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

CHAPTER 535 HEALTH HOMES

TABLE OF CONTENTS

SECTION **PAGE NUMBER**

Background 2

Policy 2

535.1 Member Eligibility and Enrollment 2

535.2 Health Home Required Functions 3

535.3 Health Home Coordination Role 4

535.4 Health Home Service Requirements 5

535.5 Provider Infrastructure 7

535.5.1 Health Home Provider Team Structure 7

535.5.1.1 Required Team Structure 7

535.5.1.2 Optional Additional Team Members 7

535.5.2 Provider Agreements 8

535.6 Documentation 8

535.7 Data Collection, Sharing and Quality Measures 9

535.8 Provider Application 9

535.9 Provider Certification Reviews 10

535.10 Prior Authorization 10

535.11 Reimbursement 10

Glossary 10

Change Log 10

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

BACKGROUND

The Affordable Care Act of 2010, Section 2703 gave States the option to establish Health Homes. By design, the Health Home is a comprehensive system of care coordination for Medicaid members with chronic conditions. Health Home providers will coordinate all primary, acute, behavioral health and long-term services and supports to treat the "whole-person" across his/her lifespan. Since the focus is on the whole-person, all of the member's health care providers are part of his/her treatment team. The goal of the WV Health Homes Initiative is to improve the member's health while reducing medical costs. Patient-centered Health Homes are intended to create a patient-centered system of care that will achieve three main goals established by Centers for Medicare and Medicaid Services (CMS):

- Improve the experience of care,
- Improve the health of the target population, and
- Reduce per capita health care costs

The Health Home service delivery concept is a longitudinal "home" that provides members access to an actively coordinated interdisciplinary array of care: medical, behavioral health, community-based social services, and support for children and adults with chronic conditions. Service will be provided through a whole-person concept that integrates continuous quality improvement in a person-centered planning process. Through this care integration, the West Virginia Health Homes Initiative is designed to:

- Reduce unnecessary emergency department visits;
- Reduce unnecessary hospital admissions and re-admissions;
- Reduce overall health care costs;
- Reduce reliance on long-term care facilities; and
- Improve the health care experience, care quality, and outcomes for members receiving services.

Access additional information on the WV Bureau for Medical Services Health Home site at http://www.dhhr.wv.gov/bms/HH/Pages/default.aspx or the Centers for Medicare and Medicaid Services at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html

POLICY

535.1 MEMBER ELIGIBILITY AND ENROLLMENT

Under federal guidelines, in order to be eligible for Health Home services, a Medicaid member must have:

- two (2) or more chronic conditions; or
- one (1) chronic condition and be at risk for a second; or
- one (1) serious and persistent mental health condition.

Chronic conditions listed in the statute include mental health, substance abuse, asthma, diabetes, heart disease, and an overweight body mass index (BMI) over 25. Additional chronic conditions, such as HIV/AIDS, may be considered by CMS for approval. These complex chronic health and/or behavioral

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

health conditions require enhanced coordination of services in order for members to receive quality care. Chronic conditions covered by West Virginia Health Homes Initiative are outlined in subparts of Chapter 535.

Health Homes referrals may come from a number of sources:

- Member request;
- Hospital Emergency Departments (ED);
- Inpatient Care Facilities;
- Referral from Medical and Behavioral Health Providers;
- Social and Legal Support Systems; or
- Other sources.

Under the Health Homes Initiative, Section 1945(3)(d) of the Social Security Act requires all hospitals to have procedures in place for referring any eligible individual with chronic conditions who seek or need treatment in a hospital emergency department to a Health Home.

Initially, members eligible for a Health Home will be notified of their eligibility and enrolled status along with a program description and identification of the Health Home provider with which they are initially enrolled. Members will be advised in the notice that they may decline to participate or choose an alternate Health Home provider without penalty.

Forms related to this notification and member enrollment, as well as other materials related to Health Homes, can be found at the BMS's website: http://www.dhhr.wv.gov/bms/HH/Pages/default.aspx.

Members who meet the target population criteria may also be referred to a Health Home on an ongoing basis once the program is implemented. The Health Home in receipt of the member's referral must submit a service request to the state's utilization management contractor (UMC) for prior authorization. Agencies that have expressed an interest in becoming a Health Home provider have been encouraged to identify all the individuals in their current practice who match the target population so they may quickly become Health Home enrollees.

535.2 HEALTH HOME REQUIRED FUNCTIONS

The Health Home must:

- Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Home services.
- Coordinate and provide access to high-quality health care services based on evidence-based clinical practice guidelines.
- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
- Coordinate and provide access to mental health and substance abuse services.
- Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings.

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families.
- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services.
- Coordinate and provide access to long-term care supports and services.
- Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services.
- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate.
- Establish a continuous quality improvement program, and collect and report data at least every four months that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

The Health Home provider will be available 24 hours a day/7 days a week.

535.3 HEALTH HOME COORDINATION ROLE

The Health Home provider is the central point for coordinating patient-centered care for members. Health Homes will provide and/or coordinate medical, mental and required outreach services. The Health Home provider will be the lead coordinator for Medicaid members enrolled with a managed care organization. The Health Home provider and the member's managed care primary care provider must communicate and coordinate services. They must ensure these services are provided through the member's managed care network.

Health Homes will provide care coordination with projected improvement of patient outcomes by engaging the services of primary care medical and behavioral health providers, and other medical specialists through:

- Providers directly managed by the Health Home or
- Formal agreements with appropriate service providers.

Health Home providers are accountable for reducing health care costs by:

- Preventing unnecessary hospital admissions, and /or emergency room visits;
- Reducing unnecessary readmissions;
- Providing crisis intervention at appropriate times;
- Assuring timely medication reconciliation; and
- Obtaining and providing timely post discharge follow up.

Other Health Home responsibilities include:

- Agreeing to provide services for all potentially eligible Health Home members referred to them by BMS;
- Communicating medical status and treatment options to the member;

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

- Following all current and future State and Federally mandated privacy and confidentiality laws, This includes following guidelines including Health Insurance Portability and Accountability Act (HIPAA) and Affordable Care Act guidelines of 2010;
- Collecting, maintaining and providing data that will be used to improve quality of care and health outcomes;
- Ensuring that provided care is person-centered, i.e., culturally and linguistically appropriate;
- Initiating appropriate referrals for all services indicated for a member's comprehensive health care that are not provided within the Health Home, including long-term services and supports; and
- Appropriate use of Electronic Health Records (EHR).

535.4 HEALTH HOME SERVICE REQUIREMENTS

Health Home services require documentation of at least one of the following services per member per month. Health Home providers are to provide services at the intensity and duration needed to stabilize the member's condition.

- **Comprehensive Care Management** includes the development, implementation, and ongoing reassessment of a comprehensive individualized patient-centered care plan for each Health Home member. The care plan's development basis is the information obtained from a comprehensive risk assessment that identifies the member's needs in areas including: medical, mental health, substance abuse/misuse, and social services. The individualized care plan will include integrated services to meet the member's physical health, behavioral health, rehabilitative, long-term care, and social service needs, as indicated.

  The care plan will identify the required core Health Home team members as well as other health and health related providers and resources. These include but are not limited to: health, behavioral health, rehabilitation, long-term care and social services depending on an individual member's need. The care plan will also identify community networks and supports needed for comprehensive quality health care. Goals and timeframes for improving the member's health, overall health care status and identified interventions will be included in the care plan, as well as schedules for plan assessment and update.

  Comprehensive care management will assure that the member (or legal health representative) is an active team member in the care plan's development, implementation, and assessment, and is informed about and in agreement with plan components. Member's family and other recognized supports will be involved in the member's care as requested by the member. The member will receive a copy of the care plan initially and any time a change is made.

  See *Section 535.6, Documentation* for further detail on required assessments and the continuity of care document, which is also called an individualized care plan.

- **Care Coordination** is the delivery of comprehensive, multidisciplinary care to a member that links all involved resources by maintaining and disseminating current, relevant health and care plan data. Care coordination includes managing resource linkages, referrals, coordination, and follow-up to plan-identified resources. Activities include, but are not limited to, appointment scheduling, conducting referrals and follow-up monitoring, participating in facility discharge processes, and communicating with other providers and members/family members.

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

- **Health Promotion** includes the provision of health education specific to a member's health and behavioral health; development of self-management plans effectively emphasizing the importance of immunizations and preventive screenings; understanding and management of prescribed medications; supporting improvement of social networks; and providing healthy lifestyle interventions. Areas of focus include, but are not limited to, substance use and smoking prevention and cessation, nutritional counseling, weight management, and increasing physical activity.

  Health promotion services assist members to participate in the development and implementation of their care plan and emphasize person-centered empowerment to facilitate self-management of chronic health conditions through informed awareness.

- **Comprehensive Transitional Care and Follow-up** is care coordination - designed to prevent avoidable emergency department visits, admissions, and readmission after discharge from an inpatient facility. For each member transferred from one caregiver or site of care to another, the Health Home team ensures proper and timely follow-up care and safe, coordinated transitions, including reconciliation of medications. Through formal relationships and communication systems with health facilities including emergency departments, hospitals, long-term care facilities, residential/rehabilitation settings, as well as with other providers and community-based services, this coordination is accomplished.

- **Patient and Family Support Services** include service provision and resource identification that assist members to attain their highest level of health and functioning. Peer supports, support groups, and self-care programs can be utilized by providers to increase members' and caregivers' knowledge about the member's diseases, promote member engagement and self-management capabilities, while assisting the member to adhere to his/her care plan.

  The primary focus of individual and family supports will be strengthened through increased health literacy. This effort will include communicated information that is language, literacy, and culturally appropriate, and designed to improve the member's ability to self-manage their health and participate in the ongoing care planning.

- **Referral to Community and Social Support Services** includes the identification of available community resources, active management of referrals, access to care, engagement with other community and social supports, coordination of services and follow-up. The member's care plan will include community-based and other social support services that address and respond to the member's needs and preferences, and contribute to achieving the care plan goals. Areas of focus include, but are not limited to, substance use and smoking prevention and cessation, nutritional counseling, weight management, and increasing physical activity.

  When necessary, the Community and Social Support Services network includes development of policies, procedures and accountabilities (through contractual agreements, where applicable) which clearly define the roles and responsibilities of the participants in order to support effective collaboration between the Health Home, community-based resources, and the member.

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

535.5 PROVIDER INFRASTRUCTURE

Each Health Home will maintain its multi-disciplinary team in a manner that assures the capacity to arrange and provide for the defined Health Home services as identified in the required services section. The definition of designated Health Home providers is intentionally broad to allow diverse organizational models to serve as Health Homes.

535.5.1 Health Home Provider Team Structure

At a minimum, each team shall include a primary care provider (physician or advanced practice registered nurse), a licensed behavioral health specialist, a registered nurse, and a care manager [who could be the nurse or the behavioral health specialist for persons with serious mental illness (SMI)]. Each team shall include an individual who is designated as a care coordinator, but who may also fill other roles. The care manager coordinates the Health Home's team care and is accountable under the medical director for assuring the identification of members' needs and that an effective plan for intervention is developed and carried out.

535.5.1.1 Required Team Structure

Specific qualifications for the required team member roles are as follows:

- Team Leader - A primary care physician or Advanced Practice Registered Nurse licensed in the state of West Virginia
- Behavioral Health Specialist – Individual with a minimum of a Masters level degree, licensed in the state of WV in counseling, psychology or social work
- Nurse – Registered Nurse licensed in the State of WV
- Care Manager - Designated as either a Registered Nurse (RN) or Licensed Behavioral Health Specialist. Certification as a case manager is desirable and required within 18 months of provider designation as a Health Home. The care manager is accountable for assuring the identification of member's needs and that an effective plan for intervention is developed and implemented.
- Care Coordinator - An individual who has a Bachelor's Degree in Social Sciences with relevant service, care or counseling experience and works under the direct supervision of the care manager. The care coordinator may also be a licensed registered nurse. Completion of a care coordination training program is required within 12 months of provider designation as a Health Home.

All team leaders, behavioral health specialists, and care managers must have a current and valid West Virginia license in their qualifying specialty.

535.5.1.2 Optional Additional Team Members

Additional Team Members may include but are not limited to the following:

- Pharmacists, social workers, mental health workers, health educators, community health workers, lay educators, peer support, etc.
- Specialists, which may include medical sub-specialists such as gastroenterologists, hepatologist, infectious disease team(s), and others depending upon the member's needs.

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

535.5.2 Provider Agreements

To assure access to appropriate medical and behavioral health services not available directly within the Health Home organization, Health Homes will augment their teams by having Memorandums of Understanding (MOUs) as necessary with providers such as, but not limited to:

- Comprehensive mental health facilities;
- Behavioral health facilities;
- Medical or behavioral health specialists as necessary;
- Hospitals;
- Emergency departments;
- Long-term care facilities; and
- Other providers that are part of the respective managed care network in which the Health Home participates.

These relationships, as defined in the MOU, will assure that information across settings is sharable in order to achieve coordinated care for all managed care Health Home members. Outside the managed care environment, Health Homes will be expected to define a medical community in which relationships are developed to assure appropriate information sharing and coordination across care settings. In addition to the relationships in the above list, the Health Home MOU should include any National Accreditation achieved by the Health Home. While accreditation is not required at this time, please identify accreditation entities by name in MOUs. Where a Health Home is not a single business entity, it is required that formal agreements (MOUs) will exist between team members and the Health Home entity that remains responsible for all services performed by the care team.

535.6 DOCUMENTATION

Each of the Health Home Services must be documented within the member's Health Home record. Each service provided must have a service note, which includes:

- Member/Member's name;
- Name of Health Home Service Provided;
- Summary of Service Provision;
- Team Member's Signature (legible);
- Team Member's Credentials (legible);
- Date of Service; and
- Start Time and Duration or Start and End Time of Service Delivery.

A continuity of care document, which is also called an individualized care plan, is required and includes:

- Integrated services that meet the member's behavioral and medical health, as well as rehabilitative, long-term care, and social service needs, as indicated
- Goals and timeframes for improving the member's overall health status with identified interventions and responsible parties
- Schedule of planned assessments and updates

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

- The continuity of care document will identify:
  - Primary care physician(s), other health and behavioral health care providers, care manager, and other health team providers involved in the member's health care
  - Community networks and other social supports needed for comprehensive quality health care

Assessment data for each member will be collected periodically by the Utilization Management Contractor. The data set requirement will be found in the subpart related to each specific type of Health Home.

Health Homes must provide documentation of carrying out at least one of the six core Health Home services (See Section *535.4 Health Home Service Requirements*) per service month to meet minimum billing requirements. The mode of contact may include, but is not limited to: face-to-face meeting(s) (no minimum requirement), telephone calls, or case conferences. Functions and services can be provided in a single location, multiple locations, in person, via telephone, or virtually. Use of electronic means of supporting all communications is encouraged.

Active, ongoing, and progressive engagement with the client must be documented in the care management record to demonstrate active progress toward outreach and engagement, care planning and/or the client achieving their personal goals. The State retains the right to review Health Home care records as required to assure that active services were being provided in each month for which a Medicaid payment was made for Health Home services.

535.7 DATA COLLECTION, SHARING AND QUALITY MEASURES

West Virginia is implementing a statewide health information exchange (HIE) that will facilitate the sharing of information across various care delivery settings. All Health Home providers are expected to participate in the HIE as it is implemented across the state.

Successful care coordination relies on interaction and communication among providers. Until the HIE is fully in place in the state each Health Home provider will also be expected to use its EHR to generate a continuity of care document. This document can be shared with other providers in order to facilitate transition in care and care coordination across care settings, with managed care organizations regarding common members.

The state will monitor the target population's outcome measures using claims and assessment data periodically and report to CMS. Data that is collected related to Health Homes will be generated from many systems including the Bureau for Medical Services, the utilization management contractor, Health Homes, pharmacy claims, and provider claims. When developed, the HIE will be used to capture meaningful use measures. Several of these will be incorporated into the information that will be used to monitor and evaluate Health Home services.

535.8 PROVIDER APPLICATION

Health Homes providers must be enrolled as WV Medicaid Providers. A provider or group may apply to the Bureau for Medical Services for certification as a WV Health Home by submitting a completed Health Home application available at http://www.dhhr.wv.gov/bms/Pages/default.aspx and the

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

required narrative. The narrative should address practice relationships, member information and service coordination as well as the ability to report on required quality measures.

535.9 PROVIDER CERTIFICATION REVIEWS

The Bureau for Medical Services or their representative will conduct annual recertification reviews to ensure compliance to State and Federal Regulations. These certification reviews include, but are not limited to:

a. Verification of the credentials of required team members
b. Patient chart review:
    - Review of care plans
    - Review of rendered Health Home service documentation
c. Specific requirements for each type of Health Home as described in the applicable subchapter

In the event that the provider does not pass the certification review, BMS will make a determination about continued participation in the Health Homes program.

535.10 PRIOR AUTHORIZATION

Prior authorization is required for all covered Health Home services. At the time of each Medicaid member's initial enrollment in the WV Health Home Program, the assigned, servicing Health Home Provider must obtain prior authorization for Health Home Service. Assessment data must be submitted via a web application.

535.11 REIMBURSEMENT

Reimbursement will be regularly reviewed. Providers cannot bill for both targeted case management and Health Home services for the same member at the same time.

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter.

REFERENCES

State Medicaid Director Letter (SMDL), #10-024, Health Homes for Members with Chronic Conditions, providing preliminary guidance to States on the implementation of Section 2703 of the Affordable Care Act, entitled "State Option to Provide Health Homes for Members with Chronic Conditions." found at: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf

CHANGE LOG

REPLACE	TITLE	CHANGE DATE	EFFECTIVE DATE
New Chapter	Health Homes		April 1, 2015

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.