



Tribes and the Health Home Program

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Yolanda Lovato, DSHS Health Home Stakeholder Engagement Manager
Marietta Bobba, DSHS Planning and Program Development Manager

Health Home Program History

- Created by Affordable Care Act (ACA) section 2703
- Allows states to provide Health Home benefits and care coordination services to high cost high risk Medicaid and Medicare/Medicaid (duals) eligible clients
- Purpose to reduce progression of chronic disease and reduce likelihood of additional chronic diseases
- Reduce inappropriate emergency department utilization and preventable hospital readmissions
- Improve health and self-management of conditions

Covers 6 specific services beyond typical medical services

- Comprehensive Care Management
- Care Coordination and Health Promotion
- Transitional Care
- Individual and Family Support
- Referrals to Community Services
- Use of Health Information Technology

Health Home Program in WA

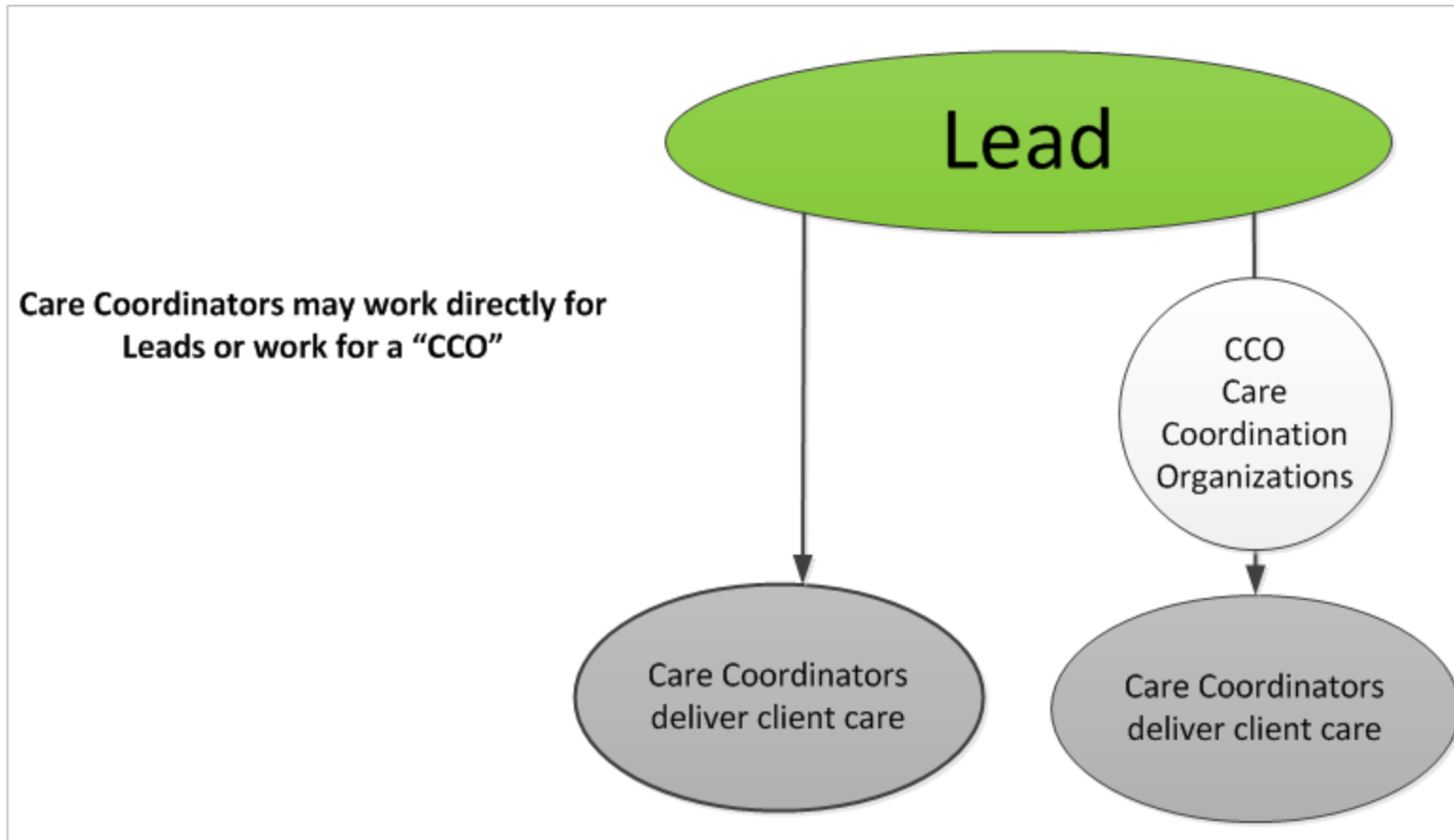
- New regular benefit in WA State Plan
- Assists client in accessing medically necessary services
- Services may be delivered face to face or telephonically
- Client and care coordinator can meet at a location of the client's choice: a clinic, the patient's home or other community location
- Does not include clients living in King or Snohomish counties

Current Health Home Providers

Community organizations and MCOs contract with HCA/DSHS as “Lead” Organizations.

Leads may provide client services or sub-contract with community organizations. These “Care Coordination Organizations” (CCOs) include mental health clinics, area agencies on aging, chemical dependency providers, HIV/AIDS networks, child social service agencies, and community health centers.

Current Health Home Providers



Care Coordinators Role

Program designed to provide “person-centered care”.

The Care Coordinator:

- Helps client to review and identify needs and challenges
- Works with client to set goals and develop a plan to meet those goals
- Helps client get the right care at the right time in the right setting, to avoid duplication of services

HH Care Coordinator - Required qualifications include:

- RNs, ARNPs, licensed practical nurses, psychiatric nurses,
- psychiatrists, physician's assistants, clinical psychologists,
- licensed mental health counselors, agency affiliated certified mental health counselors, licensed marriage and family therapists,
- MSW, BSW or related Bachelor's prepared social workers, and
- certified chemical dependency professionals

Community Health Representatives(CHRs)'s Role

- Can work as “affiliated staff” (making initial phone calls; setting appointments; mailing out information etc.)
- If otherwise qualified, A CHR can be a Care Coordinator,
- Care Coordinator is the central person developing and updating the HAP and must be a “professional” according to our State Plan Amendment
- I.H.S. certification of a CHR was not included in the “professional” category of qualified Health Home Care Coordinators

Health Home Program is changing lives

Success Story 1: 18 year old pregnant female with Type 1 Diabetes

- Non-compliant about checking and managing blood sugar during pregnancy. Didn't have a penlet that could gauge depth of needle in her finger and it went too deep. Sore fingers reduced her desire to comply.
- Had fears about giving birth but wanted to have a healthy baby and go back to school

Care Coordinator:

- Talked about labor and delivery with client to alleviate her fears
- Got client a different penlet so her fingers weren't so sore
- Referred to educational resources

Client has responded well to the Care Coordinator's support and is

- More compliant about checking and managing her blood sugar levels
- Working towards goal of completing High School education

Health Home Program is changing lives

Success Story 2: Jane is 72 years old. She and her daughter and two grandchildren live together. She watches her grandchildren while her daughter works.

- Jane weighs 327 lbs.
 - Takes insulin daily for diabetes
 - Has COPD from long term smoking
- Jane's goals are:
 - To walk to the mailbox to get her own mail
 - To lift her 3-year-old granddaughter
- Care coordinator: helped Jane take small steps to increase stamina and strength, supports Jane's goals and assured her small improvements are good improvements. Continues to work with Jane and her family.

Who is eligible for Tribal Health Home?

Clients must

- Have full Medicaid coverage including Medicaid Only or with both Medicare and Medicaid or “dual” coverage,
- Have a defined chronic condition and a PRISM risk score of 1.5 or higher
- Place of residence (not where they receive care) must be in any WA county except King and Snohomish

1,762 clients (September 2014) who self-identified as AI/AN met these criteria

Who is not eligible for Tribal Health Home?

1. Clients enrolled in another care management program such as Hospice or PACE (Program of all-inclusive care for the elderly).
2. Clients enrolled in a Primary Care Case Management (PCCM) program. Clients must dis-enroll from their PCCM as they enroll in the Health Home Program.
3. Clients who have comparable health insurance such as Medicare Advantage Part C, Tricare or private insurance.

What is PRISM?

PRISM (Predictive Risk Intelligence System) is a DSHS tool that looks at medical, behavioral health, and long-term care service claims data together to predict what future medical costs might be.

A **risk score** is assigned to the client based on this data. The risk score is one way to measure the client's risk of higher than average medical costs, using historical data.

PRISM provides a secure profile of a client's past use of Medicaid and Medicare health services. PRISM also provides clinical support tools like drug adherence screens and risk factors that can help inform care coordinators of the need to work with clients to increase activation in their own care. Already available for primary care case managers.

Contact prism.admin@dshs.wa.gov for more information.

WA Health Home Program Enrollment September 2014

FFS Leads	# Clients	Managed Care Leads	# Clients	Total Clients
Community Health Plan	84	Amerigroup	2,335	
Community Choice	1,448	Community Health Plan	7,295	
NW Regional Council	1,236	Coordinated Care	4,134	
Optum	2,719	Molina	12,128	
SE WA ALTC	2,276	United	3,038	
United Healthcare	204			
	7,967		28,930	36,897

Tribes have not yet contracted as Health Home Leads.

Tribal Health Home Leads

- AI/AN clients must give their consent to be enrolled
- When contracting, Tribes can specify what eligible clients they will serve
 - AI/AN clients only
 - Dual Eligible coverage only
 - All eligible clients

How will clients enroll with a Tribal Health Home Lead?

- Tribal Health Home Lead submits list of likely eligible clients to HCA
- HCA confirms clients' eligibility for Health Homes and returns updated list to Tribal Lead
- Tribal Lead describes the program to the client or his/her caregiver and obtains client consent to enroll them in program (and dis-enroll from PCCM if necessary)
- Clients who are currently enrolled in non-tribal Health Homes can switch to a Tribal Lead.

Comparison PCCM and Tribal Health Home

PCCM Provider	Tribal Health Home Provider
No requirement to deliver services	Provider must deliver services including completing Health Action Plan (HAP) before payment Services may be provided on multiple days but may only bill 1x per month
Receives \$3 PMPM for each client on roster	Can bill either a) <u>\$342</u> for face to face or b) <u>\$67.50</u> for non-face to face
No billing requirement	Must submit 837P encounter transaction before payment

Clinic can only bill for one Tribal Medical Encounter each day

Leads Responsible for administrative oversight

- Lead responsible for ensuring client records are created and maintained
- Required clinical records include:
 - Health Action Plan
 - Contact log and
 - Progress notes
- Records are maintained in the client's file in the clinic office or client electronic health record

Billing requirements to get paid

- Health Home Enrollment Roster is on an 834 HIPAA transaction. Lead's system must be able to read file. *Can't see enrollment with a 270 HIPAA inquiry.*
- Bill by submitting 837P HIPAA encounter data electronic transaction (similar to the 837P claims)
- Receive ETRR (encounter transaction record receipt) confirming encounter received
- Receive payment explanation on 820 file
- Required to submit Health Action Plans (HAPs) electronically

Leads submit Quarterly Reports

- Report number enrolled, number engaged (signed a consent form and completed their initial Health Action Plan)
- Identify program barriers to enrollment and engagement success
- Describe Program client success stories

Next Step:

If interested in contracting as a Lead Organization to provide Health Home services contact:

Agnes Ericson,
HCA Health Homes Contract Manager
360.725.1115
agnes.ericson@hca.wa.gov

Health Home Program Information

- Visit the web site:
http://www.hca.wa.gov/pages/health_homes.aspx
<http://www.altsa.dshs.wa.gov/stakeholders/duals/>
- Send questions to: Healthhomes@hca.wa.gov