Health Homes Overview

Hepatitis C Medicaid Affinity Group

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Health Homes

- Optional Medicaid state plan benefit authorized under section 1945 of the Social Security Act.
- Comprehensive system of care coordination for Medicaid beneficiaries with chronic conditions.
- Integrates and coordinates all primary, acute, behavioral health and long term services and supports to treat the ‘whole person’.

Eligibility Criteria

- Have two or more chronic conditions
- Have one chronic condition and are at risk for a second
- Have one serious and persistent mental health condition

Chronic conditions listed in the statute include mental health condition, substance use disorder, asthma, diabetes, heart disease, and BMI over 25. Other chronic conditions may be considered by CMS for approval.

Health Home Services

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care/follow-up
- Patient & family support
- Referral to community & social support services

Providers must demonstrate a capacity to use health information technology to link these six services, as feasible and appropriate.

Health Home Providers

States have flexibility to determine eligible health home providers:

- A designated provider: a physician, clinical/group practice, rural health clinic, community health center, community mental health center, home health agency, pediatrician, OB/GYN, or other provider

- A team of health professionals: physicians, nurse care coordinators, nutritionists, social workers, behavioral health professionals, and can be free-standing, virtual, hospital-based, or a community mental health center

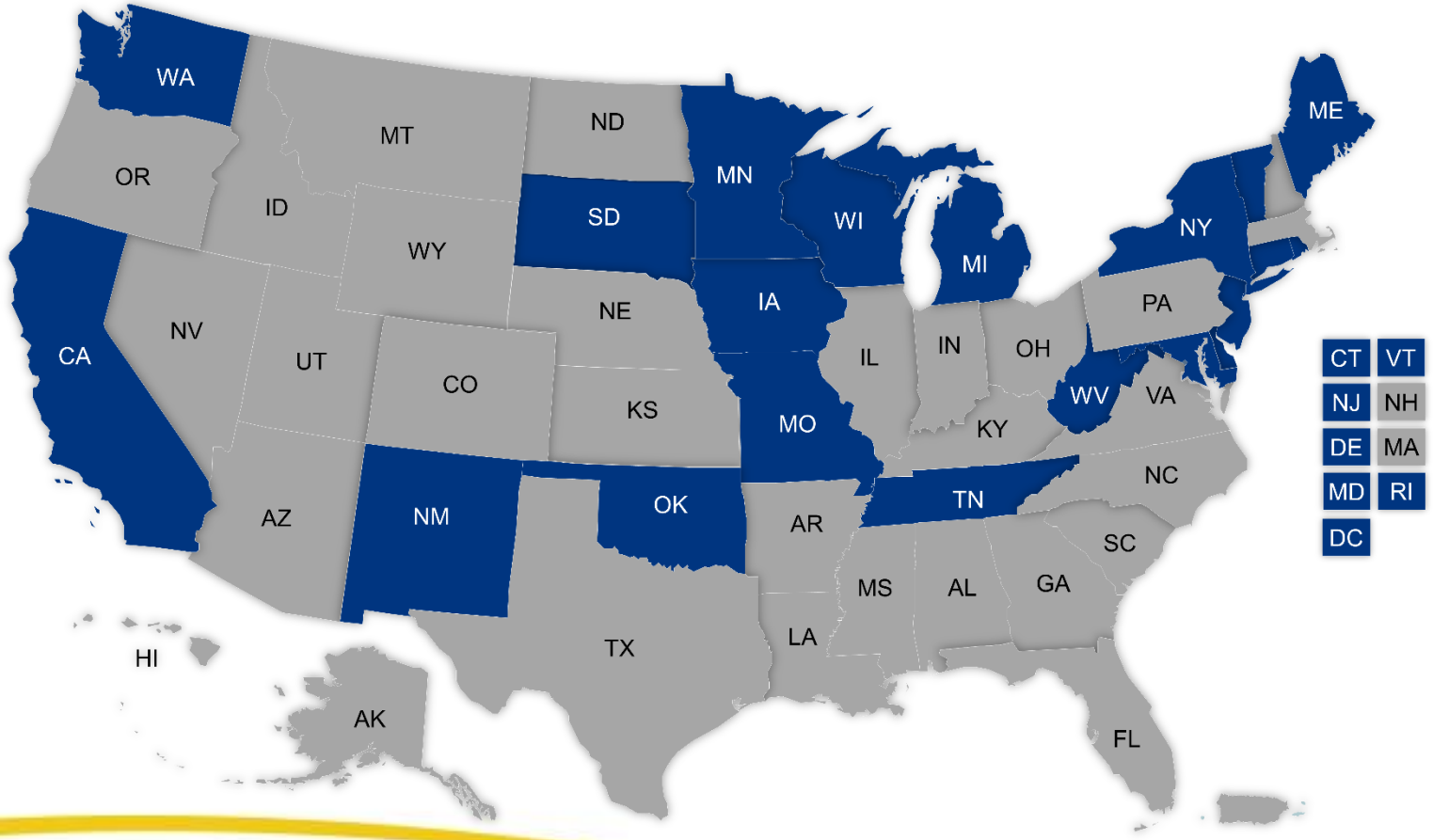
- A health team: must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractics, licensed complementary and alternative practitioners

Key Elements

- States receive 90% enhanced FMAP for the first eight quarters that the program is effective. As of October 2018, states have an opportunity through the SUPPORT Act to receive 10 quarters of enhanced FMAP for a SUD-focused health home.
- Waives comparability requirement to offer health home services in a different amount, duration, and scope.
- States required to consult with SAMHSA prior to SPA submission.
- Health Home service providers are required to report quality measures to the state as a condition of payment.

Health Home Activity

As of November 2019, 20 states and DC have a total of 35 approved health home models



Health Home Resources

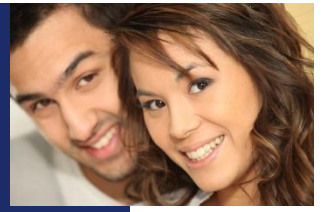
- *Health Home Information Resource Center:* https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/Health-Home-Information-Resource-Center/index.html

- *Designing Medicaid Health Homes for Individuals with Opioid Dependency: Considerations for States:* https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-irc-health-homes-opiod-dependency.pdf

West Virginia Department of Health and Human Resources (DHHR)

Bureau for Medical Services (BMS)

West Virginia Health Homes Programs




Dr. James Becker, Medical Director, DHHR

WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

What is a Health Home?

- The West Virginia Medicaid Health Homes Program was created by the Centers for Medicare and Medicaid Services (CMS) as a part of the Affordable Care Act (ACA) of 2010.
- The program consists of a team of people who assist Medicaid members with managing their healthcare needs. The goal of West Virginia Medicaid Health Homes is to help members be their healthiest and be in control of their lives.
- The Health Homes Program coordinates physical and behavioral health (both mental health and substance abuse) and long-term services, social services and supports for Medicaid members with chronic health conditions.

Health Homes – Bipolar Disorder

- West Virginia started its first Health Homes program on July 1, 2014.
- This pilot Health Homes program targets Medicaid recipients with an active diagnosis of bipolar disorder (BPD) and having or at risk of having Hepatitis B and/or C in a six-county region: Cabell, Kanawha, Mercer, Putnam, Raleigh and Wayne.
- On April 1, 2017, it expanded statewide.
- Even though a Health Home provider doesn't have to be a behavioral health center (BHC), this region also has a respectable number of BHCs available for referrals from primary care physicians.

Who is Eligible?

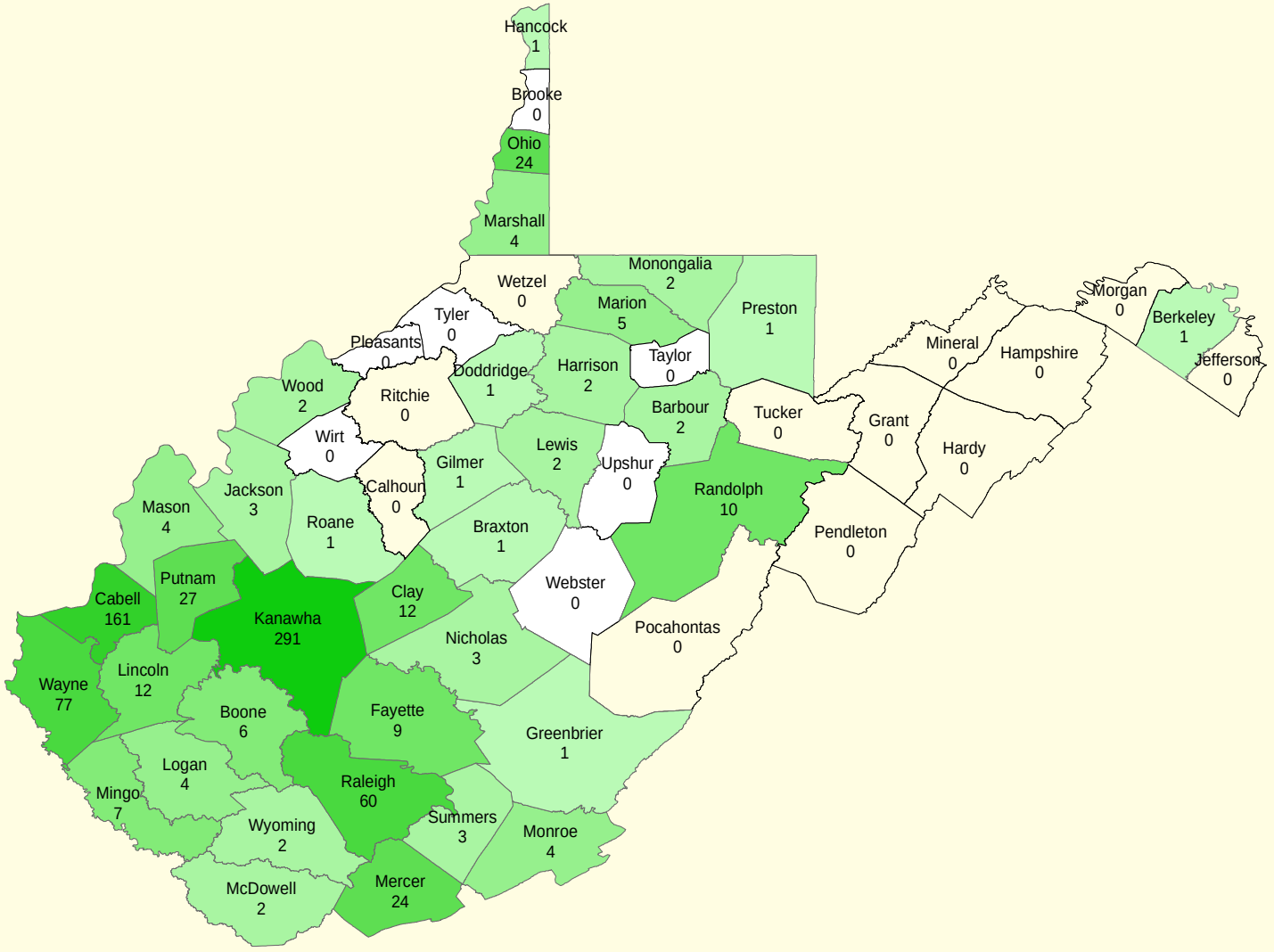
- West Virginia Medicaid members who are diagnosed with Bipolar Disorder and have or are at risk of having Hepatitis B or C; and
- Members must receive services from a provider located in a West Virginia county.

Health Homes Offers These Services

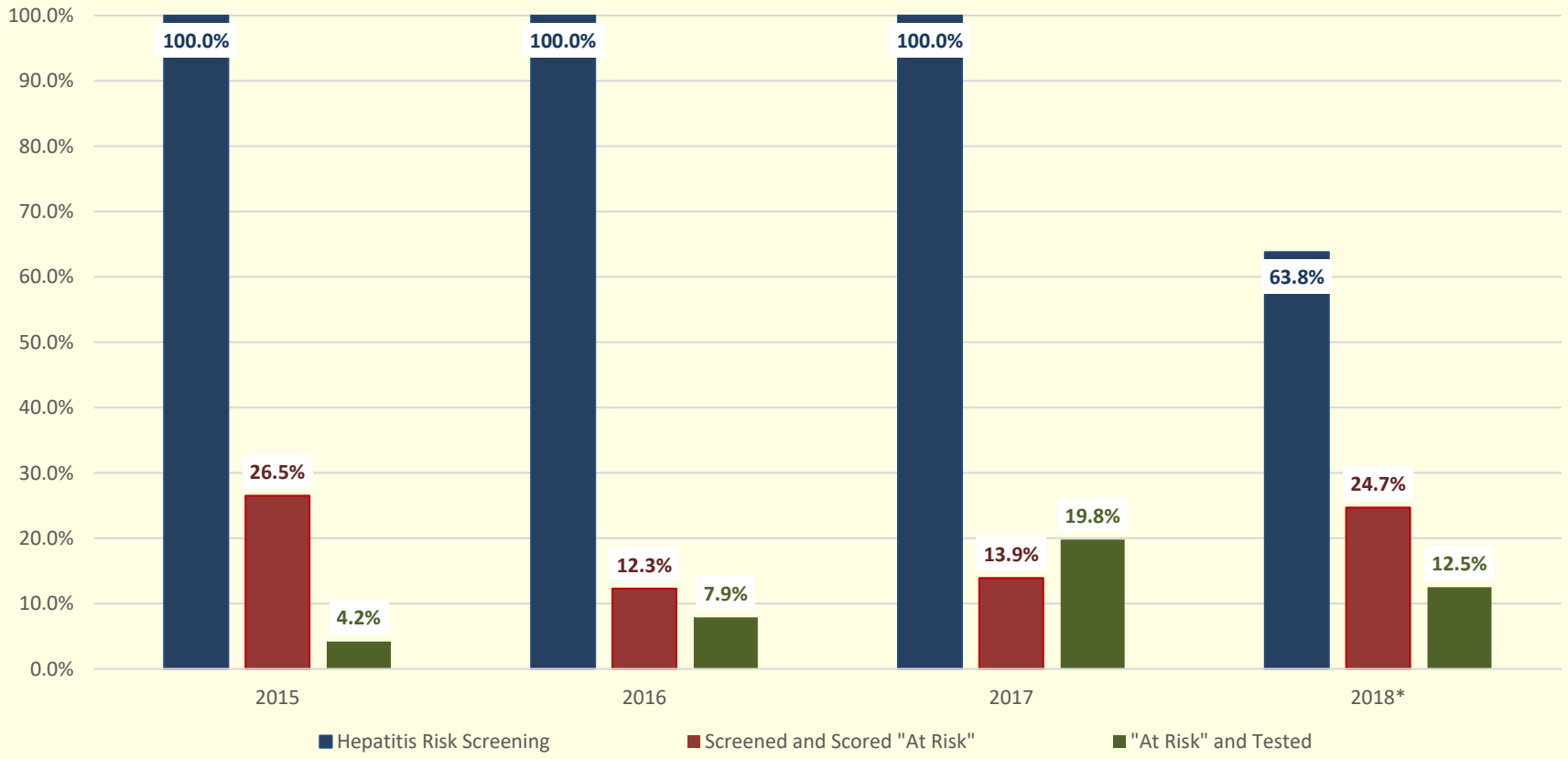
Health Homes offers the following services:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care and follow-up
- Patient and family support services
- Referral to community and social support services

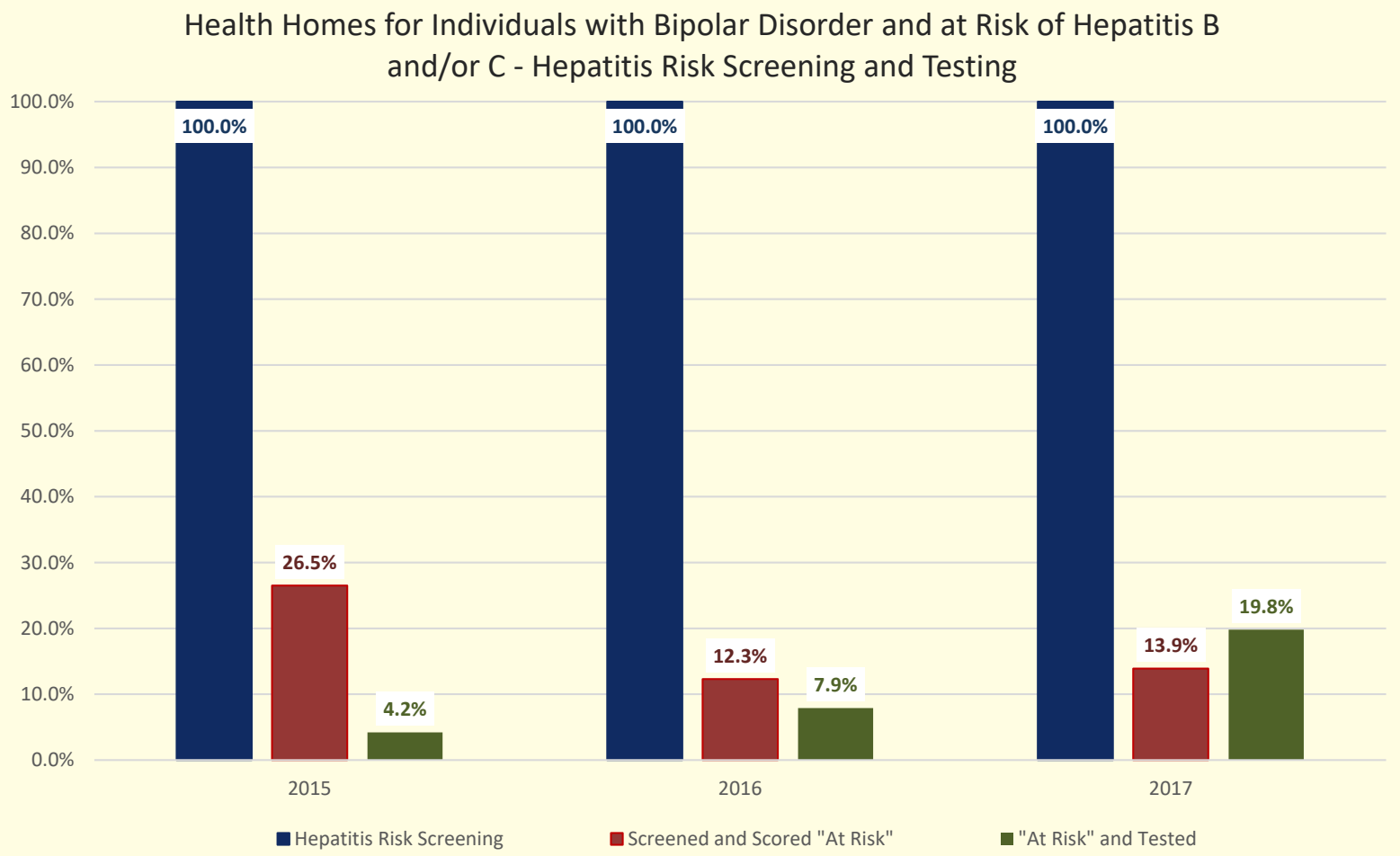
Count of Individuals Enrolled in the Bipolar Health Home (as of October 2019)



Health Homes for Individuals with Bipolar Disorder and at Risk of Hepatitis B and/or C - Hepatitis Risk Screening and Testing



*Please Note that Years 2015-2017 Represent New Enrollees Only, Year 2018 is Anyone Enrolled in the Program During the Year.


Health Homes for Individuals with Bipolar Disorder and at Risk of Hepatitis B and/or C - Hepatitis Risk Screening and Testing
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
100.0%
26.5%
4.2%
100.0%
12.3%
7.9%
100.0%
13.9%
19.8%
2015
2016
2017
Hepatitis Risk Screening
Screened and Scored "At Risk"
"At Risk" and Tested

For reference if needed:

Category	2015 New Enrollees Only	2016 New Enrollees Only	2017 New Enrollees Only	2018 All Enrollees
Percent screened, of those the percent scoring at risk, and of those at risk the percent that were tested.	2015	2016	2017	2018*
Hepatitis Risk Screening	100.0%	100.0%	100.0%	63.8%
Screened and Scored "At Risk"	26.5%	12.3%	13.9%	24.7%
"At Risk" and Tested	4.2%	7.9%	19.8%	12.5%

Category	2015 New Enrollees Only	2016 New Enrollees Only	2017 New Enrollees Only	2018 All Enrollees
Individuals screened, of those the count of individuals scoring at risk, and of those at risk the count of individuals that were tested.	2015	2016	2017	2018*
Hepatitis Risk Screening	993 of 993	618 of 618	655 of 898	550 of 862
Screened and Scored "At Risk"	263 of 993	76 of 618	91 of 655	136 of 550
"At Risk" and Tested	11 of 263	6 of 76	18 of 91	17 of 136

The methodology for 2018 changed from only looking at new enrollees to looking at all enrollees. Because of this, I included two graphs for risk screening/testing. One with and one without 2018.

Additional Information

- **Please refer to the BMS website for additional information about the Health Homes Program:**
  http://www.dhhr.wv.gov/bms/WV%20Health%20Homes/Pages/default.aspx

Questions