirements.

Date of Publication:

..... (mm/dd/yyyy)

Email to Electronic Mailing List or Similar Mechanism.

Date of Email or other electronic notification:

..... (mm/dd/yyyy)

Description:

.....

Website Notice

Select the type of website:

Website of the State Medicaid Agency or Responsible Agency

Date of Posting:

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

Website URL:

www.okhca.org

Website for State Regulations

Date of Posting:

(mm/dd/yyyy)

Website URL:

Other

Public Hearing or Meeting

Other method

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

Access

Summarize Comments

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

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

Summarize Response

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

Quality

Summarize Comments

Summarize Response

Cost

Summarize Comments

Summarize Response

- Payment methodology**
Summarize Comments

Summarize Response

- Eligibility**
Summarize Comments

Summarize Response

- Benefits**
Summarize Comments

Summarize Response

- Service Delivery**
Summarize Comments
A comment was submitted that suggested the term physician-led team be switched to provider-led team.

Summarize Response
Changes to the Health Home rules were made to reflect suggestion.

- Other Issue**

Issue
<p>Issue Name: Support for Health Home</p> <p>Summarize Comments One comment was submitted expressing support for the Health Home initiative.</p> <p>Summarize Response</p>

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Submission - Tribal Input

- One or more Indian health programs or Urban Indian Organizations furnish health care services in this State.
 - This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.
 - The State has solicited advice from Tribal governments prior to submission of this State Plan Amendment.

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

Tribal consultation was conducted in the following manner:

- Indian Tribes**

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

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

Indian Health Programs

Urban Indian Organization

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

Indicate the key issues raised in Indian consultative activities:

Access

Summarize Comments

Summarize Response

Quality

Summarize Comments

Summarize Response

- Cost**
Summarize Comments

Summarize Response

- Payment methodology**
Summarize Comments

Summarize Response

- Eligibility**
Summarize Comments
Tribal consultation members asked the OHCA if tribal facilities could participate in the Health Home initiative.
Summarize Response
OHCA informed Tribal consultation members that tribal facilities could participate in the Health Home initiative.

- Benefits**
Summarize Comments

Summarize Response

- Service delivery**
Summarize Comments

Summarize Response

- Other Issue**

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Submission - SAMHSA Consultation

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

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

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Health Homes Population Criteria and Enrollment

Population Criteria

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	
---------------------------------	--

- 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:

- One or more serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition:

Children living with serious emotional disturbances (SED) will qualify. Serious Emotional Disturbance (SED) means a condition experienced by persons from birth to 18 in which:

- The disability must have persisted for six months and be expected to persist for a year or longer.
- A condition or serious emotional disturbance as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious emotional disturbance.

The child must exhibit either:

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

There is functional impairment in at least two of the following capacities (compared with expected developmental level):

- Impairment in self-care.
- Impairment in community function manifested by a consistent lack of age appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement with the juvenile justice system.
- Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.
- Impairment in family function manifested by a pattern of disruptive behavior (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations which may result in removal from the family or its equivalent).

- Impairment in functioning at school manifested by the inability to pursue educational goals in a normal time frame.

Geographic Limitations

Health Homes services will be available statewide

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

If no, specify the geographic limitations:

By county

Specify which counties:

By region

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

By city/municipality

Specify which cities/municipalities:

Other geographic area

Describe the area(s):

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:

Automatic Assignment with Opt-Out of Health Homes provider

Describe the process used:

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

Other

Describe:

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

- The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**
- The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**
- The State provides assurance that hospitals participating under the State Plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.**
- The State provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each Health Homes enrollee will be claimed. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.**

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

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Health Homes Providers

Types of Health Homes Providers

- Designated Providers**

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

- Physicians**

Describe the Provider Qualifications and Standards:

- Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards:

- Rural Health Clinics**

Describe the Provider Qualifications and Standards:

- Community Health Centers**

Describe the Provider Qualifications and Standards:

- Community Mental Health Centers**

Describe the Provider Qualifications and Standards:

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

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

Home Health Agencies

Describe the Provider Qualifications and Standards:

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

Case Management Agencies

Describe the Provider Qualifications and Standards:

Community/Behavioral Health Agencies

Describe the Provider Qualifications and Standards:

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

Federally Qualified Health Centers (FQHC)

Describe the Provider Qualifications and Standards:

Other (Specify)

Teams of Health Care Professionals

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

Physicians

Describe the Provider Qualifications and Standards:

Nurse Care Coordinators

Describe the Provider Qualifications and Standards:

Nutritionists

Describe the Provider Qualifications and Standards:

.....

Social Workers

Describe the Provider Qualifications and Standards:

.....

Behavioral Health Professionals

Describe the Provider Qualifications and Standards:

.....

Other (Specify)

Health Teams

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

Medical Specialists

Describe the Provider Qualifications and Standards:

.....

Nurses

Describe the Provider Qualifications and Standards:

.....

Pharmacists

Describe the Provider Qualifications and Standards:

.....

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:

Working together in partnership to develop the Health Homes proposal, DMHSAS and OHCA have hosted a number of Learning Collaboratives to ensure that the provider community is well informed about the holistic care philosophy that is the foundation of the Health Homes opportunity. These collaboratives will continue into the foreseeable future as a means of continuing to educate providers through the early steps of beginning to offer Health Home services and initial and ongoing data collection efforts. A resource web page for providers is available at

http://www.ok.gov/odmhsas/Mental_Health_/Oklahoma_Health_Homes_Learning_Collaborative/index.html

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.

The Health Home Team will be comprised of a team including, a Care Coordinator, a Project Director, a Psychiatric Consultant, a Nurse Care Manager, a Family Support Provider, Youth/Peer Support Specialist and Administrative Support Staff.

Provider Standards

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

The Health Home must make assurances that it will comply with all Health Home contractual and regulatory requirements.

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Health Homes Service Delivery Systems

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

- 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:

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

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

Other: Describe below.

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

Per Member, Per Month Rates

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

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

Tier one: Outreach and engagement. This code can be billed once per month for up to three months for a member

Tier two: Resource Coordination

Tier three: Wraparound Intensive Care Coordination; Youth/Young Adult

The rates for tiers two and three are also geographically adjusted based on urban and rural location. Locations are based on Metropolitan Statistical Areas. The rate for Youth/Young Adult is the same as in the adult model.

These HH rates were derived from an analysis of caseloads and staffing configurations, productivity, staffing costs and fee- for- service utilization. Staffing costs include salaries and wages, fringe benefits and operating and support costs. Salaries and wages were based on either actual provider surveys or data from the Bureau of Labor Statistics.

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

community and social support services.

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

Incentive payment reimbursement

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

PCCM Managed Care (description included in Service Delivery section)

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

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

Tiered Rates based on:

Severity of each individual's chronic conditions

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

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

Rate only reimbursement

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

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

The State will ensure non-duplication of payment for similar services using the edits and audits of the CMS-approved Medicaid Management Information System. Codes will be converted in the system and will not be reimbursed individually for Health Home members. These include: T1016 and T1017, targeted case management; H0032 treatment plan review; H0034, medication training; T1027, peer to peer support; and H2015, peer to peer support.

- 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**

<p>Health Homes Services (1 of 2)</p> <hr/> <p>Category of Individuals CN individuals</p> <p>Service Definitions</p> <p>Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:</p> <p>Comprehensive Care Management</p> <p>Definition: Comprehensive care management is provided by the HH by working with the HH enrollee to: (1) Assess current circumstances and presenting issues, identify strengths and needs, and identify resources and/or services to assist the HH enrollee to address their needs through the provision of an initial intake and needs assessment; (2) develop an Individual Care Plan that will include enrollee-specific goals, treatment interventions, and meaningful functional outcomes; and (3) on a regular basis, review and revise the Individual Care Plan to determine efficacy of interventions and emerging needs. Integral to this service is ongoing communication, and (4) collaboration between the HH Wraparound Team and the enrollee's PCMH, behavioral health and</p>

institutional/long term care providers.

Comprehensive care management services are conducted with high-need individuals, their families, and supporters to develop and implement a whole-person oriented treatment plan and monitor the individual's success in engaging in treatment and supports. Comprehensive care management services are carried out through use of a bio-psychosocial assessment including the Child Adolescent Strengths and Needs (CANS).

A bio-psychosocial assessment of physical and psychological status and social functioning is conducted for each person evaluated for admission to the HH. Assessments may be conducted by a psychiatrist, registered nurse or a LBHP. The assessment determines an individual's treatment needs and expectations of the individual served; the type and level of treatment to be provided; the need for specialized medical or psychological evaluations; the need for the participation of the family or other support persons; and identification of the staff person(s) and/or program to provide the treatment.

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

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

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

Scope of benefit/service

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

Behavioral Health Professionals or Specialists

Description

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Nurse Care Coordinators

Description

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Nurses

Description

Medical Specialists

Description

Physicians

Description

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 provides a single point of accountability for ensuring that medically necessary services and supports are accessed, coordinated, and delivered in a strengths-based, individualized, family/youth-driven, and ethnically, culturally, and linguistically relevant manner. Services and supports, which are guided by the needs of the enrollee, are developed through a wraparound care planning process consistent with systems of care values that results in an individualized and flexible plan of care for the enrollee and family.

Care coordination is designed to facilitate a collaborative relationship among an individual with SED, his/her family, and involved systems to support the parent/caregiver in meeting the enrollee's needs.

The care coordination care planning process ensures that a care coordinator organizes and matches care across providers and child serving systems to enable the enrollee to be served in their home community.

Care coordination includes the development and implementation of the individual care plan through the wraparound care planning process for attainment of the individuals' goals and improvement of clinical outcomes and functioning.

Care coordinators are responsible for conducting care coordination activities across providers and settings. Care coordination involves case management necessary for individuals to access medical, social, vocational, educational, as well as other individualized supportive services.

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

HH providers will work with HIOs or secure messaging to access member data and to develop partnerships that maximize the use of HIT across providers. HH providers will utilize HIT to create, document, execute, and update the comprehensive, person-centered service plan for every member that is accessible to the interdisciplinary team of providers when external partners have the capability to received structured, electronic records. HH providers will also be encouraged to utilize HIT to monitor member outcomes, initiate changes in care and follow up on member testing, treatments, services and referrals. In addition, for children with SED, the SOC Wraparound teams will be required to access data from the Medicaid Management Information System (MMIS) in order to monitor use of psychotropic medications.

Scope of benefit/service

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

Behavioral Health Professionals or Specialists

Description

Nurse Care Coordinators

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Nurses

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Description

Dieticians

Description

Nutritionists

Description

Other (specify):

Name

Description

Health Promotion

Definition:

Health promotion activities include:

- education regarding the importance of immunizations and screenings, child physical and emotional development;
- linking each child with screening in accordance with the EPSDT periodicity schedule;
- monitoring usage of psychotropic medications through report analysis and follow up with outliers;
- identifying children in need of immediate or intensive care management for physical health needs;
- providing opportunities and activities for promoting wellness and preventing illness, including the prevention of chronic physical health conditions; to including wellness goals in the comprehensive care plan

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

HH providers will work with HIOs or secure messaging to access member data and to develop partnerships that maximize the use of HIT across providers. HH providers will utilize HIT to create, document, execute, and update the comprehensive, person-centered service plan for every member that is accessible to the interdisciplinary team of providers when external partners have the capability to received structured, electronic records. HH providers will also be encouraged to utilize HIT to monitor member outcomes, initiate changes in care and follow up on member testing, treatments,

services and referrals. In addition, for children with SED, the SOC Wraparound teams will be required to access data from the Medicaid Management Information System (MMIS) in order to monitor use of psychotropic medications.

Scope of benefit/service

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

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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:

- Transitional care will be provided by the HH to existing members who have been hospitalized or placed in other non-community settings, such as psychiatric residential treatment facilities, as well as to newly identified members who are entering the community.
- The HH care coordinator and team will collaborate with all parties involved including the facility, primary care physician, and community providers to ensure a smooth discharge and transition into the community and prevent subsequent re-admission(s).
- Transitional care is not limited to institutional transitions, but applies to all transitions that will occur throughout the development of the enrollee and includes transition from and to school-based services and pediatric services to adult services.
- If residential placement is needed, and for greater continuity, children are eligible to receive HH transitional care for a period not to exceed 90 days.
- The HH will develop contracts or MOAs with regional hospital(s), PRTFs or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of HH participants. The HH and its partners will maintain a mutual awareness and collaboration to identify individuals seeking emergency department services that might benefit from connection with a HH.

At a minimum, the HH will:

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

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

HH providers will work with HIOs or through secure messaging to access patient data and to develop partnerships that maximize the use of HIT across providers. The Health Home provider will utilize HIT to communicate with health facilities and other systems and to facilitate interdisciplinary collaboration among all providers, the member, family, care givers and local supports when external partners have the capability to send and receive electronic, structured records.

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

Nurse Care Coordinators will ensure that appropriate linkage to Individual and Family Support Services is facilitated to assist the children enrolled in the Health Home.

Nurses

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Medical Specialists

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Dieticians

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Nutritionists

Description

Other (specify):

Name

Family Support Providers

Description

Family Support Providers will ensure that appropriate linkage to Individual and Family Support Services is facilitated to assist the children enrolled in the Health Home.

Individual and family support, which includes authorized representatives

Definition:

The HH team is responsible for providing assistance to the family in accessing and coordinating services. These services include the full range of services that impact on individuals with SED and include, but are not limited to, behavioral health, physical health, education, substance abuse, juvenile justice, child welfare and social and family support services.

The HH team will actively integrate the full range of services into a comprehensive individualized plan of care. With agreement of the family, the HH team can play the principal role as organizer, information source, guide, advocate, and facilitator for the family by helping the family to assess strengths and needs, identifying treatment goals and needed services, and navigating agency and system boundaries.

• Support services may include advocacy, information, navigation of the treatment system, and the development of self-management skills. Referral to community and social support services will be provided by members of the HH team and will include information about formal and informal resources beyond the scope of services covered by SoonerCare, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, funding options, school-based services, faith based organizations, etc.

Whenever possible, families will be informed of opportunities and supports that are closest to home, that are the least restrictive and that promote integration in the home and community. The health home team will emphasize the use of informal, natural community supports as a primary strategy to assist health home enrollees and families.

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

Details of the member health record are in the late planning stages and will be updated, as additional information is available. The goal will be to develop a module to facilitate self-management and monitoring necessary for an enrollee to attain the highest levels of health and functioning. As part of the meaningful use compliance, HHs will work with their EHR vendors to provide patient portals. These portals will allow for ease in communicating with the members, encourage preventative care and empower members to play an active role in their recovery.

Scope of benefit/service

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

Behavioral Health Professionals or Specialists

Description

Nurse Care Coordinators

Description

Nurse Care Coordinators will ensure that appropriate linkage to Individual and Family Support Services is facilitated to assist the children enrolled in the Health Home.

Nurses

Description

Medical Specialists

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Licensed Complementary and Alternative Medicine Practitioners

Description

Dieticians

Description

Nutritionists

Description

Other (specify):

Name

Family Support Providers

Description

Family Support Providers will ensure that appropriate linkage to Individual and Family Support Services is facilitated to assist the children enrolled in the Health Home.

Referral to community and social support services, if relevant

Definition:

Referral to community and social support services will be provided by members of the HH team and will include information about formal and informal resources beyond the scope of services covered by SoonerCare, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, funding options, school-based services, faith based organizations, etc.

Whenever possible, families will be informed of opportunities and supports that are closest to home, that are the least restrictive and that promote integration in the home and community. The health home team will emphasize the use of informal, natural community supports as a primary strategy to assist health home enrollees and families.

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

HH providers will work with HIOs or through secure messaging to electronically communicate referrals to community and social support services and to follow-up on referrals and access to needed services as determined by the partnering agency's ability to communicate electronically.

Scope of benefit/service

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

Behavioral Health Professionals or Specialists

Description

Nurse Care Coordinators

Description

Nurse Care Coordinators will ensure that appropriate linkage to Individual and Family Support Services is facilitated to assist the children enrolled in the Health Home.

Nurses

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Pharmacists

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Social Workers

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Doctors of Chiropractic

Description

Licensed Complementary and Alternative Medicine Practitioners

Description

<input type="checkbox"/> Dieticians	Description
<input type="checkbox"/> Nutritionists	Description
<input checked="" type="checkbox"/> Other (specify):	Name Family Support Providers
	Description Family Support Providers will ensure that appropriate linkage to Individual and Family Support Services is facilitated to assist the children enrolled in the Health Home.
Health Homes Patient Flow	
<p>Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter: See attached flow charts and narratives.</p>	

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.**

Transmittal Number: OK-14-0011 Supersedes Transmittal Number: Proposed Effective Date: Jan 1, 2015 Approval Date:

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Attachment 3.1-H Page Number:

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:

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

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.

Oklahoma will initially perform an estimate of cost savings using the Center for Health Care Strategies (CHCS) ROI Forecasting Calculator for Health Homes and Medical Homes. The State will use a 3-year average (2009-2011) of costs from the State's MMIS for the target population, which are SoonerCare members who had a status of SMI or SED:

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

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

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

Initial Standards:

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

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

1. Have structured interoperable health information technology systems, policies, procedures and practices
 2. Utilize an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act. If the provider does not currently have such a system, they will have to provide a plan for when and how they will implement it.
 3. Join a certified health information exchange for data exchange and make a commitment to share information with all providers.
 4. Support the use of evidence based clinical decision making tools, consensus guidelines, and best practices.
- Oklahoma HH providers will be encouraged to use wireless technology as available to improve coordination and management of care and member adherence to recommendations made by their provider. This may include the use of telemedicine, cell phones, peripheral monitoring devices, and access member care management records, as feasible.

Quality Measurement

- The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.**
- The State provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.**

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

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

<p>Measure: Use of HEDIS 2011 codes for inpatient general hospital/acute care, inpatient alcohol and other admissions per 1000 members less than 21 years of age for any diagnosis. Measure Specification, including a description of the numerator and denominator. Data Sources: Claims Frequency of Data Collection: <input type="radio"/> Monthly <input type="radio"/> Quarterly <input checked="" type="radio"/> Annually <input type="radio"/> Continuously <input type="radio"/> Other</p>	
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Emergency Room Visits

<p>Measure: Use of HEDIS 2011 codes for ED visits (part of ambulatory care (AMB) measure) Measure Specification, including a description of the numerator and denominator. ER visits per 1000 members less than 21 years of age for any diagnosis. Data Sources: Claims Frequency of Data Collection: <input type="radio"/> Monthly <input type="radio"/> Quarterly <input checked="" type="radio"/> Annually <input type="radio"/> Continuously <input type="radio"/> Other</p>	
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Skilled Nursing Facility Admissions

Measure: Use of HEDIS 2011 codes for discharges for skilled nursing facility services (part of inpatient) Measure Specification, including a description of the numerator and denominator. SNF admissions per 1000 members less than 21 years of age. Data Sources: Claims Frequency of Data Collection: <input type="radio"/> Monthly <input type="radio"/> Quarterly <input checked="" type="radio"/> Annually <input type="radio"/> Continuously <input type="radio"/> Other	
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Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to the following:

Hospital Admission Rates

The OHCA will consolidate data from its fee-for-service MMIS-based claims system for the participating HH sites to assess hospital admission rates, by service (medical, surgical, maternity, mental health and chemical dependency), for the participating Health Home sites and for a control group of non-participating sites.

The annual analysis will consider:

- The experience of members with the clinical conditions of focus during the learning collaborative year (expected to grow from year 1 to year 2), and
- All members with SMI or SED drawn from a list of chronic conditions defined by the State.

Chronic Disease Management

The OHCA will monitor chronic disease management through the measures listed within the State Plan Amendment.

These include:

- Adult and adolescent BMI assessment;
- Appropriate use of lipid lowering therapy for coronary artery disease;
- Appropriate use of antihypertension multi-drug therapy where the regimen includes a thiazide diuretic.

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

Coordination of Care for Individuals with Chronic Conditions

The State will assess and measure provision of care coordination services for individuals with the chronic conditions specified within this State Plan Amendment as follows:

- Transition of records transmitted to the HH from inpatient facilities;
- Follow-up after inpatient hospitalization for mental illness;
- Initiation and engagement of alcohol and other drug dependence treatment.

Assessment of Program Implementation

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

Processes and Lessons Learned

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

Assessment of Quality Improvements and Clinical Outcomes

The State will use the quality process and outcome measures described in the prior section to assess quality improvements and clinical outcomes. For claims-based and other measures, assessment will occur both at the individual practice level, and at the aggregate level for all participating HHs. The State will track changes over time to assess whether statistically significant improvement has been achieved. For measures for which national Medicaid

benchmark data are available, comparisons will be made to regional and national benchmarks, even though such benchmarks are not specific to persons with chronic conditions.

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

Estimates of Cost Savings

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

If no, describe how cost-savings will be estimated.

Oklahoma will initially perform an estimate of cost savings using the Center for Health Care Strategies (CHCS) ROI Forecasting Calculator for Health Homes and Medical Homes. Using the ROI Forecasting Calculator, Oklahoma identified the baseline costs and utilization (most recent three-year average) for the target population (see tables below) and trended these costs forward using historical growth rates, thereby estimating future healthcare costs in the absence of intervention

Table 2: Target Population - SED
 Total Membership in Population Base 6,309
 Outreach Goal 67%
 Ramp-up Period 12 months
 Total Enrollees 4,227

The State assumed that 67% of the SED population would be successfully enrolled in HHs. Changes to the trended utilization patterns that are expected to result from the HH intervention were indicated. The ROI Calculator compares the trended utilization costs under the status quo to the expected utilization costs following the HH intervention, to estimate the associated savings or cost increases.

The State will annually perform an assessment of cost savings using a pre/post-period comparison with a control group of SoonerCare CMHCs or other behavioral health organizations serving clinically similar populations but not participating as HHs. Control group clinics will be similar to participating HHs to the extent that it is feasible to do so. They will be identified by clinic type (e.g., private behavioral health organization), geographic region, and number of SoonerCare members with or SED. Savings calculations will net out the value of supplemental payments made to the participating sites during the eight-quarter period.

Transmittal Number: OK-14-0011 Supersedes Transmittal Number: Proposed Effective Date: Jan 1, 2015 Approval Date:

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 80 per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.