



Health Home for Chronic Needs State Plan Amendment

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What is a Health Home?

- Under ACA 2703 a State Medicaid program may create a plan to provide care coordination to those with chronic health conditions.
- A “Health Home” is a place where individuals can come throughout their lifetimes to have their health care needs identified and to receive the medical, behavioral and related social services and supports they need, coordinated in a way that recognizes all of their needs as individuals – not just patients.

Health Homes SPA

- The first Health Home State Plan Amendment (SPA) in WV will focus on individuals with bipolar disorder and risk of/infected with, hepatitis B or C. This program will roll out in 6 counties.
 - Kanawha
 - Putnam
 - Cabell
 - Mercer
 - Raleigh
 - Wayne
- Health Homes will begin to see Medicaid members in July 2014.

Health Home Expectations

- Providing quality-driven, cost-effective, culturally appropriate, and person-and family-centered health home services;
- Coordinating and providing access to high-quality health care services informed by evidence-based guidelines;
- Coordinating and providing access to mental health and substance abuse services;
- Coordinating and providing access to long-term care supports and services.

Health home *services* include:

- Comprehensive Care Management;
- Care Coordination;
- Health promotion;
- Comprehensive transitional care from inpatient to other setting;
- Individual and family support;
- Referral to community and social support services;
- Use of health information technology, as feasible and appropriate.

Provider qualifications

- Minimum team of primary care provider (physician or nurse practitioner), licensed behavioral health specialist, registered nurse, care manager, care coordinator. Additional members encouraged (e.g. pharmacists, peer support, community health workers, other physicians, nurses, physician assistants, nurse practitioner, social workers, etc.)
- Care manager will be a registered nurse or a social worker, LSCW will be responsible for overall care coordination plan development. Case manager certification desired.
- Care coordinator will require BA or BS degree. Exploring possible training options for care coordination certification.

Member Enrollment

- Identification of eligible members through claims review and county of residence
 - Auto-enrollment to the Health Home covering member's county or other Health Home if there is a history.
 - Member can opt out at any time
 - Member can change Health Homes
 - Health Home is required to outreach and make connection with the member
- Ongoing enrollments initialized by Health Homes or members; validation process through BMS contractor

Health Home Measures

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Ambulatory Care-Sensitive Condition Admissions
- Medication Adherence to Antipsychotics, Antidepressants and Mood Stabilizers
- Follow-up after Hospitalization for Mental Illness
- Percent of HH enrollees completing a risk assessment for Hepatitis
- Percent of HH enrollees identified as high risk who are tested to confirm/ rule out diagnosis of Hepatitis
- Screening for Clinical Depression and Follow-up Plan

- Medical Assistance with Smoking and Tobacco Use Cessation
- Adult Body Mass Index (BMI) Assessment
- Plan- All cause Hospital Readmission
- Care Transition – Transmission Record Transmitted to Health Care Professional
- Percent of care transitions and referrals for which the health home provides a summary of care record or CCD
- All cause hospital readmission rates

Enhanced Federal Match

- A State could receive 8 quarters of 90% FMAP for health home services provided to individuals with chronic conditions, and a separate 8 quarters of enhanced FMAP for health home services provided to another population implemented at a later date.
- Additional periods of enhanced FMAP would be for new individuals served through either a geographic expansion of an existing health home program, or implementation of a completely separate health home program designed for individuals with difference chronic conditions.

Health Homes for individuals with a diagnosis of Bipolar Disorder and a risk/diagnosis of Hepatitis B and/or C

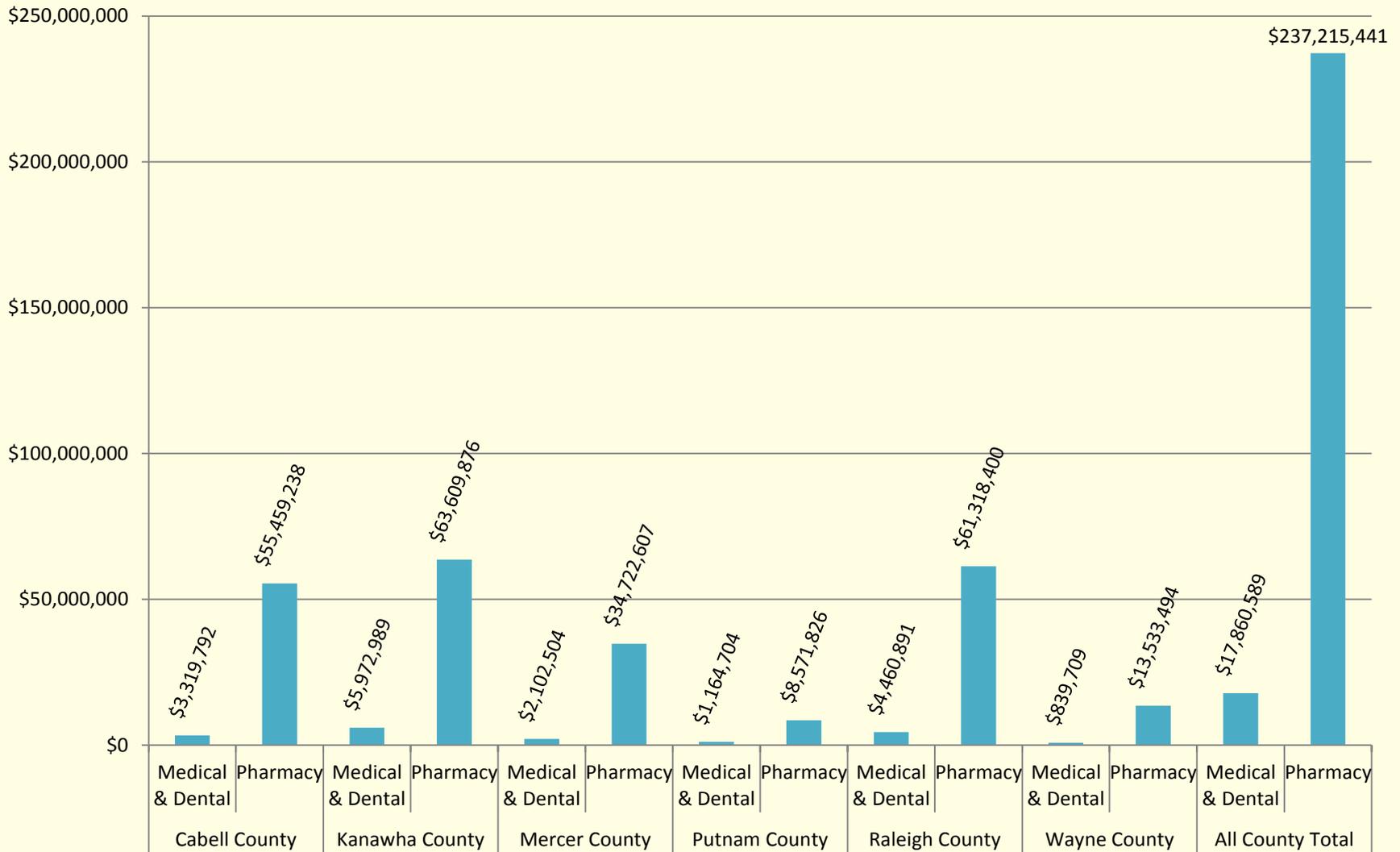
The numbers contained in the following slides are based only on fee for service claims.

Many of the individuals receiving WV Medicaid who are over 65, are also receiving Medicare which covers the majority of medical, dental, and pharmaceutical expenses.

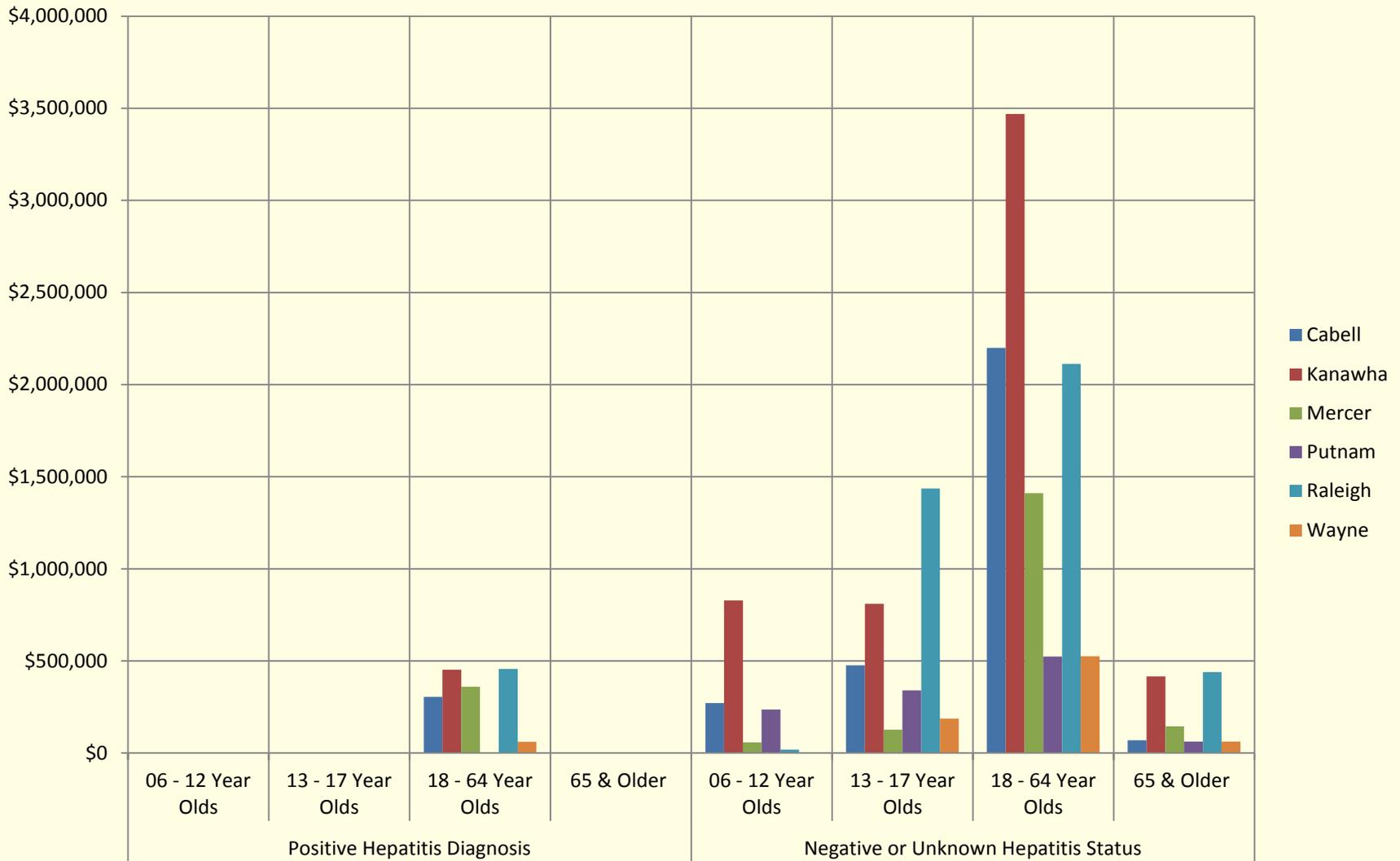
There are several individuals with expenses over \$1,000,000. These individuals experienced greatly extended hospital stays or required intensive treatment for other conditions, like hemophilia.

Potential Health Home Members Cost of Care- 2012 Baseline Data

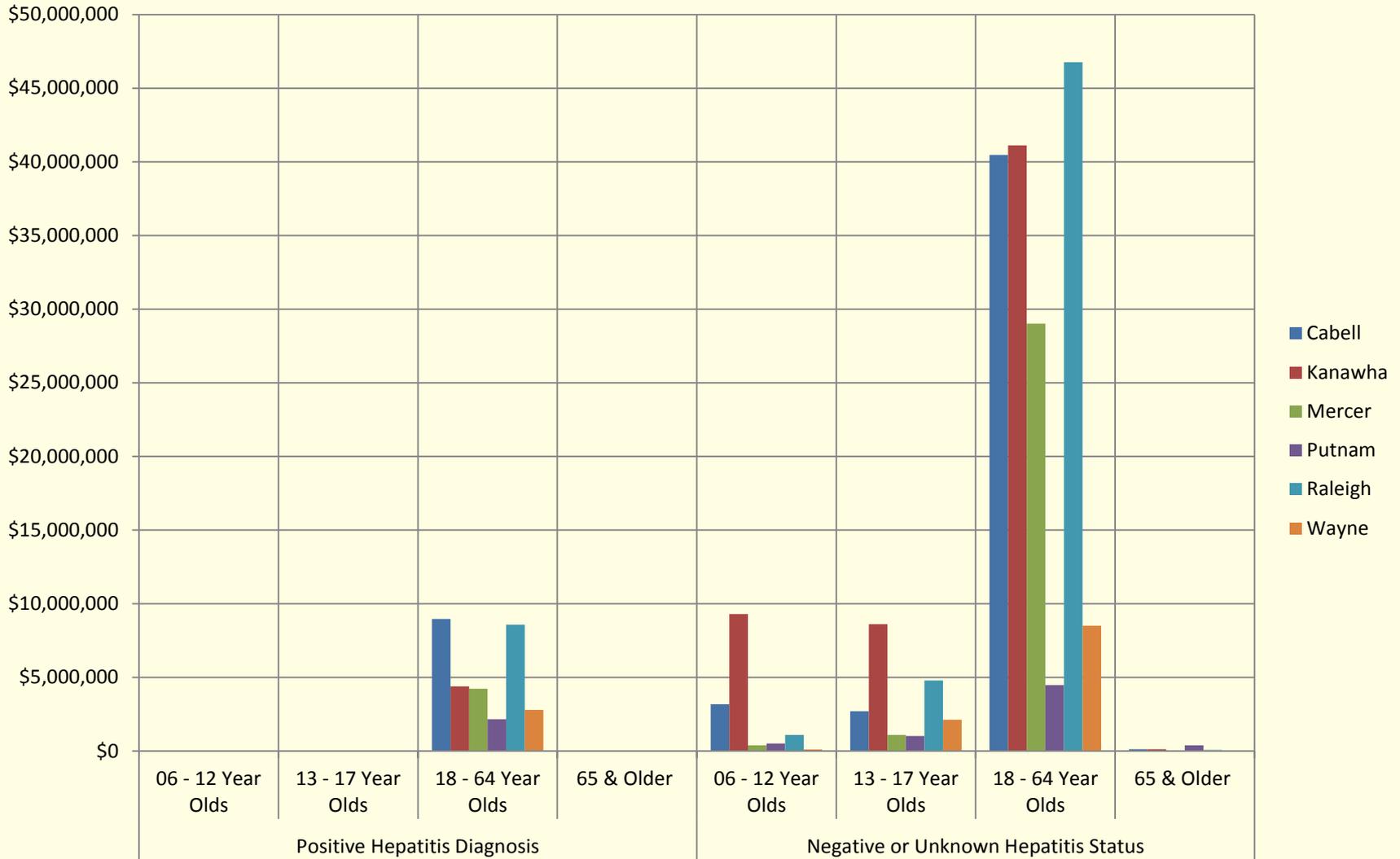
Total Cost for All Age Groups per County for Medical/Dental and Pharmacy Claims



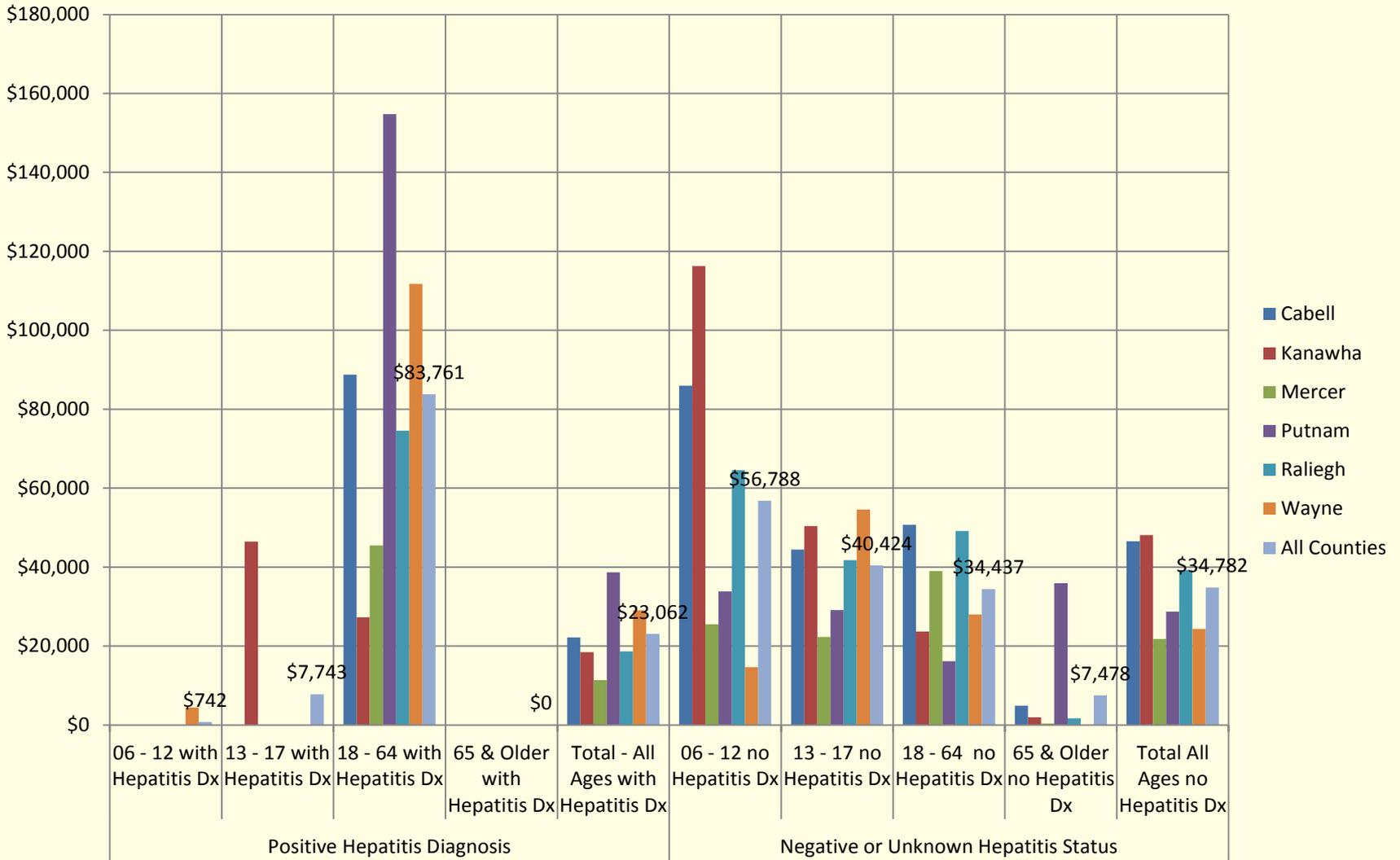
Medical & Dental Expenses for Positive vs. Negative/ Unknown Hepatitis Status



Pharmacy Expenses for Positive vs. Negative/ Unknown Hepatitis Status



Average Annual Cost per Potential Member- Pharmacy (2012)

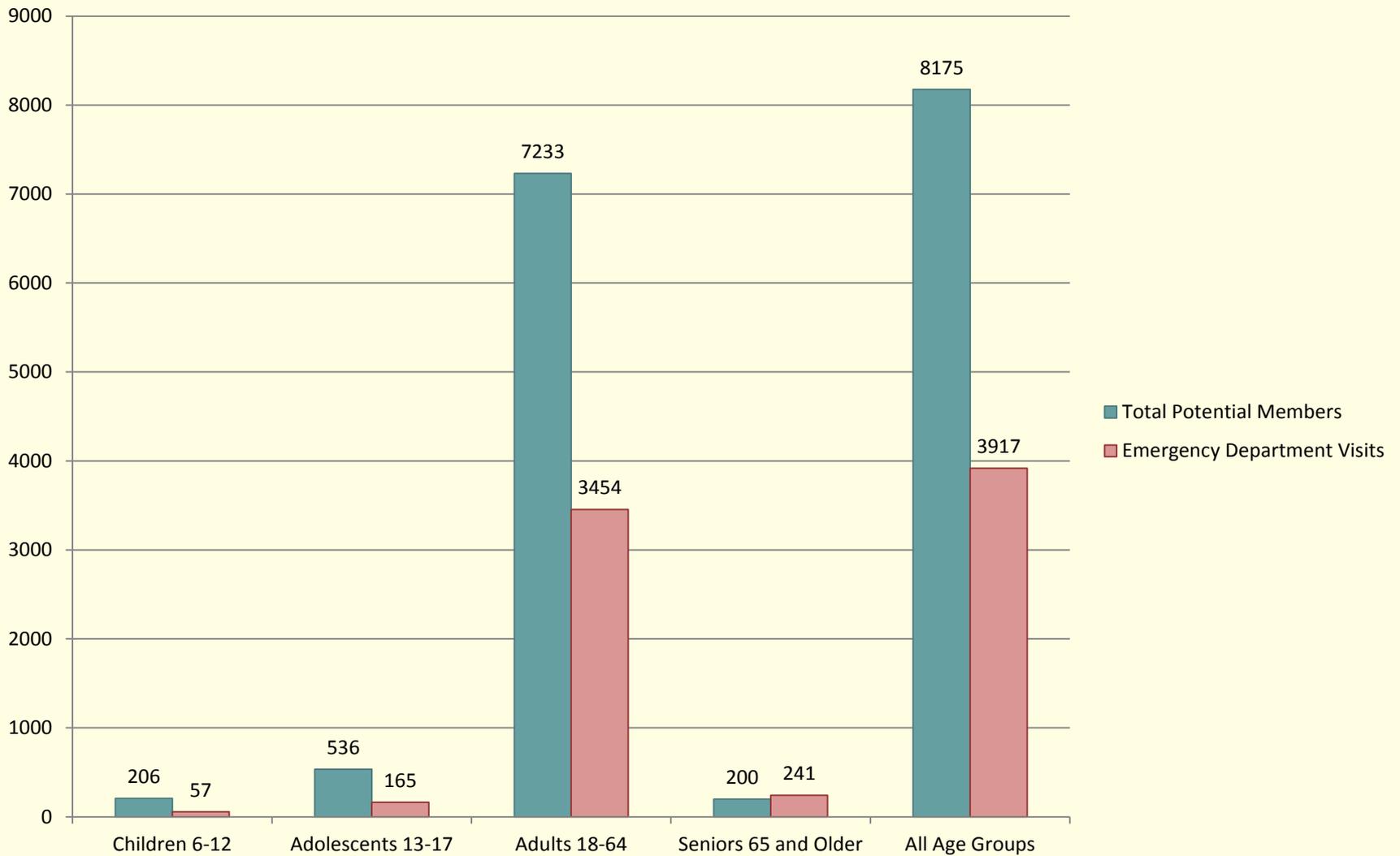


2012 Baseline Data for WV Health Homes SPA 1

Reporting Measure: Emergency Department Visit Rate

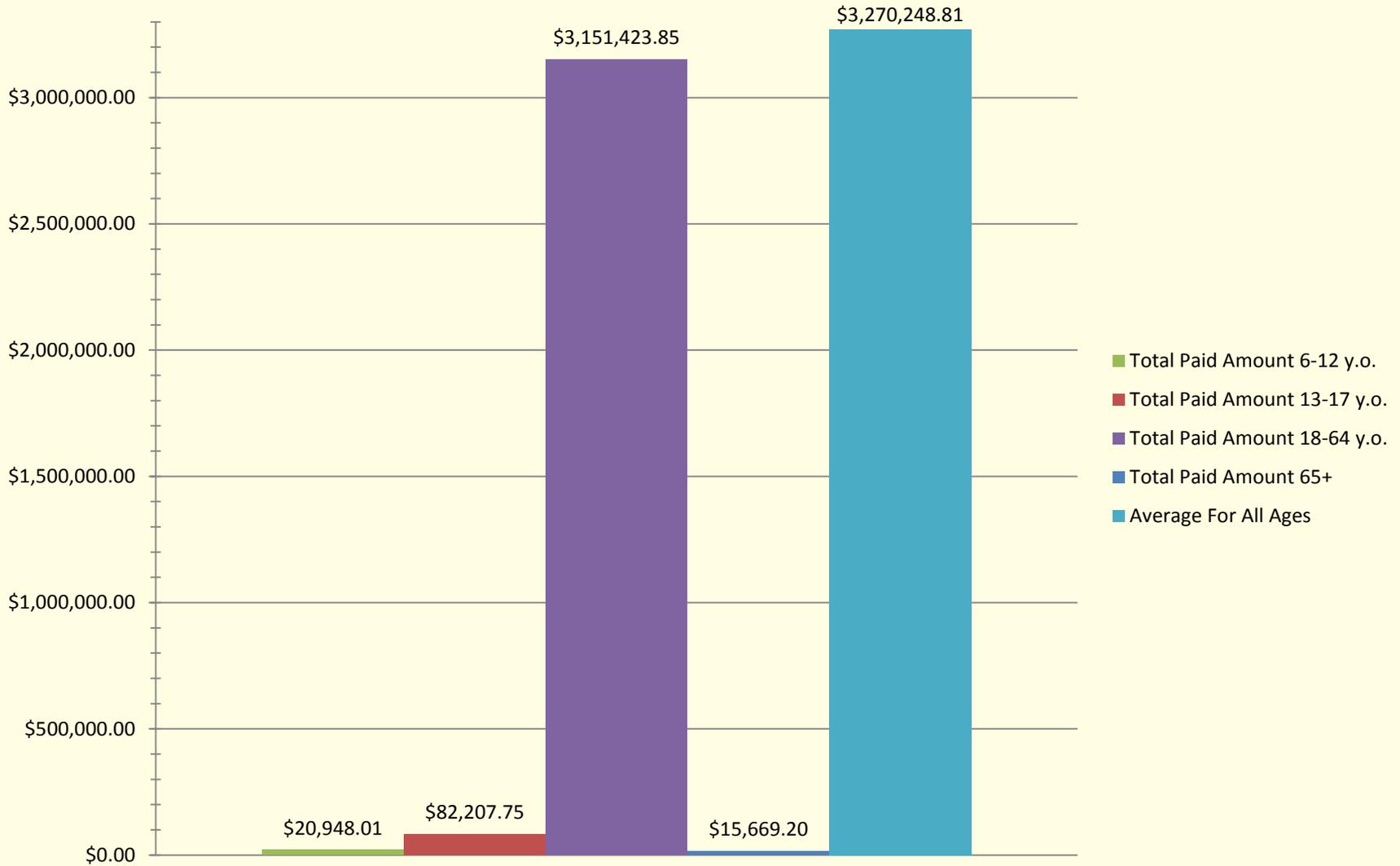
All data included is for potential Health Home Members based on 2012 treatment Data: Individuals with a Bipolar Diagnosis in Wayne, Cabell, Putnam, Kanawha, Raleigh, and Mercer Counties. This information does not include ED visits where the Medicaid Member was admitted as an inpatient to the Treatment Facility.

ED Visit Total Potential Members & ED Department Visits 2012 Baseline Data Health Homes SPA 1



Total Paid for 2012 for Emergency Department Visits Per Age Group

Health Homes SPA 1-2012 Base Data



Outcomes

- If we are successful in this effort, we believe that individuals with bipolar disorder will:
- Experience longer periods of stability of their condition;
 - Use fewer medications and will be more compliant;
 - Know their hepatitis risk and status;
 - Be educated about the spread of hepatitis;
- Be identified earlier and treated more effectively for substance abuse; and
 - Require fewer ER visits and hospitalizations