

West Virginia Health Home SPA Template

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<p>Geographic Area (Describe whether statewide or targeted)</p>	<p>West Virginia will open the Health Home opportunity to the entire state with phased implementation by geography. Implementation will begin on July 1, 2012:</p>
<p>Population Criteria (Indicate if State will be using 2 or more chronic conditions, 1 and being at risk for another or 1 serious and persistent mental illness and include the targeted chronic conditions list. Please also include in description how the individuals will be assigned to the health home)</p>	<p>Two conditions among those listed below:</p> <ul style="list-style-type: none"> Diabetes Cardiovascular disease Asthma/ COPD Alzheimer’s Disease Serious Mental Illness <ul style="list-style-type: none"> • Schizophrenia spectrum disorder • Bipolar disorder • Major depression • Anxiety • Attention Deficit Hyperactive Disorder • Pervasive Developmental Disorder • Substance abuse <p>One condition listed above and one of the following risk factors:</p> <ul style="list-style-type: none"> • BMI > 25 • Tobacco use • Living in foster care • Residence in a long term care facility • High utilization of ED and hospitalization <p>Individuals that are potentially eligible for health home services will be identified by the prospective health home during the health home application process. The health home organizations will use their EHR, practice management systems, and any internal registries to develop lists of Medicaid members who have more than one of the chronic conditions listed above, or one of these chronic conditions and one of the targeted risk factors, AND for whom the health home believes that provision of the 6 health home services will make a difference in outcomes, utilization, and cost. These lists will be verified by BMS staff or their enrollment contractor, and once verified, each the individual’s MMIS enrollment record will be flagged for health home participation. Shortly thereafter, BMS will send a notice to the member via U.S. mail and other methods as necessary, advising the member of the Health Homes initiative and their enrollment with the health home submitting their name. The notice will describe the function of a health home and what services a health home enrollee might expect, individuals’ choice in selecting a health home, and will include a listing of all health homes in the state. The notice will describe the process for individuals to opt-out of receiving health home services from the assigned health home provider and for selecting another health home; it will also include an assurance that should an individual opt out of the health home program altogether, their existing services will not be jeopardized. Other individuals with qualifying chronic conditions who are not currently receiving services at the health home may request to be part of the health home by contacting a local DHHR office or a designated health home provider. Potentially eligible individuals receiving services in the hospital ED or as an inpatient will be notified about eligible health homes and referred based on their choice of provider. Eligibility for health home services will be maintained in the state’s MMIS.</p>

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	<p><i>i. Provider Infrastructure</i></p>
<p>Provider Infrastructure (Indicate whether designated providers, team of health care professionals or health team)</p>	<p>West Virginia’s provider infrastructure will include designated primary care physician or advanced practice nurse providers working with multidisciplinary teams in a variety of possible settings: primary care and solo medical practices; comprehensive community behavioral health centers with a primary care service base; providers who serve special populations; academic medical centers; other entities meeting established qualifications.</p> <p>Each health home will define its multidisciplinary team in a manner that assures capacity to provide or arrange for the six defined health homes service. Teams working with the primary care providers as part of the health home may consist of physicians, physicians’ assistants, nurses, nurse practitioners, pharmacists, social workers, mental health workers, health educators, community health workers, and others. Each team shall include an individual who is designated as a care coordinator. The care coordinator is accountable for assuring that patient needs are identified and that an effective plan for intervention is developed and carried out. All members of the team will be responsible for communicating on patient status, treatment options, actions taken and outcomes achieved as a result of those interventions. Electronic means of supporting this communication is encouraged. All members of the team will also be responsible for ensuring that care is person-centered, culturally competent and linguistically capable.</p> <p>To assure access to appropriate medical and behavioral health services not available within the health home organization, health homes will augment their teams by having formal relationships with hospitals, emergency departments, behavioral health facilities, and long-term care facilities.</p> <p>The definition of designated provider is intentionally broad to allow for diverse organizational models to serve as health homes. Functions and services can be provided in a single location, multiple locations, or virtually. Where treatment teams are not employed by a single entity, it is expected that formal agreements will exist between team members and the health home entity that remains responsible for all services performed by the care team.</p>

Health Home Services

Comprehensive Care Management	Service Definition	Ways HIT Will Link
	<p>Comprehensive Care Management is the development, implementation, and ongoing reassessment of a comprehensive individualized patient-centered care plan for each health home member. The care plan’s design will be developed on the basis of information obtained from a comprehensive risk assessment that identifies the member’s needs in areas including: medical; mental health; substance abuse/misuse, and social services.</p> <p>The individualized care plan will include integrated services to meet the member’s behavioral health, rehabilitative, long term care, and social service needs, as indicated. The care plan will identify the primary care physician, other health and behavioral health care</p>	<p>Penetration of HIT adoption in WV is variable at the current time, although a growing number of providers are adopting EHR’s in response to the ARRA incentives and BMS has partnered with the WV Regional Extension Center to further promote the use of HIT within the Medicaid provider community. As part of the application to serve as a Health Home, providers will be expected to demonstrate a commitment to the use of HIT by all members of the Health Home team. At minimum, a certified EHR is required at the primary care site; the EHR is expected to document the elements of an individual care plan for each Health Home</p>

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	<p>providers, care manager, and other health team providers directly involved in the individual's care. The care plan will also identify community networks and supports needed for comprehensive quality health care.</p> <p>Goals and timeframes for improving the member's health, overall health care status and identified interventions will be included in the care plan, as well as schedules for plan assessment and update.</p> <p>Comprehensive care management will assure that the member (or legal health representative) is an active team member in the care plan's development, implementation and assessment and is in informed agreement with plan components. Member's family and other recognized supports will be involved in the member's care as requested by the member.</p>	<p>member. The use of HIT is also encouraged in the identification of individuals who are at highest risk and in need of more intense care management services; this will be done through analysis of population level reports of member characteristics and utilization patterns. This may also be done through electronic responses to a health risk assessment tool. To facilitate communication about care coordination and care management activities, the potential for modifying the CareConnection system is being explored; this system currently used for documentation of various service authorizations as well as care planning for mental health members.</p> <p>As the use of HIT and the implementation of a statewide health information exchange evolve, it is anticipated that the use of HIT to support all of the health homes services will also evolve.</p>
Care Coordination	<p style="text-align: center;">Service Definition</p> <p>Care Coordination is the delivery of comprehensive, multidisciplinary care to a member that links all involved resources by maintaining and disseminating current, relevant health and care plan data.</p> <p>Care coordination manages resource linkages, referrals, coordination and follow-up to plan-identified resources. Activities include, but are not limited to: appointment scheduling, conducting referrals and follow-up monitoring, participating in facility discharge processes and communicating with other providers and members/family members.</p>	<p style="text-align: center;">Ways HIT Will Link</p> <p>Each Health Home provider will be encouraged to use the HIT resources they have available through their internal EHRs to track referrals and generate reminders for follow up. Where there are available electronic linkages with partner hospitals and their EHRs, the Health Home providers will be encouraged to maximize the use of these linkages to share bi-directional information. West Virginia will be starting its roll-out of a state-wide HIE in early 2012. As the state HIE is implemented, all Health Home providers will be encouraged to fully participate, as is feasible, to utilize the HIE to share information with members of their referral network. Health Homes will also be encouraged to use the CareConnection system as it is modified to allow for documentation of relevant care coordination and referral activities.</p> <p>Health Home providers will also be encouraged to implement a patient portal to communicate with patients/ family members. Information about the open-source Health-e Me PHR will be made available as an option for Health Home use.</p>
Health Promotion	<p style="text-align: center;">Service Definition</p> <p>Health Promotion includes the provision of: health education specific to a member's health and behavioral health; development of self-management plans effectively emphasizing the importance of immunizations and preventive screenings; supporting improvement of</p>	<p style="text-align: center;">Ways HIT Will Link</p> <p>Health Home providers will be encouraged to utilize their EHRs and/ or patient portals to link to health information and resources applicable to the member's condition. Where feasible member educational materials will be generated</p>

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	<p>social networks; and providing healthy lifestyle interventions. Areas of focus include but are not limited to, substance use and smoking prevention and cessation, nutritional counseling, weight management, and increasing physical activity.</p> <p>Health promotion services assist members to participate in the development and implementation of their care plan and emphasize person-centered empowerment to facilitate self-management of chronic health conditions through informed awareness.</p>	<p>electronically to allow for customization and appropriateness to the member's condition, literacy level, and cultural preferences.</p>
<p>Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)</p>	<p>Service Definition</p>	<p>Ways HIT Will Link</p>
	<p>Comprehensive Transitional Care is care coordination services designed to prevent avoidable emergency department visits, admissions, and readmission after discharge from an inpatient facility. For each enrollee transferred from one caregiver or site of care to another, the health home team ensures proper and timely follow-up care and safe, coordinated transitions, including reconciliation of medications. This is accomplished through formal relationships and communication systems with health facilities including emergency departments, hospitals, long-term care facilities, residential/rehabilitation settings, as well as with other providers and community-based services.</p>	<p>Health Home providers will be encouraged to develop partnerships that maximize the use of HIT across various caregivers and care settings. The provider will be encouraged to use HIT when available to communicate with health facilities and to facilitate interdisciplinary collaboration among all care team members. Providers will be encouraged to share information through the statewide HIE once that capability becomes available. Providers will also be encouraged to provide enrollees with web-based access to their records that can follow the enrollees as they transition to different care settings.</p> <p>To facilitate post-hospital follow-up, BMS will be developing a means of communication to health homes about enrollees who have been admitted to a hospital. This will be based on its existing web-based CareConnection prior authorization module.</p>
<p>Individual and Family Support Services</p>	<p>Service Definition</p>	<p>Ways HIT Will Link</p>
	<p>Individual and Family Support Services include service provision and resource identification that assist members to attain their highest level of health and functioning. Peer supports, support groups, and self-care programs can be utilized by providers to increase members' and caregivers' knowledge about the member's diseases, promote member's engagement and self-management capabilities, while assisting the member to adhere to their care plan.</p> <p>A primary focus of individual and family supports will be strengthened through increased health literacy. This effort will provided through communicated information that is language, literacy, and culturally appropriate, to improve the member's ability to self-manage their and participation in the ongoing care planning.</p>	<p>Health Home providers will be encouraged to utilize their EHRs and/ or patient portals to link to health information and resources applicable to the member's condition. The use of a patient portal or PHR is encouraged to provide for patient/ family interaction with the care team and for development and monitoring of shared care plans.</p> <p>Where feasible member educational materials will be generated electronically to allow for customization and appropriateness to the member's condition, literacy level, and cultural preferences.</p>

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Referral to Community and Social Support Services	Service Definition	Ways HIT Will Link
	<p>Referral to Community and Social Support Services includes the identification of available community resources, active management of referrals, access to care, engagement with other community and social supports, coordination of services and follow-up.</p> <p>The Community and Social Support Services network includes development of policies, procedures and accountabilities (through contractual agreements) which clearly define the roles and responsibilities of the participants in order to support effective collaboration between the health home and community-based resources, and</p> <p>The member's care plan will include community-based and other social support services that address and respond to the member's needs and preferences, and contribute to achieving the care plan goals.</p>	<p>Health Home providers will be encouraged to utilize HIT as feasible to initiate, manage and follow up on community based and other social services referrals.</p> <p>To the extent feasible, the BMS CareConnection system will be used for documentation of the referral process.</p>

Provider Standards

Provider Qualifications

1. Health home providers must enroll or be enrolled in the WV Medicaid program and agree to comply with all Medicaid program requirements.
2. Care coordination and the other five health home services, identified by CMS and defined above, will be provided to all health home enrollees by an interdisciplinary team of providers. An integrated care plan will be developed and coordinated for each enrollee, and one individual will be identified as the care manager who is accountable for assuring access to medical and behavioral health care services and community social supports as defined in the care plan. The health home provider must identify the means for care plan documentation, communication, and integration across that various service delivery components of the health home. Health home providers can either directly provide, or subcontract for the provision of, health home services. The health home provider remains responsible for all health home program requirements, including services performed by the subcontractor. The health home provider is required to describe the methods and processes for providing for the health home services. Where contractual relationships are to be used, the health home provider must demonstrate that formal written agreements are in place at the time that health home services are initiated.
3. Health home providers are expected to establish a network of local community providers that will serve as referral providers for various medical, behavioral health, and facility services. At minimum, each health home must either include provision of behavioral health services or must establish a formal partnership with a behavioral health entity in order to assure appropriate access to a range of behavioral health services for all of its health home enrollees. Hospitals that are part of a health home network must have procedures in place for referring any eligible individual with chronic conditions who seek or need treatment in a hospital emergency department to a health home. Documentation describing the network and hospitals' referral commitment must be provided.
4. Health home providers must demonstrate their ability to perform each of the following functional requirements. This includes documentation of the processes used to perform these functions and the methods used to assure service delivery takes place in the described manner.
 - Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services.
 - Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines.

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- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
- Coordinate and provide access to mental health and substance abuse services.
- Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings.
- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families.
- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services.
- Coordinate and provide access to long-term care supports and services.
- Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services.
- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate.
- 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.

5. The health home provider must use an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act, and which allows the patient’s health information and plan of care to be accessible to the interdisciplinary team of providers. The health home providers must also participate in the WV Health Information Network as this capability is made available throughout the state.

Assurances

<p>The State assures that hospitals participating in the State plan or 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.</p>	<p>As a qualification for Health Home status, the designated provider or health team is required to establish formal agreements with hospitals to which their members are anticipated to be admitted. These agreements require that the hospital refer any individual member that presents to the hospital emergency department to an appropriate health home provider.</p>
<p>The State has consulted and coordinated with the Substance Abuse and Mental Health Services</p>	<p>Consultation to be conducted on February 23, 2012.</p>

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<p>Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.</p>	
<p>The State will report to CMS information submitted by health home providers to inform the evaluation and Report to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.</p>	<p>As a condition of participation as a health home provider, each health home will be required to regularly report to BMS on the various clinical process and outcomes measures defined in this SPA. All of this information will be aggregated and reported to CMS.</p>

Monitoring

	Data Sources	Measures Specifications
<p>Describe the State’s methodology for tracking avoidable hospital readmissions to include data sources and measure specifications.</p>	<p>MMIS and Health Homes roster</p>	<p>(Total readmissions in the past month that occurred within 30 days of discharge following an index admission, for which the readmission DRG is the same as the index DRG) divided by the number of discharges 2 months prior times 100. Include readmission to any hospital. Exclude discharge disposition of death, transfer to another acute care hospital</p>
<p>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 measures specifications.</p>	<p>MMIS and Health Homes roster</p>	<p>Compare total cost of care for HH members to costs of care for similar cohorts not enrolled with a HH. Calculations will exclude claims for high cost outliers more than 3 standard deviations from the mean annual cost and will include incremental HH reimbursement. HH member costs will also be compared pre- and post- HH implementation.</p>

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Describe the State’s proposal for using health information technology in providing health home services under this program and improving services 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).

West Virginia currently has several HIT initiatives in place and underway that will support the provision of health home services and improvement of care coordination across the care continuum.

- The state is in the process of implementing a statewide health information exchange that will facilitate the sharing of information across various care delivery settings. All health home providers will be expected to participate in the HIE as it is implemented across the state. The HIE will be used to capture meaningful use measures and several of these are incorporated into the information that will be used to monitor and evaluate health home services.
- A robust pharmacy data warehouse is in place that will provide for monitoring of patient adherence to prescribed drug regimens as well as appropriate use of pharmaceutical agents.
- A data warehouse is being implemented to capture MMIS claims data as well clinical data that will flow through the HIE. This data warehouse will be a primary source of evaluation information for the health homes initiative.
- CareConnection is a web-based system that is used for documentation of medically necessary services and authorization information; this system will be expended to include documentation and communication of referrals, hospital admissions, and other information that will facilitate care coordination for health homes enrollees.

Quality Measures

In the table below, measure specifications in blue denote meaningful use clinical indicators/objectives and the specification follows the corresponding NQF reference or objective definition. Measures highlighted in green are the core measures required by CMS and are also included on the list of CMS Quality Measures for Medicaid Adults.

Goal 1: Improve clinical outcomes for persons with chronic conditions (diabetes, CVD, SMI, substance abuse, asthma, or COPD, along with significant health risk factors).	Measures	Data Source	Measure Specification	How HIT will be Utilized
1. Clinical Outcomes	Diabetes: Hemoglobin A1c Poor Control (>9)	Health Homes data submission from certified EHR	NQF 0059/ MU/ACO	Data will be collected from health homes using the same system that is being put into place for collecting meaningful use measures. This will rely on use of certified EHR technology and on the planned implementation of a statewide HIE.
	Diabetes: Blood Pressure Management	SAA	NQF 0061/ MU	SAA

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	Hypertension: Blood Pressure	SAA	NCQF 0013/ MU/ ACO	SAA
	Use of Appropriate Medications for Asthma	SAA	NQF 0036/ MU	SAA
	<p>Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received the following:</p> <ul style="list-style-type: none"> • Initiation of AOD treatment. • Engagement of AOD treatment. 	Reported to BMS by Health Homes	<p>CMS Medicaid Adult Quality and HH Core (Numerator) Initiation of Alcohol and other Drug (AOD) Dependence Treatment: Members with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis.</p> <hr/> <p>Engagement of Alcohol and other Drug (AOD) Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.</p> <p>(Denominator) Members 13 years of age and older as of December 31 of the measurement year with a new episode of alcohol or other drug (AOD) during the intake period, reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators.</p>	Data will be collected from health homes using the same system that is being put into place for collecting meaningful use measures. This will rely on use of certified EHR technology and on the planned implementation of a statewide HIE.
	Rate of admission of enrollees to Crisis	Claims		Data will be submitted in

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	<p>centers (CBHC's)</p> <p>Rate of admission of enrollees with SMI to Psychiatric Hospitals</p> <p>Rate of Involuntary Commitment Evaluations for enrollees with SMI</p>	<p>BHHF</p> <p>Data submitted to BMS by Community Behavioral Health Centers</p>		<p>electronic form by BHHF. Data summaries on their enrollees will be made available to each health home.</p>
2. Experience of Care	<p>Average enrollee SF-12 score</p>	<p>SF-12 administered by health home at least once per year. Data submitted to BMS by health homes</p>		<p>Data will be collected from health homes using the same system that is being put into place for collecting meaningful use measures. System will be augmented to allow for direct online data submission from the health home.</p>
3. Quality of Care	<p>Emergency Department Visits: Preventable ambulatory care-sensitive ED visits algorithm.</p>	<p>Claims</p>	<p>The NYU Emergency department Classification Algorithm (V2.0) which is a nationally recognized tool to calculate preventable ED visits.</p>	<p>MMIS will be used as data source to populate data warehouse and BMS reporting capability. Reports on individual performance will be provided as feedback to health homes.</p>
	<p>Ambulatory Care-Sensitive Condition Admissions: Age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces need for admission to hospital per 100,00 population under age 75</p>	<p>Claims</p>	<p>CMS Medicaid Adult Quality and HH Core (Numerator) Total # of acute case hospitalizations for ambulatory care sensitive conditions under age 75 / (Denominator) Total mid-year population under age 75.</p>	<p>Data analysis of administrative claims will identify hospital discharges. Data to be collected from MMIS and BMS data warehouse when that becomes available. Reports on individual performance will be provided as feedback to health homes.</p>

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	Medication Adherence to Antipsychotics, Antidepressants and Mood Stabilizers	Rx claims data base	Numerator = Number of members on that class of medication in the past 90 days with medication possession ratios (MPR) > 80% / Denominator = Number of all members on that class of medication in the past 90 days	Data will be analyzed based on electronic claims data. Reports on individual performance will be provided as feedback to health homes.
	Members with Diabetes: Adherence to prescription medications for Diabetes.	Rx claims data	Numerator = number of members on medication for Diabetes in the past 90 days with medication possession ratio (MPR) > 80% / Denominator = number of all members on medication for Diabetes in the past 90 days	Data will be analyzed based on electronic claims data. Reports on individual performance will be provided as feedback to health homes.
	Mental health: percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge. http://qualitymeasures.ahrq.gov/content.aspx?id=14965	Claims data	CMS Adult Quality and HH Core (Numerator) An outpatient visit, intensive outpatient encounter, or partial hospitalization (refer to Table FUH-C in the original measure documentation for codes to identify visits) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. (Denominator) Members 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December of the measurement year	Data will be analyzed based on electronic claims data. Reports on individual performance will be provided as feedback to health homes.
Goal 2	Improve			

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preventive care for HH enrollees				
Clinical Outcomes				
Experience of care				
Quality of care	Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented	Data submitted by Health Homes	CMS Medicaid Adult Quality and HH Core (Numerator) Total number of patients from the denominator who have follow-up documentation (Denominator) All patients 18 years and older screened for clinical depression using a standardized tool	Data will be collected from health homes using the same system that is being put into place for collecting meaningful use measures. System will be augmented to allow for direct online data submission from the health home.
	Advising Smokers and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies	Data submitted by Health Homes	NQF 0027/ MU	Data will be collected from health homes using the same system that is being put into place for collecting meaningful use measures. System will be augmented to allow for direct online data submission from the health home.
	Percentage of members 18-74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year	Data submitted by Health Homes	CMS Medicaid Adult Quality and HH Core (Numerator) Body mass index documented during the measurement year or the year prior to the measurement year (Denominator) Members 18-74 of age who had an outpatient visit	Data will be collected from health homes using the same system that is being put into place for collecting meaningful use measures. System will be augmented to allow for direct online data submission from the health home.
Goal 3 Improve care coordination across all care				

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settings.				
Clinical Outcomes	All-cause hospital readmission rates	Claims	CMS Medicaid Adult Quality and HH core Readmissions within 30 days of discharge from an inpatient facility, regardless of the reason for either the index admission or the readmission	MMIS claims data will be used to generate
Experience of Care	CAHPS Q 34	CAHPS patient survey		
Quality of Care	Medication reconciliation is performed for more than 50% of transitions of care	Health homes data submission	Meaningful use objective	As a meaningful use objective, the data will be submitted by health homes using direct electronic transmission to the BMS system supporting the CMS incentive payment system.
	Summary of care record is provided for more than 50% of patient transitions or referrals.	Health homes data submission	Meaningful use objective	As a meaningful use objective, the data will be submitted by health homes using direct electronic transmission to the BMS system supporting the CMS incentive payment system.
	Care Coordination: % of hospital discharged members that care manager made telephonic or face-to-face contact within 72 hours following discharge.	Health homes data submission	(Numerator) Number of patients contacted within 72 hours following discharge / (Denominator) Number of members discharged.	Data will be collected from health homes using the same system that is being put into place for collecting meaningful use measures. System will be augmented to allow for direct online data submission from the health home.
	Care transitions: percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was	Health homes data submission	CMS HH Core (Numerator) Patients for whom a transition record was transmitted to the facility or primary physician or	Data will be collected from health homes using the same system that is being put into place for

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	transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge. http://qualitymeasures.ahrq.gov/content.aspx?id=15178		other health care professional designated for follow-up care within 24 hours of discharge (Denominator) All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care	collecting meaningful use measures. System will be augmented to allow for direct online data submission from the health home.
Goal 4 Improve members' experience with the health care delivery system.	Measures	Data Source	Measure Specification	How HIT will be Utilized
Clinical Outcomes				
Experience of Care	CAHPS-PCMH composite score	CAHPS enrollee survey	As defined by ARHQ	Data will be compiled and feedback provided to the respective health homes
Quality of Care	Percent of eligible Medicaid members who choose to enroll in a health home		Numerator: Number of persons who are offered health homes services minus number of persons who opt out of enrollment Denominator: Number of persons offered health home services	Data will be maintained by BMS in an electronic registry
Goal 5 Increase the use of HIT to facilitate care coordination and timely sharing of clinical information.	Measures	Data Source	Measure Specification	How HIT will be Utilized
Clinical Outcomes				
Experience of Care	More than 50% of requesting patients receive electronic copy within 3 business days	Data submission by health home through certified EHR	MU objective	As a meaningful use objective, the data will be submitted by health homes using direct electronic transmission to the BMS system supporting the CMS

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				incentive payment system
Quality of Care	% of health home providers as registered users of state HIE	WVHIN		
Goal 6 Reduce the overall cost of care over time, while improving quality.	Measures	Data Source	Measure Specification	How HIT will be Utilized
Clinical Outcomes				
Experience of Care	Primary care visit rate Primary care visit cost as percent of total cost	Claims	Numerator: Number of primary care visits in past 90 days Denominator: Number of health home enrollees	Data will be analyzed based on electronic claims data. Reports on individual performance will be provided as feedback to health homes.
Quality of Care	Use cost measures required by CMS	As described below		

Evaluations – Describe how the state will collect information from health home providers for the purpose of determining the effects of this program on reducing:

Hospital Admissions	Description	Data Source	Frequency of Data Collection
	Rate of acute care hospital admissions for the Health Home members= (number of admissions for the HH members, divided by the number of HH members) x 1000 Compare this rate pre- and post-implementation of HH initiative. Compare rate to similar cohort cared for by practices not recognized as HH.	BMS MMIS claims data	Monthly, aggregated annually
Emergency Room Visits	Description	Data Source	Frequency of Data Collection
	Rate of ER visits for HH members = (total ED visits with a discharge disposition of home divided by the number of HH members) x 1000 Compare this rate pre- and post-implementation of HH initiative. Compare rate to similar cohort cared for by practices not recognized as HH.	BMS MMIS	Monthly, aggregated annually

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Skilled Nursing Facility Admissions	Description	Data Source	Frequency of Data Collection
	Rate of SNF admissions for HH members =(total SNF admits divided by the number of HH members) x 1000 Compare this rate pre- and post- implementation of HH initiative. Compare rate to similar cohort cared for by practices not recognized as HH.	BMS MMIS	Monthly, aggregated annually
Evaluations - 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:			
Hospital Admission Rates	Consolidate BMS MMIS claims data to assess hospital admission rates by service (medical, surgical, maternity, mental health & chemical dependency) for participating Health Homes compared to a non-participating control group. <ol style="list-style-type: none"> 1. The experience of members' with clinical conditions of focus during the first year, and 2. All members with 2 or more chronic conditions, or 1 chronic condition and at risk for a second, obtained from a list of state-defined chronic conditions. 		
Chronic Disease Management	MMIS will be used to calculate process measures related to evidence-based guidelines for the targeted chronic conditions cares. Additional clinical outcome measures will be reported by Health Home providers and teams.		
Coordination of Care for Individuals with Chronic Conditions	Coordination of care is one of the elements assessed in the CAHPS-PCMH survey and data collected through this source will be used to monitor care coordination from the member perspective		
Assessment of Program Implementation	A learning community of health home participants is being set up to allow for regular sharing of experiences among health home providers and teams. Qualitative information about program implementation will be collected through this community.		
Processes and Lessons Learned	Lessons learned will be harvested through the health home learning community.		
Assessment of Quality Improvements and Clinical Outcomes	MMIS will be used to calculate process measures related to evidence-based guidelines for the targeted chronic conditions cares. Additional clinical outcome measures will be reported by Health Home providers and teams.		
Estimates of Cost Savings	MMIS data will be used to compare costs of health home members to members with similar diagnoses and age. Analysis of utilization and cost will be made. Utilization parameters will include inpatient admissions by facility type as well as ED use. Cost parameters will include total cost as well as component cost, including inpatient, primary care services, specialty care, emergency care, and pharmacy.		
Payment Methodology			
Provide type of payment and methodology including rates.	<p>TBD</p> <p>Reimbursement will only be for health home services not covered by any other available Medicaid reimbursement options unless otherwise stipulated by BMS. The criteria required for receiving a monthly PMPM reimbursement is:</p> <ol style="list-style-type: none"> a) The member meets health home eligibility criteria on the WV health home registry maintained within the MMIS; b) The member is enrolled as a health home member with the health home provider billing for the service reimbursement; c) The minimum health home service required to receive PMPM reimbursement has been provided 		

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	d) Other?:
Will payment methodology be tiered? If yes, provide methodology for tiering the payments.	TBD

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