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

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

Health Home Services ☒

How are Health Home Services Provided to the Medically Needy? Choose an item.

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i. Geographic Limitations Choose an item. If Targeted Geographic Basis, Brown, Kenosha, Milwaukee and Dane Counties

ii. Population Criteria The State elects to offer Health Home Services to individuals with: Choose an item. from the list of conditions below:

- ☐ Mental health condition
- ☐ Substance abuse disorder
- ☐ Asthma
- ☐ Diabetes
- ☐ Heart Disease
- ☐ BMI over 25
- ☒ Other chronic condition covered? HIV

The population includes Medicaid and BadgerCare Plus members with a diagnosis of HIV and who have at least one other diagnosed chronic condition, or is at risk of developing another chronic condition. Individuals at "at-risk" for developing another chronic condition include:

- Individuals having a CD4 cell count of less than 200 cells/μL or CD4 cells accounting for fewer than 14 percent of all lymphocytes
- Individuals with a body mass index <18.5 kg/ m^2
- Individuals whose fasting plasma blood sugar is 100-125 mg/dL or A1C 5.7% - 6.4%
- Individuals with systolic pressure between 120 - 139 mm Hg; diastolic pressure between 80 – 89 mm Hg
- Individuals with hyperlipidemia:
  Total cholesterol >200 mg/dL
  HDL levels <40 mg/dL for men and <50mg/dL for women
  LDL levels >130 mg/dL

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For the purposes of this benefit, a chronic condition is defined as one that has lasted at least 6 months, can reasonably be expected to continue for six months, or is likely to recur. Members meeting the above criteria will be automatically enrolled in the health home. Health home providers will be responsible for educating members about the benefits of health home enrollment and inform them of the option to disenroll. Members agree to health home services by actively participating in the assessment and care plan process.

iii. Provider Infrastructure

Designated providers as described in Section 1945(h)(5) AIDS Service Organizations identified under Wisconsin Statute ch 252.12(12)(a)8, for the purpose of providing life care services to persons diagnosed as having AIDS/HIV . The AIDS Service Organization (ASO) as the designated provider will provide health home services using a multidisciplinary approach. ASOs provide services to a significant number of Medicaid members with HIV infection. The ASOs will be responsible for outreach and communication to patients and organizations that provide services to individuals with HIV infection. The outreach will include educating patients and the AIDS/HIV community stakeholders about health homes.

The professionals listed below are identified as "best practice" for meeting the needs of all individuals with HIV infection. The other members of the multidisciplinary team will be optional as determined by each patient's health care and psychosocial needs. The other, optional members of the team could include outreach workers, peer specialists, dieticians community care representatives (for example, fitness coach). There will be no restriction on the make up of the other members of the team. The ultimate decision will be between the member and his or her primary health care provider.

The core team of health care professionals will include experts in the care and treatment of individuals diagnosed with HIV infection. In addition to the patient's primary heatlh care provider, the designated health home must ensure that the following professionals are part of the core team:

A registered nurse
A case manager
A mental health or substance abuse professional
A dentist
A pharmacist

The patient and core team members will be central to the initial comprehensive assessment of needs and to the development of a single care plan. The single care plan will addres all aspects of the member's care and treatment, including their community care needs. Each team will have a lead to ensure that there is communication, coordination and consultation among the team. For example, the team lead will do the following:

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- Ensure that the member's care and treatment needs are addressed using a multidisciplinary team approach. This includes identifying individuals the member deems central to addressing his or her health care and social services needs.
- Ensure that the member is at the center of the team and is identified as an active and informed participant in his or her own care.
- Ensure that the member and providers on the team know each other.
- Ensure that the role and responsibility of each person on the team is defined for the member.
- Ensure that each member has an identified care coordinator.
- Ensure that team members share information regarding patient care, treatment, medications prescribed, recommended self-care and upcoming visits.

Each patient will have an identified care coordinator who will be responsible for the overall coordination of the patient's care. The team lead and the care coordinator can be the same individual.

Linkages between primary and behavioral health services are basic to the provision of services to patients diagnosed with HIV infection. Health home patients who do not have a diagnosis of mental health or substance use disorder will be routinely screened for depression and substance use. The integration of behavioural and physical health will occur within the health home through the required composition of a core team that includes representatives of both disciplines.

The state will provide technical assistance to the extent necessary. For example, the Department will provide SBIRT (screening, brief intervention, referral, and treatment) training to help ensure that substance abuse screening is provided as a matter of course for all health home members. The state will continue to collaborate with the ASOs and set up calls and site audits/visits to support and monitor health home services and to ensure that health home services are provided in accordance with the requirements outlined under "Provider Standards."

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

Health Team as described in Section 1945(h)(7), via reference to Section 3502 _|_____

iv. Service Definitions	Service Name	Service Definition	Ways Health IT Will Link
	Comprehensive Care Management	Comprehensive care management involves the use of evidence-based guidelines to provide systematic, responsive and coordinated management of all aspects of primary and specialty care (physical and behavioral needs) for individuals with AIDS/HIV. Comprehensive care management includes early identification of individuals who meet the criteria for health home	All contacts with health home members will be documented in the electronic health record. The patient's electronic health record will be accessible to all members of the patient's core team.

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		enrollment.	
	Care Coordination	Care coordination is the ongoing management of the patient's medical, behavioral, pharmacological, dental care, and community care needs by a designated team lead. The team lead will ensure that the patient has a current, written, individualized, multidisciplinary care and treatment plan that addresses all aspects of the patient's care (including preventive care needs, all medical subspecialties, institutional care, home and community care).	The patient's treatment plan will be electronic and must be accessible to all members of the patient's core team.
	Health Promotion	Health promotion services include all activities aimed at prevention, assisting the patient in better understanding their disease and, learning how to direct the care and treatment they receive. Enhanced patient education and active promotion of self-management and self care are part of health promotion.	The designated team lead will be responsible for ensuring that the patient's electronic treatment plan is updated to include all patient education, including medication management and self care regimen.
	Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)	Comprehensive transitional care involves the establishment of an automatic referral arrangement between institutional care providers and the health home provider to ensure that there is immediate communication and/or referrals of patients with AIDS/HIV who are admitted to the institution or are seen in the emergency room. Automatic referrals include the establishment of policies and procedures to assure that there is systematic and timely sharing of information related to the patient's institutional or emergency room care. Transitional care will include timely face-to-face or telephone contacts with the	The care coordinator will be responsible for ensuring that the patient's electronic treatment plan is updated to reflect all transitional care needs.

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		patient (or the patient's authorized representative) after an emergency room visit or a hospital or nursing home discharge. Transitional care includes reviewing the discharge summary with the patient and assisting them in receiving the recommended care, including scheduling follow-up appointments and filling prescriptions.	
	Individual and Family Support Services (including authorized representatives)	Individual and family support services include activities related to advocating on the member's behalf and mobilizing services and support for the member. It will include contacts with anyone identified as instrumental to the member's day-to-day support and care. Peer-to-peer information sharing and support are included in these support services. Individual and family support services include imparting information in a manner that is simple, clear, straightforward and culturally appropriate.	The care coordinator will update the patient's electronic health record to reflect all activities related to individual and family support services.
	Referral to Community and Social Support Services	Referral to community and social support services includes activities related to providing assistance to members to ensure they have access to social support services identified in the care plan. To the extent feasible, the health home provider will establish meaningful working relationships with community-based organizations that provide services to individuals with HIV infection.	The care coordinator will document all referrals and the outcome of those referrals in the patient's electronic health record.

v. Provider Standards	Designated providers must: 1. Be located in a setting that integrates medical, behavioral, pharmacy, and oral health care

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2. Be accredited by a nationally recognized accreditation program, as a patient-centered medical home or, meet the requirements detailed below:

   - Have systems and infrastructure in place to provide comprehensive health home services to individuals with AIDS/HIV
   - Provide written support, from the highest level of the provider organization, for coordinated care through the use of a health home model
   - Meet all of the qualification standards outlined below:

     ☐ Adopt written standards for patient access and patient communication
     ☐ Use data to show that they meet standards for patient access and patient communication
     ☐ Use electronic charting tools to organize clinical information
     ☐ Use data to identify diagnoses and conditions among individual provider's patients that have a lasting detrimental effect on health
     ☐ Adopt and implement guidelines that are based on evidence for treating and managing AIDS and HIV-related conditions
     ☐ Actively support and promote patient self-management
     ☐ Systematically track patient test results and have a systematic way to identify abnormal patient test results
     ☐ Establish procedures to systematically accept referrals from hospitals (inpatient and outpatient) that treat individuals with AIDS/HIV
     ☐ Systematically track referrals using an electronic system
     ☐ Measure the quality of the performance of individual providers and of individuals who perform services on behalf of these providers, including the provision of clinical services, patient outcomes, and patient safety
     ☐ Report to employees and contractors of individual providers and to other persons on the quality of the performance of these providers and of individuals who perform services on behalf of the providers

3. Agree to the following practices in providing services:
   - Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
   - Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
   - Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines ;
   - Coordinate and provide access to medication management, mental health and substance abuse services;
   - 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

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	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; ▪ 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.

vi. Assurances	A. The State assures that hospitals participating under the State plan or a waiver of such plan will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.	Designated health home providers, AIDS Service Organizations (ASOs), have working relationships with their local hospitals. The state will encourage health home providers to establish automatic referral arrangements between health home providers and hospitals that admit or treat patients with HIV infection. The ASOs will be required to educate hospitals and local emergency departments about the health home benefit and encourage direct telephone contacts when a patient with HIV infection seeks treatment at their facility. In addition, hospitals will be encouraged to refer the member to the health home for follow up care.
	B. The State has consulted and coordinated with the Substance Abuse and Mental Health Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.	The state will coordinate with SAMHSA in addressing issues related to the prevention and treatment of mental illness and substance abuse among eligible individuals with AIDS/HIV.
	C. The State will report to CMS information submitted by health home providers to inform the evaluation and Reports to Congress as described in section 2703(b) of the Affordable Care Act, and as described by CMS.	The state will collect and report on all data as requested by CMS, including the required "Health Homes Core Quality Measure Set, and other data as needed to inform the mandated evaluation and Reports to Congress as stated in this assurance request. The state will provide the data on an agreed upon schedule and format.
	D. Assurance of non-duplication of case management services for health home enrollees.	The state will assure that health home services and payments will not duplicate any other case management-like services or

		payments. Waiver members identified in the state's claims payment system are not eligible for health home enrollment. The claims processing system will deny claims for waiver members. Claims for targeted case management will be denied for health home enrollees. The state will implement a system audit to monitor claims payment and will only pay a waiver or TCM claim if there were no health home payments within the previous 60 days. Should a health home claim be submitted after the 60 days (for the same period as the TCM claim, for example) the health home claim will be denied.

vii. Monitoring	A. Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications.	The state will rely on claims data and on data submitted by the health home provider. The exact measure is yet to be determined.
	B. Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications.	The state will use paid claims data to compare costs for providing health care services to members with AIDS/HIV prior to the implementation of the health home and annually thereafter to identify the areas of cost reduction. The state will also assess the costs of providing services to members with AIDS/HIV who are not enrolled in the health home and compare these costs and outcomes to those of members in the health home
	C. Describe the State's proposal for using health information technology in providing health home services under this program and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).	The state will require health home providers to adopt health information technology, including the use of electronic health records which interface with specialty and inpatient care providers, for the provision of services.

viii. Quality Measures

Comprehensive Care Management

Goal 1: Reduce the risk of complicating opportunistic infections and improve health outcomes

	Measure	**Data Source**	**Measure Specification**	**How Health IT will be Utilized**
Clinical Outcomes	(Institutes of Medicine and HRSA indicators for clinical HIV care.)	Public health surveillance data MMIS Medical record	Denominator: The number of health home patients with a CD4 count of ≤350 cells/μL.	The patient's electronic health record

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	The percentage of health home patients, with a CD4 count of ≤350 cells per microliter (µL), who initiates antiretroviral therapy (ART).		Numerator: The number of health home patients with a CD4 count of ≤350 cells/µL who initiate ART.	
Experience of Care				
Quality of Care				

Care Coordination

Goal 2: Ensure the integration of oral health care and medical health care for HIV patients

	Measure	**Data Source**	**Measure Specification**	**How Health IT will be Utilized**
Clinical Outcomes				N/A
Experience of Care				
Quality of Care	(HRSA performance measure for HIV) The percentage of HIV-infected oral health patients who had a dental and medical health history (initial or updated) at least once in the measurement year.	MMIS Patient health record	Denominator: The number of HIV-infected oral health patients, >12 months old, that received a clinical oral evaluation at least once in the measurement year. Numerator: The number of HIV-infected oral health patients, older than 12 months, who had a dental and medical health history at least once in the measurement year.	The patient's electronic health record

Health Promotion

	Measure	**Data Source**	**Measure Specification**	**How Health IT will be Utilized**
Clinical Outcomes				
Experience of Care				

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Quality of Care				

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

	Measure	**Data Source**	**Measure Specification**	**How Health IT will be Utilized**
Clinical Outcomes				
Experience of Care				
Quality of Care				

Individual and Family Support Services (including authorized representatives)

	Measure	Data Source	Measure Specification	How Health IT will be Utilized
Clinical Outcomes				
Experience of Care				
Quality of Care				

Referral to Community and Social Support Services

	Measure	**Data Source**	**Measure Specification**	**How Health IT will be Utilized**
Clinical Outcomes				
Experience of Care				
Quality of Care				

ix. Evaluations

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

	Description	**Data Source**	**Frequency of Data Collection**
i. Hospital admissions	The number of hospital admissions and the length of stay for individuals enrolled in the health home(s)	Claims data	Quarterly
ii. Emergency room visits	The number of emergency room	Claims data	Quarterly

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	visits for individuals enrolled in the health home		
iii. Skilled Nursing Facility admissions	The number of nursing home stays for individuals enrolled in the health home	Claims data	Quarterly

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

i. Hospital admission rates	The state will use claims data for fee-for-service claims paid on behalf of members enrolled in the health home. The state will compare admission rates for the health home participants to the rates of members with AIDS/HIV who are not participating. Additionally, the state will use pre-implementation (baseline) data to compare to post-implementation rates.
ii. Chronic disease management	The state will use claims data (examples, office visits, lab testing, pharmacy, emergency room visits) to monitor chronic disease management. In addition, providers will be required to submit semi-annual reports responding to a series of identified indicators (for example, the number of face-to-face visits between the member and the care coordinator and the number of patients who received self-management counseling and support).
iii. Coordination of care for individuals with chronic conditions	The state will use claims data to determine the amount of care coordination provided. The state will monitor data reports and survey results from health home providers to further determine the level and frequency of coordination activities.
iv. Assessment of program implementation	The state Medicaid and Public Health (AIDS/HIV) Divisions will collaborate on the assessment of program implementation. Assessment activities are to be determined but could include joint health home visits and reviews of reports and data.
v. Processes and lessons learned	The state Medicaid and Public Health (AIDS/HIV) Divisions will collaborate on the review of the processes established by the health homes. The state will work in partnership with the health home providers to identify aspects of the health home implementation that works and those that need modification. A significant portion of this activity will be a reliance on the outcome of member surveys (both formal and informal).
vi. Assessment of quality improvements and clinical outcomes	The state Medicaid and Public Health (AIDS/HIV) Divisions will use the clinical outcome measures described above to assess quality improvements and gains/set backs in clinical outcomes within the health homes.
vii. Estimates of cost savings	On an annual basis, the state will perform an analysis of the cost of providing care to members within and outside of the health home. The exact focus of the analysis is yet to be determined but will include an analysis of the level of utilization for routine care versus emergency care (inpatient hospital, emergency department and ambulance transportation).

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Attachment 4.19-B Payment Methodology

Payment Type	Provider Type	Description	Tiered?
Monthly Case Rate	AIDS Service Organi-zations	Reimbursement will be limited to a monthly case rate. The reimbursement will be the same regardless of the frequency or intensity of care management activities provided within the month, except that health home providers will be required to provide at least one care management activity during the billable month. Health home providers must submit a claim to receive payment. Allowable care management activities include: ▪ Comprehensive care management ▪ Care coordination and monitoring ▪ Assessment and care plan updates ▪ Health promotion ▪ Comprehensive transitional care (including appropriate follow-up from inpatient to other settings) ▪ Individual and family support services (including authorized representatives) ▪ Referral to community and social support services ▪ Activities related to updating the care plan and documenting contacts Allowable activities will include face-to-face, telephone and other modes of communication among the care team, the member and collaterals. Direct health care or social services are not covered. This fee is reimbursable only for eligible members who have gone through the assessment and care plan development process and who have an assigned care coordinator. Reimbursement will be limited to the lesser of the amount billed or the established maximum fee. The state considered the following factors in developing the monthly rate: the development of a core health home team, associated Medicaid reimbursement rates (based on max fee schedule), claims data to determine appropriate levels of service across provider types, and the acuity and chronicity of members being served. Reimbursement will be the same for private and public providers. Maximum allowable fees and reimbursement rates under the methods and standards set forth in this Attachment are published in the schedules posted online on the Wisconsin Medicaid website at: https://www.forwardhealth.wi.gov/WIPortal/Max%20Fee%20Home/tabid/77/Default.aspx Health home services rates, as of October 1, 2012, are effective for services provided on or after that date. If and when rate are updated, the update will be based on analysis of care management provided by those professionals and based on the acuity of and chronicity of the members receiving home health services.	No

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		The State assures CMS that health home service payments will not result in any duplication of payment or services between Medicaid programs, services, or benefits, including management care, other delivery systems including waivers, any future health homes, and other state plan services.	
Alternate Payment Methodology	AIDS Service Organi-zations	Health home providers will receive a flat fee for the initial, comprehensive assessment of needs and the development of the integrated care plan. This initial fee is reimbursable only for members who meet the eligibility criteria and who agree to participate in the health home. The member's agreement to participate in the health home is determined by their active participation in the assessment and care plan development process. Health home providers will be allowed to bill a comprehensive assessment and care plan review once every 365 days if the member's health and support needs dictate the need. Reimbursement will be limited to the lesser of the amount billed or the established maximum fee. Payment of this service is limited to once every 365 days or less if the state approves a greater frequency. Providers must submit a claim to receive this fee. The state considered the following factors in developing the rate for the initial comprehensive assessment and care plan development: the development of a core health home team, associated Medicaid reimbursement rates (based on max fee schedule), claims data to determine appropriate levels of service across provider types, and the acuity and chronicity of members being served. Reimbursement will be the same for private and public providers. Maximum allowable fees and reimbursement rates under the methods and standards set forth in this Attachment are published in the schedules posted online on the Wisconsin Medicaid website at: https://www.forwardhealth.wi.gov/WIPortal/Max%20Fee%20Home/tabid/77/Default.aspx Health home services rates, as of October 1, 2012, are effective for services provided on or after that date. The State assures CMS that health home service payments will not result in any duplication of payment or services between Medicaid programs, services, or benefits, including management care, other delivery systems including waivers, any future health homes, and other state plan services.	No