State-by-State Health Home State Plan Amendment Matrix: Summary Overview

This matrix outlines key program design features from draft health home State Plan Amendments (SPAs) submitted to the Centers for Medicare & Medicaid Services (CMS). This document captures what states have proposed in draft or final SPAs submitted as of January 2012. Note that ***program design changes may be required to address any concerns CMS may have and as such, states are continuously revising their draft SPAs***. For more information about health homes (HH), visit www.integratedcareresourcecenter.com.

STATE	TARGET POPULATION	DELIVERY SYSTEM	HH PROVIDERS	ENROLLMENT	PAYMENT	GEOGRAPHIC AREA
IOWA	Consistent with definition in statute plus Hypertension.	FFS Program	Interested clinics/practices that contain at least one MD, DO or ARNP meeting State standards that align with a PCMH delivery model.	Patient can opt-in when beneficiary presents at HH provider's office.	Care management PMPM Performance payment based on quality.	Statewide
MISSOURI **CMHC SPA STATUS: FINAL SPA APPROVED (10/20/11)**	SPMI only Mental health (MH) or substance abuse (SA) disorder plus a chronic condition. MH or SA disorder plus tobacco use.	Managed care program Fee-for-service (FFS) program State contracting directly with HH providers.	CMHC meeting State qualifications CMHCs well-positioned to be HH providers after ongoing investments in recent years (e.g., disease management, care management, electronic health records (EHR), etc.).	Eligible individuals identified, auto-assigned, and notified by State. Beneficiary has option to change HH providers or opt out. Potential eligible individuals receiving services in emergency department (ED) notified and referred to a health home.	Clinical care management per-member-per-month (PMPM) payment. Interested in shared savings strategy and performance incentive payment – both for HH providers and for Medicaid - and will revisit after initial approval.	Statewide
MISSOURI **PCP SPA STATUS: FINAL SPA APPROVED (12/22/11)**	At least two of the following: asthma, cardiovascular disease, diabetes, developmental disabilities (DD), or overweight (BMI >25); *or* One of the previous chronic conditions and at risk of developing another.	Managed care program FFS program State contracting directly with HH providers	Designated providers of HH services will be FQHCs, RHCs and primary care clinics operated by hospitals.	Eligible individuals identified, auto-assigned and notified by State. Beneficiary has option to either change HH providers or opt out of program. Potential eligible individuals receiving services in ED notified and referred to a health home.	same as CMHC	Statewide

State	Target Population	Delivery System	HH Providers	Enrollment	Payment	Geographic Area
New York **CHRONIC BEHAVIORAL AND MEDICAL HEALTH CONDITIONS** **SPA STATUS: FINAL SPA APPROVED (2/3/12)**	Individuals with SMI, chronic medical and behavioral health conditions	Managed care and FFS	Any interested providers or groups of providers that meet State defined health home requirements that assure access to primary, specialty and behavioral health care and that support the integration and coordination of all care.	Auto-enrollment (with opt-out)	PMPM adjusted based on region, case mix (from Clinical Risk Group (CRG) method) and eventually by patient functional status.	Three-phase regional roll-out; phase one includes 10 counties
New York **MANAGED LONG TERM CARE PLANS SPA**	Individuals enrolled in Managed Long Term Care program with multiple chronic conditions including diabetes, heart disease, osteoarthritis, dementia, COPD and obesity.	Managed care	Managed Long Term Care Plans, including Partially Capitated Managed Long-Term Care Plans, Medicaid Advantage Plus Plans, and, Programs of All-Inclusive Care for the Elderly.	Voluntary; moving toward mandatory enrollment	Will be included in overall PMPM rate to MLTC plans	Based on location of the MLTC plans
North Carolina **SPA STATUS: SUBMITTED FOR CMS REVIEW, NOT YET APPROVED**	Consistent with definition in statute List of qualifying conditions include 10 conditions based on analysis of prevalence in Medicaid population. These include chronic medical and behavioral health conditions.	PCCM Program	Medical Homes and pregnancy medical home	Enrollment in Health Homes program is voluntary through Community Care of North Carolina (CCNC). Health home services will be delivered through the CCNC program.	Tiered PMPM reimbursement based on ABD or non-ABD status	Statewide
Oregon **SPA STATUS: SUBMITTED**	Consistent with definition in statute, with additional chronic conditions (hepatitis C, HIV/AIDS,	Managed care and FFS	Patient-Centered Primary Care Homes (PCPCH) will be defined by six core attributes, each of which is	Voluntary	PMPM based on standard met by practice or provider group; reflecting foundational,	Statewide

STATE	TARGET POPULATION	DELIVERY SYSTEM	HH PROVIDERS	ENROLLMENT	PAYMENT	GEOGRAPHIC AREA
FOR CMS REVIEW, NOT YET APPROVED	chronic kidney disease, cancer)		further detailed by standards and measures. Oregon Health Authority will recognize practices as Tier 1, 2, or 3 PCPCHs Primary care providers or practices that meet the State's qualifying criteria. A team of health care professionals.		intermediate and advanced functions.	
RHODE ISLAND **CEDARR FAMILY CENTERS SPA STATUS: FINAL SPA APPROVED (11/23/11)**	Diagnosis of SMI or SED, two chronic conditions or one of the following and risk of developing another: Mental health condition, Asthma, Diabetes, DD, Down Syndrome, mental retardation, seizure disorders.	Managed care and FFS	CEDARR Family Centers certified to meet HH criteria (CEDARR Family Centers provide services to Medicaid-eligible children who are identified as having 1 or more special health care needs).	Voluntary	Alternate payment methodology; rate developed based on level of effort required and market based hourly rate.	Statewide
RHODE ISLAND **CMHO SPA STATUS: FINAL SPA APPROVED (11/23/11)**	Individuals with SPMI who are eligible for State's community support program.	Managed care and FFS	7 CMHOs and 2 smaller providers of specialty mental health services	Auto-assignment (with opt-out). Potentially eligible individuals receiving services in the hospital ED or inpatient will be notified about health homes and referred.	Case rate	Statewide
WASHINGTON **SPA STATUS: SUBMITTED FOR CMS REVIEW, NOT**	ABD population, currently with one or more chronic conditions and is receiving FFS home- and community-based services (HCBS)	FFS State contracting directly with HH providers	Area Agencies on Aging	Opt-in enrollment process	PMPM rate based on RN Care manager, case ratio, and required Health Home Services.	Statewide

STATE	TARGET POPULATION	DELIVERY SYSTEM	HH PROVIDERS	ENROLLMENT	PAYMENT	GEOGRAPHIC AREA
YET APPROVED						

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State-by-State Health Home SPA Comparison Matrix: Detailed State Programs

STATE: IOWA	
PROGRAM DESIGN FEATURE	**DESCRIPTION**
Target Population	Two chronic conditions (mental health condition; substance use disorder; asthma; diabetes; heart disease; BMI over 25 or the 85 percentile; hypertension); One chronic condition and at risk for another; SPMI
Geographic Area	Statewide
Delivery Systems	Iowa is primarily FFS with a mental health managed care carve out (Magellan) and a PCCM program called MediPASS with approximately 195,000 members. MediPASS members that qualify for a HH and agree to participate will be removed from MediPASS as they enroll in the HH.
Enrollment	Member enrollment will be an opt-in process when the members presents at a HH provider's office. The provider will assess the patients' conditions to determine if they qualify for HH services. The provider will discuss the benefits of HH services with the member and present the member with an agreement form. The provider will send Medicaid the signed member agreement and a patient assessment that tiers the severity of the chronic conditions for the provider's PMPM payment.
Building Blocks	Building off CMHC/FQHC/ACT partnership pilot project for "integrated health homes", to improve coordination and integration of behavioral and physical health services
Provider Standards/Qualifications	Providers will need to comply with the Iowa Dept. of Public Health rules, which are likely to require NCQA, Joint Commission or other national PCMH accreditation. Until those rules are final, providers must complete a TransforMed self-assessment and achieve NCQA accreditation within 1st year of operation.
Payment Methodology	Standard FFS reimbursement plus a PMPM targeted only to eligible/qualified individuals who have chronic disease, tiered payment based on acuity/risk (determined by an assessment tool and verified retrospectively through claims) of the individual; Performance payment starting in year two and tied to quality outcomes measures.
Key Components of Health Homes	Designated providers include MD, DO or ARNP, supported by a team of health professionals and support staff. A HH may include multiple sites identified as a single organization who share policies, procedures, and electronic systems. Continuity of care documents (CCD) for each patient, describing medical needs; Provide/arrange care with qualified professionals for all health needs; Member of physician-directed care team as care coordinator (responsible for transitions, appointments, education, support); Maintain systems/protocols for tracking referrals; Must implement diabetes management program and behavioral health screening tool; 24/7 access; Must adopt, implement an EHR and develop a plan to achieve MU; Must connect to the State Health Information Network when available.
Definition of Comprehensive Care Management	The provider is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care (monitoring, arranging, and evaluating appropriate evidence based and/or evidence informed preventive services) with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care. Eligible patients shall have

STATE: IOWA	
	a Continuity of Care Document (CCD), detailing all important aspects of the patient's medical needs, treatment plan and medication list. The CCD shall be updated and maintained by the health home including the personal provider. Each health home shall implement a formal screening tool to assess behavioral health (mental health and substance abuse) treatment needs along with physical health care needs.
Definition of Care Coordination	Dedicate a care coordinator, defined as a member of the physician-directed care team, responsible for assisting members with medication adherence, appointments, referral scheduling, understanding health insurance coverage, reminders, transition of care, wellness education, health support and/or lifestyle modification, and behavior changes. The designated provider coordinates, directs, and ensure results are relayed back to the health home. The use of HIT is the recommended means of facilitating these processes that include the following components of care: o Mental health/ behavioral health o Oral health o Long term care o Chronic disease management o Recovery services and social health services available in the community o Behavior modification interventions aimed at supporting health management (e.g., obesity counseling and tobacco cessation, health coaching) o Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
Definition of Health Promotion	Includes coordinating or providing behavior modification interventions aimed at supporting health management, improving disease outcomes, disease prevention, safety and an overall healthy lifestyle. Use Clinical Decision Support within the practice workflow. Implement a formal Diabetes Disease Management Program.
Definition of Comprehensive Transitional Care	Comprehensive transitional care from inpatient to other settings includes the services required for ongoing care coordination. For all patient transitions, a health home shall ensure the following: o Receipt of updated information through a CCD. o Receipt of information needed to update the patients care plan (could be included in the CCD) that includes short-term transitional care coordination needs and long term care coordination needs resulting from the transition. o The health home shall establish personal contact with the patient regarding all needed follow up after the transition.
Definition of Individual and Family Support Services	Communicate with patient, family and caregivers in a culturally appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives. Activities could include but are not limited to: o Advocating for individuals and families, o Assisting with obtaining and adhering to medications and other prescribed treatments. o Increasing health literacy and self management skills
Definition of Referral to Community and Social	Referral to community and social support services Includes coordinating or providing recovery services and social health services available in the community, such as understanding eligibility for various health care programs, disability benefits, and identifying housing programs

STATE: IOWA	
Support Services	
Quality Measures	TBD

STATE: MISSOURI: Community Mental Health Center SPA

PROGRAM DESIGN FEATURE	DESCRIPTION
Target Population	SPMI only; mental health condition plus chronic condition (e.g., asthma, cardiovascular disease, diabetes, DD, overweight); substance use disorder plus chronic condition; or mental health or substance use disorder plus tobacco use
Geographic Area	Statewide by catchment area
Delivery Systems	Beneficiaries in managed care or FFS will be enrolled in health homes; State making HH payments directly to HH providers
Enrollment	Auto-assignment of eligible beneficiary to CMHC with possibility to opt-out; potential eligible individuals receiving services in ER notified and referred to a health home
Building Blocks	Building off of recent investments in CMHCs (e.g., wrap-around services including disease management, care management, EHRs)
Provider Standards/ Qualifications	In addition to being a CMHC, each health home provider must meet state qualifications that minimally require: significant number of Medicaid patients; strong engaged leadership; meet state requirements for patient empanelment; meet minimum access requirements. Prior to implementation of HH service coverage, provide assurance of enhanced patient access to the health team, including the development of alternatives to face-to-face visits, such as telephone or email, 24 hours per day 7 days per week; must actively use EHRs; utilize interoperable patient registry to input annual metabolic screening results, track and measure care, automate care reminders and produce exception reports for care planning; use a behavioral pharmacy management system to determine problematic prescribing patterns; conduct wellness interventions based on level of risk; complete status reports to document client's housing, legal, employment status education, custody, etc.; must convene regular internal HH team meetings. Ongoing qualification include: must develop contract or MOU with regional hospitals or systems for transitional care planning (within 3 months of implementation); develop quality improvement plans; demonstrate fundamental health home functionality at 6 and 12 months; demonstrate significant improvement on clinical indicators; demonstrate cost effectiveness; meet NCQA Level 1 PCMH requirements (or submit application for NCQA recognition by 18 months by date at which supplemental payments start); participate in statewide learning activities.
Payment Methodology	Clinical care PMPM payment in addition to existing FFS or managed care organization (MCO) payments for direct services. Administrative payment is included in the rate to support transforming traditional CMHCs into health homes. Minimum health home service required for PMPM payment is documentation by a health home director or nurse care manager on a monthly health home activity report that the enrolled individual has received care management monitoring for treatment gaps or another health home service.
Key Components of Health Homes	CMHCs as designated provider - must meet State qualifications; physician-led with health team of a health home Director, a health home primary care physician consultant, nurse care manager(s) and health home administrative support staff; optional staff include an individual's treating physician and psychiatrist, mental health case manager, nutritionist/dietician, pharmacist, peer recovery specialist, grade school personnel; care is person-centered and culturally competent; coordinate and provide access to preventive, mental health, substance abuse services and chronic disease management; coordinate and provide access to long term care supports and services. CMHCs will be supported in statewide learning

	activities to promote practice transformation.
Definition of Comprehensive Care Management	Comprehensive care management services, conducted by the nurse care manager, primary care physician consultant, and health home director with the participation of other team members, include: • Identification of high-risk individuals and use of client information to determine level of participation in care management services; • Assessment of preliminary service needs; treatment plan development, which will include client goals, preferences and optimal clinical outcomes; • Assignment of health team roles and responsibilities; • Development of treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions; • Monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines and; • Development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.
Definition of Care Coordination	Care coordination is the implementation of the individualized treatment plan (with active client involvement) through appropriate linkages, referrals, coordination, and follow-up to needed services and supports, including referral and linkages to long-term services and supports. Specific activities include, but are not limited to: appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes, and communicating with other providers and clients/family members. Nurse care managers with assistance from health home administrative support staff will be responsible for conducting care coordination activities across the health team. The primary responsibility of the nurse care manager is to ensure implementation of the treatment plan for achievement of clinical outcomes consistent with the needs and preferences of the client.
Definition of Health Promotion	Health promotion services shall minimally consist of providing health education specific to an individual's chronic conditions, development of self-management plans with the individual, education regarding the importance of immunizations and screenings, child physical and emotional development, providing support for improving social networks and providing health- promoting lifestyle interventions, including but not limited to, substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity. Health promotion services also assist clients to participate in the implementation of the treatment plan and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions. The HH director, primary care physician consultant, and nurse care manager will provide health promotion activities.

STATE: MISSOURI: Community Mental Health Center SPA	
Definition of Comprehensive Transitional Care	In conducting comprehensive transitional care, a member of the health team provides care coordination services designed to streamline plans of care, reduce hospital admissions, ease the transition to long-term services and supports, and interrupt patterns of frequent hospital emergency department use. The health team member collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing clients' and family members' ability to manage care and live safely in the community, and shift the use of reactive care and treatment to proactive health promotion and self management. The HH director, primary care physician consultant, and nurse case manager will all provide comprehensive transitional care activities, including, as possible, participating in discharge planning.
Definition of Individual and Family Support Services	Individual and family support services activities include, but are not limited to: advocating for individuals and families, assisting with obtaining and adhering to medications and other prescribed treatments. In addition, health team members are responsible for identifying resources to help support individuals in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services. A primary focus will be increasing health literacy, self management, and participation in ongoing revisions of care/treatment plans. For individuals with DD, the health team will refer to and coordinate with the approved DD case management entity for habilitation-related services and coordinate with the approved DD case management entity for care-related services. Nurse care managers will provide this service.
Definition of Referral to Community and Social Support Services	Referral to community and social support services, including long-term services and supports, involves providing assistance for clients to obtain and maintain eligibility for health care, disability benefits, housing, personal need and legal services, and additional support services as needed. For individuals with DD, the health team will refer to and coordinate with the approved DD case management entity for these services. The nurse care manager and administrative support staff will provide this service.
Quality Measures	Measures include: prevent/reduce hospital admission rate; ED visits; readmissions within 30 days; adherence to antipsychotics, antidepressants and mood stabilizers; care coordination/contact with care manager post discharge; reduced illicit drug use and excessive drinking; use of personal EHR; satisfaction with services; use of CyberAccess; BMI control; metabolic screening; adult diabetes under control; appropriate medication prescribed for members with pediatric/adult asthma; adherence to asthma/COPD medication; hypertension under control; lipid levels under control; adherence to CVD/anti-hypertensive medication; use of statin for history of CAD

STATE: MISSOURI: Primary Care Provider SPA	
PROGRAM DESIGN FEATURE	**DESCRIPTION**
Target Population	At least two of the following: asthma, cardiovascular disease, diabetes, developmental disabilities (DD), or overweight (BMI >25); One of the previous chronic conditions and at risk of developing another. At risk criteria includes: tobacco use and diabetes.
Geographic Area	Statewide for Federally Qualified Health Centers, Rural Health Clinics and primary care clinics operated by hospitals.
Delivery Systems	Beneficiaries in managed care or FFS will be enrolled in health homes; State making HH payments directly to HH providers
Enrollment	Auto-assignment of eligible beneficiary to PCHH with possibility to opt-out; potential eligible individuals receiving services in ER notified and referred to a health home
Building Blocks	Building off of established infrastructure of FQHCs, RHCs and primary care clinics operated by hospitals
Provider Standards/ Qualifications	In addition to being a FQHC, Rural Health Clinic or primary care clinic operated by a hospital, each health home provider must meet state qualifications, which may be amended from time-to-time as necessary and appropriate, but minimally require that each health home: have a substantial percentage of its patients enrolled in Medicaid; have strong, engaged leadership; meet state requirements for patient empanelment; meet the state's minimum access requirements. Prior to implementation of HH service coverage, provide assurance of enhanced patient access to the health team, including the development of alternatives to face-to-face visits, such as telephone or email, 24 hours per day 7 days per week; have a formal and regular process for patient input into services provided, quality assurance, access and other practice aspects; have completed EMR implementation and been using the EMR as its primary medical record solution, to e-prescribe, and to generate, or support the generation of through a third party such as a data repository, clinical quality measures relevant to improving chronic illness care and prevention for at least six months prior to the beginning of HH services; actively utilize MO HealthNet's comprehensive electronic health record for care coordination and prescription monitoring for Medicaid participants; utilize an interoperable patient registry; within three months of PCHH service implementation, have a contract or MOU with regional hospital(s) or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions of primary care health home participants, maintain a mutual awareness and collaboration to identify individuals seeking ED services that might benefit from connection with a primary care health home site, and motivate hospital staff to notify the primary care health home's designated staff of such opportunities; the state will assist in obtaining hospital/primary care health home MOU if needed; convene regular internal PCHH team meetings; meet ongoing certification requirements such as develop quality improvement plans; demonstrate fundamental medical home functionality at 6 and 12 months; demonstrate improvement on clinical outcome and process indicators; submit application for NCQA recognition by 18 months.
Payment Methodology	Clinical care PMPM payment in addition to FFS or managed care organization (MCO) payment for direct services. Administrative payment included in the rate to support transformation to meet person-centered Primary care health home requirements. Minimum health home service required for PMPM payment is documentation by a health home director or nurse care manager on a monthly health home activity report that the enrolled individual has received care management monitoring for treatment gaps or another health home service.

STATE: MISSOURI: Primary Care Provider SPA	
Key Components of Health Homes	Practice sites will be physician-led and shall form a health team comprised of a primary care physician (i.e., family practice, internal medicine, or pediatrician) or nurse practitioner, a licensed nurse or medical assistant, behavioral health consultant, a nurse care manager and the practice administrator or office manager. The team is supported as needed by the care coordinator and Health Home Director. In addition, other optional team members may include a nutritionist, diabetes educator, public school personnel and others as appropriate and available. Primary care practices will be supported in transforming service delivery by statewide learning activities.
Definition of Comprehensive Care Management	Comprehensive care management services are conducted by the nurse care manager and involve identification of high-risk individuals and use of client information to determine level of participation in care management services; assessment of preliminary service needs; treatment plan development, which will include client goals, preferences and optimal clinical outcomes; assignment by the care manager of health team roles and responsibilities; development of treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions; monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines and; development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.
Definition of Care Coordination	Care coordination is the implementation of the individualized treatment plan (with active client involvement) through appropriate linkages, referrals, coordination and follow-up to needed services and supports. Specific activities include, but are not limited to: appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes and communicating with other providers and clients/family members. Nurse Care Managers with the assistance of the Care Coordinator will be responsible for conducting care coordination services across the health team. The primary responsibility of the Nurse Care Manager is to ensure implementation of the treatment plan for achievement of clinical outcomes consistent with the needs and preferences of the client.
Definition of Health Promotion	Health promotion services shall minimally consist of providing health education specific to an individual's chronic conditions, development of self-management plans with the individual, education regarding the importance of immunizations and screenings, child physical and emotional development, providing support for improving social networks and providing health promoting lifestyle interventions, including but not limited to, substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity. Health promotion services also assist patients to participate in the implementation of the treatment plan and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions. The Primary Care Health Home Director, Nurse Care Manager, Behavioral Health Consultant and appropriate primary care health home Administrative Support staff will provide health promotion services.
Definition of Comprehensive Transitional Care	In conducting comprehensive transitional care, a member of the health team provides care coordination services designed to streamline plans of care, reduce hospital admissions, ease the transition to long term services and supports and interrupt patterns of frequent hospital emergency department use. The health team member collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing clients' and family members' ability to manage care and live safely in the community, and shift the use of reactive care and treatment to proactive health promotion and self management. The HH director and nurse care manager will provide comprehensive transitional care activities, including, as possible, participating in discharge planning.

STATE: MISSOURI: Primary Care Provider SPA	
Definition of Individual and Family Support Services	Individual and family support services activities include, but are not limited to: advocating for individuals and families, assisting with obtaining and adhering to medications and other prescribed treatments. In addition, health team members are responsible for identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services. A primary focus will be increasing health literacy, ability to self manage their care and facilitate participation in the ongoing revision of their care/treatment plan. For individuals with DD the health team will refer to and coordinate with the approved DD case management entity for services more directly related to Habilitation and coordinate with the approved DD case management entity for services more directly related to a particular healthcare condition. Nurse Care Managers, Behavioral Health Consultant and Care Coordinator will provide individual and family support services.
Definition of Referral to Community and Social Support Services	Referral to community and social support services involves providing assistance for clients to obtain and maintain eligibility for health care, including long term services and supports, disability benefits, housing, personal need and legal services, and additional support services as needed. For individuals with DD, the health team will refer to and coordinate with the approved DD case management entity for these services. The nurse care manager and care coordinator will provide this service.
Quality Measures	Measures include: prevent/reduce hospital admission rate; ED visits; readmissions within 30 days; care coordination/contact with care manager post discharge; reduced illicit drug use and excessive drinking; depression screening; MH screening through EPSDT; substance abuse screening; use of personal EHR; satisfaction with services; use of CyberAccess; BMI control; weight assessment and counseling for youth; child vaccinations; adult and child diabetes under control; blood pressure and lipid levels under control for members with diabetes; adherence to diabetes medication; appropriate medication prescribed for members with pediatric/adult asthma; adherence to asthma/COPD medication; hypertension under control; lipid levels under control; adherence to CVD/anti-hypertensive medication

STATE: NEW YORK: Chronic Behavioral and Medical Conditions SPA

PROGRAM DESIGN FEATURE	DESCRIPTION
Target Population	SMI only; Two or more chronic conditions; HIV/AIDS and at risk for another chronic condition. Conditions include: mental health condition; substance use disorder; asthma; diabetes; heart disease; BMI over 25; HIV/AIDS; hypertension and other conditions associated with 3M™ Clinical Risk Group categories of chronic behavioral and medical conditions.
Geographic Area	Three phase regional roll-out; beginning in 10 counties (Bronx, Brooklyn, Nassau, Warren, Washington, Essex, Hamilton, Clinton, Franklin, Schenectady)
Delivery Systems	Managed care and FFS
Enrollment	Auto-enrollment (with option to choose another or opt-out)
Building Blocks	Chronic Illness Demonstration Projects; Managed Addiction Treatment Services (MATS); Targeted Case Management; Medical home initiative
Provider Standards/Qualifications	Under New York State's approach to HH implementation, a HH provider is the central point for directing patient-centered care and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual arrangements with appropriate service providers, of comprehensive, integrated services. General qualifications are as follows: • HH providers/plans must be enrolled (or be eligible for enrollment) in the NYS Medicaid program and agree to comply with all Medicaid program requirements. • HH providers can either directly provide, or subcontract for the provision of, HH services. HH provider remains responsible for all program requirements, including services performed by subcontractor. • Care coordination and integration of heath care services will be provided to all HH enrollees by an interdisciplinary team of providers, where each individual's care is under the direction of a dedicated care manager who is accountable for assuring access to medical and behavioral health care services and community social supports as defined in the enrollee care plan. • Hospitals that are part of a HH 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 DOH designated health home provider. • HH providers must demonstrate their ability to perform each of the eleven CMS health home core functional components and must provide written documentation that demonstrates how the core health home service requirements are being met. • HH provider must meet: core health home requirements for the core health home services, requirements for use of HIT to link services and quality measurement and reporting requirements, and must provide written documentation that demonstrate how requirements are being met.
Payment Methodology	Health Homes meeting State and federal standards will be paid a per member per month care management fee that is adjusted based on 1) region, 2) case mix (from Clinical Risk Group (CRG) method) and this fee will eventually be adjusted by (after the data is available) 3) patient

	functional status. This risk-adjusted payment will allow providers to receive a diverse population of patients and assign patients to various levels of care management intensity without having to meet preset standards for contact counts. Providers will be able to respond to and adjust the intensity and frequency of intervention based on patient's current condition and needs. The care management fee will be paid in two increments, based on whether patient is 1) in the finding group or 2) intervention group. A reduced PMPM (80%) will be paid for the case finding group for outreach and engagement and is only available for the first three months after a patient has been assigned to a health home. Then, nothing can be billed for that patient for the next three months. Following this interval, case finding can be billed for another three months while outreach and engagement is attempted again. Once a member has been assigned to a care manager and enrolled in a health home program the active care management PMPM (full PMPM amount) may be billed. A unit of service will be defined as a billable unit per service quarter that will be distributed monthly. In order to be reimbursed for a billable unit of service per quarter health home providers must at a minimum, provide one of the core health home services. The monthly distribution will be paid via the case finding and active care management PMPM. Once a patient has been assigned a care manager and is enrolled in the health home program the active care management PMPM may be billed.
Key Components of Health Homes	NYS plans to certify health homes that build on current provider partnerships. Eligible providers include managed care plans, hospitals, medical mental and chemical dependency treatment clinics, primary care practices, PCMHs, FQHCs, TCM and certified home health care agencies that meet provider standards. It is expected that health home providers will develop health home networks with primary, medical, specialty and mental health providers, substance abuse service providers, community based organizations, managed care plans and others to provide enrollees access to needed services. Health homes will use multidisciplinary teams, led by 1 dedicated care manager who will assure that enrollees receive needed medical, behavioral, and social services. There will be one plan of care, one care mgmt record, and regular case reviews. Optional team members may include nutritionists/dieticians, pharmacists, outreach workers including peer specialists and other representatives as appropriate to meet the enrollee needs (housing representatives, entitlement, employment). The state will provide educational opportunities for health home providers, such as webinars, regional meetings and/ or learning collaboratives to foster shared learning, information sharing and problem solving. Managed care considerations: • The managed care organization will be informed of members assigned to a Health Home or will assign its members to a Health Home for health home services. • Plans may need to expand their networks to include additional State designated health home providers to ensure appropriate access. • Plans will need to have signed contracts including clearly established responsibilities with the provider based health homes. • The managed care plan will be required to inform either the individual's Health Home or the State of any inpatient admission or discharge of a Health Home member that the plan learns of through its inpatient admission initial authorization and concurrent review processes as soon as possible to promote appropriate follow-up and coordination of services. • Plans will assist State designated Health Home providers in their network with coordinating access to data, as needed. • Plans will, as appropriate , assist with the collection of required care management and patient experience of care data from State designated Health Home providers in its network.

Integrated Care Resource Center

STATE: NEW YORK: Chronic Behavioral and Medical Conditions SPA

Definition of Comprehensive Care Management	A comprehensive individualized patient centered care plan will be required for all HH enrollees. The care plan will be developed based on the information obtained from a comprehensive health risk assessment used to identify the enrollee's physical, mental health, chemical dependency and social service needs. The individualized care plan will be required to include and integrate the individual's medical and behavioral health services, rehabilitative, long term care, social service needs, as applicable. The care plan will be required to clearly identify: 1.) the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager and other providers directly involved in the individual's care; 2.) community networks and supports that will be utilized to address their needs; 3.) Goals and timeframes for improving the patient's health, their overall health care status and the interventions. The care manager will be required to ensure the individual/guardian plays a central and active role in development and execution of their care plan, and that they are in agreement with the goals, interventions and timeframes. Family and other supports involved in the patient's care should be identified and included in execution of the plan as requested by the individual. The care plan must also include outreach and engagement activities which will support engaging the patient in their own care and promote continuity of care. In addition, the plan of care will include periodic reassessment of the individual's needs and goals and clearly identify the patient's progress in meeting goals. Changes in the plan of care will be made based on changes in patient need.
Definition of Care Coordination	The health home provider will be accountable for engaging and retaining health home enrollees in care, as well as coordinating and arranging for the provision of services, supporting adherence to treatment recommendations, and monitoring and evaluating the enrollee's needs. The plan of care will identify all services necessary to meet goals needed for care management of the enrollee such as prevention, wellness, medical treatment by specialists and behavioral health providers, transition of care from provider to provider, and social and community services where appropriate. In order to fulfill the care coordination requirements, the HH provider will assign each individual enrollee one dedicated care manager who is responsible for overall management of the enrollee's plan of care. The enrollee's HH care manager will be clearly identified in the patient record and will have overall responsibility and accountability for coordinating all aspects of the individual's care. The HH provider will be responsible to assure that communication will be fostered between the dedicated care manager and treating clinicians to discuss as needed enrollee's care needs, conflicting treatments, change in condition, etc. which may necessitate treatment change (i.e., written orders and/or prescriptions). The HH provider will be required to develop and have policies, procedures and accountabilities (contractual agreements) in place, to support and define the roles and responsibilities for effective collaboration between primary care, specialists, behavioral health providers and community based organizations. The health home providers policies and procedures will direct and incorporate successful collaboration through use of evidence-based referrals, follow-up consultations, and regular, scheduled case review meetings with all members of the interdisciplinary team. The health home provider will have the option of utilizing technology conferencing tools including audio, video and /or web deployed solutions when security protocols and precautions are in place to protect PHI to support care management/coordination activities. The health home provider will be required to develop and utilize a system to track and share patient information and care needs across providers, monitor patient outcomes, and initiate changes in care as necessary to address patient need.
Definition of Health Promotion	Health promotion begins with outreach and engagement activities. NYS' health home plan for outreach and engagement will require a health home provider to actively seek to engage patients in care by phone, letter, HIT and community "in reach" and outreach. Each of these outreach and engagement functions will all include aspects of comprehensive care management, care coordination, and referral to community and social

	support services. All of the activities are built around the notion of linkages to care that address all of the clinical and non-clinical care needs of an individual and health promotion. The HH provider will support continuity of care and health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers. The HH provider will promote evidence based wellness and prevention by linking HH enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self- help recovery resources, and other services based on individual needs and preferences. Health promotion activities will be utilized to promote patient education and self management of their chronic condition.
Definition of Comprehensive Transitional Care	Comprehensive transitional care will be provided to prevent enrollee avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing or treatment facility) and to ensure proper and timely follow up care. To accomplish this, the health home provider will be required to develop and have a system in place with hospitals and residential/rehabilitation facilities in their network to provide the health home care manager prompt notification of an enrollee's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting. The HH provider will also have policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals and residential/rehabilitation settings, providers and community based services to ensure coordinated, and safe transition in care for its patients who require transfers to/from sites of care. The hh provider will be required to develop and have a systematic follow-up protocol in place to assure timely access to follow-up care post discharge that includes at a minimum receipt of a summary care record from the discharging entity, medication reconciliation, and a plan for timely scheduled appointments at recommended outpatient providers. The HH care manager will be an active participant in all phases of care transition, including: discharge planning and follow-up to assure that enrollees received follow up care and services and re-engagement of patients who have become lost to care.
Definition of Individual and Family Support Services	The patient's individualized plan of care will reflect and incorporate the patient and family or caregiver preferences, education and support for self-management; self help recovery, and other resources as appropriate. The provider will share and make assessable to the enrollee, their families or other caregivers (based on the individual's preferences), the individualized plan of care by presenting options for accessing the enrollee's clinical information. Peer supports, support groups, and self-care programs will be utilized by the health home provider to increase patients' and caregivers knowledge about the individual's disease(s), promote the enrollee's engagement and self management capabilities, and help the enrollee improve adherence to their prescribed treatment. The provider will discuss and provide the enrollee, the enrollee's family and care givers, information on advance directives in order to allow them to make informed end-of-life decisions ahead of time. The health home provider will ensure that all communication and information shared with the enrollee, the enrollee's family and caregiver is language, literacy and culturally appropriate so it can be understood.
Definition of Referral to Community and Social Support Services	The HH provider will identify available community-based resources and actively manage appropriate referrals, access to care, engagement with other community and social supports, coordinate services and follow-up post engagement with services. To accomplish this, the HH provider will develop policies, procedures and accountabilities (through contractual agreements) to support effective collaboration with community-based resources, that clearly define the roles and responsibilities of the participants. The plan of care will include community-based and other social support services, appropriate and ancillary health care services that address and

	respond to the patient's needs and preferences, and contribute to achieving the patient's goals.
Quality Measures	Measures include: inpatient utilization; ED visits; mental health utilization; follow up after MH hospitalization; follow up after hospitalization for alcohol and chemical dependency detoxification; adherence to antipsychotics, antidepressants and mood stabilizers; follow up care for children prescribed ADHD medication; use of appropriate medication for members with asthma; asthma medication management; HbA1c and LDL-c testing; beta-blocker treatment after heart attack; lipid testing for cardiovascular conditions; comprehensive care for members living with HIV/AIDS; Chlamydia screening; colorectal cancer screening

STATE: NEW YORK: Managed Long-Term Care Plans SPA	
PROGRAM DESIGN FEATURE	**DESCRIPTION**
Target Population	The State elects to offer Health Home Services to individuals enrolled in Managed Long Term Care Plans (MLTCP). These include: Partially Capitated Managed Long Term Care Plans (PCMLTC), Medicaid Advantage Plus Plans (MAP) or a Program of All-Inclusive Care for the Elderly (PACE). Individuals enrolled in MLTCPs exhibit multiple chronic conditions including diabetes, heart disease, osteoarthritis, dementia, COPD and obesity. MLTCP members, as a condition of enrollment, must meet a nursing home certifiable level of care based on the New York State Assessment Instrument, the Semi-Annual Assessment of Members (SAAM).
Geographic Area	Based on location of MLTCPs
Delivery Systems	Managed care
Enrollment	Voluntary, moving toward mandatory enrollment through waiver
Building Blocks	Managed Long Term Care Plans certified or authorized under Article 4403-f of the New York State Public Health Law that meet State-qualifying criteria, including Partially Capitated Managed Long-Term Care Plans, Medicaid Advantage Plus Plans, and, Programs of All-Inclusive Care for the Elderly.
Provider Standards/Qualifications	Provider must be a Managed Long Term Care Plan (MLTCP) certified or authorized under Article 4403-f of the New York State Public Health Law that meets State-qualifying criteria, including Partially Capitated Managed Long Term Care Plans; PACE Plans; or Medicaid Advantage Plus Plans. Provider must: • Be enrolled or eligible to be enrolled in the NYS Medicaid program and agree to comply with all Medicaid program requirements and all standards of the State Medicaid Plan. • Directly provide, or subcontract for the provision of, health home services; the health home provider is responsible for all health home program requirements, including health home services performed by the subcontractor. • Provide care coordination and integration of an interdisciplinary team of providers. • Comply with professionally recognized standards of health care and implement practice guidelines consistent with State and federal regulatory requirements. • Assure support and continuity of care through proactive collaboration with health home member, family, community services, interdisciplinary team and network and non-network service providers. • Meet health home federal requirements for the provision of health home services and provide written documentation demonstrating how the requirements are being met.
Payment Methodology	Risk Adjusted prospective monthly capitation payment for each MLTCP member. Rates reflect savings compared to fee-for-service care delivery. PMPM rate includes a component that reflects care management functions and activities. Benefit package varies according to plan model.

Key Components of Health Homes	Eligible providers include Managed Long Term Care Plans, including Partially Capitated Managed Long-Term Care Plans, Medicaid Advantage Plus Plans, and, Programs of All-Inclusive Care for the Elderly and provide care coordination and integration of an interdisciplinary team of providers. Plans will comply with professionally recognized standards of health care and will assure support and continuity of care through proactive collaboration with health home member, family, community services, interdisciplinary team and network and non-network service providers.
Definition of Comprehensive Care Management	Policies and procedures are in place to create, document, execute and update an individualized, person-centered plan of care for each MLTCP member. The comprehensive member assessment identifies needed health care interventions, long-term care services and supports, social services and as required, behavioral health and substance abuse services, is developed. The member's plan of care: integrates a continuum of health care, long-term care services and supports and rehabilitative service needs and clearly identifies the care manager or care management team, primary care physician/nurse practitioner, and other providers, such as specialist and behavioral health care, if needed and directly involved in the member's care; clearly identifies long-term care services and supports, primary, specialty, behavioral health and community networks that address the member's specific needs; care clearly identifies family members and other supports involved in the member's care. Family and other supports are included in the plan and in care activities as requested by the member; identifies goals for improving the member's health and functional ability and identifies interventions that may contribute to this improvement; care incorporates regular reassessment of member needs, services and supports by the care management team; the plan of care is adjusted based on short or long-term variations in member's health and functional status. The member and the member's caregiver play a central and active role in the development and execution of the plan of care and should agree with the goals, interventions and timeframes included in the plan.
Definition of Care Coordination	The health home provider: coordinates and/or arranges member services; supports the member's compliance with treatment recommendations; monitors and evaluates the member's continuing needs, including health maintenance, prevention and wellness, long term care services and supports, medical/specialist, behavioral health, care transitions, and social and community supports through the creation of an individual plan of care; assigns each member a care manager or care management team responsible for overall management of the member's care plan. The HH care manager or care management team is identified in the member record. The care manager or care management team has overall responsibility and accountability for coordinating all aspects of the member's HH care. They must have: • A method of communication in place between the care manager/care management team and the treating clinicians that assures that the care manager/care management team can discuss with clinicians on an as needed basis, changes in member condition that may necessitate a change in treatment; Policies, procedures and accountabilities to support effective linkages between primary care, long term care, specialist and behavioral health providers, evidence-based referrals and follow-up and consultations that clearly define roles and responsibilities; regular case reviews.
Definition of Health Promotion	The health home provider offers opportunities for preventive health care information and education to member and family supports and assures preventive health care services, as needed, are included as part of the individual service plan. The health home provider promotes evidence based wellness and prevention by linking health home members with resources for smoking cessation, diabetes, asthma, hypertension, self help recovery resources, and other services based on the member's needs and preferences.

Definition of Comprehensive Transitional Care	The health home provider: has a system in place to notify the health home of a member's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting; has procedures in place with practitioners and health care facilities, as practicable, to help ensure coordinated, safe transitions in care for patients who require such transfers; utilizes HIT, as available and feasible, to facilitate interdisciplinary collaboration among all providers, the member, family, care givers, and local supports; provides information necessary to facilitate transitional care; and has a follow-up procedure in place to assure timely access to follow-up care information post discharge.
Definition of Individual and Family Support Services	The member's plan of care reflects member and family/caregiver preferences, education and support for self-management, self help recovery, and other resources, as appropriate. The plan of care is accessible to the member and family/caregiver based on the member's preference. The health home provider utilizes peer supports, support groups and self-care programs to increase member's knowledge of their disease, opportunities for self management, and to improve adherence to prescribed treatment; discusses advance directives with members and their families or caregivers; and communicates and shares information with members and their families or caregivers with appropriate consideration for language, literacy and cultural preferences.
Definition of Referral to Community and Social Support Services	The health home provider has policies, procedures and accountabilities to support effective collaborations with community-based resources. The HH provider is also responsible for identifying available community-based resources and assists with appropriate referrals, access, follow-up and coordination of services.
Quality Measures	Service based measures include: documented care plan; alcohol and substance abuse screening; adherence to care plan; satisfaction; care coordination/regular contact with members and effective linkages between health home and network/non-network providers; influenza and pneumonia vaccination; weight monitoring; ADL functioning; medication management; interdisciplinary team documentation and care coordination process; readmissions; follow up contact post discharge; ED visits; short term/long term nursing home admissions; chronic condition education; linkages with community and social support services;

STATE: NORTH CAROLINA	
PROGRAM DESIGN FEATURE	**DESCRIPTION**
Target Population	Two chronic conditions (Mental health, blindness, chronic cardiovascular disease, chronic pulmonary disease, congenital anomalies, chronic disease of the alimentary system, chronic endocrine and metabolic disease, chronic infectious disease, chronic mental and cognitive conditions, chronic musculoskeletal conditions and chronic neurological disorders), One medical condition and at risk for another (presumed with presence of some diagnosis, i.e. diabetes, hypertension, BMI over 25, etc.); SPMI. Conditions specific to pregnancy (i.e. gestational diabetes, gestational hypertension, etc.) are not considered qualifying conditions; however, will be monitored as presenting a risk of developing a chronic condition. Individuals with a single health home qualifying condition and a condition specific to pregnancy (i.e. gestational diabetes) will be eligible for health homes.
Geographic Limitations	Statewide
Delivery Systems	PCCM
Enrollment	Enrollment in Health Homes program is voluntary through Community Care of North Carolina (CCNC). Health home services will be delivered through the CCNC program
Building Blocks	CCNC program building blocks include: medical homes or pregnancy medical homes as designated HH providers; regional, provider-run non-profit community networks; care management infrastructure (statewide, regional network, and provider level); and non-profit statewide coordinating agency to work with Medicaid.
Provider Standards/Qualifications	Each CCNC Network executes agreements with local PCPs to work collaboratively with the Network to provide HH services. In addition to meeting basic requirements of Medicaid primary care providers (e.g., 24 hours per day/7 days per week coverage, admitting privileges, etc.), Network providers must do the following as part of their participation in the Network: • Cooperate with the CCNC Network in the development and utilization of care management systems and tools for managing the care of Medicaid enrollees. • Comply with the policies and procedures developed by the Network's Medical Management Committee and / or Steering Committee that aim to effectively manage the quality, utilization, and cost of services, including but not limited to inpatient admissions; emergency room visits; specialty and ancillary referrals; early detection and health promotion; Health Check (EPSDT); chronic and high cost diseases, at risk patients; and pharmacy prescribing patterns. • Cooperate with the Network's patient risk assessment process to identify and track those Medicaid recipients that would most benefit from targeted care management and disease management activities. • Participate, as required by the network, in interdisciplinary teams to help manage and optimize patient care of those enrollees at highest risk and cost. • Authorize and coordinate with the Network care managers in carrying out the enhanced care management activities targeting Medicaid recipients enrolled with the practice. • Participate in the implementation of network approved care management plans for at-risk and/or high-cost enrollees.

	• Work in concert with the network to develop strategies to address special needs of the Medicaid population; develop local referral processes and communication with specialists; promote self-management; develop plans to meet CCNC utilization and budget targets; evaluate and implement appropriate changes in service utilization; and develop and refine CCNC measures, utilization reports, management reports, quality improvement goals and care management initiatives.
Payment Methodology	PMPM payment for CCNC PCP, tiered based on ABD or non-ABD status; team of health care professionals (CCNC Networks), tiered based on ABD or non-ABD status or CC4C; team of health care professionals (pregnancy medical home care management networks), not tiered
Key Components of Health Homes	Primary care provider serves as medical home (24/7 assistance); HH program provides 3 elements of wraparound services that work with PCMHs (1. Provider run community networks for managing care, comprised of physicians, hospitals, social service agencies, and county health departments; 2. Care management infrastructure; 3. Statewide coordinating agency - works with Medicaid, regional networks, primary care providers and case managers); Must have care plan, self-management plan; Four quadrant model used for communication, collaboration, assessment, referral and clinical care management; LMEs lead care coordination for MH and substance abuse pop; Networks provide transitional care management to all hospitals in region, mandated to maintain active referring relationships; CCNC transitional care nurses work in hospitals with large volumes of ABD population - facilitate transitions and inform PCMH/other providers of admission, medication, etc.
Definition of Comprehensive Care Management	Comprehensive care management involves active participation from PCPs, care managers, and patient and family/caregivers and includes: patient identification and comprehensive assessment through direct referrals, by mining administrative claims data (e.g. risk stratification tools, frequent hospital and emergency room admissions), through screenings and assessments and chart reviews that identify gaps in care; developing an individualized care plan involving the health care team including the care manager, primary care provider, patient and family/caregiver; care coordination where the care manager ensures the care plan is implemented, communicated and coordinated across providers and delivery settings; reassessment and monitoring; and outcomes and evaluation. An average aid to Families with Dependent children caseload ranges from 5,000-7,500 enrollees per care manager and an average ABD caseload ranges from 1,500-3,500 enrollees per care manager. Case loads are assigned with the assumption that only 5-10% of the population will require care management at any given time and care managers provide interventions at varying levels of intensity (some face to face, others telephonic).
Definition of Care Coordination	Care Coordination, a core component of Care Management, is the implementation of the individualized care plan (developed by the health care team with active PCP, care manager, and patient and family/caregiver involvement) through appropriate linkages, referrals, coordination and follow-up to needed services and supports. Specific activities include, but are not limited to: appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes and communicating with other providers and clients/family members. Care managers or PCP team members are responsible for conducting care coordination activities across providers and settings, with their primary responsibility being to ensure implementation of the care plan for achievement of clinical outcomes consistent with the needs and preferences of the client. CCNC care manager care coordination interventions are identified and documented in CMIS. The Mental Health Integration Program aims to improve the screening and treatment of mental health conditions in the primary care setting and enhance the medical care of individuals with behavioral health problems. CCNC is working to implement the four quadrant clinical integration model as the foundation for communication, collaboration, assessment, referral and clinical management of care. After an initial pilot period, the model is being implemented statewide, with primary care practices having incorporated behavioral health treatment in the primary care provider office setting while also supporting enhanced referral processes for more complex patients to specialty mental health services and behavioral health care coordination. The CCNC central office and networks use psychiatrists to coordinate implementation of the quadrant model and to

	identify patients with behavioral and physical health care needs for the PCPs. For patients with high mental health and substance abuse needs, North Carolina's Local Management Entities (LMEs) take a lead care coordination role working with CCNC networks and behavioral health providers. North Carolina's LMEs are responsible for the management and oversight of the public system of mental health, DD, and substance abuse services at the community level. North Carolina is in the process of expanding its 1915b/c waiver program to cover a significant portion of the state, and the waiver converts LME reimbursement to risk capitation. For high need behavioral health care patients, the LME/MCO develops the care plan in collaboration with the behavioral health specialist and PCP and patient. Under the four quadrant model of primary care/behavioral health integration, LMEs/MCOs take the lead in care coordination activities for quadrant II individuals, including coordination with health homes to ensure integration of all care needs. Assessment and planning includes identification of risk factors and health conditions and coordination with or referral to PCPs. For quadrant IV patients, both the CCNC network and the LME/MCO collaborate and provide joint care management services and consultation as needed. They encourage, support and facilitate communication between the PCP and behavioral health service provider to ensure integration of all care needs.
Definition of Health Promotion	Health Promotion services assist patients to participate in the implementation of their care plan and place a strong emphasis on skills development for management and monitoring chronic health conditions. Health promotion is an integral service provided by PCPs and their care teams or CCNC care managers. Most of the quality improvement initiatives conducted by the networks include a health promotion component, which educates PCPs and their care teams about ways to promote health with their patients and also gives PCPs easily accessible tools to use with their patients. Health promotion services include CCNC care managers and PCPs or their care teams providing health education and coaching specific to an individual's chronic conditions, development of self-management plans with the individual, education regarding the importance of immunizations and screenings, promoting lifestyle interventions, including but not limited to, substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity.
Definition of Comprehensive Transitional Care	A transition occurs any time a patient moves from one care setting to another or when s/he moves from one area to another within the same care setting. Every CCNC hospital admission is assessed for transitional care need using real-time data from multiple sources. Transitional care is initiated, in some cases on the first admission, for patients with chronic conditions at high risk of readmission and for conditions in which the admission is ambulatory-care sensitive. Networks provide transitional care management to all hospitals in their region. Networks are mandated to maintain active referring relationships with all hospitals to facilitate access to primary care following hospital discharge or emergency department services. Onsite embedded care management is provided through 55 CCNC transitional care nurses who work full time in hospitals with large volumes of admissions from the ABD population. Hospitals with embedded transitional care managers account for 80% of Medicaid ABD inpatient admissions. The primary role of the care manager in the transitional care process is to: facilitate interdisciplinary collaboration among providers during transitions; encourage the PCPs, patients and family/caregivers to play a central and active role in the formation and execution of the care plan; promote self-management skills and direct communication among the patient and caregiver, the PCP and other care providers; achieve medication reconciliation by consulting with the network pharmacist, hospital, PCP, specialists, and the patient and his/her caregiver. The Community Care networks connect the PCP/medical home to the community. To support more effective transitions, networks have forged links with all North Carolina hospitals to obtain timely information about their hospitalized patients.## #

STATE: NORTH CAROLINA	
	CCNC care managers also schedule visits with patients in the hospital and follow up with home visits within three days of discharge. One of the key functions is to perform medication reconciliation on hospitalized patients and provide valuable knowledge about the patient's home environment and support issues. CCNC transitional care staff update the patient's medical homes about hospitalizations, other prescribed medications, social environmental concerns and other agencies providing services and make sure the PCP receives discharge summaries. Network pharmacists review medication lists and alert the PCP of discrepancies and other findings. Transitional care staff share information among a variety of local agencies, including behavioral health providers and long term care support providers.
Definition of Individual and Family Support Services	Individual and family support services activities are provided by PCPs and their care teams or CCNC care managers and include, but are not limited to: advocating for individuals and families, assisting with obtaining and adhering to medications and other prescribed treatments. In addition, health team members are responsible for identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services and access to long-term care and support services. PCPs have a key role in CCNC initiatives to support appropriate referrals. Many network activities are geared toward supporting and educating PCPs on how to promote access to community services and resources in their role as health home provider. For patients in need of long term care and aging services, Regional networks have each formed a LTC steering committee to connect CCNC network primary care practices to local Aging and Disability Resources Centers and Area Agencies on Aging. CCNC network clinical directors lead the steering committees. CCNC networks also produce resource manuals for network practices tied to local and regional continuum of medical, social and long term care services. North Carolina received the CMS "state demonstration to integrate care for dual eligible individuals" grant, which is enabling further improvements in this area. CCNC networks provide detailed protocols regarding effective approaches to supporting recipients with chronic illnesses with regard to self-management of chronic illnesses and access to community and medical resources to support improved health and well-being. Care managers develop relationships with recipients and when possible, their family and social supports through face to face and telephonic interactions.
Definition of Referral to Community and Social Support Services	Community Care works holistically. We require network providers, with care management support, to attend not only to the delivery of physical health care services but to address social, mental and community issues that may impact health and medical care. Care management recognizes the social and environmental factors that affect population health. As part of our care management approach, Community Care works to increase access to appropriate community and social support services, and to utilize and organize community resources. Local agency and resource knowledge is a key advantage of our use of locally-based care managers, and they share this knowledge with network providers by providing Resource Manuals containing relevant contact information for an array of community and social support services.
Quality Measures	Goal based measures include: ED visits; access to care; getting needed care; getting care quickly; inpatient admissions; asthma hospitalizations; heart failure admissions; CAHPS – chronic conditions supplemental questions; practices with co-located behavioral health providers. Service based measures include: members meeting CCNC priority criteria who receive comprehensive health assessment or an intervention; CAHPS – coordination of care, behavioral health, HEDIS measure set, chronic conditions supplemental questions; mammography; pap smear; colorectal cancer screening; well-child visits; adolescent well-care visits; blood pressure control for diabetes and hypertension; preventable readmissions; heart failure 30-day readmissions; medication reconciliation after non-mental health hospital discharge

STATE: OREGON	
PROGRAM DESIGN FEATURE	**DESCRIPTION**
Target Population	Two chronic conditions (asthma, cardiovascular disease, diabetes, mental health condition, substance use disorder, a BMI >25, Hepatitis C, HIV/AIDS, Chronic Kidney Disease, Cancer); One chronic condition and at risk for another; SMI
Geographic Limitations	Statewide
Delivery Systems	Managed Care and FFS
Enrollment	Voluntary
Building Blocks	Primary Care Medical Homes (PCMH); Primary care providers or practices that meet the State's qualifying criteria.
Provider Standards/Qualifications	The Division will use a Patient-Centered Primary Care Home (PCPCH) Health Home model which is defined by six core attributes (Access to Care, Accountability, Comprehensive Whole Person Care, Continuity, Coordination and Integration and Person and Family Centered Care) each having a number of corresponding standards and measures. These measures have been divided into "Tiers" to reflect the level of complexity of service described by the measure. Practices will provide information, corresponding to each of the measures, to the Oregon Health Authority (OHA) allowing the OHA to recognize practices as Tier 1, 2, or 3 PCPCHs/Health Homes. Only those practices providing services described by the PCPCH model will be recognized by the OHA as PCPCHs/Health Homes.
Payment Methodology	Tiered; PCPCH/Health Homes receive a per member per month based upon the standard met by the individual practice or provider group. The PCPCH/Health Home measures are divided into "Must-Pass Measures" and levels or "Tiers" that reflect basic to more advanced PCPCH/Health Home functions. Must-Pass and Tier 1 measures focus on foundational primary care home elements that should be achievable by most primary care clinics in Oregon with significant effort, but without significant financial outlay. Tier 2 and Tier 3 measures reflect intermediate and advanced functions. The PMPM management fee will be made monthly, is in addition to the FFS payments made for direct services under state plan authority for those provider types listed above.
Key Components of Health Homes	Individual primary care providers, primary care clinics, pediatric provider or clinics, FQHCs, RHCs, Community Mental Health Programs or Drug and Alcohol Treatment Programs with integrated PCPs; Non-physician health care providers can be part of teams; Must have care plan; Develop self-management and prevention goals; Referrals and access to non-health care community resources/social supports services; Co-location of behavioral health and primary care encouraged; Written agreement/procedures with hospitals, local practitioners for transitional care. OHA will support providers as they transition to PCPCH/HHs through written materials, learning collaborative, and joint technical meetings with the health plans.
Definition of Comprehensive Care Management	The Patient Centered Primary Care Home (PCPCH)/Health Home will be able to identify patients with high risk environmental or medical factors, including patients with special health care needs, who will benefit from additional care planning. The PCPCH will coordinate the care of these populations, and will ensure high risk patients or patients with special health care needs have a person-centered plan that has been developed and reviewed with the patient and/or caregivers. Further care management activities will include but are not limited to defining and following self

	management goals, developing goals for preventive and chronic illness care, developing action plans for exacerbations of chronic illnesses, and developing end- of-life care plans when appropriate.
Definition of Care Coordination	Care coordination will be an integral part of the HH. Patients will choose and be assigned to that provider/clinic or team to increase continuity with the chosen provider or team, and to ensure individual responsibility for care coordination functions. A person-centered plan will be developed based on the needs and desires of the patient with at least the following elements: options for accessing care, information on care planning and care coordination, names of other primary care team members when applicable and information on ways the patient participates in this care coordination. Care coordination functions can include but are not limited to: tracking of ordered tests and result notification, tracking referrals ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and clinicians, and direct collaboration or co-management of patients with specialty mental health, substance abuse, and providers of services and supports to people with developmental disabilities and people receiving long term care services and supports. Co-location of behavioral health and primary care is strongly encouraged.
Definition of Health Promotion	The PCPCH/HH provider will support continuity of care and health promotion through the development of a treatment relationship with the individual, other primary care team members and community providers. The HH provider will promote the use of evidence based, culturally sensitive wellness and prevention by linking the enrollee with resources for smoking cessation, diabetes, asthma, self-help resources and other services based on individual needs and preferences. Health promotion activities will be utilized to promote patient/family education and self-management of the chronic conditions.
Definition of Comprehensive Transitional Care	The PCPCH/HH will emphasize transitional care by demonstrating either a written agreement and/or procedures in place with its usual hospital providers, local practitioners, health facilities and community based services to ensure notification and coordinated, safe transitions, as well as improving the percentage of patients seen or contacted within 1 week of facility discharges.
Definition of Individual and Family Support Services	The PCPCH/HH will have processes for patient and family education, health promotion and prevention, self management supports, and information and assistance obtaining available non-health care community resources, services and supports. The person centered plan will reflect the client and family/caregiver preferences for education, recovery and self management. Peer supports, support groups and self care programs will be utilized to increase the client and caregivers knowledge about the client's individual disease.
Definition of Referral to Community and Social Support Services	The PCPCH/HH will demonstrate processes and capacity for referral to community and social support services, such as patient and family education, health promotion and prevention, and self management support efforts, including available community resources. Care coordination functions will include the use of the person centered plan to manage such referrals and monitor follow up as necessary.
Quality Measures	Goal based measures include: readmission rate following pneumonia hospitalization; prevention education; ambulatory care utilization; information sharing among providers; transition record at time of ED discharge; follow up post MH hospitalization; BMI documentation. Service based measures include: MH utilization; BMI documentation

STATE: RHODE ISLAND – CEDARR Family Center

PROGRAM DESIGN FEATURE	DESCRIPTION
Target Population	SMI or SED, two chronic conditions (mental health, Asthma, Diabetes, DD, Down Syndrome, Mental Retardation or Seizure Disorder) or one chronic condition and at risk of another
Geographic Limitations	Statewide
Delivery Systems	Managed Care and FFS
Enrollment	Eligible individuals can choose from any CEDARR Family Center to receive services
Building Blocks	CEDARR Family Centers certified to meet HH criteria (CEDARR Family Centers provide services to Medicaid-eligible children who are identified as having 1 or more special health care needs.
Provider Standards/Qualifications	Existing certification standards mandate that CEDARR Family Centers: 1.) Be legally incorporated with defined governance structure; 2.) Function as integrated system; 3.) Use principles of family centeredness; 4.) Have statewide capacity, geographically accessible; 5.) Work closely with direct service providers and community agencies. They can be found at: http://www.dhs.ri.gov/Portals/0/Uploads/Documents/Public/Children%20w%20Spec%20Needs/CEDARR_cert_stds.pdf The current standards under which CEDARR Family Centers operate are utilized as the provider standards for health homes. In addition, providers of health home services agree to: provide quality driven, cost effective, person-centered services; coordinate and provide access to high quality services informed by evidence based practices; coordinate and provide access to preventive and health promotion services; coordinate and provide mental health and substance abuse services; provide the six health home services; coordinate and provide access to chronic disease management services, including self-management support; coordinate and provide access to long term supports and services; develop a person-centered plan for each individual that coordinates and integrates all clinical and non-clinical services; demonstrate a capacity to use HIT to link services, facilitate communication among team members, between the health team and individual and family care givers and provide feedback to practices; establish a continuous quality improvement program and establish a protocol to collect and transmit data to the state; conduct yearly (documented) outreach to PCPs and Medicaid managed care plan (if applicable); conduct yearly (documented) BMI screening for all children six and up; conduct yearly (documented) depression screening using the CESDC scale for all children 12 and up; conduct yearly review of immunizations, screenings and other clinical information contained in the KIDSNET Health Information System..
Payment Methodology	Alternate payment methodology; payment based on average and relative level of effort required by CEDARR Family Center service team to perform services, development of market based hourly rate, considering factors such as: prevailing wages, adjustments to direct wages, fringe benefits, etc. Each of the three different CEDARR services have been assigned a payment based the assumptions of time, level of effort and staff involvement required in order to successfully complete each service per DHS service definition.
Key Components of Health Homes	The CEDARR Family Center will operate as a designated provider of health home services. CEDARR Family Centers are comprised of teams of licensed health care professionals such as psychologists, licensed clinical social workers, Masters level RNs and licensed marriage and family therapists, as well as staff to provide care coordination, individual and family support and other health home services. The health home team minimally comprises of a licensed clinician and a family service coordinator. The team will consult and coordinate and collaborate on a regular basis with the child's primary care physician/medical home and with other providers providing treatment services to that child. Medical specialists and

	other medical professionals will be included on the team depending on the unique needs of the enrolled child.
Definition of Comprehensive Care Management	Comprehensive Care Management is provided by CEDARR Family Centers by working with the child and family to: assess current circumstances and presenting issues, identify continuing needs, and identify resources and/or services to assist the child and family to address their needs through the provision of an Initial Family Intake and Needs Determination; develop a Family Care (or Treatment) Plan which will include child specific goals, treatment interventions and meaningful functional outcomes; and regular review and revision of the Family Care Plan to determine efficacy of interventions and emerging needs. Integral to this service is ongoing communication and collaboration between the CEDARR Team and the clients Primary Care Physician/Medical Home Managed Care Organization, Behavioral Health and Institutional/Long Term Care Providers. This service will be performed by the Licensed Clinician with support from the Family Service Coordinator.
Definition of Care Coordination	Care Coordination is designed to be delivered in a flexible manner best suited to the family's preferences and to support goals that have been identified by developing linkages and skills in order for families to reach their full potential and increase their independence in obtaining and accessing services. This includes: Follow up with families, Primary Care provider, service providers and others involved in the child's care to ensure the efficient provision of services; Information about specific disorders, treatment and provider options, systems of support, services, assistance and legal rights available to Children with Special Health Care Needs and their families, resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, funding options, school-based services, faith based organizations, etc.; service delivery oversight and coordination to ensure that services are being delivered in the manner that satisfies the requirements of the individual program(s) and meet the needs of the child and family; Assistance in locating and arranging specialty evaluations as needed, in coordination with the child's Primary Care Provider. This also includes follow-up and ongoing consultation with the evaluator as needed. Care Coordination will be performed by the Licensed Clinician or the Family Service Coordinator depending on the exact nature of the activity.
Definition of Health Promotion	Health Promotion assists children and families in implementing the Family Care Plan and in developing the skills and confidence to independently identify, seek out and access resources that will assist in managing and mitigating their conditions and in preventing the development of secondary or other chronic conditions, addressing family and child engagement, promoting optimal physical health and behavioral health and addressing and encouraging activities related to health and wellness. This service will include the provision of health education, information, and resources with an emphasis on resources easily available in the families' community and peer group(s). This service will be performed by the Licensed Clinician.
Definition of Comprehensive Transitional Care	Transitional Care will be provided by the CEDARR Team to both existing clients who have been hospitalized or placed in other non-community settings as well as newly identified clients who are entering the community. The CEDARR Team will collaborate with all parties involved including the facility, primary care physician, Health Plan (if enrolled) and community providers to ensure a smooth discharge into the community and prevent subsequent re-admission(s). Transitional Care is not limited to Institutional Transitions but applies to all transitions that will occur throughout the development of the child and includes transition from Early Intervention into School based services and pediatric services to adult services. This service will be provided by the Licensed Clinician with support from the Family Service Coordinator.

STATE: RHODE ISLAND – CEDARR Family Center	
Definition of Individual and Family Support Services	The CEDARR Team is responsible for providing assistance to the family in accessing and coordinating services. These services include the full range of services that impact on Children with Special Health Care Needs and include, but are not limited to, health, behavioral health, education, substance abuse, juvenile justice and social and family support services. The CEDARR Team will actively integrate the full range of services into a comprehensive program of care. At the family's request, the CEDARR Team can play the principal role as organizer, information source, guide, advocate, and facilitator for the family by helping the family to assess strengths and needs, identify treatment goals and services, and navigate agency and system boundaries. This service will be performed by the Licensed Clinician or the Family Service Coordinator depending on the exact nature of the activity.
Definition of Referral to Community and Social Support Services	Referral to Community and Social Support Services will be provided by members of the CEDARR Team and will include information about formal and informal resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, funding options, school-based services, faith based organizations, etc. Whenever possible**,** families will be informed of opportunities and supports that are closest to home, that are the least restrictive and that promote integration in the home and community. Members of the CEDARR Team will emphasize the use of informal, natural community supports as a primary strategy to assist children and families. This service will be provided by the Licensed Clinician or the Family Service Coordinator depending on the exact nature of the activity.
Quality Measures	Measures include: collaboration during care plan development; use of electronic medical record; coordination with MCOs; satisfaction with services; accessibility/availability of services; timely appointments for initial assessment; timely completion of care plans; timely review of care plans; health education; stress; community based referrals; ability to take part in age appropriate social activities; BMI calculation and intervention; reduction in BMI; depression screening; follow up treatment/evaluation if positive screening for depression; ED visits; prevention of acute care admissions; medical follow up within 7 days of ACS admission/ACS ED visit; active participation by health home staff for admissions > 7 days; contact by health home staff post discharge for admissions > 7 days; readmission/ED visits within 30 days of discharge; psychiatric and non-psychiatric admissions within 30 days of discharge

STATE: RHODE ISLAND – Community Mental Health Organization (CMHO)

PROGRAM DESIGN FEATURE	DESCRIPTION
Target Population	Individuals eligible for the State's community support program with serious and persistent mental health condition
Geographic Limitations	Statewide
Delivery Systems	Managed Care and FFS
Enrollment	Rhode Island will auto-assign individuals to a HH provider with patient's choice of opting-out to choose another HH; Potentially eligible individuals receiving services in the hospital ED or inpatient will be notified about health homes and referred appropriately.
Building Blocks	Rhode Island has seven CMHOs, which along with two other smaller providers of specialty mental health services form a statewide, fully integrated, mental health delivery system, providing a comprehensive range of services to clients. The seven CMHO's and the two smaller specialty providers are all licensed by the state. The two specialty providers will be expected to meet the same requirements as the seven CMHOs. Each CMHO is responsible for establishing an integrated service network within its own catchment area, and for coordinating service provision with other catchment areas.
Provider Standards/Qualifications	In addition to meeting state licensure requirements, BHDDH will also require CMHOs to: report on designated Core Quality Measures; have a psychiatrist(s)/advanced practice psychiatric registered nurse specialist assigned to each individual receiving CMHO health home services, available 24/7 for individuals in need of referral, mental health crisis intervention or stabilization, etc.; conduct wellness interventions; participate in any statewide learning sessions; within three months of implementation have developed a contract or MOU with regional hospitals or systems to ensure formal structure for transitional care planning, to include communication of inpatient admissions and maintain mutual awareness and collaboration to identify individuals seeking ED services that might benefit from CMHO health homes; convene ongoing and documented internal health home team meetings; participate in CMS and state-required evaluation activities; develop required reports; maintain compliance with the terms and conditions as a CMHO health home provider; and, present a proposed health home delivery model (including description of the health team and members roles/functions, how the six services will be carried out, processes for integrating physical health and behavioral health, hospitals the CMHO will establish transitional care agreements with, a list of primary care practices the CMHO will develop referral arrangements with and use of EHRs) that the state determines to have a reasonable likelihood of being cost-effective. Community support professionals will undergo a 17-week certification training program.
Payment Methodology	Case rate methodology
Key Components of Health Homes	The team will vary according to unique needs of individuals but will minimally consists of a Master's team coordinator who will serve as the central coordinator of health home services, psychiatrist, registered nurse MA level clinician, CPST Specialist/hospital liaison and and CPST Specialist and Peer Specialist. Other team members may include: primary care physicians, pharmacists, substance abuse specialists, vocational and community integration specialists. CMHOs will participate in statewide learning activities to promote practice transformation.

STATE: RHODE ISLAND – Community Mental Health Organization (CMHO)

Definition of Comprehensive Care Management	Comprehensive care management services are conducted with high need individuals, their families and supporters to develop and implement a whole-person oriented treatment plan and monitor the individual's success in engaging in treatment and supports. Comprehensive care management services are carried out through use of a biopsychosociall assessment. A biopsychosocial assessment of each individual's physical and psychological status and social functioning is conducted for each person evaluated for admission to the CMHO. Assessments may be conducted by a psychiatrist, registered nurse or a licensed and/or master's prepared mental health professional. The assessment determines an individual's treatment needs and expectations of the individual served; the type and level of treatment to be provided, the need for specialized medical or psychological evaluations; the need for the participation of the family or other support persons; and identification of the staff person (s) and/or program to provide the treatment. Based on the biopsychosocial assessment, a goal-oriented, person centered care plan is developed, implemented and monitored by a multi-disciplinary team in conjunction with the individual served. Comprehensive care management services may be provided by any member of the CMHO health home team; however, Master's Level Health Home Team Coordinators will be the primary practitioners providing comprehensive care management services.
Definition of Care Coordination	Care coordination is the implementation of the individualized treatment plan (with active involvement of the individual served) for attainment of the individuals' goals and improvement of chronic conditions. Care managers are responsible for conducting care coordination activities across providers and settings. Care coordination involves case management necessary for individuals to access medical, social, vocational, educational, as well as other individualized supportive services, including, but not limited to: • Assessing support and service needs to ensure the continuing availability of required services; • Assistance in accessing necessary health care; and follow up care and planning for any recommendations • Assessment of housing status and providing assistance in accessing and maintaining safe and affordable housing; • Conducting outreach to family members and significant others in order to maintain individuals' connection to services; and expand social network • Assisting in locating and effectively utilizing all necessary community services in the medical, social, legal and behavioral health care areas and ensuring that all services are coordinated; and • Coordinating with other providers to monitor individuals' health status, medical conditions, medications and side effects. Care coordination services may be provided by any member of the CMHO health home team; however, CPST Specialists will be the primary practitioners providing care coordination services.
Definition of Health Promotion	Health promotion services encourage and support healthy ideas and concepts to motivate individuals to adopt healthy behaviors. The services also enable individuals to self-manage their health. Health promotion services may be provided by any member of the CMHO health home team. Health promotion activities place strong emphasis on self-direction and skills development for monitoring and management of chronic health conditions. Health promotion assists individuals to take a self-directed approach to health through the provision of health education. Specific health promotion services may include, but are not limited to, providing or coordinating assistance with: promoting individuals' health and ensuring that all personal health goals are included in person centered care plans; promotion of substance abuse prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and increased physical activity; providing health education to individuals and family members about chronic conditions; providing prevention education to individuals and

	family members about health screening and immunizations; providing self-management support and development of self-management plans and/or relapse prevention plans so that individuals can attain personal health goals; and promoting self direction and skill development in the area of independent administering of medication. Health promotion services may be provided by any member of the CMHO health home team; however, Psychiatrists and Nurses will be the primary practitioners providing these services.
Definition of Comprehensive Transitional Care	Comprehensive transitional care services focus on the transition of individuals from any medical, psychiatric, long-term care or other out-of-home setting into a community setting. Designated members of the health team work closely with the individual to transition the individual smoothly back into the community and share information with the discharging organization in order to prevent any gaps in treatment that could result in a re-admission. To facilitate timely and effective transitions from inpatient and long-term settings to the community, all health home providers will maintain collaborative relationships with hospital emergency departments, psychiatric units of local hospitals, long-term care and other applicable settings. In addition, all health home providers will utilize hospital liaisons to assist in the discharge planning of individuals, existing CMHO clients and new referrals, from inpatient settings to CMHOs. Care coordination may also occur when transitioning an individual from a jail/prison setting into the community. Hospital liaisons, community support professionals and other designated members of the team may provide transitional care services. The team member collaborates with physicians, nurses, social workers, discharge planners and pharmacists within the hospital setting to ensure that a treatment plan has been developed and works with family members and community providers to ensure that the treatment plan is communicated, adhered to and modified as appropriate. Comprehensive transitional care services may be provided by any member of the CMHO health home team; however, Hospital Liaisons will be the primary practitioners providing these services.
Definition of Individual and Family Support Services	Individual and family support services are provided by community support professionals and other members of the health team to reduce barriers to individuals' care coordination, increase skills and engagement and improve health outcomes. Individual and family support services may include, but are not limited to: providing assistance in accessing needed self-help and peer support services; advocacy for individuals and families; assisting individuals identify and develop social support networks; assistance with medication and treatment management and adherence; identifying resources that will help individuals and their families reduce barriers to their highest level of health and success; and connection to peer advocacy groups, wellness centers, NAMI and Family Psychoeducational programs. Individual and family support services may be provided by any member of the CMHO health home team; however, CPST specialists will be the primary practitioners providing these services.
Definition of Referral to Community and Social Support Services	Referrals to community and social support services provide individuals with referrals to a wide array of support services that will help individuals overcome access or service barriers, increase self-management skills and improve overall health. Referrals to community and social support services involves facilitating access to support and assistance for individuals to address medical, behavioral, educational, and social and community issues that may impact overall health. The types of community and social support services to which individuals will be referred may include, but are not limited to: primary care providers and specialists; wellness programs, including smoking cessation, fitness, weight loss programs, yoga; specialized support groups (i.e. cancer, diabetes support groups); substance treatment links in addition to treatment – supporting recovery with links to support groups, recovery coaches, 12-step; housing (Sober Housing); social integration (NAMI support groups, MHCA OASIS, alive program (this program and MHCA are Advocacy and Social Centers) and/or Recovery Center;; assistance with the identification and attainment of other benefits; SNAP; connection with the Office of programs/jobs; social integration and social skill building; faith based organizations; employment and educational program or training. Referral to community and social support services may be provided by any member of the CMHO health home team; however, CPST specialists will be the primary

STATE: RHODE ISLAND – Community Mental Health Organization (CMHO)	
	practitioners providing these services.
Quality Measures	Measures include: documentation of physical and behavioral health needs; follow up visit post discharge; regular source of health care; annual physical; contact by hospital liaison post discharge; ED visits; ED visits for a mental health condition; satisfaction with services; accessibility of care; percent who smoke; percent who report illicit drug use; BMI documentation; pap test; mammogram; colonoscopy; depression screening and follow up; initiation of AOD treatment and encouragement of AOD treatment for adults with new episode of alcohol or other drug dependence; smoking cessation/counseling; drug/alcohol abusers counseled/referred to treatment; diabetes under control; appropriately prescribed asthma medication; hypertension under control; lipid levels under control; adherence to asthma/COPD medication; adherence to CVD/anti-hypertension medication; use of statin medication for history of CAD; follow up post MH hospitalization; transition record transmitted to PCP/facility within 24 hours; appropriate ambulatory care prevents/reduces admissions; readmissions

Integrated Care Resource Center

STATE: WASHINGTON

PROGRAM DESIGN FEATURE	DESCRIPTION
Target Population	Aged and disabled populations in FFS and Medicaid HCBS (LTC); One or more of the following: diabetes, heart failure, coronary artery disease, cerebrovascular disease, renal failure, chronic pain associated with musculoskeletal conditions and other chronic illness, including mental illness, fibromyalgia, cancer, chronic respiratory conditions, depression and obesity; One of the following risk factors: living alone, experiencing isolating moods and behaviors, self rating of health as fair or poor, deteriorated self-sufficiency, more than 8 medications
Geographic Limitations	Statewide
Delivery Systems	FFS; State contracting directly with HH providers
Enrollment	Opt in enrollment process
Building Blocks	Area Agencies on Aging
Provider Standards/Qualifications	The qualified provider will: • Provide CCM services based on protocols that: a) are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field; b) consider the needs of enrollees, and c) are updated as new information becomes available. • Provide updates to its approved staffing model to DSHS when there are staffing changes. • Ensure that all nurses employed as Care Managers are properly licensed and credentialed, based on contractor policies and procedures. • Maintain active relationships with community resources such as chemical dependency, mental health and other medically necessary services. • Maintain sufficient data to identify the physicians who provide services to each enrollee. • Ensure that the number of Care Managers participating in the program is enough to provide adequate access to all services covered by this Agreement. • Maintain documentation of services provided by the CCM program for each enrollee in the CARE system
Payment Methodology	TBD
Key Components of Health Homes	AAAs as health homes; Team made up of RN (for care coordination, transitions, care planning) and other health and social service providers; Develop health action plan and reports that indicate progress with goals; Appropriate linkages with resources, referrals, follow-up; Client activation score determines health coaching methodology for health education, focus on prevention and healthy lifestyles; Focus on reducing hospital admissions and ER use - transition services include post hospital home visits and phone calls; Team assists with maintaining benefits, housing, etc
Definition of Comprehensive Care Management	Comprehensive care management services are conducted by licensed registered nurses and involve: 1.) Identification of high-risk individuals and use of client information to determine level of participation in care management services including level of activation; assessment of preliminary service needs; 2.) health action plan development, which will include individualized client goals, preferences and optimal clinical outcomes;3.) assignment by the care manager of health team roles and responsibilities; 4.) development of treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions; 5.) transitional care services

	provided during hospital or outpatient settings of care; 6.)monitoring of individual and population health status and service use to determine response to interventions provided by health home teams and; 7.) development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.
Definition of Care Coordination	Care Coordination is the implementation of the individualized Health Action Plan developed by the client and the RN Care Manager. The HAP is informed by multiple data sources, the preferences of the client, through appropriate linkages, referrals, coordination and follow-up to needed services and supports. Specific activities include, but are not limited to: appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes and communicating with other providers, caregivers (paid and unpaid informal supports). Nurse Care Managers will be responsible for conducting care coordination activities across the health team. The primary responsibility of the nurse care manager is to ensure implementation of the Health Action Plan for achieving clinical outcomes and self-management skills consistent with the needs, optimal level of activation and preferences of the client.
Definition of Health Promotion	Health promotion services assist clients to participate in the implementation of their HAP as well as to achieve self-identified health outcomes. RN Care Managers use the client's activation score and level (1-4) to determine the coaching methodology for each client and develop a teaching and support plan. Health promotion services shall minimally consist of providing health education specific to an individual's chronic conditions, development of self-management plans with the individual, education regarding the importance of routine preventive care, providing support for improving social and community networks and providing health promoting lifestyle interventions, including but not limited to, substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, and increasing physical activity.
Definition of Comprehensive Transitional Care	In conducting comprehensive transitional care, the RN Care Manager provides care coordination services designed to reduce hospital admissions and interrupt patterns of frequent hospital emergency department use. The RN Care Manager collaborates with physicians, nurses, social workers, rehabilitative therapists, discharge planners, pharmacists, and others to support the HAP with a specific focus on increasing clients' and family members' ability to manage care and live safely in the community, and shift the use of reactive care and treatment to proactive health promotion and self management. Transitional care services will include discharge visit during hospitalizations, post hospital home visits and telephone calls. The RN Care Manager will provide supports to assure the client understands discharge care needs including medication management, follow up appointments, and management of their chronic or acute conditions, including when to seek medical care.
Definition of Individual and Family Support Services	Individual and family support services activities include, but are not limited to: advocating for individuals and families, assisting with obtaining and adhering to medications and other treatments, and authorization of family caregiving support services when needed.
Definition of Referral to Community and Social Support Services	Referral to community and social support services involves providing care coordination and comprehensive care management with LTC case managers, mental health case managers and counselors, and other community and social services support providers accessed by the client. Assistance for clients to obtain and maintain eligibility for healthcare, disability benefits, housing, personal need and legal services are coordinated with the client's department case manager.
Quality Measures	Measures include: depression screening; substance abuse screening; ED visits; decrease in nursing facility placements; decrease in hospitalizations; readmissions; increase in PAM score