U.S. Department of Health and Human Services
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MEDICAID HEALTH HOMES IN ALABAMA:

REVIEW OF PRE-EXISTING INITIATIVES AND STATE PLAN AMENDMENT FOR THE STATE'S FIRST HEALTH HOMES UNDER SECTION 2703 OF THE AFFORDABLE CARE ACT

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Alabama's Health Home Program at a Glance	
Health Home Eligibility Criteria	2 chronic conditions, 1 chronic condition and at risk of another, serious mental illness
Qualifying Conditions	• Mental illness • Substance use disorder • Asthma • Diabetes • Transplant recipients (within last 5 years) • CVD • COPD • Cancer • HIV/AIDS • Sickle cell anemia
Enrollment*	70,206
Designated Providers	Patient Care Networks of Alabama (PCNAs), Medicaid-enrolled primary medical providers (PMPs)
Administrative/ Service Framework	The state offers health home services through a designated team of health care providers that include primary care providers, behavioral health providers, state-employed case managers, and the PCNAs. PCNAs operate as independent, nonprofit entities that contract with the state and participating Medicaid providers to offer wraparound care management services for eligible beneficiaries enrolled in the state's PCCM, Patient 1st. The PCNA program--and by extension the health homes program--operates in four targeted geographic regions, comprising 21 of the state's 67 counties.
Required Care Team Members	Not specifically mandated, though all providers must meet state requirements related to licensure. PCNAs are also required to meet certain staffing requirements. Depending on patient needs, the team may include a PMP, mental health provider, substance abuse provider, care manager/coordinator, pharmacist, transitional care nurse, dietician, and community health worker.
Payment System	Per member per month (PMPM) care management fee
Payment Level	PCNA: $9.50 PMP: $8.50
Health Information Technology (HIT) Requirements	PCNAs and PMPs are currently not required to have an electronic health record (EHR) or use an electronic Continuity of Care Document to exchange information. Alabama is in the process of implementing a statewide health information exchange platform known as One Health Record™. Providers who receive HITECH EHR incentive payments will be required to connect to One Health Record™ when operational. In the meantime, providers use existing web-based tools.
* January 2014 data provided to the Centers for Medicare and Medicaid Services' Health Home Information Resource Center.	

Introduction

Alabama's Section 2703 Health Homes State Plan Amendment (SPA) was approved by the Centers for Medicare and Medicaid Services (CMS) on April 8, 2013 with a retroactive effective date of July 1, 2012. To be eligible for services, beneficiaries must have a serious mental illness (SMI), two chronic conditions, or have one chronic condition and be at risk of another chronic condition. The qualifying chronic conditions include a mental illness, substance use disorder, asthma, diabetes, heart disease, cardiovascular disease (CVD), chronic obstructive pulmonary disease (COPD), cancer, HIV with an 18 month lookback of Medicaid claims data for identification of medications, and sickle cell anemia. People who have received a transplant within the last five years are also eligible for inclusion. Alabama considers any beneficiary with one of these targeted conditions to be at-risk for developing another chronic condition.

The state offers health home services through a designated team of health care providers that include primary care providers (PCPs), behavioral health providers, state-employed case managers, and providers known as Patient Care Networks of Alabama (PCNA). PCNAs were established in 2011 and operate as independent, nonprofit entities that contract with the state and participating Medicaid providers to offer wraparound care management services for eligible beneficiaries enrolled in the state's primary care case management (PCCM) program, Patient 1st. Enrollment in Patient 1st is mandatory for all Medicaid beneficiaries, with the exception of certain groups of children (described further in the next section), members of federally recognized Indian tribes, and those who are dually eligible for Medicaid and Medicare. Though case management services are available statewide through the Patient 1st program, the PCNA program--and by extension the health homes program--operates in four targeted geographic regions, comprising 21 of the state's 67 counties.[1]

Implementation Context

Alabama is implementing a range of health care payment and delivery reforms, many of which have implications for both the health homes program and the national evaluation. These reforms include medical home transformation activities, health information technology (HIT) initiatives, and changes to the state's managed care program, among others.

Care Delivery Reforms

Alabama operates a PCCM program known as Patient 1st, which was established in 1997 under a Section 1915(b) waiver. In September 2013, the Patient 1st program was incorporated into the State Plan.[2] All Medicaid enrollees must participate, with the exception of dually eligible individuals, members of federally recognized tribes, and children who are in foster care, who receive case management services through specialized providers, or who are eligible for Supplemental Security Income.[2] Roughly

650,000 of the state's 930,000 beneficiaries are currently enrolled in the program.[3] Participating providers (known as Primary Medicaid Providers [PMPs]) receive a risk-adjusted case management fee for all enrolled patients, and in turn are expected to directly provide primary care and serve as gatekeepers to specialty care. PMPs may also refer patients for case management services, which are provided through contracts with the Alabama Departments of Public Health (ADPH) and the Alabama Department of Mental Health (ADMH). ADPH and ADMH case managers provide traditional case management services, including risk assessment, care plan development, patient education, and transportation assistance.

The PCNA program (described in greater detail below) was established in 2011 on a pilot basis, with the goal of providing enhanced care management services for high-risk, high-need beneficiaries. The first three PCNAs were established in the northern, eastern, and western regions of the state; a fourth PCNA was established in the southern region in 2012, as part of the program's transition from pilot to health home status. In March 2013, the state legislature passed SB 340, which called for the Medicaid agency to establish provider-based, risk-bearing managed care entities known as Regional Care Organizations (RCOs).[4] It is anticipated that RCOs will build on the PCNA model, expanding over time to cover the majority of Medicaid beneficiaries. Eventually, RCOs will manage and be at-risk for the full continuum of primary, behavioral, and long-term care services provided within their respective regions. The details of the RCO program are still under development, and implementation is dependent on federal approval of the state's pending Section 1115 waiver application.[5] Provider networks are expected to be in place by April 2015, and will begin receiving capitation payments by October 2016.[6] While RCOs are under development, the state will continue, and possibly expand, the existing PCNA program.

The primary goal of the Patient 1st program (and by extension the PCNA program) is to provide a medical home for Medicaid enrollees. Other medical home initiatives underway in the state include the CMS Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration, which includes seven practices in Alabama.[7] This demonstration began in 2011, and will run for three years. Participating practices receive a monthly care management payment, as well as technical assistance to support their application for Level 3 medical home recognition from the National Committee for Quality Assurance (NCQA).[8]

Two Alabama Area Agencies on Aging are also participating in the Community-based Care Transitions Program, which is aimed at reducing readmission for Medicare beneficiaries with chronic conditions. Under this program, grantees receive a two-year award from CMS, which may be extended annually until the end of the five-year demonstration project. Top of Alabama Regional Council of Governments in Alabama will partner with four hospitals to implement a Care Transitions Intervention program for Medicare patients in three counties--two of which are also served by PCNA organizations.[9] This program provides coaching, medication reconciliation, chronic disease management, and referrals for patients following discharge from a participating hospital. The Southern Alabama Regional Council on Aging will partner with eight

regional hospitals in seven rural counties designated as Health Professional Shortage Areas. However, these counties are not currently served by a PCNA.[10]

Payment Reforms

Alabama is one of 12 states participating in the Medicaid Emergency Psychiatric Demonstration, which was created under Section 2707 of the Affordable Care Act. Under current Medicaid payment rules, private psychiatric hospitals may not be reimbursed for providing emergency inpatient psychiatric care without a prior admission to an acute care hospital. This exclusion, known as the "Institution for Mental Diseases (IMD) exclusion," is cited as a contributing factor to high emergency department utilization, as well as higher costs. The demonstration will test whether eliminating this exclusion will lead to better health outcomes, reduced burden on hospital emergency departments, and lower costs for Medicaid beneficiaries experiencing a mental health crisis.[11] In Alabama, the demonstration includes four free-standing psychiatric hospitals which together cover more than 30 counties. All four hospitals have assigned nurses to conduct follow-up with Medicaid beneficiaries at three, 21, and 90 days after discharge.[12]

Payment reform demonstrations are also underway at the provider level. The Bundled Payments for Care Improvement (BPCI) Initiative is testing four bundled payment models, two of which include Alabama providers. Model 2 and Model 3--which involve the University of Alabama and Amedisys Home Health, respectively, are retrospective bundled payments that reconcile actual expenditures for an entire episode of care against a target price for the same episode. Participants may select up to 48 clinical condition episodes to be paid for under this bundled model. Model 2 payments will cover both hospital and post-acute care for 30, 60, or 90 days after discharge, while Model 3 will cover episodes in the post-acute period only, beginning no more than 30 days after discharge, and ending either 30, 60, or 90 days after initiation of the episode of care.[13] Providers will phase in their assumption of financial risk over several months; by October 2014, providers will be at full risk for their selected episodes of care.

Health Information Technology Infrastructure

Alabama is implementing a statewide health information exchange (HIE) known as One Health Alabama (described further below), which builds on the infrastructure developed through the state's Together for Quality Initiative. Together for Quality was funded through a two-year Medicaid Transformation Grant from CMS, and sought to create HIT infrastructure that linked existing data sources and would allow providers to better manage care for their patients.[14] As part of this initiative, the state-developed a web-based HIE known as Q-Tool, which supported both clinical decision-making tools and e-prescribing functions. Q-Tool was first piloted in 11 counties before being made available more broadly.[15] The state also partnered with BlueCross BlueShield (BCBS), the largest private insurance carrier in the state. As part of this partnership, BCBS made its medical and pharmacy claims available through Q-Tool, allowing enrolled providers to access health information on any patient who had transitioned from BCBS to

Medicaid coverage. To encourage participation, Patient 1st providers who used Q-Tool received an extra dollar in per patient case management fees. By January 2010, roughly 300 providers were enrolled in Q-Tool.[16] Q-Tool was discontinued at the end of the grant period in September 2010, as the state began work on One Health.

The Together for Quality initiative also included implementation of a care management program for patients with asthma and diabetes, and a data hub for information exchange among Medicaid and other state agencies.[14] The HIT infrastructure underpinning this care management program--Realtime Medical Electronic Data Exchange (RMEDE)--is operated by the University of South Alabama's Center for Strategic Health Innovations, and it allows enrolled providers to track key health indicators for their diabetic and asthmatic patients.[15] This system also supports an in-home monitoring program for patients with congestive heart failure, hypertension, and diabetes.[17] Enrolled patients use a telephonic system to enter their own health data, which are then sent to RMEDE. If a patient's metrics are outside of established parameters, the system generates an alert for follow-up by the PMP or an ADPH Nurse Care Manager. RMEDE also generates monthly reports that can be used for targeted intervention and quality improvement activities.

Implications for the Alabama Section 2703 Medicaid Health Homes Evaluation

Alabama has implemented its health home program in selected geographic areas, which may improve the ability to identify a comparison group for analysis of key outcomes. However, the health homes program is built directly within an existing care management infrastructure, and it is unclear what changes--if any--have been made to these underlying care structures and processes as part of the implementation of health homes. Several aspects of the program--particularly the HIT infrastructure supports and data collection systems--are still under development. It also is not yet clear how health homes will participate in the state's efforts to establish RCOs, or align with other reform efforts underway. PCNAs and Patient 1st providers will have differing levels of capacity for care management, coordination, and integration. Analyses will need to take into account baseline characteristics and major changes over time, enrollee and provider time in the program, and, to the extent possible, identify enrollees in other care management programs prior to enrollment.

Population Criteria and Provider Infrastructure

Alabama offers health home services to categorically needy beneficiaries with SMI, two chronic conditions, or one chronic condition and the risk of developing another. The qualifying chronic conditions include a mental illness, substance use disorder, asthma, diabetes, heart disease, CVD, COPD, cancer, HIV/AIDS, and sickle cell anemia. Any beneficiary with one of these conditions is considered to be at-risk for developing

another chronic condition. Beneficiaries who have received a transplant within the last five years are also eligible for inclusion (see Table 1).

Health home services are delivered by a team of providers working across care settings. Primary responsibility for care management rests with a patient's designated Patient 1st Primary Medicaid Provider (PMP), who works in partnership with a regional PCNA--described in greater detail below--to coordinate the full range of a patient's medical, behavioral, social, and long-term care needs. Depending on their diagnosis, patients may instead receive care management through a state-licensed Community Mental Health Center (CMHC), a substance abuse provider, or an ADPH care manager. PMPs or PCNAs can refer patients for screening to determine their eligibility for care management services with those providers. If they are deemed ineligible, they are referred back to the PMP. Any patient who is unstable but deemed ineligible for care management through a behavioral health or ADPH provider may be referred to the PCNA for care management.

Patient Care Networks of Alabama (PCNAs)

PCNAs were established in 2011 as an enhancement of the state's existing PCCM program, Patient 1st. Modeled after the Community Care of North Carolina program, PCNAs are regional networks that build on local care capacity to support Patient 1st PMPs in managing and coordinating care for their highest-need patients. Four networks are operational, and provide services in 21 of the state's 67 counties. As stated in the original Request for Proposal (RFP), the goals of the program are to develop and implement holistic, patient-centered care plans; promote the patient-centered medical home model; improve care quality and health outcomes; reduce emergency department and inpatient utilization; and improve utilization of HIT.[18] PCNAs are expected to provide care coordination, direct care management, transitional care, medication management, and population health management for health home enrollees.

PCNAs operate as 501(c)(3) nonprofit entities, and must establish contracts with the state and with the PMPs enrolled in their network. In addition to these contractual relationships, PCNAs are expected to develop working relationships with CMHC and substance abuse providers, and the local Departments of Public Health and Human Resources. The relationships between these various entities and organizations are reinforced through the PCNA board of directors, at least half of whom must be made up of Patient 1st primary care physicians. Boards must also include at least one representative from an FQHC, a hospital, the health department, a CMHC, a state-licensed substance abuse provider, and a community pharmacist.[19] PCNA staff composition varies, but each entity must designate an Executive Director; a Medical Director; a Network/Clinical Pharmacist; and a Chronic Care Clinical Champion, who works directly with high-risk patients and supports existing case managers in the network. Additional staff members include care managers, transitional care nurses, behavioral health nurses, dieticians, and community health workers. Since 2012, PCNAs have been required to include the local CMHC in their management meetings,

and must have an identified member of their staff with behavioral health expertise to work with the local CMHC.

The state outlined four primary roles for these networks in supporting health home patients:[19]

1. Coordinate the work of providers across settings to ensure effective, nonduplicative, higher quality care.

2. Provide direct care management for Medicaid patients who are unstable.

3. Facilitate care integration between primary care and CMHC or substance abuse providers.

4. Review health home enrollee data on a monthly basis, in collaboration with PMPs.

PCNAs are also expected to sponsor regional meetings for providers enrolled in the network, as well as learning collaborative opportunities. The state intends to supplement these activities through providing statewide learning opportunities and technical assistance.

Identification and Enrollment

Alabama identifies eligible individuals through a monthly review of claims data, with a lookback of the previous 18-month period. For those with organ transplants, the lookback period is five years. Hospitals and PMPs may also identify and refer patients for enrollment. Once identified, those patients are contacted by mail and permitted to choose a PMP, after which they will be enrolled with the PCNA contracted to that practice. The patient may choose to opt-out of receiving health home services, or may switch provider at any time. However, enrollment with a PMP is still mandatory for nonhealth home services covered under the state's PCCM program. As previously noted, individuals who qualify for health home services based on either a mental health or substance use disorder will receive care management primarily through a CMHC or substance abuse provider, rather than their PMP. PCNAs may serve all health home patients with chronic conditions, regardless of diagnosis.

Service Definitions and Provider Standards

The service definitions provided in the SPA are adapted in Table 2 below. Comprehensive care management is the primary responsibility of the PMP, who must develop relationships with local CMHCs and substance abuse providers to ensure effective care management for patients with mental health or substance abuse diagnoses. Coordination is led by the PCNA, which serves as a liaison between the patient, PMP, other care management providers, and state agencies. Coordination

activities may also be led by CMHC, substance abuse, or ADPH case managers, depending on patient need, but these latter providers are reimbursed through a different methodology (see Payment section). Health promotion, care transition, individual and family support services, and referral to community and social support services may be provided by any member of the health home team.

In addition to meeting the 11 core standards identified by CMS, all health home team member must meet state and federal licensure requirements, and have the ability to provide health home services as stipulated in the SPA (See Table 2).

Use of Health Information Technology

Alabama is in the process of implementing a statewide HIE platform known as One Health Record™, which will connect providers with state agencies and eventually serve as the primary platform for patient data exchange. A consumer portal is already operational through One Health Record™, as is a platform for direct secure messaging between providers who are connected to it. Eventually, the state envisions that the network will allow providers to view paid claims data, access emergency department utilization data, implement e-prescribing, and review clinical data. Providers who receive Health Information Technology for Economic and Clinical Health (HITECH) Act EHR Incentive Payments will be required to connect to One Health Record™. However, neither Patient 1st PMPs nor PCNAs currently are required to have an electronic health record (EHR) or use an electronic Continuity of Care Document to exchange information. Once connected to One Health Record™, both PMPs and PCNAs will use its standardized format for data exchange.

In the interim, the state is encouraging continued use of existing web-based tools like RMEDE, which the state expects to integrate with One Health Record™. The state has recently developed a new data repository to link to One Health Record™, which has replaced the data warehouse maintained by the University of South Alabama. PMPs and PCNAs will use this repository to access clinical and administrative data and report quality measures.

Payment Structure

Payment to PMPs and PCNAs for the provision of health home services will be made on a per member per month (PMPM) case rate basis. PMPs receive $8.50 PMPM, while PCNAs receive $9.50 PMPM.[2] (Rural health centers and FQHCs that participate as PMPs do not qualify for the case management fee.**Error! Bookmark not defined.**) These payments will be made in addition to standard fee-for-service reimbursement, and are paid for patients meeting three criteria: (1) they are enrolled with a PMP who is participating in a PCNA; (2) they are identified by either the state, the PMP, or the PCNA as having one of the qualifying conditions; and (3) they have received a minimum level of care management services, which includes monitoring for

treatment gaps in care. PCNAs are expected to review patient data on a monthly basis to identify such gaps, and follow-up with the PMP or the patient to determine that any identified issues are being addressed. Care management services provided by CMHCs, substance abuse providers, and ADPH care managers are not reimbursed through a PMPM. These providers receive a standard fee reimbursement.

Quality Improvement Goals and Measures

The state has identified seven goals for the health homes program, and has set corresponding targets for performance improvement. These goals are listed in Table 3 below, along with the corresponding measures that will be used to evaluate progress against the identified benchmark goals. Most of the selected measures will be generated through claims; other data sources include Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data, data from ADMH, and eventually One Health Record™ chart audit. The state is also developing a standardized web-based assessment to collect depression screening data.

Evaluation Measures and Methods

The evaluation measures and methods described in the SPA are adapted in Table 4 below (sentences that were identical across cells were deleted). The state plans to assess the impact of health home services at the practice, network, and state level, based on the selected quality measures. No consistent evaluation design is specified for key health home outcome measures. For hospital admissions, the intent is to measure, for persons age 18 or older as of December 31 of the measurement year, the acute admission rate for each qualifying condition in the geographic areas covered by health homes and in the remainder of the state, the number of all-cause readmissions after an acute admission, and the predicted probability of an acute readmission. For skilled nursing facility (SNF) use, total admissions for health home enrollees in Patient 1st will be compared with total SNF admissions among health home enrollees outside of Patient 1st. Cost savings will be assessed by comparing actual PMPM amounts for the included geographic regions with projected PMPM. The projection methodology is not described.

TABLE 1. Target Population and Designated Providers--Alabama	
SPA Approval (Effective Date)	April 09, 2013 (July 1, 2012)
Designated Provider(s)	Patient 1st PMPs, CMHCs, ADPH, and substance abuse providers partnering with a PCNA
Health Home Team Composition	Not specifically mandated, though all providers must meet state requirements related to licensure. PCNAs are also required to meet certain staffing requirements. Depending on patient needs, the team may include: • PCP • Mental health provider • Substance abuse provider • Care manager/coordinator • Pharmacist • Transitional care nurse • Dietician • Community health worker
Target Population	Medicaid beneficiaries with SMI, 2 chronic conditions, or 1 chronic condition and the risk of developing another
Qualifying Chronic Conditions	• Mental illness • Substance use disorder • Asthma • Diabetes • Heart disease • Transplant recipients (within the last 5 years) • CVD • COPD • Cancer • HIV/AIDS • Sickle cell anemia

TABLE 2. Health Home Service Definitions--Alabama	
Care Coordination	Defined as an enrollee-centered, assessment-based inter-disciplinary approach to integrating health care and social support services in which an individual's needs and preferences are assessed, a comprehensive care plan developed, and services managed, monitored and reassessed as needed by an identified care coordinator following evidence-based standards of care to the degree possible. In addition to the core elements of care coordination/care management, the care coordinator provides disease management education, medication reconciliation, facilitation of sub-specialty referrals, transitional care interventions, works to ensure appropriate level of care is being provided and unnecessary emergency department visits are avoided, as well as providing education to patients about the importance of a medical home. Activities within scope of this service are performed by PCNAs, CMHCs, substance abuse providers, or ADPH care managers, in accordance with patient needs. They include: • Staffing to support the PMP in care management. Patient care team must be accessible to individuals 24/7. • Screening for clinical depression. • Development of a comprehensive assessment of an individual's health and psychosocial needs and preferences, including health literacy status and deficits. • Planning with the individual, family or caregiver, providers, the payer, and the community to maximize health care responses, quality, and cost-effective outcomes. • Development of a comprehensive health plan that is person-centered for each individual and coordinates and integrates all of the individual's clinical and nonclinical health care related needs and services. Development of the comprehensive health plan is collaborative with the enrollee and family or caregiver and using a team approach. The comprehensive health plans must have the capacity to accommodate individuals with multiple diseases and co-morbidities. The comprehensive health plan identifies the individual, caregiver, PCNA, specialists and other ancillary providers involved in the participant's care. • Coordination and access to preventive and health promotion services, including prevention of mental illness and substance use disorders. • Coordination and access to mental health, substance abuse, and LTSS. • Establishment of a continuous quality improvement program, and collection and reporting 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. • Management, monitoring and reassessment of an individual as needed by an identified care coordinator following evidence-based standards of care and enrollee-centered, assessment-based inter-disciplinary approach to integrating health care and social support services. • Traditional case management services through public health, including assistance with understanding program requirements, helping with transportation needs, and assessment of the home environment and factors that may impede patient compliance with medical care protocols; also includes mental health, substance abuse and child health issues such as understanding the need for preventive care. • Disease management education, medication reconciliation, facilitation of sub-specialty referrals and transitional care interventions. • Facilitated communication and coordination between members of the health care team in order to minimize fragmentation in the services. • Empowerment of the individual to problem-solve by exploring care options to achieve desired outcomes. • Encouragement of the appropriate use of health care services to improve quality of care and maintain cost-effectiveness. • Assistance in transitioning of care to the next appropriate level. • Promotion of individual self-advocacy and self-determination. • Advocating for both the individual and the Medicaid Program to facilitate positive outcomes for the individual, the health care team, and the Medicaid Program.

TABLE 2. (*continued*)	
Comprehensive Care Management	Activities within the scope of this service are performed by the PMP and include: • Identifying high-risk individuals (in addition to the efforts by the state directly to identify high-risk enrollees). • Conducting outreach to, planning and communicating with other primary and specialty care providers regarding a patient's care. • Developing a comprehensive health plan informed by the patient, which integrates care across various systems (mental health/substance abuse/primary care). Clarifying and communicating the patient's preference to all involved providers while assuring timely delivery of services.
Health Promotion	Activities within the scope of service are performed by all team members, and include: • Patient education to the individual, family or caregiver, and members of the care team about treatment options, community resources, insurance benefits, psychosocial concerns, care management, etc. Also, patient education about the importance of a medical home. • Adhering to EPSDT requirements. • Providing health education specific to an individual's chronic conditions. • Providing education regarding the importance of immunizations and screenings, child physical and emotional development. • Providing health-promoting lifestyle interventions, such as substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity. • Development of a treatment relationship with the individual and the inter-disciplinary team of providers. • Promoting evidence-based wellness and prevention by linking health home enrollees with resources based on individual needs and preferences.
Comprehensive Transitional Care	Activities within the scope of service are performed by all team members. PMPs are expected to assist the enrollee in the safe transitioning of care to the next most appropriate level, including movement from inpatient to a nursing facility or home setting. PCNAs assist the enrollee in the safe transitioning of care to the next most appropriate level.
Individual and Family Support Services	Activities within the scope of service are performed by all team members. PMPs are expected to provide patient and family support as appropriate. PMPs must educate and empower the enrollee and the family or caregiver about treatment options, community resources, insurance benefits, psychosocial concerns, care management, etc., so that timely and informed decisions can be made. Other care management providers (PCNAs, CMHCs, substance abuse providers, and ADPH) are expected to provide patient and family support as appropriate. PMPs and PCNAs to advocate for both the state and the enrollee to facilitate positive outcomes for the enrollee and where a conflict arises to prioritize the needs of the enrollee.
Referral to Community and Social Supports	Activities within scope of service are performed by all team members. Where relevant and as appropriate, PMPs and PCNAs are specifically required to establish an ongoing process with community providers and other community agencies to coordinate the planning and provision of care management and other support services for enrollees needing those services. However, all care management managers may engage in this activity for their specific population. Services include LTSS such as housing, home delivered meals, services for individuals with disabilities and adult day care. For individuals with public health needs, the ADPH will take the lead to assure community and social support services relevant to public health and obtained through the public health infrastructure are available to health home services enrollees. Since much of the public health infrastructure in Alabama is through the state, the ADPH will coordinate these efforts as a participant in the team.

TABLE 3. Health Home Goals and Quality Measures--Alabama	
Goal-Based Measures	
Improve Health Outcomes for Adults with Diabetes	Benchmark goals: • Increase care compliance for diabetic patients receiving health home services by 2% in year 1 and another 2% by year 2. Clinical outcome measures: • Percent of patients with a diagnosis of diabetes mellitus who had an HbA1c test performed during the past year. • Percentage of patients 18-75 years of age with a diagnosis of diabetes mellitus (type 1 and type 2) who had a low-density liproprotein cholesterol (LDL-C) test in the past year.
Improved Health Through Reduction in Adult Body Mass Index (BMI)	Benchmark goals: • Increase identification of adult BMI level by 2% over baseline year (2012). Clinical outcome measures: • Adult BMI assessment.
Reduction in Hospital Readmission and Ambulatory Care-Sensitive Condition Admissions	Benchmark goals: • Reduce ambulatory care-sensitive condition admissions rate by 2.5% in year 1 and another 2.5% by year 2. • Reduce the 30 day readmission rate by 2.5% in both year 1 and year 2. Clinical outcome measures: • Ambulatory care-sensitive condition admission. Quality of care measures: • Plan all-cause readmission.
Improve Care Coordination for People with Asthma	Benchmark goals: • Increase influenza immunization rate in children with an asthma diagnosis by 1% in year 1 and year 2. • Decrease emergency department visit rate for asthmatic enrollees by 5% in year 1 and another 2.5% by year 2. Clinical outcome measures: • Influenza immunization rate in children with an asthma diagnosis. Quality of care measures: • Percent of patients with an emergency department/urgent care office visit for asthma in the past 6 months.
Improve Care Coordination Through Transmission of Transition Records	Benchmark goals: • Increase the timely transmission of transition record (inpatient discharges to home/self-care or any other site of care) by 5% in year 1 and another 2.5% by year 2. Quality of care measures: • Percent of patients for whom a care transition record was transmitted to the follow-up care provider within 24 hours of discharge.

TABLE 3. (*continued*)	
Goal-Based Measures (*continued*)	
Improve Pediatric Preventive Care	Benchmark goals: • Increase the percentage of children receiving well-child checks by 2% from the baseline for year 1 and year 2. Clinical outcome measures: • Percentage of children age 12-21 who had at least 1 comprehensive well-care visit with a PMP. Experience of care measures: • CAHPS 1.0 survey response regarding access to dental care for children. Quality of care measures: • Percentage of children (under age 21) who had at least 1 dental visit during the measure year.
Improve Treatment for Depression	Benchmark goals: • Benchmark goal to be determined based on information collected from the baseline. Quality of care measures: • Percentage of patients age 18 and older screened for clinical depression using a standardized tool, with follow-up documented.
Service-Based Measures	
Comprehensive Care Management	Quality of care measures: • Percentage of discharges for members age 6 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.
Care Coordination	Clinical outcome measures: • Percentage of adolescents and adult members with a new episode of alcohol or other drug (AOD) dependence who received initiation and engagement of AOD treatment.
Comprehensive Transitional Care	Quality of care measures: • Transition record with state-specified elements received by discharged patients (inpatient discharges to home or any other care site).

TABLE 4. Evaluation Methodology--Alabama	
Hospital Admission Rates	Assess hospital admission rates, by service (medical, surgical, maternity, mental health and chemical dependency), for acute care hospitals (nonpsychiatric hospitals) in the participating health home geographic sites and remainder of state for the chronic conditions identified as eligible for health home services using Medicaid Claims (annual). MMIS claims data will be analyzed using current and new data warehouse and distributed via email or disc distribution. Eligible population will be those 18 years of age and older, as of December 31 of the measurement year. The focus of the collection is the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. The state will utilize the quality process and outcome measures described in the SPA to assess quality improvements and clinical outcomes. For registry-based, claims-based and audit-based measures, assessment will occur both at the individual practice level, the PCNA level, at the aggregate level for each geographic area, and for all participating health homes. For claims-based measures, the state will track change over time to assess whether statistically significant improvement has been achieved. One year after One Health Record™ is operational, the state will move to national measures where national measures exist.
Chronic Disease Management	The state will assess the provision of chronic disease management by the PMPs and Networks for individuals with the chronic conditions specified within the SPA based on the selected quality measures. The state has determined that it will start with national standardized methodologies, including the use of National Quality Forum and/or CHIPRA measure specifications until further clarification is provided, for pre/post-comparisons. The Alabama Medicaid care management system has data on referrals sent, which tracks referrals to social services and community and social support. One Health Record™ consumer portal is already operational and provides information to consumers on Alabama state programs. One Health Record™ will provide the infrastructure for PMPs and PCNAs to also connect with state agencies, including Medicaid, ADPH, and ADMH and other health home providers who choose to connect to One Health Record™ through a state “gateway” that will be available in 2012. PMPs and PCNAs will be encouraged to utilize current HIT systems and connect to One Health Record™ when it becomes available to communicate with patients, family and caregivers in a culturally appropriate manner. The state has also already put into place quality measure reporting requirements for health homes that apply to both the PMPs and the PCNAs, including the collection and reporting of data on patient outcomes and the collection of data on patient experience of care. The state is planning a CAHPS survey for CY 2013. Barriers to implementation identified by the state include the remaining uncertainty of the final set of measures, as adult measures are anticipated the first quarter of CY 2012. The state will not be able to address all of the core set of measures on the effective date of the SPA, but has a plan to address barriers to implementation, including but not limited to health information capacity statewide. The state is developing a timeline by which to phase in the implementation, to be completed within one year. The state has identified proxy measures that will be reported to CMS in the interim. Alabama will establish business and technical operational structures to comply with the evaluation reporting requirements, including: nature, extent, and use of the health home model of service delivery, assessment of program implementation processes and lessons, assessment of quality improvements and clinical outcomes and estimates of cost savings. MMIS claims data can be shared across the systems. It will be analyzed using the current and future state enterprise wide data repository/warehouse system along with other systems as they become available through One Health Record™ and Medicaid eligibility system enhancements. Chart review replacement will be considered once One Health Record™ is operational for a year to give all providers the opportunity to fully utilize their EHR systems. The Alabama care management system is used for data analysis and will continue to be used until and if it is replaced by a future state enterprise wide data repository/ warehouse that includes analytical capabilities. The PMPs and PCNAs will be encouraged to utilize current HIT systems and connect to One Health Record™ when it becomes available to link to, promote, manage and follow health promotion activities such as the use of public health and patient registries.

TABLE 4. (*continued*)	
Coordination of Care for Individuals with Chronic Conditions	The state will also assess the provision of care coordination services for individuals with the chronic conditions specified within this SPA based on the measurements presented earlier in the State Plan. The state has already put into place quality measure reporting requirements for health homes that apply to both the PMPs and the PCNAs, including the collection and reporting of data on patient outcomes and the collection of data on patient experience of care. The state is planning a CAHPS survey for CY 2013. MMIS claims data can be shared across the systems. It will be analyzed using the current and future state enterprise wide data repository/warehouse system along with other systems as they become available through One Health Record™ and Medicaid eligibility system enhancements. Chart review replacement will be considered once One Health Record™ is operational for a year to give all providers the opportunity to fully utilize their EHR systems. The Alabama care management system is used for data analysis and will continue to be used until and if it is replaced by a future state enterprise wide data repository/warehouse that includes analytical capabilities. The PMPs and PCNAs will be encouraged to utilize current HIT systems and connect to One Health Record™ when it becomes available to link to, promote, manage and follow health promotion activities such as the use of public health and patient registries. The state will not be able to address all of the core set of measures on the effective date of the SPA, but has a plan to address barriers to implementation, including but not limited to health information capacity statewide. The state is developing a timeline by which to phase in the implementation, to be completed within one year. The state has identified proxy measures that will be reported to CMS in the interim. Alabama will setup business and technical operational structures to comply with the evaluation reporting requirements including: nature, extent and use of the health home model of service delivery, assessment of program implementation processes and lessons learned, assessment of quality improvements and clinical outcomes, and estimates of cost savings.
Assessment of Program Implementation	The state will monitor implementation through the evaluation process addressed in the State Plan. The Medicaid Agency is also working directly with the ADPH, ADMH, etc. and meeting regularly to goals established in the State Plan and performance indicators provided elsewhere in the SPA. The state will monitor health home providers to ensure that health home services are being provided that meet the state's health home provider standards and CMS' health home core functional requirements. Oversight activities will include, but not be limited to contract management, clinical and claims data review and analysis, and other activities defined by the state for Medicaid program integrity and ongoing management.
Processes and Lessons Learned	The state will monitor implementation through the evaluation process addressed in the State Plan. The Medicaid Agency is also working directly with the Alabama Department of Human Resources, ADMH, ADPH and meeting regularly to goals established in the State Plan and performance indicators provided elsewhere in the SPA. Federal requirements are provided in contracts between the state and the PCNAs, and the state and the PMPs.
Assessment of Quality Improvements and Clinical Outcomes	The state will utilize the quality process and outcome measures described in the prior section to assess quality improvements and clinical outcomes. For registry-based, claims-based and audit-based measures, assessment will occur both at the individual practice level, the network level, at the aggregate level for each geographic area, and all participating health homes. For claims-based measures, the state will track change over time to assess whether statistically significant improvement has been achieved. One year after One Health Record™ is operational, the state will move to national measures where national measures exist. The state has already put into place quality measure reporting requirement s for health homes that apply to both the PMPs and the PCNAs, including the collection and reporting of data on patient outcomes and the collection of data on patient experience of care. The state is planning the CAHPS survey for CY 2013.

TABLE 4. (*continued*)	
Estimates of Cost Savings	The state will determine total cost for all patients in the region, divided by the total number of eligible beneficiaries reported monthly, stratified by age (<1, 1-5, 6-18, >19), and also report median PMPM for providers in region, as no national measurement is available to match. PMPM amounts for the geographic regions will be compared with projected PMPM to determine cost savings. Through the use of the proposed CHIPRA measures, the adult Medicaid measures and the Meaningful Use measures, the state seeks to align with some of the information, including cost savings, which will be collected for the report to Congress.

APPENDIX: Pre-Existing Initiatives in Alabama							
	Patient 1st/ PCNA[2,17,18,19]	**RCOs[5,6]**	**FQHC Advanced Primary Care Demonstration[7,8]**	**Community-Based Care Transition[9,10]**	**Medicaid Emergency Psychiatric Demonstration[11,12]**	**BPCI Initiative-- Models 2 and 3[13]**	**Together for Quality[14,15]**
Timeline	• 1997: Patient 1st was established • 2011: PCNA was established in 3 regions • 2012: Fourth PCNA was established; counties added to existing networks	• October 2013: RCO regions established • October 2014: RCO boards approved by Medicaid • April 2015: Provider networks in place • October 2015: RCO solvency requirements met • October 2016: RCOs accept capitation payments	The demonstration began in September 2011, and will run through August 2014	• The demonstration will run from 2011-2015. • Grants were awarded on a rolling basis until September 2012 • Awardees receive grants for 2 years, which may be extended annually thereafter	The demonstration began in March 2012, and will run until 2015	• Phase 1 (preparation period) began January 2013, and will end in fall 2014 • Phase 2 (risk-bearing phase) will begin either October 2013 or January 2014 • Providers will be fully at-risk for target episodes by October 2014	Grant period ran from June 2008-September 2010
Geographic Area	Patient 1st is statewide; PCNA covers 21 counties in 4 regions	Statewide	Statewide	3 counties in northern Alabama, and 7 counties in southern Alabama	Statewide	Counties served by the six participating facilities	Piloted in 11 counties
Sponsors	Alabama Medicaid	Alabama Medicaid	CMS, Health Resources and Services Administration, National Association of Community Health Centers	CMMI	CMMI	CMMI	CMS, Alabama Medicaid, BCBS
Scope	• Patient 1st: all Medicaid enrollees, certain groups excepted • PCNA: all Patient 1st Medicaid enrollees in their network who meet health home eligibility	• All Medicaid providers • All Medicaid beneficiaries, excluding duals and people receiving care under existing waivers	7 practices in Alabama	12 hospitals serving Medicare beneficiaries with multiple chronic conditions	• 4 free-standing psychiatric hospitals • Medicaid recipients between age 21-64 who are experiencing a psychiatric emergency	• 1 hospital • 5 home health facilities • Medicare beneficiaries receiving a targeted episode of care	Medicaid providers in the pilot counties and their enrolled Patient 1st patients

APPENDIX (*continued*)							
	Patient 1st/ PCNA[2,17,18,19]	**RCOs[5,6]**	**FQHC Advanced Primary Care Demonstration[7,8]**	**Community-Based Care Transition[9,10]**	**Medicaid Emergency Psychiatric Demonstration[11,12]**	**BPCI Initiative-- Models 2 and 3[13]**	**Together for Quality[14,15]**
Goals	• Provide Medicaid recipients with a medical home • Achieve long-term cost, quality, access, and utilization objectives through improved care management	• Establish networks to manage the continuum of health services under a single capitated rate • Reduce fragmentation and enhance care access • Improve quality and contain cost	Evaluate the effect of the advanced primary care practice model on care quality, health outcomes, and the cost of care provided to Medicare beneficiaries served by FQHCs	• Establish or enhance partnerships between hospitals and CBOs • Implement transitional care models to improve quality of care and reduce readmission	• To assess whether eliminating the IMD payment exclusion improves access to and quality of psychiatric care • To determine whether this change in reimbursement policy is cost-effective	• Test new methods of paying for acute and post-acute care • Promote care coordination • Reward quality and contain costs	• Create a web-based HIE with clinical support and e-prescribing tool for providers (Q-Tool) • Implement a care management system for Patient 1st Medicaid recipients with asthma and diabetes (Q4U) • Establish a data hub for sharing information across state agencies (Qx)
Payment Approach	• Patient 1st: $8.00 PMPM for health home, $0.50 PMPM for all other enrollees • PCNA: $9.50 PMPM	Global capitation payment	$6 PMPM care management fee, paid in addition to the "all inclusive per visit payment" that FQHCs receive for providing Medicare services	CBOs are paid an all-inclusive rate per discharge of an eligible Medicare beneficiary, only once within a 180-day timeframe for a given beneficiary	Standard Medicaid hospital payment	• Retrospective bundled payment made for select episodes of care • Model 2 covers acute and post-acute care; Model 3 covers post-acute care	• Providers were paid an additional $1 PMPM for using Q-Tool
Technical Assistance (TA)	• Patient 1st providers receive support from their PCNA where available, and PCNAs receive monthly TA and training from the state	No information found	TA will support practices in medical home transformation and achieving NCQA recognition	CBOs are encouraged to contact their Medicaid Quality Improvement Organization for support; the Lewin Group will provide TA for all awardees	No information found	• CMMI will host TA calls with participating providers, and has made resources available on-line	No information found

APPENDIX (*continued*)							
	Patient 1st/ PCNA[2,17,18,19]	**RCOs[5,6]**	**FQHC Advanced Primary Care Demonstration[7,8]**	**Community-Based Care Transition[9,10]**	**Medicaid Emergency Psychiatric Demonstration[11,12]**	**BPCI Initiative-- Models 2 and 3[13]**	**Together for Quality[14,15]**
HIT Use	• Patient 1st: Providers are required to connect to One Health to receive HITECH support • PCNA: Use of RMEDE and One Health Record™	RCOs and providers are expected to rely on existing tools like RMEDE, and will eventually rely on One Health Record™ for HIE	Practices are not required to have an EHR, but are encouraged to adopt tools such as registries and schedulers	No information found	No information found	No information found	Q-Tool was implemented, and RMEDE was used to support Q4U care management activities
Evaluation Methods	See Evaluation section	No information found	CMS will conduct bi-annual NCQA recognition readiness assessments, and an independent evaluator will assess impact on access, quality and cost outcomes.	CMS will contract with an independent evaluator to assess program performance. Outcomes of interest include 30, 90, and 180-day readmission, mortality, and emergency department visits	CMS will contract with an independent evaluator to assess: • Impact on average inpatient stays, emergency department visits, and costs • Discharge planning by participating hospitals • Percentage of Medicaid enrollees admitted as a result of the demonstration compared to those admitted through other means	No information found	The state contracted with the School of Public Health at the University of Alabama at Birmingham to conduct the evaluation, which was published in 2010

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This paper is an attachment to the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation (ASPE) report "***Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Annual Report - Year Two***". The full report is available at: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.cfm.

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EVALUATION OF THE MEDICAID HEALTH HOME OPTION FOR BENEFICIARIES WITH CHRONIC CONDITIONS: Annual Report - Year Two

Files Available for This Report

Full Report (including state appendices)
- Executive Summary: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2es.cfm
- HTML: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.cfm
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Alabama appendix only
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